The profile of psychologists in Belgium

Research report

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Preface

In 2017, the Belgian Commission of Psychologists[1] launched a call for a study documenting mental healthcare provision by (clinical) psychologists in Belgium. One of the main reasons for this research call was the new law on mental health provision that was passed in 2015. The Law on the Practice of Healthcare Professions (LHCP, 2015)[2] regulates the practice of clinical psychology (article 68/1), clinical orthopedagogy (article 68/2), and psychotherapeutic care (article 68/2/1).

In the same period, an Interuniversity Consortium was formed in response to the new law on mental health professions. This consortium consists of representatives of Belgian universities that offer MSc programmes in Clinical Psychology, Educational Sciences, and School and Educational Psychology[3]. The consortium is centrally concerned with the implications of the new law in terms of policy as well as the education and training of future clinical psychologists, clinical educationalists (orthopedagogues), school and educational psychologists, and those entitled to practise psychotherapy in Belgium. The consortium aims to bring MSc programmes in clinical psychology, school and educational psychology, and educational sciences (orthopedagogy) into line with the new law, and has also developed policy papers concerning the implications of the new law on postgraduate training and continuing professional development (CPD). Prompted by these developments in legislation and in response to the research call of the Commission of Psychologists, the Interuniversity Consortium has joined forces with the Commission of Psychologists to carry out a national survey study among psychologists and educationalists in Belgium (http://ppatworkinbelgium.be).

The research call of the Commission of Psychologists covered two themes. The **first theme**, "Availability and mental healthcare use in clinical psychology", concerned both the need and provision of psychological healthcare in Belgium in different regions. The **second theme**, "Field of work of school and educational psychology", concerned the characteristics of the workforce of psychologists in the educational domain, and is the focus of a separate research report (see Spilt, Wouters, Frenay, & Colpin, 2021).

In **this report**, we focus on the availability of mental healthcare offered by (clinical) psychologists in Belgium, including the settings in which (clinical) psychologists are active, their tasks, expertise, continuing professional development, and perceived challenges. A future report will address the psychological healthcare needs in Belgium based on a population-representative study of the prevalence of mental health disorders in Belgium, and the relationship between the availability of mental healthcare, mental healthcare use, and unmet needs.

[1] Psychologencommissie/Commission des Psychologues; The Commission of Psychologists is an independent federal government body with responsibility for all psychologists in Belgium. See www.compsy.be.
[2] De Wet op de Uitoefening van de Geestelijke Gezondheidszorgberoepen/La Loi sur l'Exercice des Professions de Soins de Santé; see https://www.health.belgium.be/en/health/mental-health-professions.
[3] Universiteit Gent, Vrije Universiteit Brussel, Université Libre de Bruxelles, KU Leuven, Université catholique de Louvain, Université de Mons, and Université de Liège.

Research questions concerning the field of work of **orthopedagogues** will be addressed in a separate report, carried out by researchers from the “Parenting and Special Education” research unit at KU Leuven (Noens et al., in prep.).

Chapter 1: Overview and aims

1.1. Introduction

Mental health problems constitute an important problem from a socioeconomic, societal, and personal perspective. Population-representative studies have shown that mental health problems are the leading cause of **disability** worldwide, accounting for almost 40% of healthy life-years lost through disease (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006; Murray & Lopez, 1996). Epidemiological studies further suggest a high **prevalence** of mental health disorders in combination with considerable **unmet needs** and **delays** in seeking treatment, even in well-developed industrialized countries, including Belgium (Alonso et al., 2004; Thornicroft et al., 2017; Wang et al., 2007). In Belgium, the most recent General Mental Health Survey found that 33% of the general population older than 15 years reported mental health problems, of which 17.7% were likely to have a diagnosable mental health disorder (Gisle, Drieskens, Demarest, & Van der Heyden, 2020,). This latter finding is particularly surprising given the high level of availability and ease of access to mental health services in highly developed countries, and the well-demonstrated effectiveness of both pharmacotherapy and psychotherapy for most mental health problems (Andrade et al., 2014). Attitudes in relation to mental health problems, and particularly the conviction that one has to be able to deal with one's own psychological problems, seem to be the most important barrier to healthcare seeking in relation to mental health issues worldwide (Andrade et al., 2014).

Differences between countries in access to and use of mental health services also seem to be determined to a considerable extent by **differences between national mental healthcare systems** (Dezetter et al., 2013; Wang et al., 2007). Such differences have been extensively reviewed (IAPT, 2012; Wang et al., 2007), and their advantages and disadvantages in relation to the current Belgian mental healthcare system have recently been comprehensively documented (Kohn et al., 2016). Belgium has a very specific mental health service system in this regard (Kohn et al., 2016). As in many other Western countries, as well as good access to primary medical care (i.e., General Practitioners (GP), psychiatrists), there is a high density of specialized mental health services across the different tiers of care (ranging from psychologists and psychotherapists working in private practice to community mental health centres and specialized outpatient and inpatient services, and psychologists working in medical contexts such as cardiology, internal medicine, and neonatology). In fact, Belgium is among the countries with the highest number of specialized inpatient and outpatient clinics in the world (Kohn et al., 2016). Yet, unlike in many other Western countries, a universal state health insurance system is in place, with no or very few limits or constraints on consultations with primary care physicians, use of mental health services more generally, and the prescription of pharmacotherapy. Out-of-pocket expenditure for medical care and consultations with doctors is very limited, as it is largely covered by this insurance. However, there is almost no reimbursement of mental health services provided by non-medical professionals (i.e., psychologists, psychologist-psychotherapists) (Vanclooster, Vanderhaegen, Bruffaerts, Hermans, & Van Audenhove,

2013; Vrijens et al., 2015). This might change as a result of the inclusion of clinical psychologists in the **Law on the practice of Healthcare Professions** (LHCP)[4].

The specific mental healthcare system is likely to have a major **impact on healthcare seeking and use**. Although population-representative studies show that the majority of patients in well-developed countries first consult a healthcare professional in the general health sector for mental health problems (Wang et al., 2007), this seems to be particularly the case in Belgium. In fact, the most recent population-based study conducted found that up to 75% of patients seeking help in Belgium for mental health problems do so first in the medical care sector, mostly consulting their GP (Dezetter et al., 2013; Wang et al., 2007). This suggests that GPs are the gatekeepers to mental healthcare, which may be quite appropriate given their role in the healthcare system more generally (Dezetter et al., 2013). However, as in other countries, this study also showed that there were **high levels of unmet needs** for mental health problems in Belgium. In addition, there were clear problems with the **prioritization** of care (e.g., overuse of medication and psychotherapy by individuals who do not meet criteria for mental health problems, but under-treatment of individuals with diagnosable mental health problems). Finally, and perhaps most disconcertingly, there was only a very weak relationship between the severity of mental health problems and follow-up, and very few patients who sought treatment actually received **minimally adequate treatment** (e.g., a minimum dose of pharmacotherapy or psychotherapy); this finding has been well replicated in population-representative studies (Bruffaerts, Bonnewyn, & Demyttenaere, 2007; Demyttenaere et al., 2004; Ten Have, Nuyen, Beekman, & de Graaf, 2013; Wang et al., 2007). For major depression in the past 12 months, for instance, only 1 in 3 patients receive minimally adequate treatment (Thornicroft et al., 2017).

At the same time, it is important to note that the most recent population-based study on mental health service use in Belgium was conducted in 2001–2003 (Alonso et al., 2004), and thus the situation is very likely to have changed in the meantime. For instance, several population-based studies have found evidence for **cohort effects** in mental health service use, with recent cohorts seeking more help for mental health problems (Wang et al., 2007). In fact, the 2010 Eurobarometer study found that the prevalence of Belgian people seeking help for mental health problems has increased by 50% between 2006 and 2010 (European Commission, 2010). Furthermore, in a recent report on the organization of mental healthcare for adults in Belgium, the Belgian Healthcare Knowledge centre (KCE)[5] concluded that recent **data on mental health care needs** in the Belgian population are largely **lacking** and thus that it is currently difficult to determine whether the availability of mental health care is well **aligned** with mental health care needs in the population (Mistiaen, et al., 2019).

There is therefore an urgent **need for a comprehensive study** documenting (a) available mental health **services** and (b) mental health service **use** in Belgium. Such a study will provide detailed and up-to-date information that can be used to design and allocate mental health services on a rational, transparent, and ethical basis (Wang et al., 2007). A similar initiative in the United Kingdom, for instance, has led to the Improving Access to Psychological Therapies (IAPT) programme, which is aimed at addressing unmet

[4] De Wet op de Uitoefening van de Geestelijke Gezondheidszorgberoepen/La Loi sur l'Exercice des Professions de Soins de Santé; see https://www.health.belgium.be/en/health/mental-health-professions.
[5] https://kce.fgov.be/en

needs, overuse of pharmacotherapy, and problems with access to evidence-based psychological therapies in the United Kingdom, and has had considerable success (IAPT, 2012).

Regarding the availability of mental healthcare, this study focuses on mental healthcare as offered by (clinical) psychologists. In a ground-breaking study in 2003, Lietaer, Van Broeck and Igodt were the first to systematically document the sociodemographic and work profile of psychotherapists in Belgium. In their study they focused on psychotherapy as offered by psychotherapists with an MSc in psychology (57%), and all those with another educational background who provided psychotherapeutic care in Belgium at the time. The **current report** provides an update of their pioneering study and focused more broadly on the **provision of mental healthcare by all those with an MSc in Psychology**.

1.2. Overall aims

The overall research aims of this project were therefore two-fold. We investigated:

- The **availability of mental healthcare** offered by those working in the domain of clinical psychology and
- The **use of mental healthcare** in Belgium, including barriers to healthcare seeking, unmet needs, and factors associated with mental healthcare use.

This report focuses on the first aim regarding the **availability of mental healthcare** in Belgium as offered by (clinical) psychologists. To address this aim, we conducted a web-based survey in psychologists, who were (a) working in Belgium as a psychologist at the time of the survey or (b) obtained their master's degree (MSc) in Psychology in Belgium. This sample was part of a larger study in Belgian professionals with an academic master's degree or a professional bachelor's degree in Psychology or Educational Sciences (obtained either in Belgium or abroad), but this report only includes participants with an MSc in psychology. Participants with an MSc in psychology were included whether or not they were currently employed, and whether or not their current employment focused on improving (mental) health or wellbeing. We also conducted a series of focus groups to contextualize the quantitative results from the survey.

Chapter 2 describes the design and **methodology** of the web-based survey, and **Chapter 3** presents the **results** focusing on 8 overarching topics:

1) The *sociodemographic profile of psychologists*: demographic features of (clinical) psychologists in Belgium as compared to population-based data.
2) *Domains of specialization* of those with an MSc in psychology
3) *Professional situation*: the types of employment of (clinical) psychologists, their registration with the Commission of Psychologists, and their membership of professional organizations
4) *Further education of psychologists in Belgium*, with a focus on further education of at least 1 year, including training related to the LHCP
5) *Availability of mental healthcare offered by those with an MSc in psychology*: aspects of mental healthcare such as the provision of client[6] care, target groups (e.g, young people versus adults), and presenting psychological problems of patients
6) *Types of professional activities*, including the professional activities of (clinical) psychologists in relation to the different domains outlined in the LHCP (prevention, assessment, and counselling and treatment), the provision of psychotherapeutic care, and personal and professional development (e.g., short training, supervision).
7) *Career development of (clinical) psychologists*, including the transition from the university to the field of work, sectors in which (clinical) psychologists are employed.

[6] We use the terms 'client' and 'patient' interchangeably in this report; the term 'patient' is not used in every field of psychology.

8) *Challenges that (clinical) psychologists face*: information work pressure, work-life balance and coping strategies when experiencing work pressure or problems with work–life balance; information on the concerns of psychologists regarding societal changes, new laws and decrees, and key themes in their field of work, and ways (clinical) psychologist deal with these challenges.

Finally, **Chapter 4** provides a summary and discussion of the **main conclusions**.

Chapter 2: Methods

2.1. Introduction

This chapter describes the methodology of the **web-based survey** we conducted. We first provide information on the **participants and procedures**, followed by an overview of the specific **questions** contained in the online survey. Finally, we also briefly describe the participants and procedure of the **focus groups** that were held to contextualize the main findings of the study.

2.2. Survey participants and procedures

The study was presented as a large-scale national study about the professional profile of psychologists and educationalists (pedagogues) in Belgium (see www.ppatworkinbelgium.be). The study focuses on **professionals with an academic master's degree** in psychology or educational sciences. All those with an academic master's degree (MSc) in Psychology or Educational Sciences (obtained either in Belgium or abroad) were invited to participate, whether or not they were currently employed, and whether or not their current employment focused on improving (mental) health or wellbeing. Although a 5-year university training is required to be recognized as a psychologist by the Commission of Psychologists, the survey was constructed in such a way that it could also be completed by professionals with a bachelor degree[7] (e.g., a bachelor in applied psychology). For example, in the pupil guidance centres (CLB/CPMS/Kaleido[8]), it is not required to have an academic MSc to be employed as a psychoeducational consultant[9]: bachelors and masters perform similar professional tasks. This was of interest to the second theme concerning the characteristics of the workforce of psychologists and pedagogues in the educational domain, which is described in a separate report (see Spilt et al., 2021). Thus, although the recruitment procedure was primarily directed at academic masters, professional bachelors were not excluded beforehand. However, they are not part of this report.

Potential participants were **contacted via several sources**, including the Commission of Psychologists, the alumni databases of all Belgian universities with a Faculty of Psychology and Educational Sciences (all alumni of the faculty of Psychology and Educational sciences subscribed on the alumni mailing list received an invitation irrespective of academic discipline), professional associations (e.g. associations under the

[7] In Belgium, there is distinction between a professional bachelor programme and an academic bachelor programme in the psychology and educational sciences training programme. Whereas an academic bachelor programme is offered at a university and prepares the student for a master's programme, someone who obtained a professional bachelor degree can already start working in the field of psychology and educational sciences (with more limited responsibilities than those who obtained an MSc in psychology). Professional bachelor programmes are offered at a university college, and usually take place in smaller groups of students compared with university programmes.

[8] „Centrum voor Leerlingenbegeleiding" in the Flemish community, „centre Psycho-Médico-Social" in the French community, „Kaleido Zentrum für die gesunde Entwicklung von Kindern und Jugendlichen in der Deutschsprachigen Gemeinschaft" in the German community.

[9] « Psycho-pedagogisch consulent »/ « conseillers psycho-pédagogiques/ ».

umbrella of the Belgian Federation of Psychologists (BFP-FBP)), and network organizations (e.g., networks of mental healthcare organizations, networks of schools and pupil guidance centres). Participants were also recruited via mailing lists, websites, magazines, and personal networks, as we also wanted to reach psychologists in independent practice.

Potential participants were invited to complete an **online survey** (see below) accessed via a website that was specifically designed for and designated for this study (www.ppatworkinbelgium.be). After providing **informed consent**, participants were offered the choice to fill in the online survey in one of **four languages**: Dutch (Flemish)[10], French, German, or English. The online survey was launched on December 10, 2018 and participants were able to complete the survey until February 17, 2019. Reminders were sent by e-mail after about a month (mid-January). In addition, updates concerning the number of participants were regularly posted on the project's website.

In total, 5,829 individuals provided informed consent and partially or fully completed the survey (see Appendix A). Of these, 4,271 participants indicated they had obtained an MSc in psychology and 33 had a joint degree in psychology and educational sciences. This **subsample of 4,304 participants** (73.8% of the total sample) is the focus of this report (see Figure 1). Most of these participants fully completed[11] the survey (*n* = 3,642; 84.6%). Less than 1% completed the questionnaire in German or English, 33.0% completed the French version, and 66.1% completed the Flemish version. The majority of respondents were female (82.2%) and their average age was 38 years (range 22–86 years).

Of the 1,525 participants without an MSc in psychology, 1,229 (21.1%) indicated they had an MSc in educational sciences, 37 (0.6%) had an MSc in a related domain (e.g. sexology, cultural anthropology, speech sciences, social work), 27 (0.5%) had an MSc in a different domain (e.g. language, law and criminology, philosophy), and 232 (4.0 %) had an MSc in a different field (outside the broad domain of psychology, educational sciences, or related domains), but did not report which degree they had obtained.

[10] In Belgium, there are three language communities: the Flemish Community, the French Community and the German Community. As participant language will be an indicator of language community throughout this report, we further use the term "Flemish" instead of "Dutch".

[11] Full completion means they reached the end of the questionnaire and they answered every question that was assigned to them by the built-in logic of the web survey. Full completers differed from partial completers in participants' language (Flemish participants more often fully completed the questionnaire), work status (participants who were not working more often fully completed the questionnaire) and type of (self-)employment (participants who were self-employed as a primary occupation less often fully completed the questionnaire compared with psychologists in salaried employment) (see Appendix B). However, these differences did not reach the threshold for a small effect size. Full completers and partial completers did not differ in age, gender, and type of MSc in psychology (clinical psychology versus other domain of psychology).

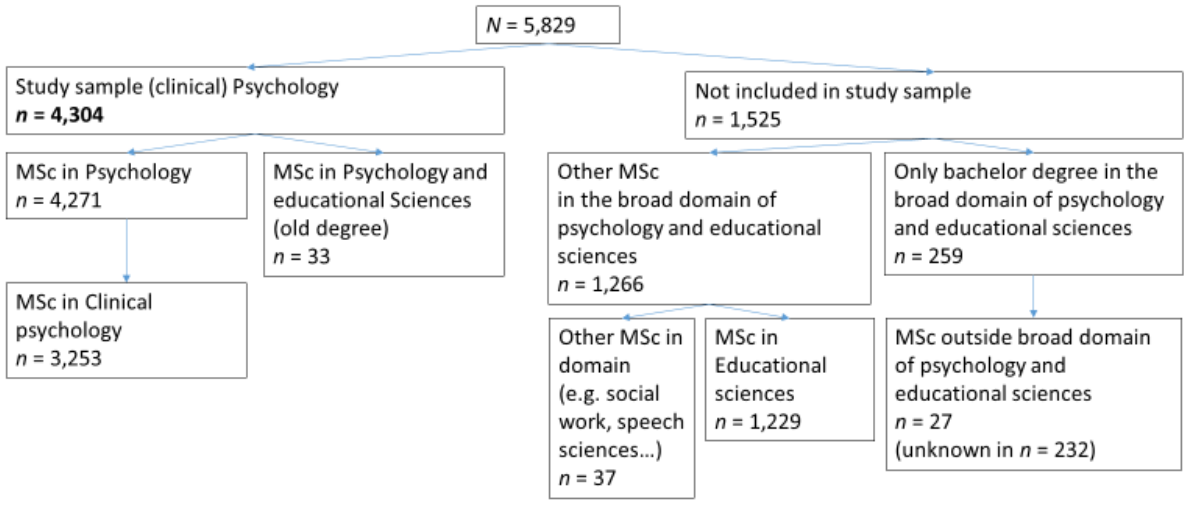

Figure 1. Description of the survey sample.

As **this report** focuses on the profile of psychologists and mental health provision as offered by psychologists, only **participants with an MSc in psychology or a joint degree in psychology and educational sciences** were included in the current report. Other reports will focus on participants with a degree in Psychology or in Educational Sciences working in the field of school and educational psychology (Spilt et al., 2021), and on orthopedagogues (Noens et al., in prep).

2.3. Online survey

During its development, the online survey went through an extensive series of iterations based on input by several **stakeholders** and an expert group consisting of representatives of several domains in the field of (clinical) psychology. The survey was also **piloted** at various stages, and feedback by participants led to additional changes to optimize the balance between the length of the questionnaire and the information that could be obtained, while at the same time minimizing the burden on participants to complete the questionnaire.

The survey was programmed using **Qualtrics** software, and consisted of the following **sections**:

- *Demographic features* (gender, age, first language, nationality, and country of birth) and professional situation (e.g. full-time or part-time employment, salaried or self-employment)
- *Education* (master's degree and further education) and continuing professional development (e.g. intervision, attending conferences, membership of a professional association)
- *Employment sectors* (e.g. mental healthcare sector) and settings (e.g. mental healthcare centre, psychiatric hospital, multidisciplinary group practice). As those with an MSc in psychology often

combine jobs, participants were asked to indicate the sectors and settings they worked in for up to three jobs in salaried employment and three jobs in self-employment
- *Professional activities* (e.g. prevention, diagnostic assessment, psychotherapeutic care)
- *First employment* in the broad domain of psychology and educational sciences after graduation; any prior employment before becoming a psychologist
- *Concerns* regarding the field of work (e.g. concerns about new laws, work pressure) and professional support.

There was an **additional set of questions** for psychologists working in an educational or school setting, addressing the research aims of the project on **school and educational psychology**, on perceived competencies and continuing professional development.

As the survey was web-based, participants were guided through the survey based on their responses. Completion of the survey took around 30 minutes (median = 29.6 minutes).

Ethical approval for the research project was obtained from the KU Leuven Social and Societal Ethics Committee (SMEC, number G- 2018 04 1202). Active informed consent was obtained from all participants.

2.4. Focus group discussions

We organized **two focus groups**, one for French-speaking psychologists (June, 2019) and one for Flemish-speaking psychologists (August, 2019). A call for participants was made through the project's website. Additionally, participants were recruited by the research team, focusing on a balanced representation of several sectors and profiles (purposeful sampling).

The **Flemish group** consisted of six participants with a degree in clinical psychology, four men and two women. Two of them worked in salaried employment, two combined salaried employment and self-employment, and one was semi-retired and continued some self-employed work. All of them worked in the mental healthcare sector for at least one of their jobs. The **French group** consisted of six participants (five women and one man), five with a degree in clinical psychology and one with a degree in school or educational psychology. Five of them worked in the mental healthcare sector for at least one of their jobs. One person worked in salaried employment, two participants combined salaried employment and self-employment, and three participants were self-employed.

Each focus group lasted **two hours**. The moderator started the discussion with a short presentation on the aims of the study and the role of the focus group. Research findings were presented on three topics, and each topic was followed by a discussion. The **topics** were (a) challenges and concerns (including work pressure and concerns about the LHCP), (b) regulation of the profession (e.g. use of the title of "psychologist" and the code of ethics of psychologists) and (c) further education and continuing professional development.

The findings from these focus groups were used to guide analyses and to help interpret and **contextualize** the **quantitative findings**.

2.5. Analyses

Descriptive statistics, such as frequency distributions and measures of central tendency, were used to describe the main study variables. **Group differences** were explored using independent *t*-tests or analysis of variance for continuous variables and χ^2 tests for categorical variables. Because of the relatively large sample size, and as sample size affects statistical significance, we **emphasize effect sizes**[12] rather than statistical significance in the interpretation of the results, particularly when investigating possible differences between language communities, domains of specialization, types of employment and age groups.

As participants who combined jobs reported on their work activities for **each job separately**, some analyses were conducted for each job separately. In these analyses, we focused on the **main job in salaried** employment and the **main job in self-employment**. We also created variables to combine **information from several jobs**, e.g. when discussing type of employment.

[12] Thresholds for a small effect-size are: $r = .10$, $d = 0.20$, $R^2 = .02$, $\eta^2 = .01$, $\varphi = .10$, $V = .10$.

Chapter 3: Results

This chapter first describes the demographic features of participants, and also discusses the extent to which the participants are representative of the Belgian population of people with an MSc in psychology. Next, we discuss the types of specialization (3.2) and the professional situation of those holding an MSc in psychology in Belgium (3.3), followed by an overview of further education (3.4), the availability of mental healthcare offered by psychologists in Belgium (3.5), professional activities that psychologists are typically involved in (3.6), career development (3.7), and challenges for the profession (3.8).

3.1. Sociodemographic profile

3.1.1 Population data

This study was not designed as a population-based representative study. However, in order to be able to compare the current sample with the population of psychologists, we gathered **information concerning the demographic features** of psychologists from the following sources:

- The *Department of Education* of the Flemish Community and the French Community, and the universities with a faculty of psychology and educational sciences have data on the amount of the total number of graduates with an MSc in Psychology
- The *Labour Force Survey* (LFS)[13] contains data on the number people in Belgium who work "as a psychologist".
- The *Commission of Psychologists*[14] keeps a list of graduates with an MSc in psychology who are registered with the commission.
- The *National Institute for the Social Security of the Self-Employed*[15] was able to supply information on the number of self-employed clinical psychologists.

Number of graduates with an MSc in psychology

We requested information on the number of graduates between 1975 and 2018, trying to capture the **population** that was **aged between 23 and 65 years** at the time of the survey, as those years represent the **usual years of work activity**. The Department of Education and the universities with a faculty of psychology and educational sciences kindly provided us the information available to them. The Department of Education responsible for the French community was able to provide us with data

[13] Enquête naar de arbeidskrachten/Enquête sur les forces de travail; https://statbel.fgov.be/nl/enquete/enquete-naar-de-arbeidskrachten-eak

[14] https://www.compsy.be/en/about-us

[15] Rijksinstituut voor de Sociale Verzekeringen der Zelfstandigen/L'Institut national d'assurances sociales pour travailleurs indépendants; https://www.rsvz.be/nl

concerning the number of graduates between 2005 and 2017; the Department of Education for the Flemish community provided data concerning the number of graduates between 2000 and 2018.

Table 1. Number of graduates in psychology based on data from the Belgian universities

Number of graduates between 1975 and 2018	*n*	%
Belgium	38,481	
Flemish-speaking universities	18,984	49.3
French-speaking universities	19,497	50.7

Table 2. Number of psychologists based on data from the Department of Education

	Time period	
	2005–2017	2000–2018
Department of Education	*n*	*n*
Flemish	9308	12,719
French	8009	*10,944*
Total	17,317	*23,663*

Note. Between 2005 and 2017, there were data available for both communities. Numbers in italic are estimates based on the proportion of Flemish and French graduates between 2005 and 2017.

Based on the data provided by the universities, the proportion of people who obtained an MSc in psychology between 2000 and 2018 is 58.9% of the total number of psychologists who graduated since 1975. When this percentage is applied to the data from the Departments of Education, the estimated number of graduate psychologists is 40,167 since 1975. Thus, the working-age population of people with an **MSc in psychology** in Belgium likely **ranges between 38,481 and 40,167**.

Number of registered psychologists

In 2018, 14,245 individuals were registered as a psychologist with the Commission of Psychologists (Table 3). In the same year, according to the LFS, **17,295 people were working as a psychologist**. These numbers include psychologists working in salaried employment and in self-employment.

Table 3. Number of registrations with the Commission of Psychologists in 2018

Community	*n*	%
Flemish-speaking	6,695.15	47.0
French-speaking	7,549.85	53.0
Both communities	14,294	

According to the National Institute for the Social Security of the Self-Employed[16], in 2017, **6,209 clinical psychologists worked in self-employment**. However, this number does not capture psychologists who were already working in self-employment before (March) 2009[17] (Table 4). In the same year (2017), according to the LFS, 16,137 people were working as a psychologist, either in salaried employment or in self-employment.

Table 4. Number of self-employed clinical psychologists in 2017 (based on registrations since 2009)

Type of self-employment	*n*	%
Self-employment as a primary occupation	2,658	42.8
Self-employment as a primary occupation	3,273	52.7
Self-employment after (semi-) retirement	278	4.5
All types	6,209	

3.1.2 Demographic features of participants with an MSc in psychology

Demographic features of the participants with an MSc in psychology or a general MSc in psychology/educational sciences (*n* = 4,304) are provided in Table 5. Participants were included if they had **obtained their MSc in psychology in Belgium**, or were **working in Belgium** at the time of the survey. As a result, our sample includes 69 participants (1.6%) who obtained their MSc in psychology outside Belgium, and 74 participants (1.8%) who were working exclusively outside Belgium at the time of the survey.

[16] See https://www.nisse.be/en

[17] In the registration of the NISSE, working as a clinical psychologist does not imply an MSc in clinical psychology. Further, the NISSE informed us that other activities in the field of psychology can be included in the category 'clinical psychologist', when a more appropriate category is lacking and the person is working in the field of psychology (but, there are categories available for e.g. "coach" and "consultant"). Further, before 2009, psychologists were not registered separately; they were registered as a paramedical profession in general (together with several other professions, such as nurses, dieticians, and physiotherapists; in 2019, the number of professionals registered as a paramedic was 11,391). Psychologists who were already working in self-employment before March 2009 are still categorized as paramedics. Thus, the number of self-employed clinical psychologists reported by the NISSE underestimates the real number of self-employed psychologists in Belgium.

Table 5. Demographic features of participants

		Participants' language				
		Dutch (Flemish) *n* = 2,847 66.15%	**French** *n* = 1,419 32.97%	**German** *n* = 29 0.67%	**English** *n* = 9 0.20%	**Total** ***N* = 4,304**
Demographic features						
Age cohort (%)	<30 years	27.7	21.0	27.6	*n* < 5	25.5
	30–39 years	36.4	33.8	34.5	*n* < 5	35.5
	40–49 years	20.2	23.3	17.2	*n* < 5	21.2
	50–59 years	11.1	14.2	*n* < 5	*n* < 5	12.1
	60–64 years	2.9	3.5	*n* < 5	*n* < 5	3.1
	≥65 years	1.7	4.3	*n* < 5	*n* < 5	2.6
Age (years)	*M*	37.53	40.08	39.07	36.22	38.38
	SD	10.79	12.06	13.06	9.37	11.30
Gender (%)	Male	18.3	16.9	20.7	22.2	17.8
	Female	81.7	83.1	79.3	77.8	82.2
Work region (%)*	Flanders	89.1	2.3	*n* < 5	*n* < 5	59.8
	Wallonia	2.2	65.5	82.1	/	22.9
	Brussels	11.6	32.2	*n* < 5	*n* < 5	18.4
	Outside Belgium	3.6	5.0	*n* < 5	*n* < 5	4.1

Note: *Compared with the full sample of participants with an MSc in psychology (*n* = 4,304) (including 3.7% non-working participants). Participants could be employed in more than one region, as was the case for 8.2% of participants in (self-)employment.

As shown in Table 5, the **majority** of the sample was **Flemish** speaking (or at least completed the Flemish survey; 66%) and worked in Flanders (59.8%). The German-speaking community of psychologists in Belgium is small, which was reflected in the small number of German-speaking participants (*n* = 29, 0.67%). The vast majority (82.2%) of participants were **female**. More than half of the participants were younger than 40 years of age (60%), and the **average age was 38 years**. Less than 7% had been born outside Belgium (Figure 2).

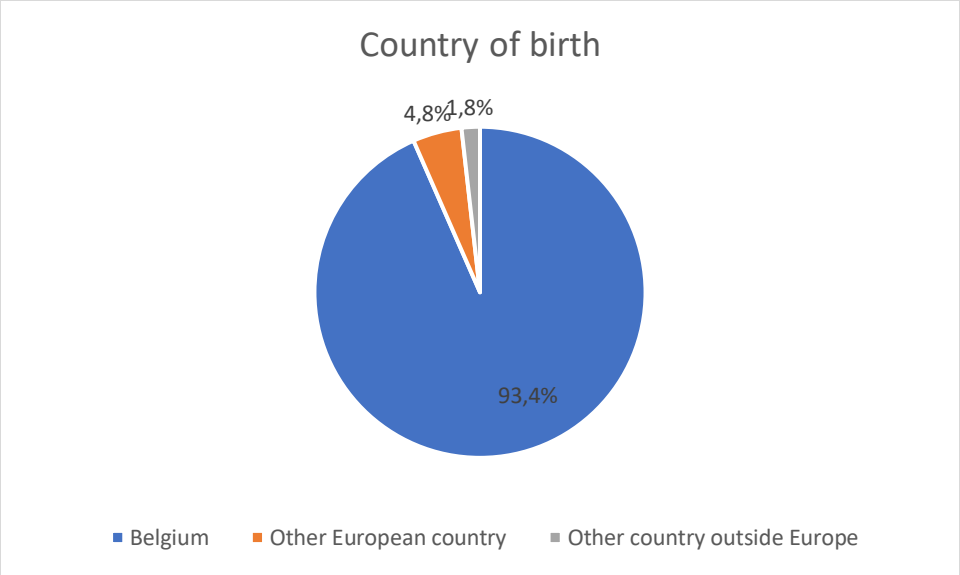

Figure 2. Country of birth of participants with an MSc in psychology (*n* = 4,304).

There were **age differences** between language communities ($F(3, 77.98) = 15.71$, $p < .001$). Participants in the French-speaking sample were on average significantly older than those in the Flemish-speaking sample ($M_D = -2.54$, $SD_D = 0.38$, $p < .001$). There were no other significant differences in demographic features (i.e. age and gender) between participants responding in the different languages.

Although this study was not designed as a population-representative study, we were interested to see to **what extent** the sample was **representative** of the total population of psychologists in Belgium. As noted, we obtained information on demographic features of psychologists in Belgium from several sources: (a) statistics on students graduating from the MSc programmes of the Belgian universities (Table 1), (b) statistics on the number of students graduating from psychology MSc programmes based on data from the Department of Education of the Flemish Community and the French Community (Table 2), (c) statistics of the Belgian Commission of Psychologists concerning the number of officially registered and certified psychologists (Table 3), (d) and population statistics from the national government on the number of inhabitants of Belgium (Statbel).

The majority of the psychologists in this study completed the **Flemish-language** version of the questionnaire (66.2%). This is in line with Belgian population statistics showing that 62.9% of Belgian inhabitants are Flemish. According to Belgian population statistics, the German-language community accounts for 0.68% of the Belgian population[18], the same proportion as in our sample (0.67%). Thus, compared with statistics on the **distribution of the Belgian population** across the different language communities, our sample seems representative (Cramer's $V = .04$).

When we look at the **registration of psychologists** with the Belgian Commission of Psychologists, we see a different picture: more than half of psychologists registered with the commission are from the French-

[18] See https://statbel.fgov.be/nl/nieuws/belgie-telde-op-1-januari-2018-11376070-inwoners

speaking community (Cramer's *V* = .20). Information from the universities on the number of individuals with an MSc in psychology[19] also indicates a **more equal distribution between French speakers and Flemish speakers**. Thus, our sample more closely represents the language distribution in the Belgian population statistics than the language distribution of Belgian psychologists, at least based on registration with the Belgian Commission of Psychologists (see Section 3.3.3 for data on registration with this commission) and the language distribution of the Belgian population with an MSc in psychology.

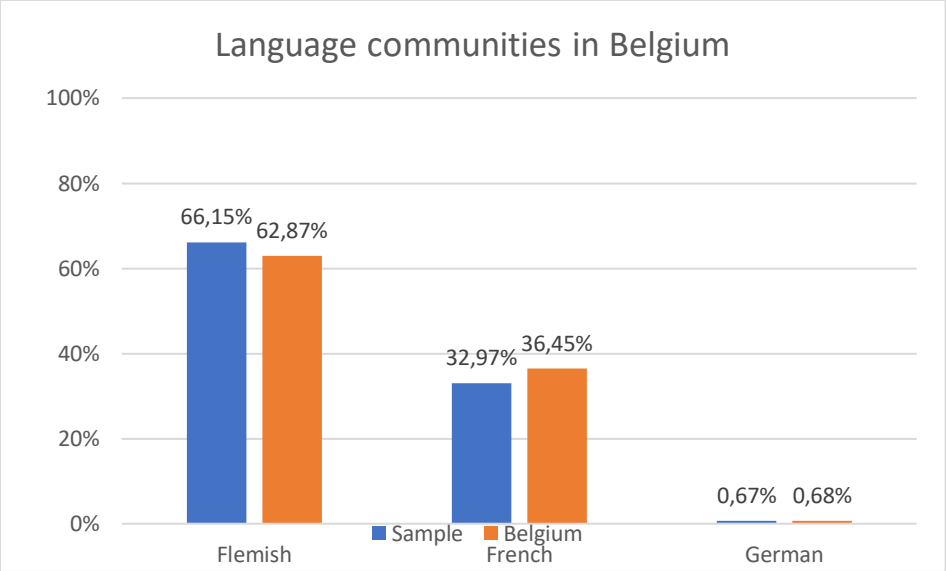

Figure 3. Comparison between participant language and distribution of the Belgian population across language communities in Belgium.

[19] Information from the Departments of Education was based on the number of MSc students graduating between 2005 and 2017; information from the universities was based on the number of MSc students graduating between 1975 and 2018; differences between data from the universities and data from the Departments of Education on the one hand, and data from the Commission of Psychologists on the other hand, can at least in part be explained by a difference in registration rates: our study shows that of the Flemish-speaking participants, 69.1% were registered with the commission, while among the French-speaking participants 78.3% were registered (see Section 3.3.3).

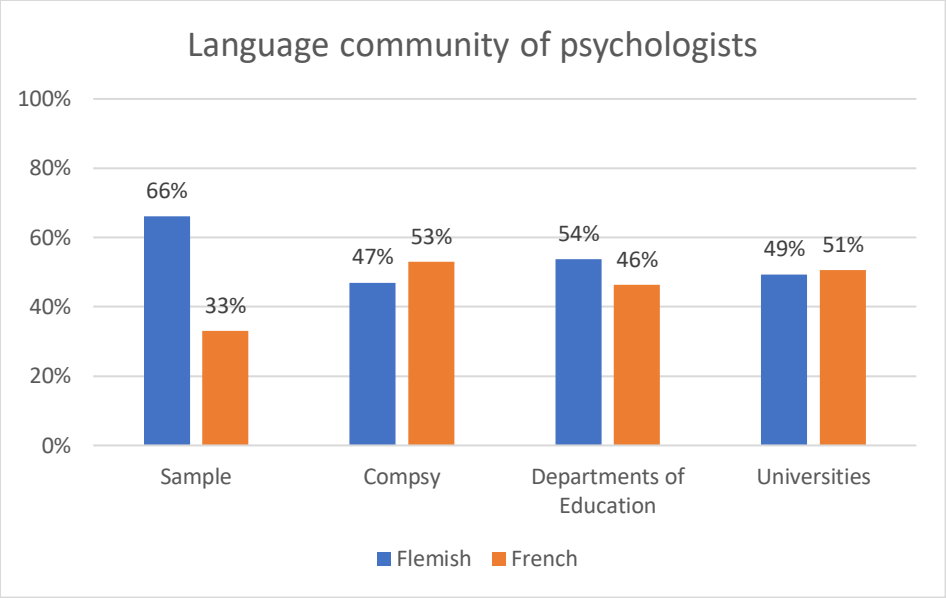

Figure 4. Comparison between participant language and distribution of the MSc in psychology across language communities in Belgium. Compsy, Commission of Psychologists.

As can be seen in Figure 5, the gender distribution in the current sample reflects the gender distribution of psychologists in Belgium (around 83% are female)[20] (Cramer's *V* = .02).

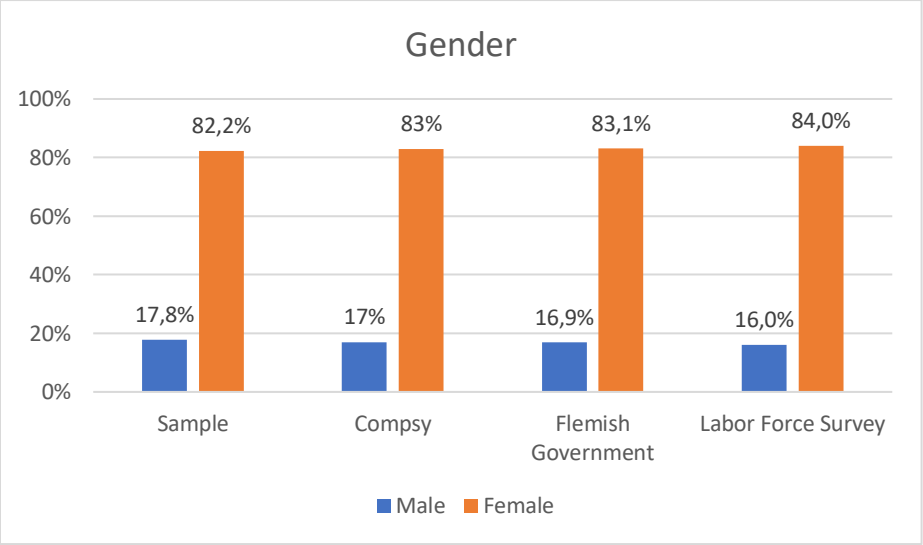

Figure 5. Gender distribution of psychologists in Belgium. Compsy, Commission of Psychologists.

[20] We compared the current sample (*n* = 4,304) with data from the Commission of Psychologists (2018), information from the Belgian Labour Force Survey (2018), and data on gender provided by the Department of Education for the Flemish community, in students with an MSc in psychology who graduated between 1999 and 2018. We were unable to obtain data on the gender distribution of individuals holding an MSc in psychology from the Department of Education for the French community of Belgium.

The **age distribution** of the psychologists in the current sample was also highly **similar** to the age distribution of psychologists registered by the Commission of Psychologists (Cramer's *V* = .14) and the Belgian universities (Cramer's *V* = .05): the largest cohort was between 30 and 40 years old, and included about one-third of the psychologists who participated in this study. The other age cohorts (20–30 years and 40–50 years) each included one-quarter to one-fifth of the participating psychologists (Figure 5).

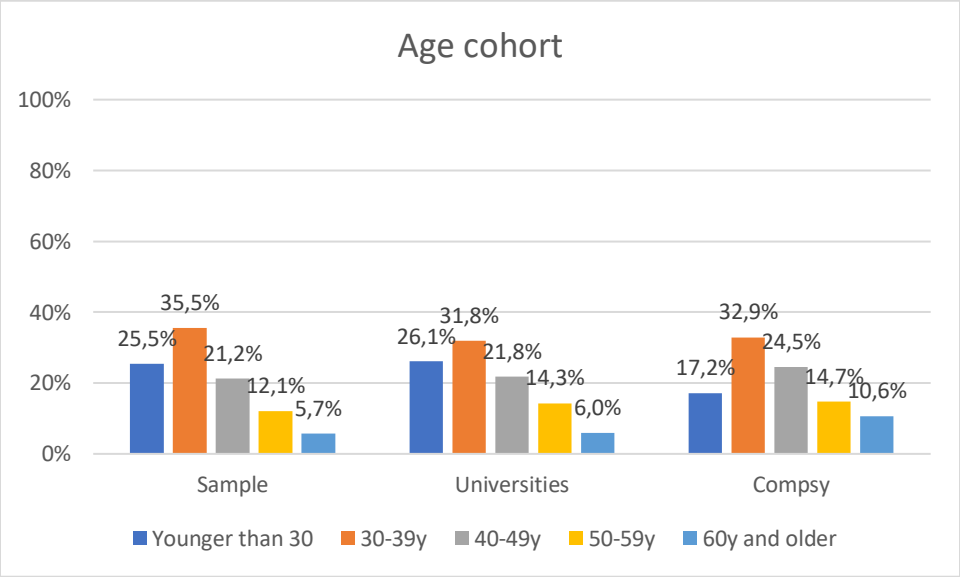

Figure 6. 10-year age cohorts in the sample of participants with an MSc in psychology (*n* = 4,304) compared with data from the Belgian universities and the Commission of Psychologists (Compsy).

As shown in Figure 7, a linear model fitted the data best, indicating a **steady increase in the number of psychologists** graduating from Belgian universities over time. Based on the observed number of graduates in Belgium between 1977 and 2016[21], there was a strong linear growth ($F(1,6) = 249.83$, $R^2 = .98$, $p < .001$). Unstandardized coefficients indicated that each 5-year age cohort counted 765 more graduates than the previous (older) cohort ($B = 764.86$, $SE\ B = 48.39$, $t = 15.81$, $p < .001$). On average, a 5-year cohort counted 4321 graduates ($M = 4{,}320.50$, $SD = 1895.87$). This strong linear growth is also reflected in the current sample of participants with an MSc in psychology (between 25 years old and 65 years old[22]) (($F(1,6) = 207.00$, $R^2 = .98$, $p < .001$) (see Figure 8). On average, a 5-year cohort counted 502 participants ($M = 502.25$, $SD = 297.16$), and unstandardized coefficients indicated that each 5-year cohort counted 120 participants more than the previous (older) 5-year age cohort ($B = 119.60$, $SE\ B = 8.31$, $t = 14.39$, $p < .001$).

[21] This time range was chosen to match the 5-year age cohorts in the sample.

[22] For this analysis, we excluded graduates in the oldest (65 years and older) and youngest (younger than 25 years) cohorts, as they do not include 5 years each.

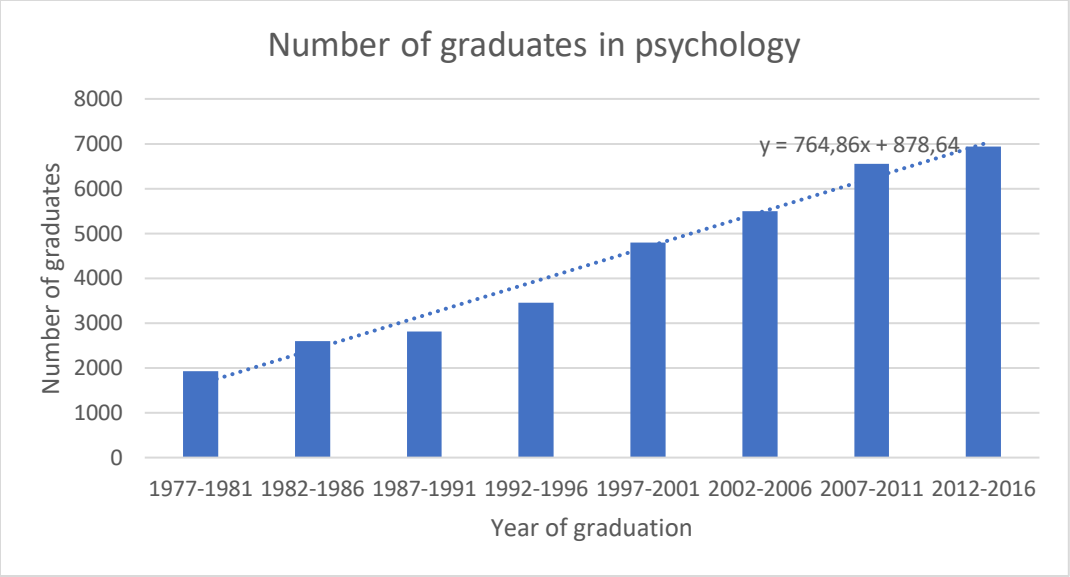

Figure 7. Number of graduates in psychology per 5 years, between 1977 and 2016 (*n* = 34,564).

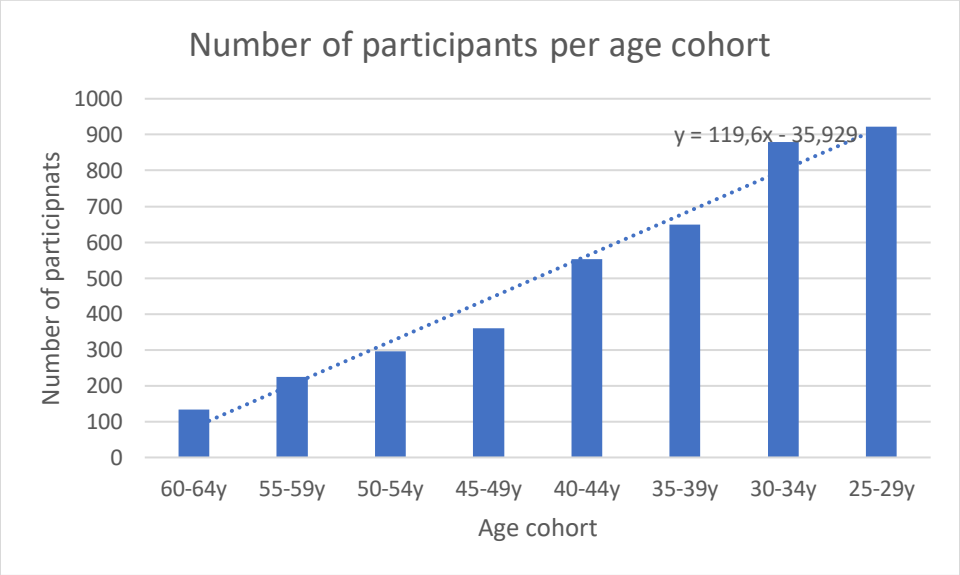

Figure 8. 5-year age cohorts in the sample of participants with an MSc in psychology between 25 and 65 years old (*n* = 4,018).

The **regional distribution** in our sample shows small differences with the distribution of the Belgian population in general (Cramer's *V* = .12) and with the region of residence of psychologists registered by the Commission of Psychologists (Cramer's *V* = .16). According to Belgian population statistics, 58%, 32%, and 11% of Belgians live in Flanders, Wallonia, and Brussels, respectively. The Commission of Psychologists reports that 48% of those with an MSc in Psychology live in Flanders. In our sample of participants with a job in the broad domain of psychology and educational sciences (*n* = 3,909), those **working in Flanders**

are somewhat overrepresented compared with the data recorded by the Commission of Psychologists (Cramer's *V* = .11).

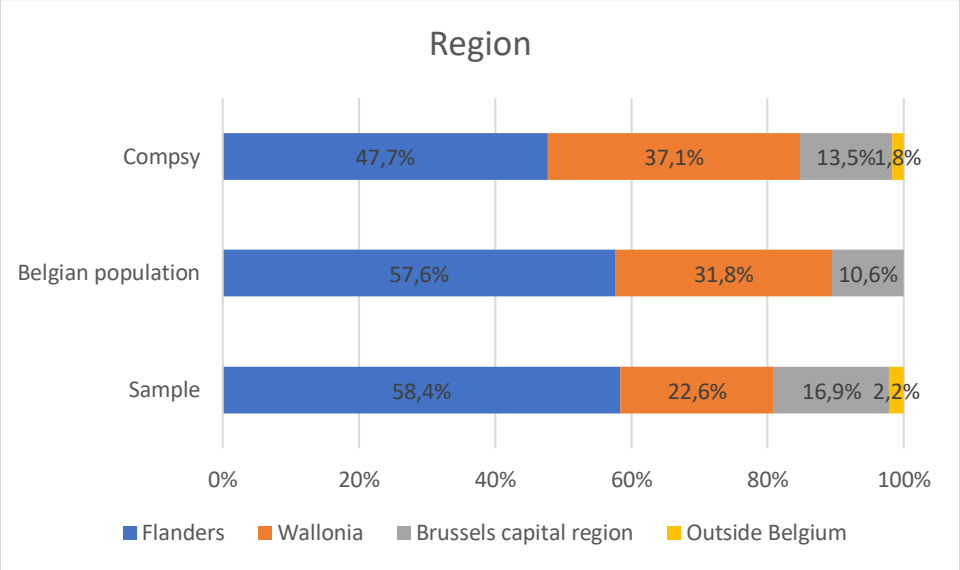

Figure 9. Geographical region of work in the sample of participants with an MSc in Psychology working in the broad domain of psychology and educational sciences (*n* = 3,909) compared with data from the Belgian population (Statbel) and from the Commission of Psychologists (Compsy).

As the regions of Flanders and Wallonia are differently represented, we looked at the distribution of participants from the different **Belgian provinces** separately for each region. We compared the region of work of participants who worked in the broad domain of psychology and educational sciences in our sample (*n* = 3,909) with (a) registration with the Commission of Psychologists and (b) Belgian population statistics. These data show a **good representativeness per region** (Figures 10 and 11). The sample distribution of Flemish provinces did not differ meaningfully from the distribution in the data held by the Commission of Psychologists (Cramer's *V* = .05) nor from the distribution in the Belgian population (Cramer' *V* = .08). Likewise, the sample distribution of Walloon provinces did not differ from the distribution in the data from the Commission of Psychologists (Cramer's *V* = .07). Differences from the distribution in the Belgian population were small (Cramer's *V* = .16).

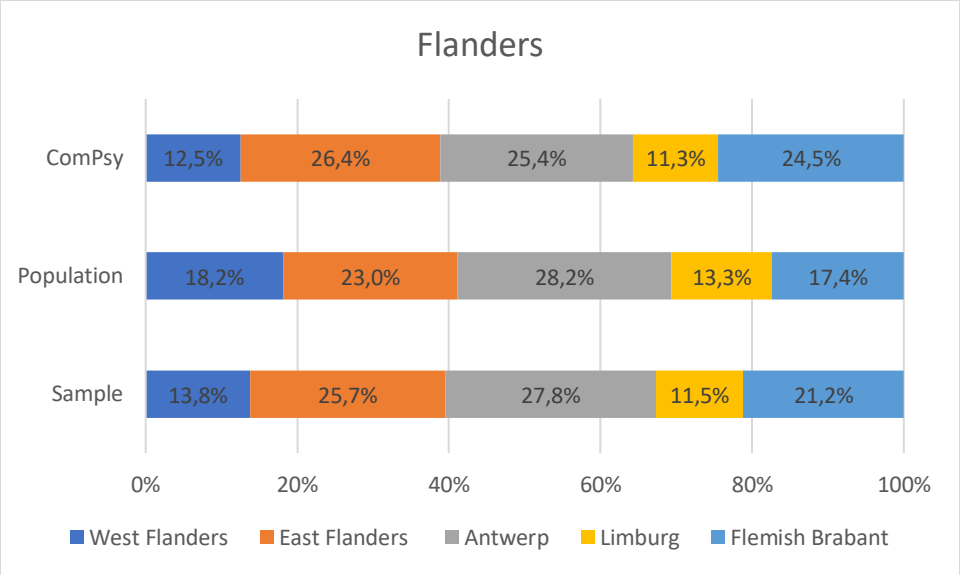

Figure 10. Distribution of psychologists in Flanders by province. Compsy, Commission of Psychologists.

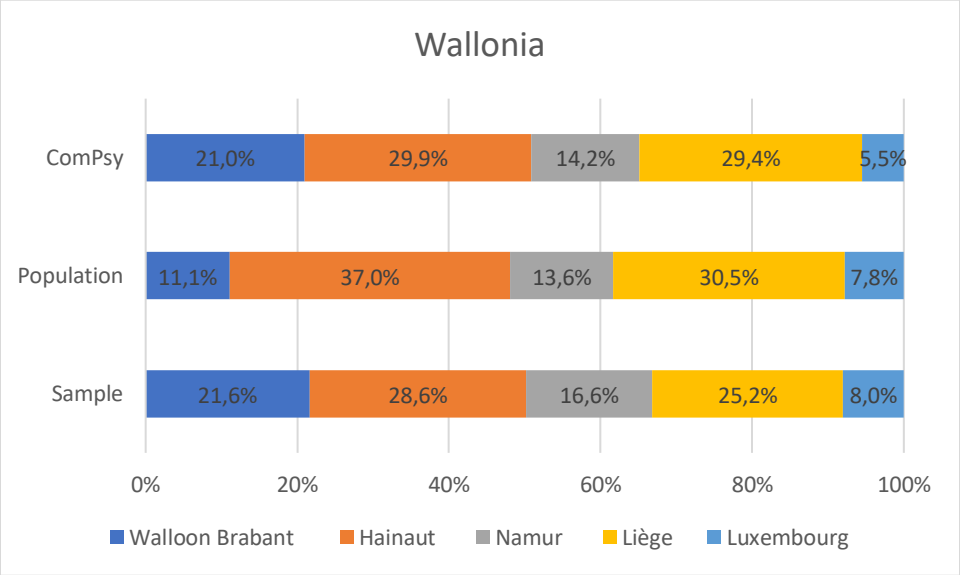

Figure 11. Distribution of psychologists in Wallonia by province. Compsy, Commission of Psychologists.

3.1.3 Conclusion on demographic profile

Population statistics show that people with an MSc in psychology and registered psychologists are a **young** group of people, with 50.1–57.9% being younger than 40 years of age. Further, the profession is **predominantly female**, with 83% female graduates. These features are represented in the study sample. Further, population statistics show an approximately equal distribution between the Flemish and the French communities in the number of MScs and registered psychologists. The language distribution of our

sample reflected the distribution of the Belgian population in general, with more Flemish-speaking participants. Within the regions of Flanders and Wallonia, the distribution of the sample by province was sufficiently representative for the population of registered psychologists.

3.2. Domain of specialization

3.2.1 Domains of specialization in the study sample

Within MSc programmes in psychology, a **specialization in different domains** in psychology is possible. Figure 12 shows the distribution of the domains of specialization in psychology. As domains of specialization show **variation in time and between universities**, participants were requested to **select the closest match** with their educational background. Response options were '*clinical or health psychology*'[23], '*personnel management and industrial/organizational psychology*', '*school or educational psychology*' and '*theoretical and experimental psychology*'[24]. *Other specializations* include e.g. 'neuropsychology', 'social/cultural psychology', or 'forensic psychology'. When domain of specialization was not specified by the participant, these participants were also included in the category 'other'. Participants who obtained several MScs in psychology, are included in 'multiple MScs in psychology'. **Clinical or health psychology** was the **most frequent** domain of specialization, reported by 3,253 participants (75.6% of the sample[25]). Domains of specialization differed between language communities ($\chi^2(5) = 398.01$, Cramer's $V = .30$, $p < .001$, $n = 4{,}295$) (Figure 13).

[23] Throughout this report, we will usually use the term 'clinical psychology' when referring to the MSc in clinical or health psychology.

[24] 'Special education, disability studies, and behavioural disorders (orthopédagogie clinique) was also a specified option. This domain of specialization is offered within psychology MSc programmes in the French Community, whereas in the Flemish Community these domains are typically offered within MSc programmes in Educational Sciences. We wanted to enable identification of this domain of specialization in the study sample in the context of the LHCP for clinical educationalists/orthopedagogues (see https://www.health.belgium.be/en/health/mental-health-professions), which is outside the scope of this report.

[25] 72.5% reported they only completed an MSc in clinical psychology, 3.1% also obtained an MSc in another domain of psychology.

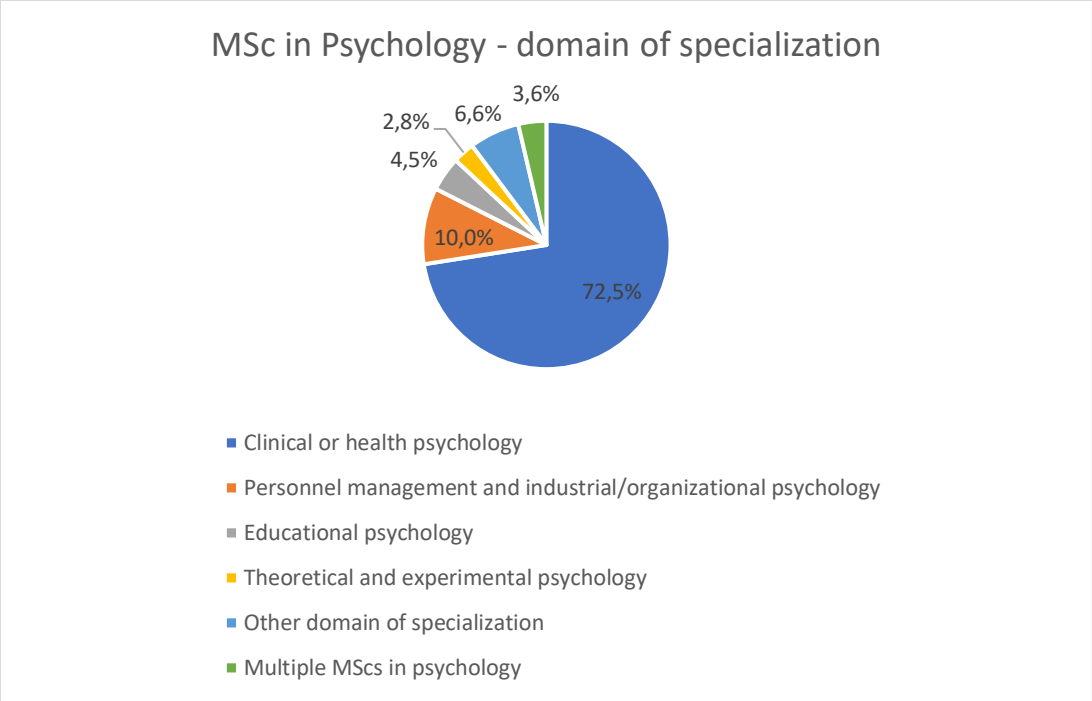

Figure 12. Domains of specialization of participants with an MSc in psychology (*n* = 4,304).

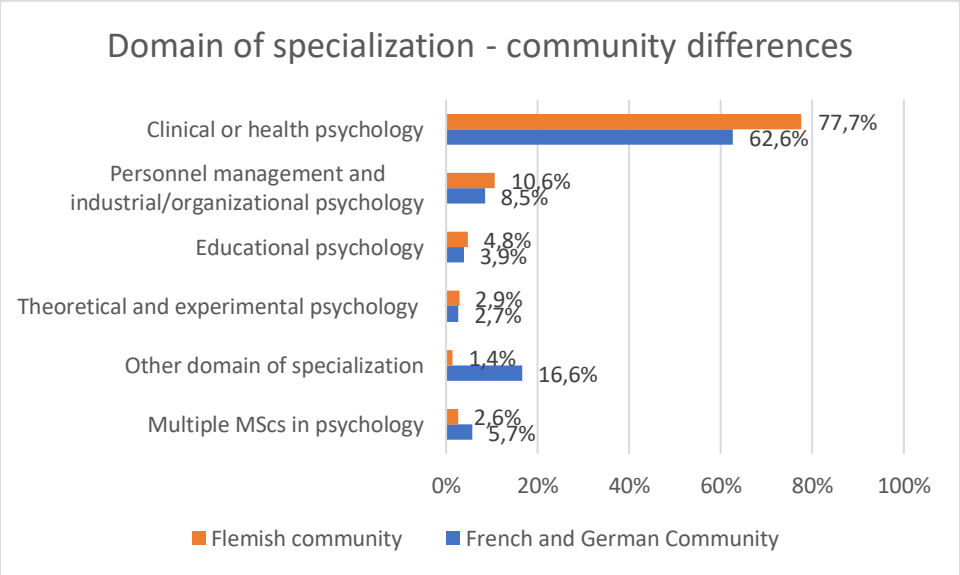

Figure 13. Community differences in domain of specialization of participants with an MSc in psychology (*n* = 4,295)

There are substantial **differences** between the different types of specialization offered at the different **universities**. Because there are also important differences between the Flemish and French MSc

programmes, we analysed these data according to the participants' language. English-speaking participants (*n* = 9) were not included in these analyses because of their small number.

Based on data from the universities in the **Flemish Community**, the major specializations are clinical or health psychology, personnel management and industrial/organizational psychology, and theoretical and experimental psychology. The university of Leuven also offers a master's in school psychology, which can be described as a specialization in clinical psychology that focuses on educational settings.

In the current study, of the 2,847 participants with an MSc in psychology who completed the questionnaire in Flemish, the vast majority (79.9%) had a specialization in clinical or health psychology.

Table 6. **Domain of specialization in psychology – Flemish-speaking participants**

Domain of specialization	***n***	**%**
Clinical or health psychology	2,274	79.9
Personnel management and industrial/organizational psychology	327	11.5
Theoretical and experimental psychology	100	3.5
School psychology	152	5.3
Other or no information[26]	69	2.4

In the **French Community**, students who want to obtain an MSc in psychology have to choose between "in-depth" ("*finalité approfondie*"), which prepares for a job in research, or "specialized" ("*finalité spécialisée*"), which prepares for a job "in the field" or in non-research settings. Furthermore, students can typically choose courses from a list of topics in order to specialize in certain areas. As a result, in Wallonia, there are more options in the curriculum compared with those offered in the Flemish universities.

Despite this great variety, the majority of French- or German-speaking psychologists in our sample (*n* = 1,448) had an MSc in clinical or health psychology (67.1%), as in the Flemish Community. However, social/cultural psychology and neuropsychology are also important domains of specialization. Further, neuropsychology is sometimes organized as a specialization within the MSc in clinical psychology (i.e., clinical neuropsychology) in the French Community. In addition, special education, disability studies, and behavioural disorders ("orthopédagogie clinique") is offered within psychology MSc programmes in the French Community, whereas in the Flemish Community these domains are typically offered within MSc programmes in Educational Sciences[27].

[26] The category "other" was used for psychologists with a general degree in psychology and educational sciences, when psychologists did not specify their domain of specialization, or when their domain of specialization was not listed (e.g., a small number of participants in the Flemish sample had studied neuropsychology or forensic psychology, which is not offered as an MSc in Flemish universities).

[27] The German Community does not have a university in Belgium. They usually attend universities in the French Community, or they study abroad.

Table 7. Domain of specialization in psychology – French- and German-speaking participants

Domain of specialization	*n*	%
Personnel management and industrial/organizational psychology	144	9.9
Clinical or health psychology	972	67.1[28]
Theoretical and experimental psychology	73	5.0
Educational psychology	73	5.0
Special education, disability studies, and behavioural disorders[29]	39	2.7
Neuropsychology	83	5.7
Social/cultural psychology	33	2.3
Other or no information[30]	119	8.2

3.2.2 Data on representativeness

In terms of **representativeness**, we examined statistical information on (graduated) psychology students collected by the Flemish universities from 1975 to 2018. Specific domains of specialization in psychology were first offered in 2009 at the universities of Ghent and Leuven. Before 2009, graduating received a general MSc in psychology. The university of Brussels has offered two domains of specialization (Clinical or health psychology and Personnel management and industrial/organizational psychology) since 1975.

The available information on domains of specialization shows that most psychologists have a clinical/health orientation (70%). The domain of School psychology focuses on working in educational settings (e.g., centres for student guidance (CLB/CPMS)); they represent 2% of those with an MSc in psychology. Around 25% of psychologists have a master's in the Personnel management and industrial/organizational orientation, and 3% graduate in Theoretical and experimental psychology.

Figure 14 shows the distribution of the domains of specialization in the study sample for Flemish-speaking participants and in the population. In the current sample, the distribution of domains of specialization differs from the distribution in student data held by the universities in the Flemish Community (Cramer's V = .18). Participants with an MSc in **clinical or health psychology** are **somewhat overrepresented** compared with the available Flemish data (70.3% in the population, compared with 79.9% in the study sample; Cramer's V = .11), while those with a specialization in personnel management and industrial/organizational psychology are underrepresented (11.5% in the sample compared with 24.4% in the population; Cramer's V = .17). This is perhaps not unsurprising given the aims of the study and the way it was presented to participants, despite our efforts to be as inclusive as possible. The percentage of participants with an MSc in Theoretical and experimental psychology (3.5%) did not differ meaningfully from student data (3.3%), and neither did the percentage of participants with an MSc in school psychology (5.3% in the sample compared with 2.0% in the population) (Cramer's V < .10).

[28] Including clinical neuropsychology, n = 13.
[29] "Orthopédagogie clinique"
[30] The category "other" was used for psychologists with a general degree in psychology and educational sciences, when psychologists did not specify their domain of specialization, or when their domain of specialization was not listed (e.g. a small number of participants studied forensic psychology).

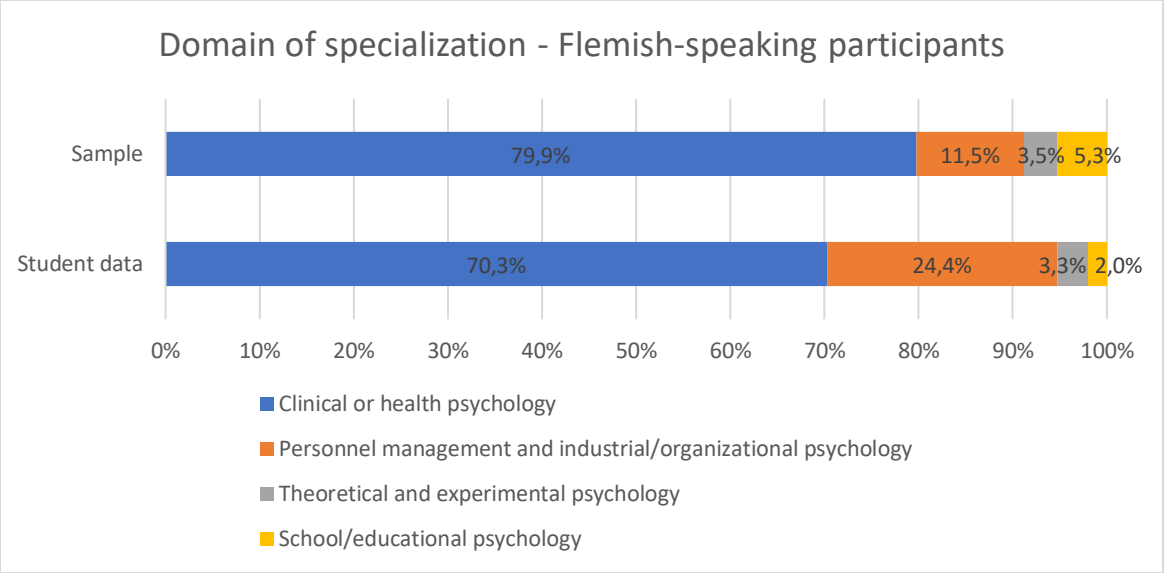

Figure 14. Domain of specialization in psychology: comparison with population data for the Flemish-speaking participants.

Figure 15 shows the distribution of the domains of specialization in the study sample for **French-speaking participants** and in the population. For the French Community, we have data on domains of specialization from only two universities. As not all universities offer all domains of specialization, we were unable to investigate the representativeness of participants in the current sample for all domains. However, as in the Flemish Community, participants with an **MSc in clinical or health psychology are over-represented** (67.2% in the study sample compared with 55.7% in the population; Cramer's $V = .12$). Social and cultural psychology is under-represented (Cramer's $V = .15$)[31]. The prevalence of the other domains of specialization did not differ significantly compared with the data of students in the French community, i.e. Cramer's V did not reach the threshold for a small effect size (Cramer's $V < .10$).

[31] We have to take into account that neuropsychology and social or cultural psychology were not listed as a separate option. Thus, our sample statistics for these domain of specialization are based on specifications freely provided by participants.

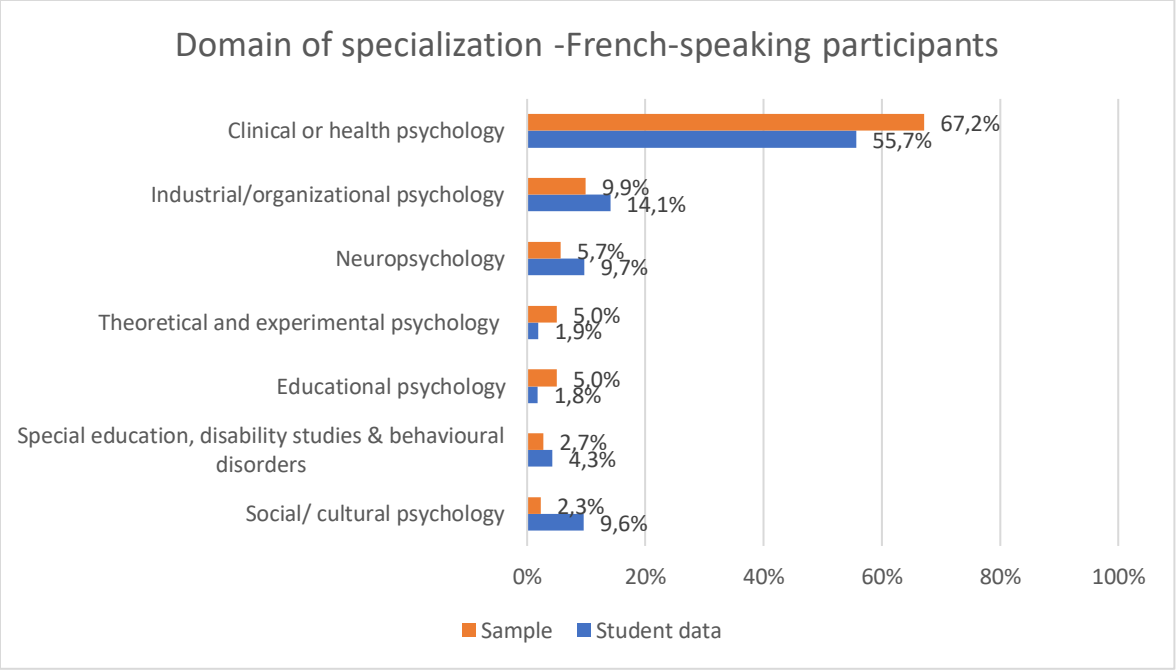

Figure 15. Domain of specialization – comparison with population data for the French-speaking participants.[32]

3.2.3 Conclusion on domain of specialization

Data from the universities show that of those with an **MSc in psychology** in the Flemish community, about 70% obtain an MSc in clinical psychology; in the French-speaking region this is about 56%[33]. In the current study, participants with an MSc in clinical psychology (75.6%) are thus **slightly overrepresented** relative to the national-level data; this most probably reflects the general aim and purpose of this study, with psychologists being employed in domains other than clinical psychology (broadly defined) being, on average, perhaps less likely to consider the study relevant to them, leading to a somewhat lower rate of participation of psychologists working in other domains and/or with an educational background other than clinical psychology.

[32] Most data on students are based on the information provided by the universities, except for those on theoretical and experimental psychology. Data from the Belgian Department of Education show the distribution of the two finalities in the French-speaking community, “spécialisée” and “approfondie”. The latter is equivalent to theoretical and experimental psychology. These data show that 1.9% of students choose this domain of specialization.

[33] These percentages reflect the number of psychologists who specialized in clinical psychology, specifically. In the French-speaking region, neuropsychology is also an important domain of specialization, and shows some relatedness to clinical psychology.

3.3. Professional situation

3.3.1 Professional situation of participants with an MSc in psychology

This section describes the employment characteristics of the participants with an MSc in psychology. We also compare these sample characteristics with population data, to assess representativeness.

Type of (self-)employment

Of the 4,304 MSc graduates in psychology who participated, 96.3% were (self-)employed. **Active working status** was highest in those between 30 and 60 years of age (97.7–98.6%). Active working status was slightly higher in the Flemish-speaking participants (97.4%) compared with the French- and German-speaking participants (94.3%) ($\chi^2(1) = 25.99$, $\varphi = -.08$, $p < .001$). Active working status was also somewhat higher in participants with an MSc in clinical psychology (97.1%) compared with those with another MSc in psychology (93.9%) ($\chi^2(1) = 22.42$, $\varphi = .07$, $p < .001$). However, these differences did not reach the threshold for a small effect-size.

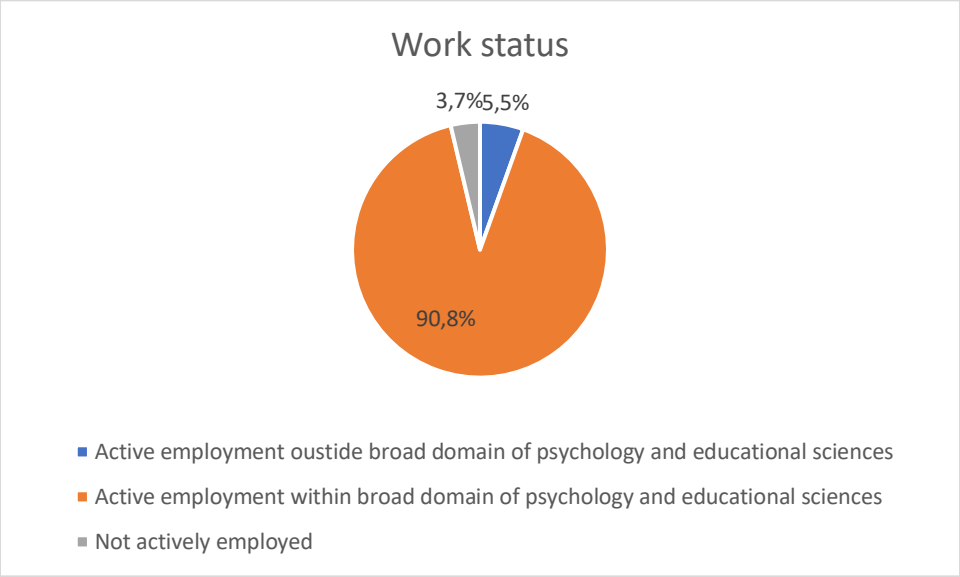

Figure 16. Work status of participants with an MSc in psychology.

Around 76.6% of participants with an MSc in psychology were employed (**salaried employment**) and 47.9% were **self-employed** (as a primary or secondary occupation). Among the 3.7% of participants who reported that they were not working at the time of the survey, half of them were **unemployed** (1.7% of the sample)[34]. In the youngest age cohort (<30 years), 5.1% of participants were not working, with 4.5% being unemployed.

[34] In Belgium, 5.4% of the population was unemployed in 2019 (and 3.2% when only the subgroup with a higher education is taken into account). See https://statbel.fgov.be/nl/themas/werk-opleiding/arbeidsmarkt/werkgelegenheid-en-werkloosheid and https://bestat.statbel.fgov.be/bestat/.

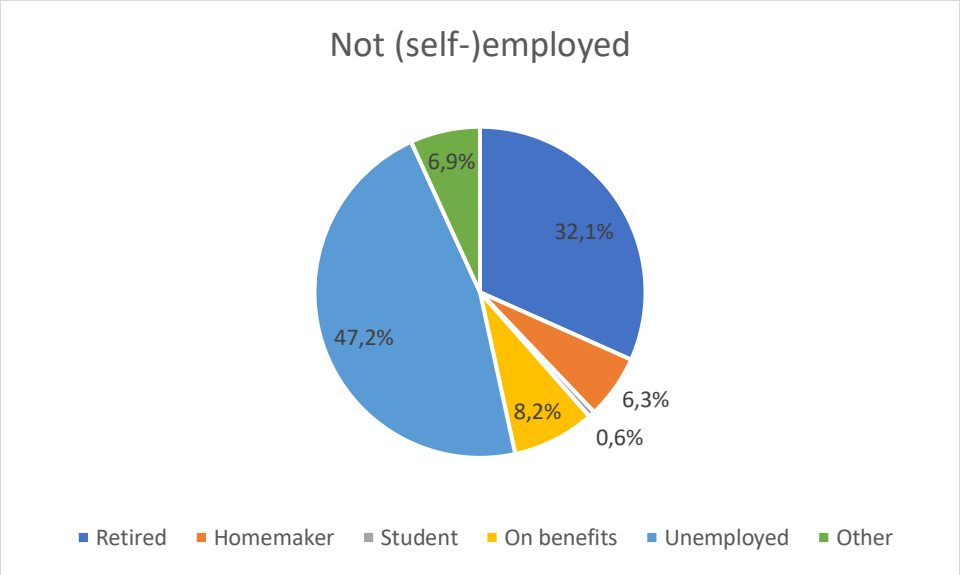

Figure 17. Situation of participants who were not (self-)employed.

Table 8 shows the distribution of type of employment in participants who were (self-)employed (*n* = 4,145). Half of them (50.3%) worked only in salaried employment, 29.2% combined salaried employment with self-employed activities, and 19.8% were self-employed as a primary occupation.

Table 8. Type of employment of participants with an MSc in psychology and an active work status[35]

Type of employment	**%**
Salaried employment	**79.5**
Only salaried employment	50.3
Self-employment as a secondary occupation	29.2
Self-employment	**49.7**
Self-employment as a primary occupation	19.8
Self-employment as a secondary occupation	29.2
Self-employment after retirement	0.7

Figure 18 shows type of employment separately for participants who work in Flanders (*n* = 2,573), Wallonia (*n* = 984), the Brussels capital region (*n* = 794) and participants who (also) worked outside Belgium (*n* = 178). Participants could be employed in more than one region, as was the case in 333 participants in (self-)employment (8.2%). The distribution of different types of employment was quite similar in the different regions (Cramer's *V* = .07).

[35] See Appendix C for supplementary results on type of employment in participants with an MSc in clinical psychology.

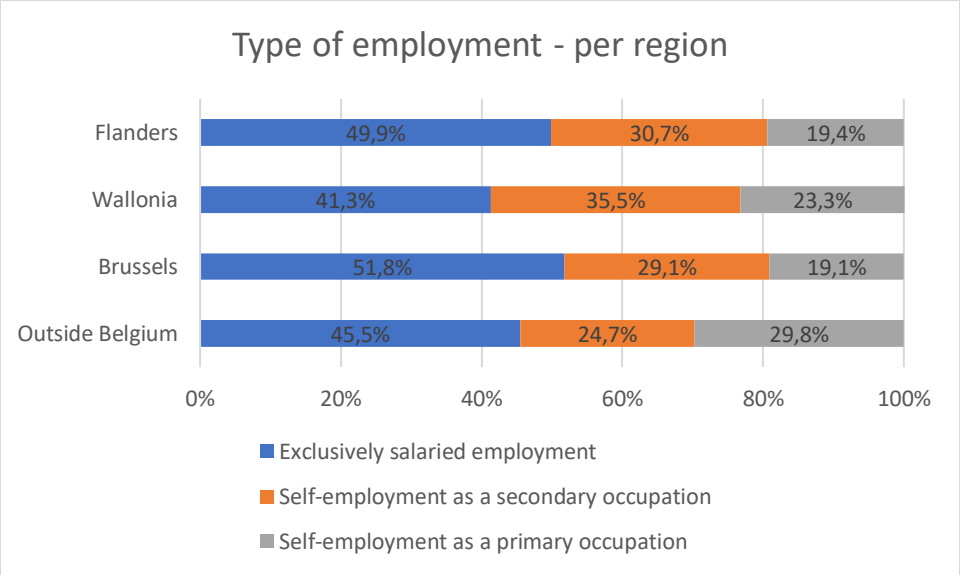

Figure 18. Type of employment per region. Self-employment as a secondary occupation includes participants in semi-retirement.

Type of employment differed marginally according to the **language** of the participant, with Flemish-speaking participants with an MSc working somewhat less often in self-employment compared with French-speaking participants ($\chi^2(3) = 17.80$, Cramer's $V = .07$, $p < .001$), although the differences were again very small and did not reach the threshold for a small effect-size.

Table 9. Type of employment in Flemish-speaking versus French- and German-speaking participants with an MSc in psychology and an active work status

Type of employment (%)	Flemish (*n* = 2,272)	French and German (*n* = 1,365)
Only salaried employment	52.6	45.8
Self-employment as a primary occupation	18.7	21.9
Self-employment as a secondary occupation	28.1	31.4
Self-employment after retirement	0.6	0.9

Type of employment differed according to the **domain of specialization**, with participants with an MSc in clinical psychology more often being self-employed ($\chi^2(3) = 114.58$, Cramer's $V = .17$, $p < .001$), in particular being in self-employment as a secondary occupation.

Table 10. Type of employment of participants with an MSc in clinical psychology versus another domain of specialization

Type of employment (%)	MSc in clinical psychology (*n* = 3,158)	MSc in another domain of psychology (*n* = 987)
Only salaried employment	46.0	64.2
Self-employment as a primary occupation	20.5	17.5
Self-employment as a secondary occupation	32.8	17.4
Self-employment after retirement	0.6	0.8

Type of employment differed according to **age cohort** (n = 4,145, $\chi^2(12) = 785.12$, Cramer's $V = .25$, $p < .001$). As shown in Table 11, salaried employment decreases with age, whereas self-employment (as a primary or a secondary occupation) increases.

Table 11. Type of employment: differences in age cohort

	Age cohort				
	<30 years	30–39 years	40–49 years	50–59 years	≥60 years
Type of employment (%)					
Only salaried employment	65.0	52.8	40.0	40.1	26.6
Self-employment as a primary occupation	12.3	16.8	22.4	30.1	45.7
Self-employment as a secondary occupation	22.7	30.4	37.6	29.7	13.8
Self-employment after retirement	0.0	0.0	0.0	0.2	13.8

Full-time or part-time employment

Around 57.3% of the female psychologists and 75.7% of the male psychologists with an active working status reported **working full-time** (n = 4,134, $\chi^2(1) = 83.72$, $\varphi = .14$, $p < .001$). Of those who work part-time, the majority work 4 days a week. On average, participants with an MSc in psychology worked 90% (expressed in full-time equivalents (FTE); $M = 0.90$, $SD = 0.22$). Mean FTE was lower in **female** participants ($M = 0.89$, $SD = 0.22$) compared with male participants ($M = 0.95$, SD = 0.24) ($t(4132) = 5.59$, $p < .001$). The employment percentages (i.e., FTE) were similar in the different **age** cohorts, except for older participants (≥60 years), who had a mean FTE of 69% compared with a mean of 91% in the other age cohorts ($F(4, 862) = 36.45$, $p < .001$). Participants from the Flemish-language **community** had a higher employment percentage ($M = 0.92$, $SD = 0.20$) than participants from the French- and German-language communities combined ($M = 0.87$, $SD = 0.25$) ($t(2271.64) = 5.32$, $p < .001$). Finally, participants with an **MSc in clinical**

psychology had a slightly lower employment percentage (*M* = 0.90, SD = 0.22) than participants with an MSc in another domain of specialization of psychology (*M* = 0.92, *SD* = 0.21) (*t*(1697.42) = 3.26, *d* = 0.16, *p* < .001).

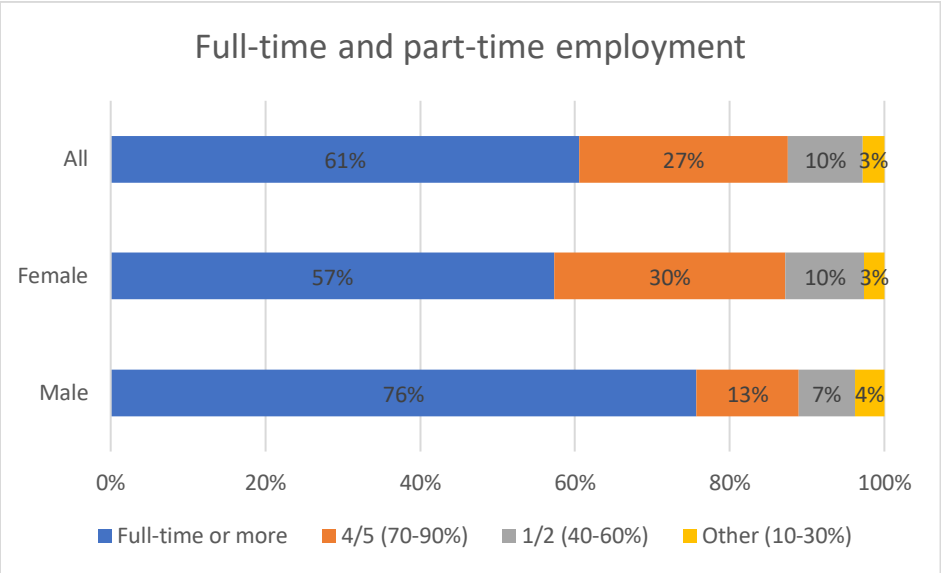

Figure 19. Full-time and part-time employment of working participants with an MSc in psychology (*n* = 4,134).

Number of jobs

To calculate the number of jobs held by participants with an MSc in (clinical) psychology, we asked participants to report the **different contracts** they had with an employer. This means that an employee can have several jobs with the same employer (e.g., when one works in two departments of a hospital and has a contract with each department). Two positions covered by one contract were considered as one job (e.g., one works as a teacher and as a special needs coordinator in a school, under one contract). Similarly, if a self-employed psychologist is active in only one practice/organization, this counts as one job. If someone is self-employed in two practices (with a contract for each practice), this counts as two jobs. Participants were provided with these definitions in the survey.

This analysis focused on psychologists who were employed (*n* = 4,127, data were missing for 18 participants. As Table 12 shows, 42.0% of (self-)employed participants with an MSc in psychology combine different jobs.

Table 12. Number of jobs

	n	%
1 job	**2,392**	**58.0**
1 job in salaried employment	1,922	46.6
1 job in self-employment	471	11.4
2 jobs	**1,317**	**31.9**
1 job in salaried employment and 1 job in self-employment	843	20.4
2 jobs in self-employment	243	5.9
2 jobs in salaried employment	231	5.6
3 jobs or more	**417**	**10.1**
1 job in salaried employment and 2 jobs in self-employment	139	3.4
3 jobs in self-employment	130	3.1
2 jobs in salaried employment and 1 job in self-employment	66	1.6
Other	82	2.0

The most frequent profiles were (a) *one job in salaried employment* only, (b) *the combination of one job in salaried employment with one job in self-employment*, and (c) *one job in self-employment* only. Together, these profiles accounted for 78% of (self-)employed participants with an MSc in psychology.

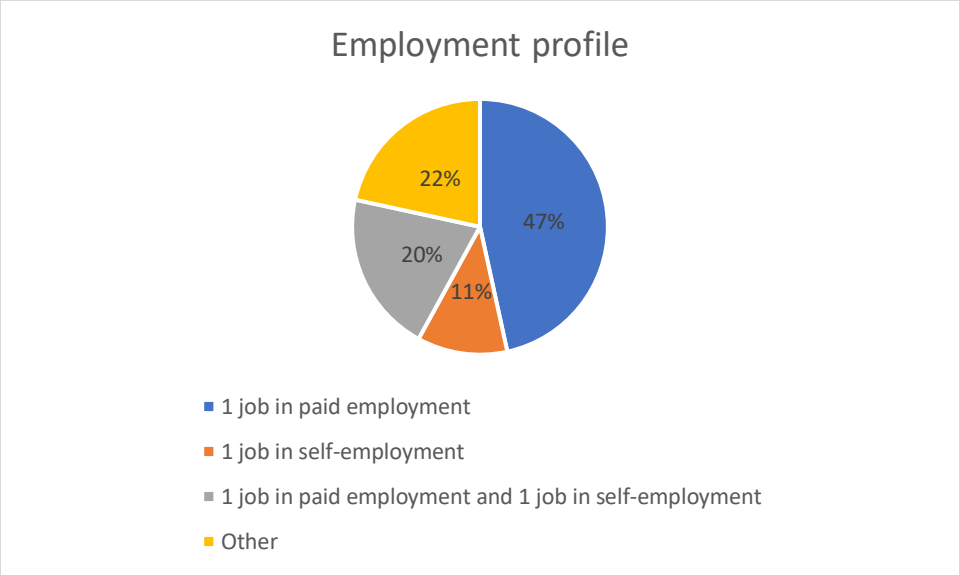

Figure 20. Employment profile of participants with an MSc in psychology.

Contract type

Of 3,263 psychologists who completed questions on the type of **contract in their primary salaried employment**, 87.3% had a contract best described as a **fixed** contract or a temporary contract with the prospect of obtaining a fixed contract, and 84.7% were **remunerated** at a pay grade of a Master of

Sciences (or higher). In 74.8% of participants, both criteria applied – that is, they had (the prospect of) a fixed contract and were remunerated at master level (or higher). This contract type (fixed contract with remuneration at master level) did not differ significantly between those with an MSc in clinical psychology (73.9%) and those with an MSc in another **domain of specialization** of psychology (77.6%) ($\chi^2(1) = 4.37$, $p > .01$); however, it was slightly more common in the French- and German-speaking subsample (78.5%) than the Flemish-speaking subsample (73.1%), but this difference did not reach the threshold for a small effect-size ($n = 3{,}258$, $\chi^2(1) = 10.69$, $p < .01$, $\varphi = .06$).

Representativeness

Salaried and self-employment

Population estimates concerning employment in Belgium are based on the LFS[36] and the National Institute for the Social Security of the Self-Employed[37] from 2017. Comparison of the current sample with these data shows **small differences** between the distribution of salaried and self-employment in our sample compared with psychologists in the Belgian population (Cramer's $V = .11$). The current sample includes, relatively speaking, somewhat more people working in self-employment (49.7% versus 38.5%), especially **self-employment as a secondary occupation** (29.2% versus 20.3%), compared with the national average (see Table 13)[38]. However, as explained in 3.1.1, the NISSE only included psychologists who registered their self-employment since March 2009; psychologists already working in self-employment at that time were registered as "**paramedic professions**". Thus, **estimates for the distribution** of self-employment in the population maybe somewhat inaccurate as they **probably underestimate** the real number of psychologists working in self-employment.

Table 13. Professional situation of MSc in psychology in Belgium

Professional situation (%)	Sample	Population
Salaried employment	**79.5**	**81.8**
Only salaried employment	50.3	61.5
Self-employment as a secondary occupation	29.2	20.3
Self-employment	**49.7**	**38.5**
Self-employment as a primary occupation	19.8	16.5
Self-employment as a secondary occupation	29.2	20.3
Self-employment after retirement	0.7	1.7

[36] Enquête naar de arbeidskrachten/Enquête sur les forces de travail; https://statbel.fgov.be/nl/enquete/enquete-naar-de-arbeidskrachten-eak

[37] Rijksinstituut voor de Sociale Verzekeringen der Zelfstandigen/L'Institut national d'assurances sociales pour travailleurs indépendants; https://www.rsvz.be/nl

[38] As explained in a previous footnote, the data of the NISSE on the number of self-employed psychologists underestimate the number of psychologists working in self-employment; before 2009, psychologists were categorized as a paramedical profession in general, and psychologists registered before 2009 remained categorized as such.

Second job

Population estimates are again based on the LFS, data from 2017. According to LFS reports, 3.9% of working Belgians have a second job. This proportion is much lower than in our sample (in which 42% reported having at least one other job). The LFS does suggest, however, that the **majority of second jobs are in self-employment** and are more often situated in the **sector "Human health and social work activities"**. These findings are in line with the characteristics of our sample.

Full-time or part-time employment

Here, population estimates are based on the LFS data of 2017 only, using data from all sectors and the sector "Human health and social work activities" as this sector relates most to the work of psychologists. **Population estimates** of the LFS concern **only the main job** of those in **salaried employment**; they do not include population estimates concerning full-time or part-time employment of people who combine jobs, or concerning self-employed jobs. In addition, according to the LFS report, only 3.9% of working Belgians (either in self- or salaried employment) have a second job, whereas in our sample 42% had more than one job. This means that the comparison of full-/part-time employment between population-level statistics and the study sample is not straightforward. Thus, we compared the total employment percentage of participants (see Table 15) and the employment percentage of the main job in salaried employment of participants (see Table 16) with the population estimates of the LFS (see Table 14).

In our sample, 39.5% of (self-)employed participants reported working part-time when all jobs are combined, and 53.8% work part-time in their main job in salaried employment. In the LFS, 27.3% of Belgian inhabitants in salaried employment work part time in their main salaried employment, and this proportion increases to 48.5% in the sector Human health and social work activities. This suggests that **part-time employment** is more prevalent in the **human health and social work activities sector** in the population (Cramer's V = .22) compared with other sectors in the population. Part-time employment in our sample was similar as part-time employment in the human health and social work activities sector in the population (Cramer's V < .10[39]).

Women in Belgium more often work part-time than men (all sectors: Cramer's V = .37; Human health and social work activities sector: Cramer's V = .36). This is also the case in our sample (n = 4,134, $\chi^2(1) = 83.72$, φ = .14, p < .001). About half of part-time workers work 4 days out of 5. This is also the case in our sample. The proportion of women working part-time (all jobs combined) in our sample (42.7%) is lower than the rate of part-time employment for Belgian women in the human health and social work activities sector (for their main job in salaried employment) (55.4%) (Cramer's V = .13). The men in our sample showed a similar employment percentage as Belgian men in the human health and social work activities sector (Cramer's V = .05), whereas women in our sample worked full-time somewhat more often (Cramer's V = .13).

[39] This was true when all jobs were combined and when only the main job was considered.

Table 14. Full-time and part-time employment rate of the main job in salaried employment in Belgium (in 2017)

Employment rate (%)	Male	Female	All
All sectors			
Full-time or more	88.6	55.5	72.7
Part-time (number of days (FTE%))	13.4	45.5	27.3
4/5 (70–90%)	5.3	20.9	12.8
1/2 (40–60%)	4.1	17.8	10.6
Other	2.0	5.9	3.9
Human health and social work activities sector			
Part-time	20.1	55.4	48.5

Note. Statbel used the following categories: Percentages between 40% and 60% were categorized as working halftime, percentages between 70% and 90% were categorized as working 4 days out of 5 (80%); the category "other" comprises percentages lower than 40%, percentages between 60 and 70%, and percentages higher than 90%[40]. FTE, full-time equivalent.

Table 15. Full-time and part-time employment rate of (self-)employed participants (*n* = 4,134)

Employment rate (%)	Male	Female	All
Full-time or more	75.7	57.3	60.5
Part-time (number of days (FTE%))	24.3	42.7	39.5
4/5 (70–90%)	13.2	29.9	26.9
1/2 (40–60%)	7.3	10.2	9.7
Other (10–30%)	3.8	2.6	2.8

Note. We followed the categorization of Statbel. As our variable on employment percentage was categorical (grouped by 10%), there were no values lower than 10%, between 60% and 70%, or higher than 90%. FTE, full-time equivalent.

[40] See https://statbel.fgov.be/nl/themas/werk-opleiding/arbeidsmarkt/deeltijds-werk#figures

Table 16. Full-time and part-time employment rate of the main job in salaried employment in study sample (*n* = 3,279)

Employment rate (%)	Male	Female	All
Full-time or more	62.3	43.0	46.2
Part-time (number of days (FTE%))	37.7	57.0	53.8
4/5 (70–90%)	17.8	29.0	27.1
1/2 (40–60%)	16.8	24.2	23.0
*Other**	3.1	3.8	3.7

Note. *Some of the information for this variable was based on a continuous variable. In line with the categorization of Statbel, the category "other" comprises percentages lower than 40%, percentages between 60 and 70%, and percentages higher than 90%. FTE, full-time equivalent.

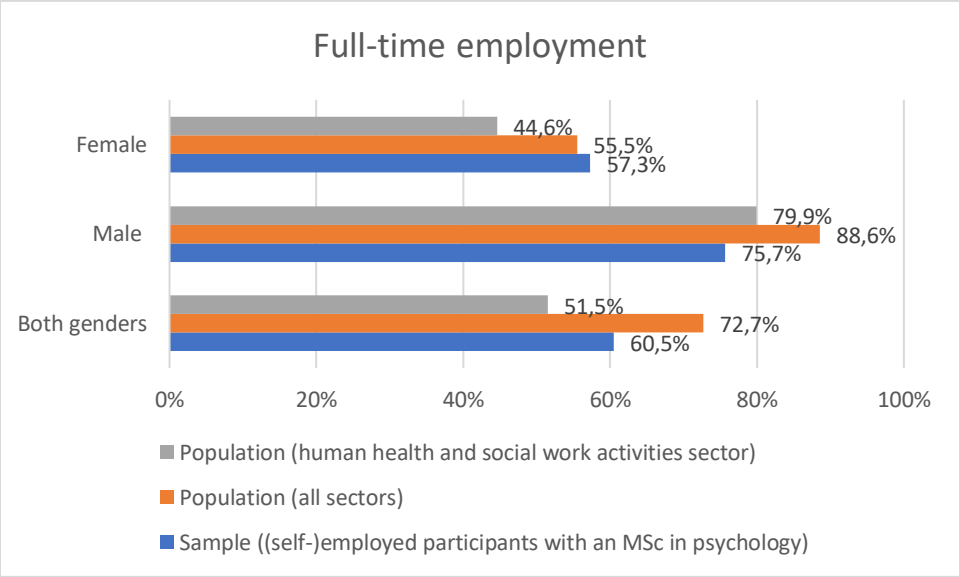

Figure 21. Full-time employment in the sample (self-)employed participants with an MSc in psychology (*n* = 4,134) and in the Belgian population (statistics of Statbel).

3.3.2 Employment in the broad domain of psychology or educational sciences

Professional situation of participants working in the broad field of psychology

We asked participants whether their **job** was **related to the broad field of psychology or educational sciences**, on a 4-point Likert scale ranging from "yes, very much" to "no, not at all" (see Table 17). The vast majority of participants indicated that their job was indeed situated in this field: *n* = 3,909 (91.6% of participants with an MSc in psychology, *n* = 4,266, 95.2% of (self-)employed participants, *n* = 4,107; data were missing for 38 participants), consistent with the purpose of the web survey. Among participants with one or more jobs in salaried employment, 91.6% indicated that (one of) their job(s) was related to the

field. Among participants with one or more jobs in self-employment, 98.9% indicated that (one of) their job(s) was related to the field. Hence, particularly those participants who were in self-employment reported having a job in the broad domain of psychology and educational sciences ($\chi^2(1) = 119.29$, Cramer's $V = -.17$, $p < .001$, $n = 4{,}107$).

Table 17. Employment in the broad domain of psychology or educational sciences per job

	Salaried employment			Self-employment		
Employment in domain of psychology (%)	Job 1 (*n* =3,280)	Job 2 (*n* = 304)	Job 3 (*n* = 13)	Job 1 (*n* = 1,928)	Job 2 (*n* = 502)	Job 3 (*n*= 111)
Yes, very much	75.4	66.8	69.2	94.0	83.1	69.2
Yes, somewhat	17.1	23.7	7.7	4.0	8.8	7.7
No, not really	4.8	4.3	23.1	1.1	2.8	23.1
No, not at all	2.7	5.3	0.0	0.9	5.4	0.0

Figures 22 and 23 show the type of employment and full-time employment in participants with an MSc in psychology who work in the broad domain of psychology in one or more jobs. Similar to previous analyses in the larger sample, the distribution of **type of employment** showed small differences with the population data (Cramer's $V = .15$), which can be explained by a change in categorization of self-employed clinical psychologists by the NISSE in 2009, and full-time employment was somewhat more common in our sample of female psychologists compared with population data on female employment in the human health and social work activities sector (Cramer's $V = .11$).

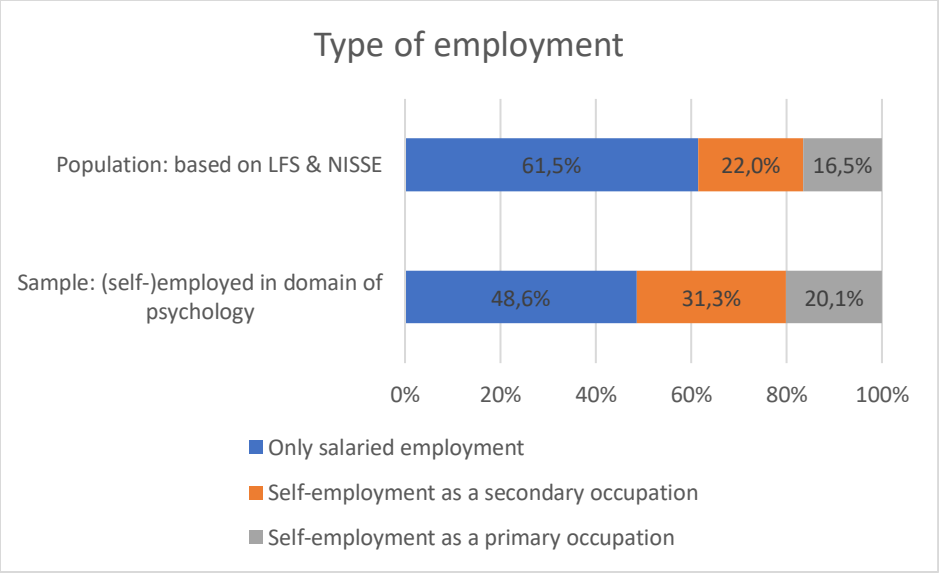

Figure 22. Type of employment in participants with an MSc in psychology who work in the broad domain of psychology and educational sciences, compared with population statistics on the employment of individuals with an MSc in psychology.

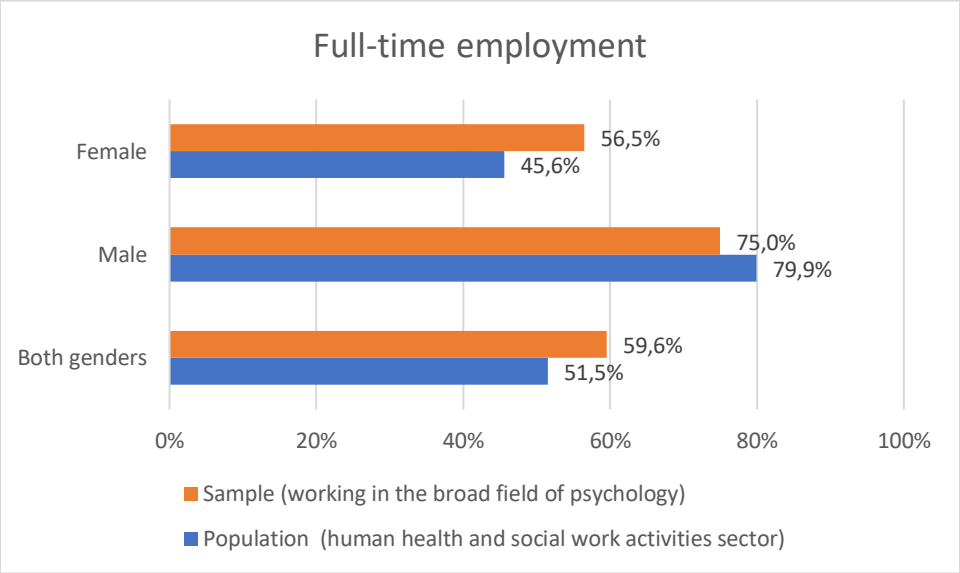

Figure 23. Full-time employment in participants with an MSc in psychology who work in the broad domain of psychology and educational sciences, compared with population statistics on full-time employment in the human health and social work activities sector.

Psychologists in **salaried employment** less often reported having a job related to the field than psychologists who are self-employed (as their primary or secondary activity[41]) (91.6% versus 98.0% and 99.4%, respectively; $\chi^2(2) = 121.45$, Cramer's $V = .17$, $p < .001$). There were also some **regional differences** ($n = 4{,}351$[42], $\chi^2(2) = 62.77$, $p < .001$, Cramer's $V = .12$). Psychologists who work in the Brussels region ($n = 794$) less often practiced a job related to the field of psychology compared with psychologists who work in Flanders ($n = 2{,}573$) or Wallonia ($n = 984$) (see Figure 24). There was no relationship with age ($\rho = .03$, $p > .05$; $\chi^2(4) = 12.52$, $p > .05$; $n = 4{,}145$).

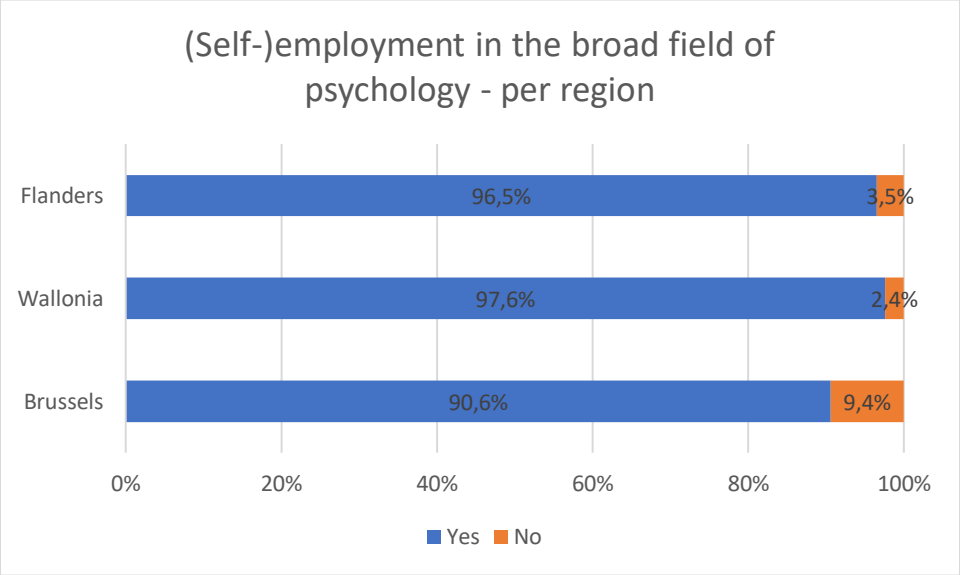

Figure 24. Employment in the broad field of psychologists in participants working in Flanders, Wallonia or Brussels.

Sectors

We also asked participants to indicate in which **sector** their **main employment** was situated. In these analyses, we focused on the participants who indicated they were working in the broad domain of psychology and educational sciences. We asked participants to indicate the sector(s) of the organization in which they were working. Participants could indicate multiple sectors.

Most psychologists in **salaried employment** reported, as would be expected, being employed in sectors related to mental healthcare, education, social welfare, and healthcare (Table 18). Notably, those with a secondary job in self-employment more often have a salaried employment in mental healthcare (40.7%) than those who work only in salaried employment (27.2%).

[41] Self-employment as a secondary activity here includes psychologists who combine independent work with receiving a pension ($n = 28$).
[42] Participants could be employed in more than one region.

Table 18. Sector of main job in salaried employment

	Only salaried employment	Self-employment as a secondary occupation
Sector (%)		
Social welfare, social services, and interest groups	15.8	17.9
Mental healthcare	27.2	40.7
Healthcare	14.4	15.1
Education, training, and student counselling	27.2	24.9
Forensic sector	7.3	4.0
Public administrations/government	7.6	3.1
Commercial services	4.5	1.2
Industrial sector	2.5	0.5
Research sector	10.2	5.0
Leisure, culture, and sport	0.5	0.4
Other	3.8	2.8
n	1,833	1,125
Missing	13	13

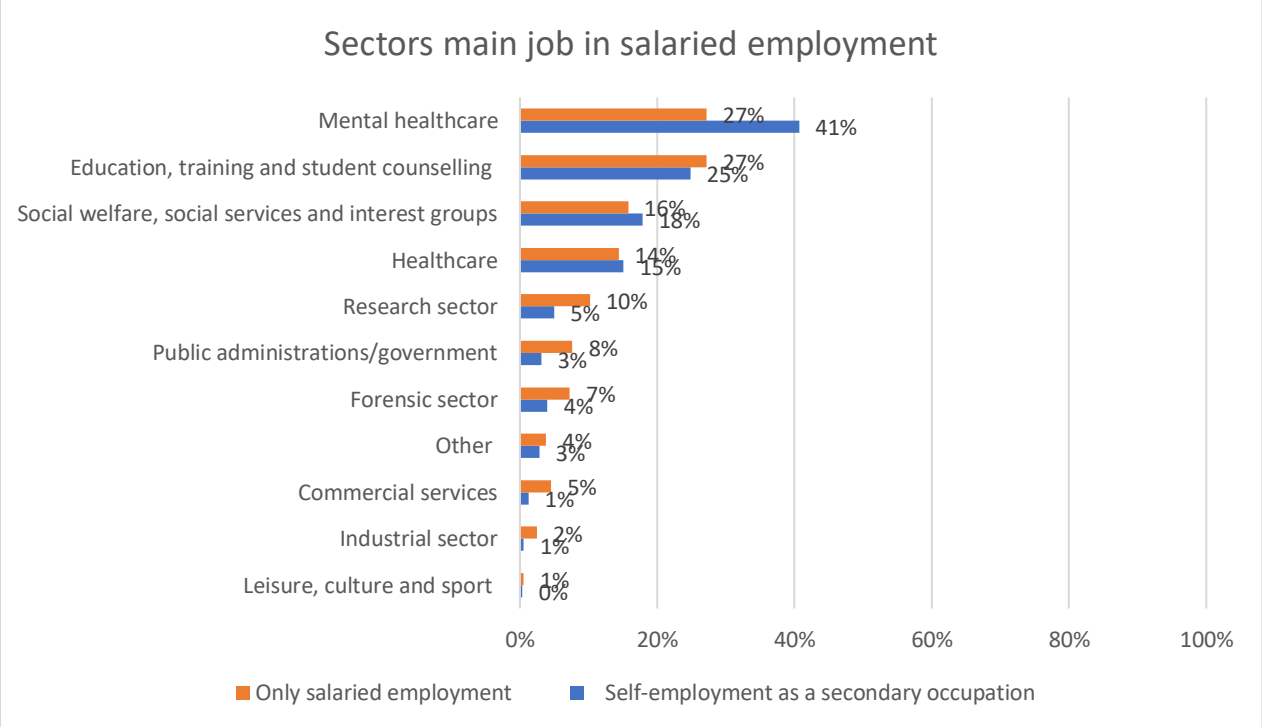

Figure 25. Sectors of main job in salaried employment.

Analyses on the main job in **self-employment** show that most psychologists reported working in mental healthcare in this job (66.8% of psychologists with self-employment as their primary occupation and 78.7% of those with self-employment as a secondary occupation). Jobs in general healthcare were second most common, but the proportion of psychologists working in general healthcare is clearly much lower (16.1–22.7%) than in mental healthcare. The predominance of jobs in the mental healthcare sector is even more obvious among those in self-employment compared with those in salaried employment. See Table 19 and Figure 26 for a more detailed view.

Table 19. Sector of main job in self-employment

	Primary occupation	**Secondary occupation/ after retirement**
Sector (%)		
Social welfare, social services, and interest groups	11.1	5.1
Mental healthcare	66.8	78.7
Healthcare	22.7	16.1
Education, training and, student counselling	13.1	7.8
Forensic sector	4.6	2.2
Public administrations/government	2.6	0.7
Commercial services	9.2	0.9
Industrial sector	3.4	0.3
Research sector	1.8	1.0
Leisure, culture and sport	1.3	0.9
Other	9.2	7.9
n	758	1,101
Missing	20	20

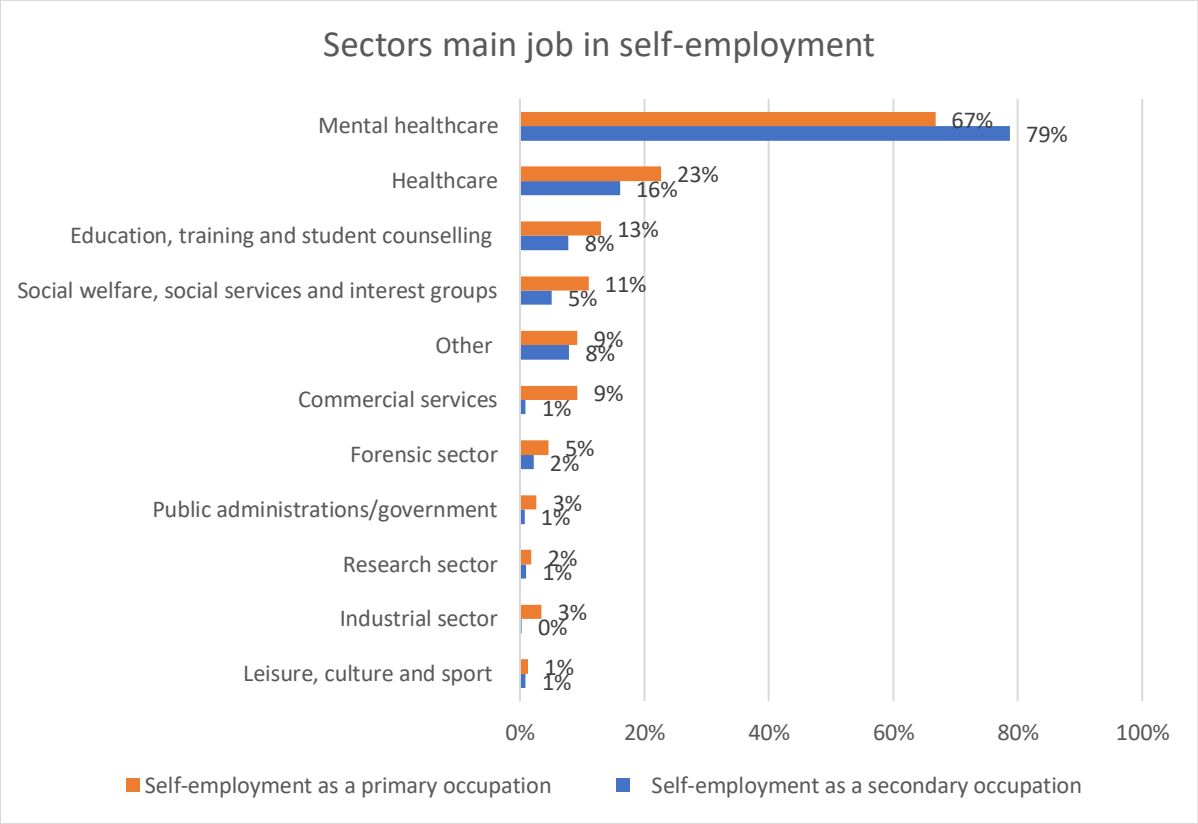

Figure 26. Sectors of main job in self-employment.

Figure 27 shows the data for those with an **MSc in clinical psychology** whose main job is in salaried employment (*n* = 1,645) and for those whose their main job is in self-employment (*n* = 1,087) among the Flemish-speaking participants. Figure 28 shows the respective data for main salaried job (*n* = 650) and main self-employed job (*n* = 456) among the French- and German-speaking participants.

The sectors mental healthcare (42% and 90% of MSc in clinical psychology, in their main jobs in salaried and self-employment, respectively), healthcare (14% and 9%), education (21% and 9%), and social welfare (16% and 7%) are again the main sectors for those with an MSc in clinical psychology. Only a very small proportion of participants with an MSc in clinical psychology reported working in the leisure, industry, and commercial services sectors (less than 2%).

Among the **French- and German-speaking participants**, there is a more equal distribution between healthcare (22% and 37% of MSc in clinical psychology, in their main jobs in salaried and self-employment, respectively) and mental healthcare (30% and 57%, respectively), whereas in the **Flemish-speaking community**, the mental healthcare sector is clearly the most important for those with an MSc in clinical psychology (42% and 90% in their main jobs in salaried and self-employment, respectively).

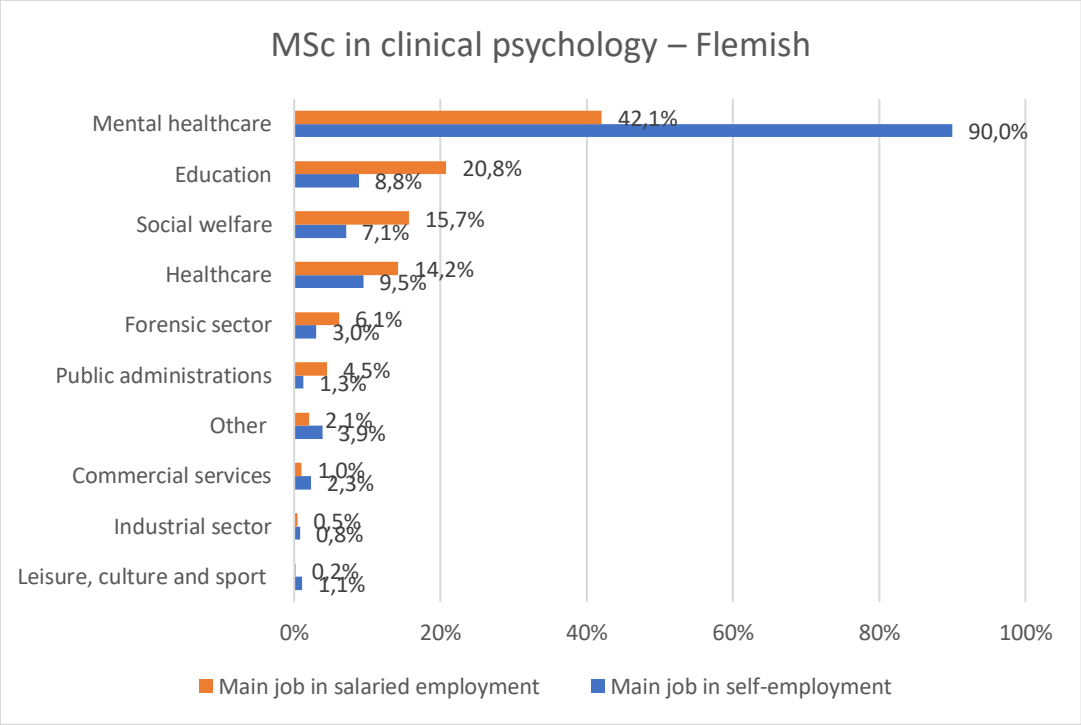

Figure 27. Sectors of main job in salaried employment (*n* = 1,645) and main job in self-employment (*n* = 1,087) among Flemish-speaking participants with an MSc in clinical psychology.

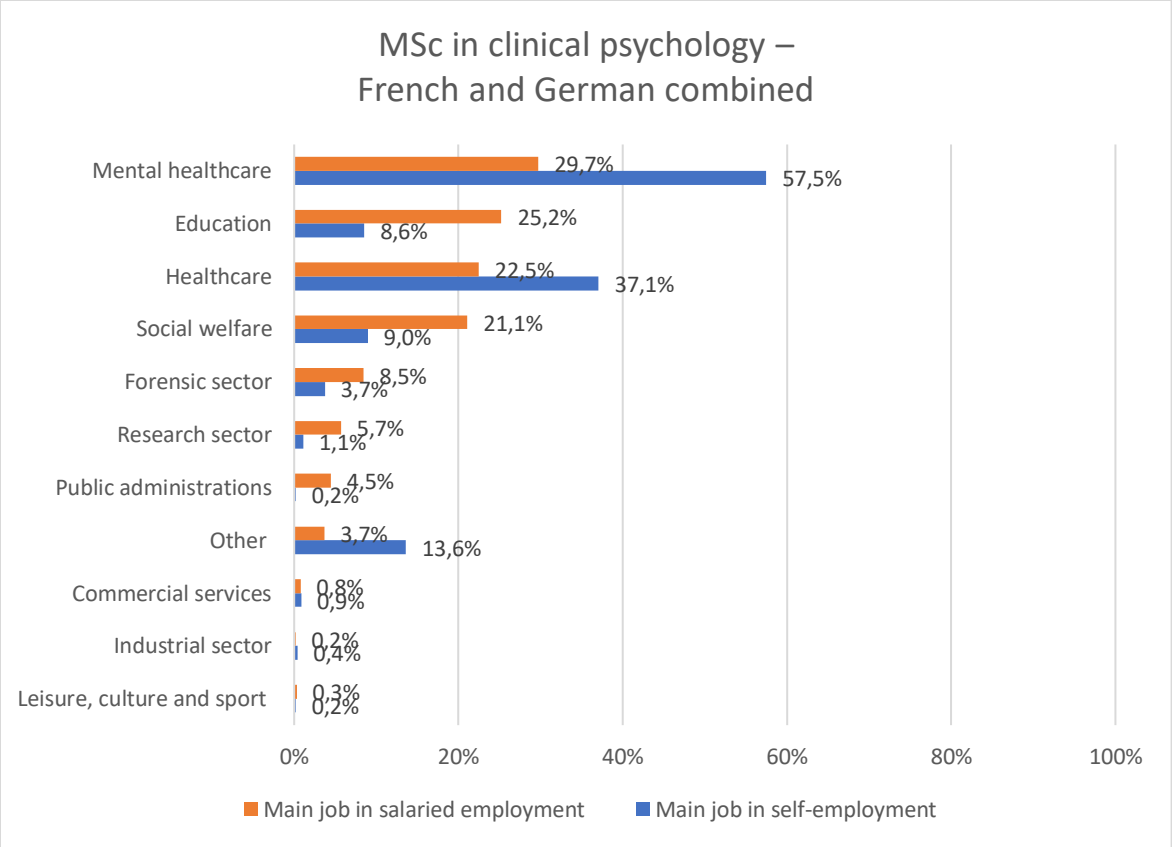

Figure 28. Sectors of main job in salaried employment (*n* = 650) and main job in self-employment (*n* = 456) among French- and German-speaking participants combined with an MSc in clinical psychology.

3.3.3 Registration with the Commission of Psychologists, familiarity with the code of ethics, and professional title

In this section, we discuss several features related to the **professional identity** as a psychologist, such as **registration** as a psychologist with the Commission of Psychologists and using of the professional title of 'psychologist'. This registration also means that they are bound to a **code of ethics** that regulates their profession.

Familiarity with the code of ethics

We asked participants with an MSc in psychology with an active employment status whether they had read the **Code of Ethics for Psychologists** (www.compsy.be/en/read-entire-code-ethics) and how **familiar** they were with this code; 3,571 participants responded to this question. The majority reported they had read the code of ethics once but were not (fairly) well acquainted with it. Only 20.3% indicated that they were (fairly) familiar with the code of ethics, and 11.1% reported they had never read it.

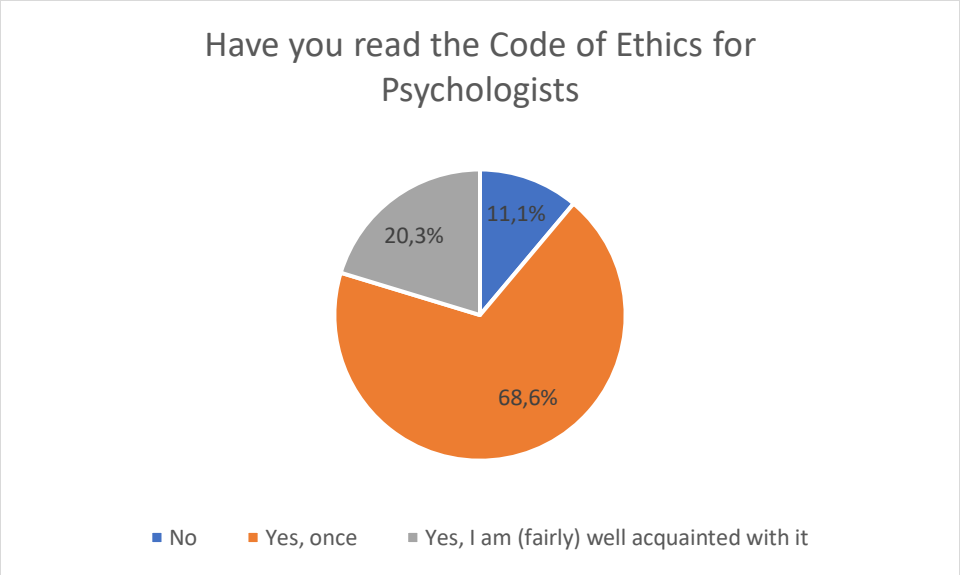

Figure 29. Familiarity of participants (*n* = 3,571) with the Code of Ethics for Psychologists.

Participants who reported they had read the code **at least once**, further reported on the **frequency** of consultation (*n* = 3,713) (Figure 30). The majority hardly ever consulted the code (56.1%). Frequency of consultation was higher in those who reported some acquaintance with the code ($\chi^2(5) = 633.91$, Cramer's $V = .46$, $p < .001$) However, on average, even psychologists who indicated familiarity with the code only consulted the code on a yearly basis (median = one or more times a year; 57.1%)

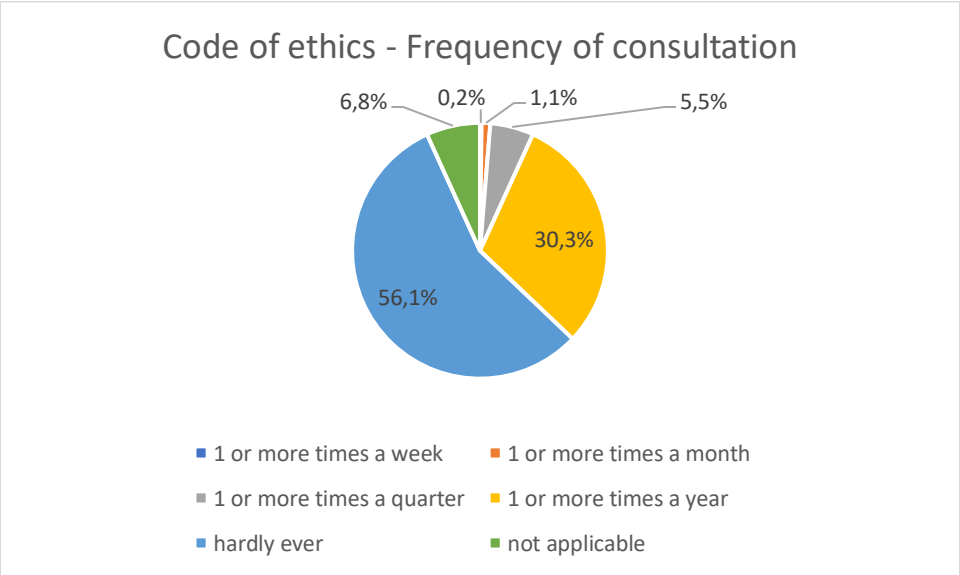

Figure 30. Frequency of consulting the Code of Ethics in participants who reported they had read the code of ethics (*n* = 3,173).

We also inquired whether (self-)employed participants with an MSc in psychology **believed they were obliged** to act according to the Code of Ethics for Psychologists. In psychologists who worked in the broad domain of psychology (*n* = 3,384), 88.5% was (fairly) sure the code of ethics applied to them, 4.0% indicated they did not know whether or not the Code of Ethics was a mandatory code for them, and 7.4% was (fairly) sure the code of ethics did not apply to them. Further, 29.4% had to (additionally) comply to job- or sector- specific ethical guidelines.

Familiarity with the code of ethics was higher in psychologist who were working in the broad domain of psychology, compared with those working outside the **field of psychology** (*n* = 3,563, $\chi^2(2) = 141.87$, Cramer's $V = .20$, $p < .001$) (see Figure 31).

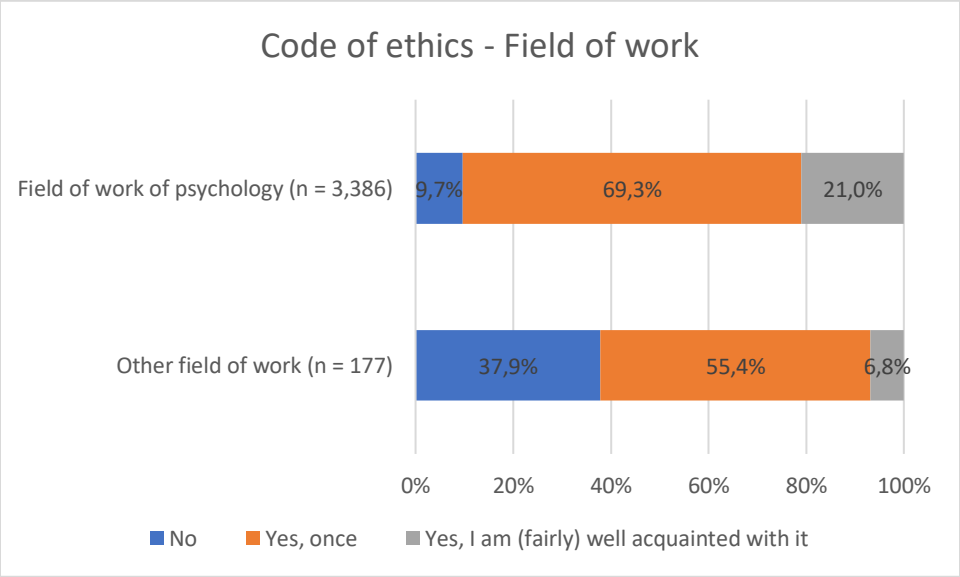

Figure 31. Familiarity with the Code of Ethics for Psychologists: differences between participants who work in the broad field of psychology and those working outside the field of psychology.

Familiarity with the code of ethics differed according to the **domain of specialization**: participants with an MSc in clinical psychology reported greater familiarity with the code than those with an MSc in another domain of psychology (*n* = 3,571, $\chi^2(2) = 164.52$, Cramer's $V = .22$, $p < .001$). Despite this, 7.6% of those with an MSc in clinical psychology reported never having read the code of ethics.

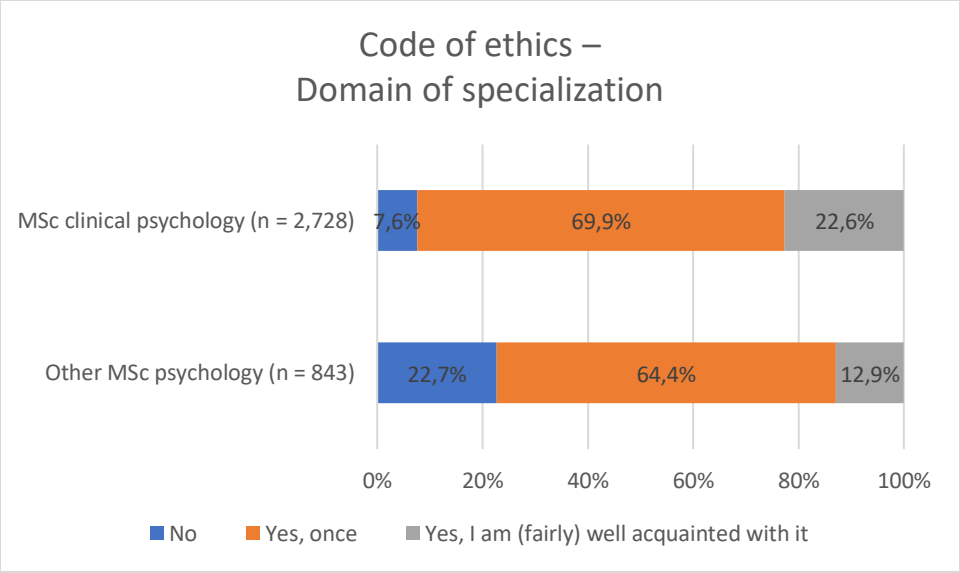

Figure 32. Familiarity with the Code of Ethics for Psychologists: differences between participants with an MSc in clinical psychology and those with an MSc in another domain of psychology.

Knowledge of the code of ethics also differed according to the **language** of the participants. Those with an MSc in psychology who completed the survey in French or German reported greater familiarity with the code than Flemish-speaking participants (n = 3,566, $\chi^2(2) = 104.24$ Cramer's $V = .17$, $p < .001$).

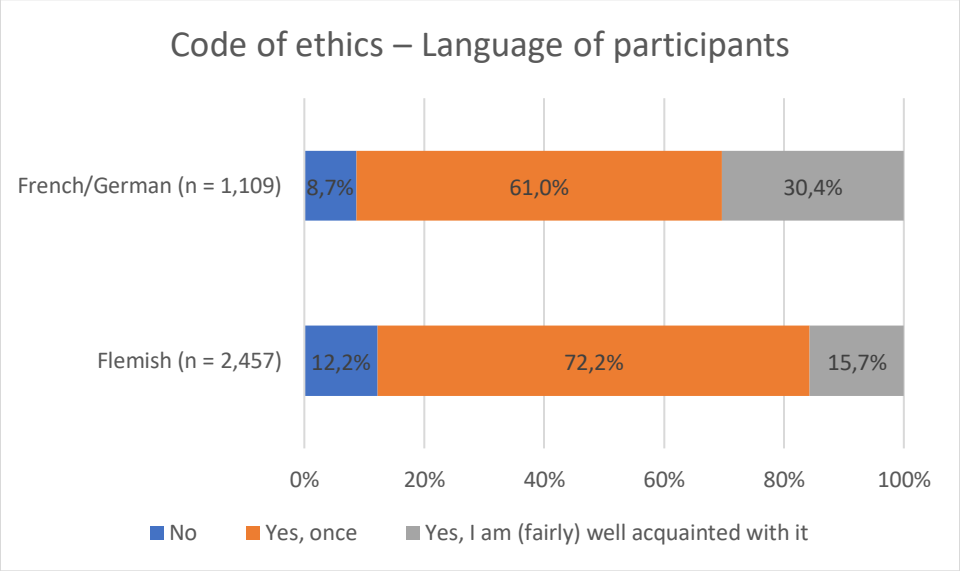

Figure 33. Familiarity with the Code of Ethics for Psychologists: differences according to language of participants.

Psychologists who only worked in **salaried employment**, were less familiar with the Code of Ethics compared with psychologists who also worked in self-employment (n = 3, 571, $\chi^2(2) = 151.84$, Cramer's $V = .21$, $p < .001$).

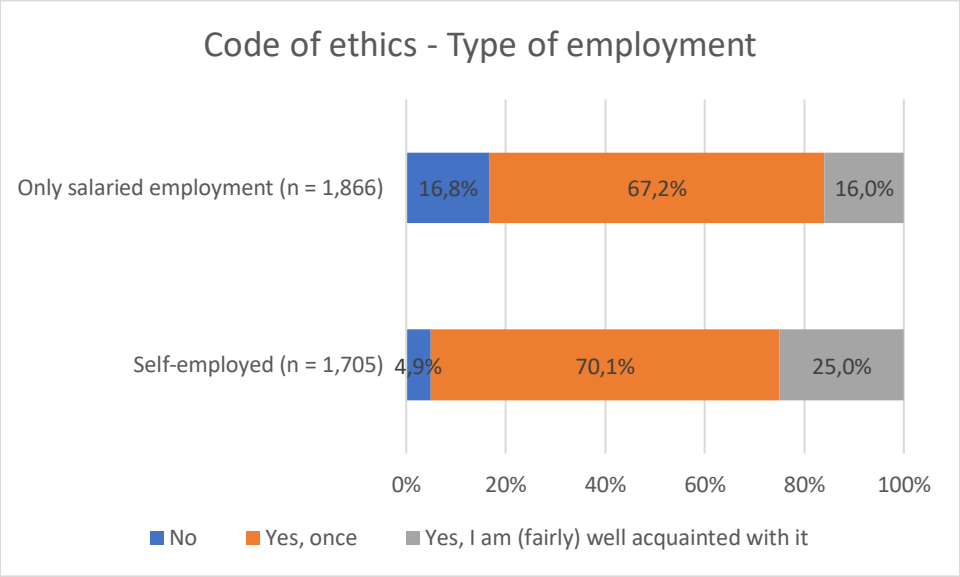

Figure 34. Familiarity with the Code of Ethics for Psychologists: differences according to type of employment.

Finally, knowledge of the code of ethics showed a significant relationship with the **age** of the psychologist, with older psychologists reporting somewhat more knowledge of the code, but this relationship did not reach the threshold for a small effect size ($\rho = .05$, $p < .01$; $\chi^2(4) = 28.66$, Cramer's $V = .06$, $p < .001$).

Registration with the Commission of Psychologists

In terms of the further development of the profession of psychology, it is also interesting to have data on the number of psychologists who are **registered with the Belgian Commission of Psychologists**.

Of the 3,618 participants with an MSc in psychology who reported on registration with the Commission of Psychologists (data were missing in 16% of the sample), 2,783 (76.9 %) reported that they had**, at least once**, registered with the Commission of Psychologists, and 2,598 (71.8%) reported being **currently** registered (registrations must be renewed annually) (Figure 35). Current registration was somewhat lower in the Flemish-speaking sample (69.1%) compared with the French- and German-speaking sample (78.3%) (n = 3,613, $\chi^2(1) = 32.41$, $\varphi = .10$, $p < .001$) (Figure 36).

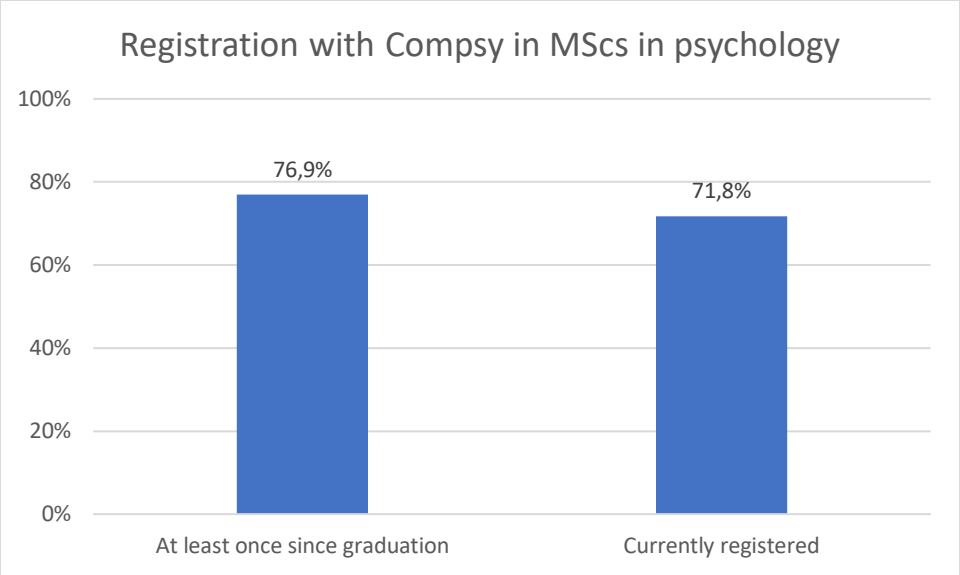

Figure 35. Current and lifetime registration with the Commission of Psychologists (ComPsy) (*n* = 3,618).

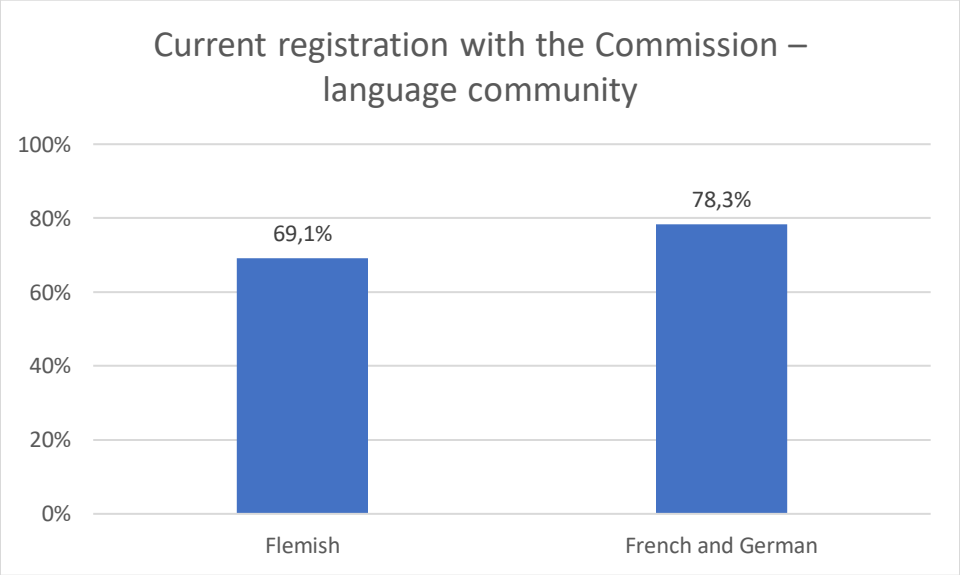

Figure 36. Registration differences according to language community (*n* = 3,613).

We further investigated whether there were differences in the level of current registration according to **professional situation** (paid versus self-employed), **domain of specialization** of the MSc in psychology (clinical or other), and **age**. Registration was markedly higher in self-employed psychologists (92.0%) than in psychologists in salaried employment (52.3%) (n = 3,618, $\chi^2(1) = 705.08$, $\varphi = -.44$, $p < .001$) (see Figure 37), and was higher among those with an MSc in clinical psychology (80.7%) compared with those with an

MSc in another domain of specialization of psychology (42.1%) (n = 3,618, $\chi^2(1) = 470.59$, $\varphi = .36$, $p < .001$) (see Figure 38).

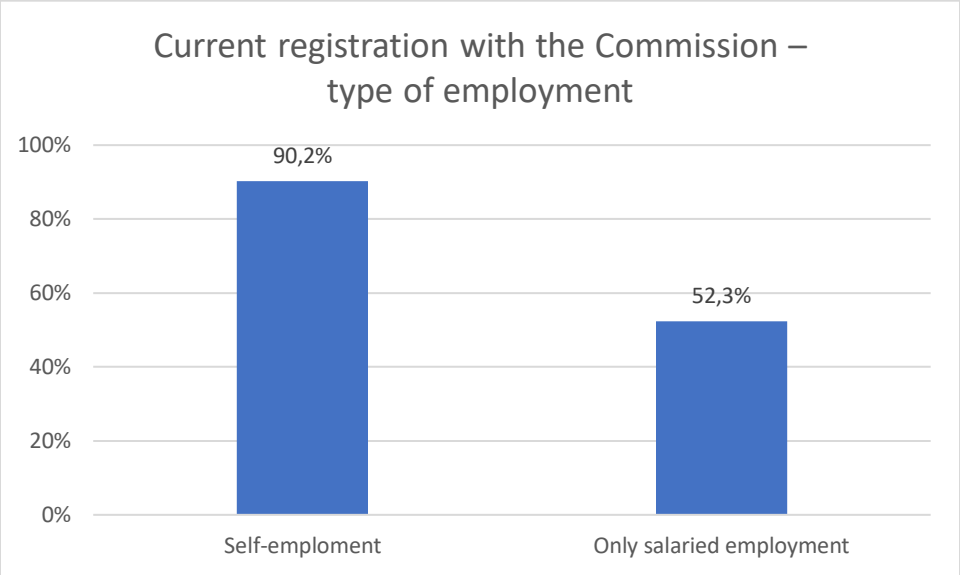

Figure 37. Registration differences according to type of employment (n = 3,618).

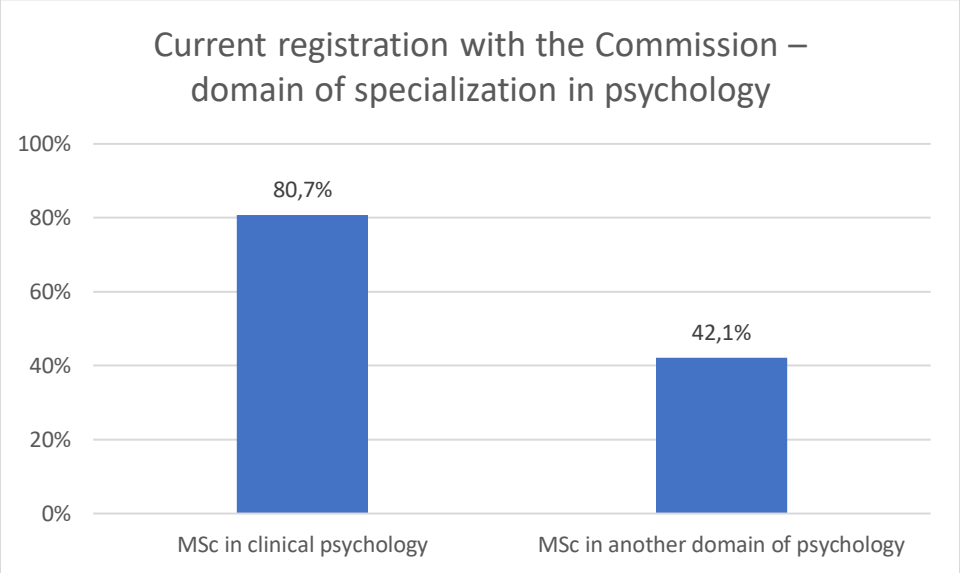

Figure 38. Registration differences according to domain of specialization in MSc in psychology (n = 3,618).

Age effects[43] were less pronounced, with the exception of psychologists who were younger than 25 years, among whom 56.7% had (yet) registered. Registration among psychologists aged between 25 and 40 years ranged from 69.3% to 71.2%; registration among psychologists aged between 40 and 65 years was somewhat higher, ranging from 73.0% to 78.7% (n = 3,617, $\chi^2(9) = 30.01$, Cramer's $V = .09$, $p < .001$).

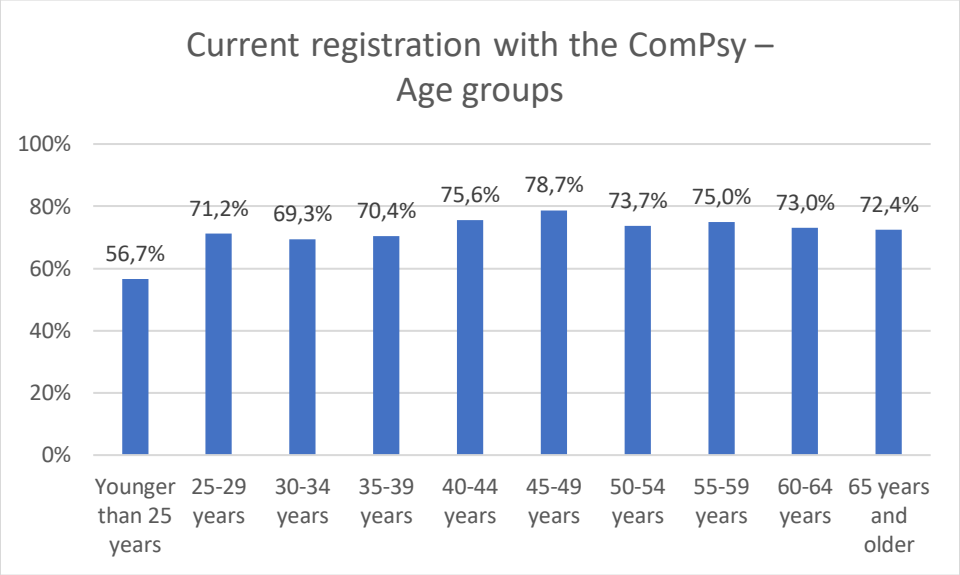

Figure 39. Registration differences according to age group (n = 3,617).

Finally, registration was higher in participants with an MSc in psychology who **worked in the broad domain of psychology** (75.3%), compared with participants who did not work in the broad domain of psychology (27.8%) (n = 3,610, $\chi^2(1) = 272.28$, $\varphi = .28$, $p < .001$) (Figure 40).

[43] Age cohorts were <25 , 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, and 65+ years.

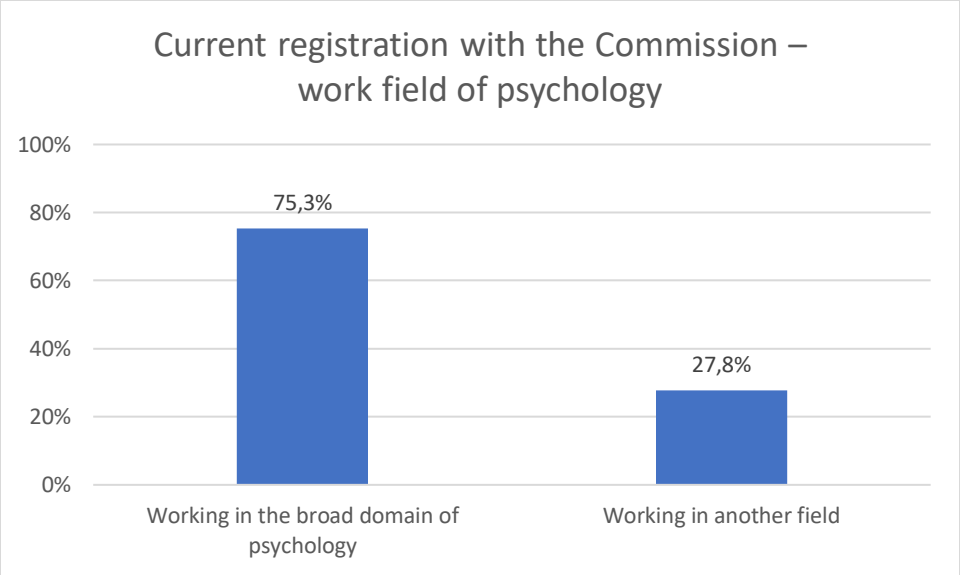

Figure 40. Registration differences according to field of work (*n* = 3,610).

Professional title

Psychologists who worked in salaried employment reported on the professional title in their contract, and self-employed psychologists reported on the professional title(s) they used. Of the full sample of psychologists (*n* = 4,253; data were missing for 51 participants), 69.1% used the title of "psychologist" in at least one of their jobs. In the subsample of **psychologists who worked in the broad domain of psychology** (*n* = 3,894; data were missing for 15 participants), **75.3% used this professional title**.

We also explored group differences in this subsample. There was a strong relationship between use of the title of psychologist and current registration with the Commission of Psychologists (n = 3,347, $\chi^2(1)$ = 933.63, φ = .53, $p < .001$). Among registered psychologists, 88.6% reported using the title of psychologist; among non-registered psychologists, only 36% did so. This also implies that 11.8% of psychologists who work in the field of psychology and use the professional title are not currently registered with the commission. Figure 41 shows the distribution of both characteristics – registration and title – and whether or not these are both present in psychologists who work in the field.

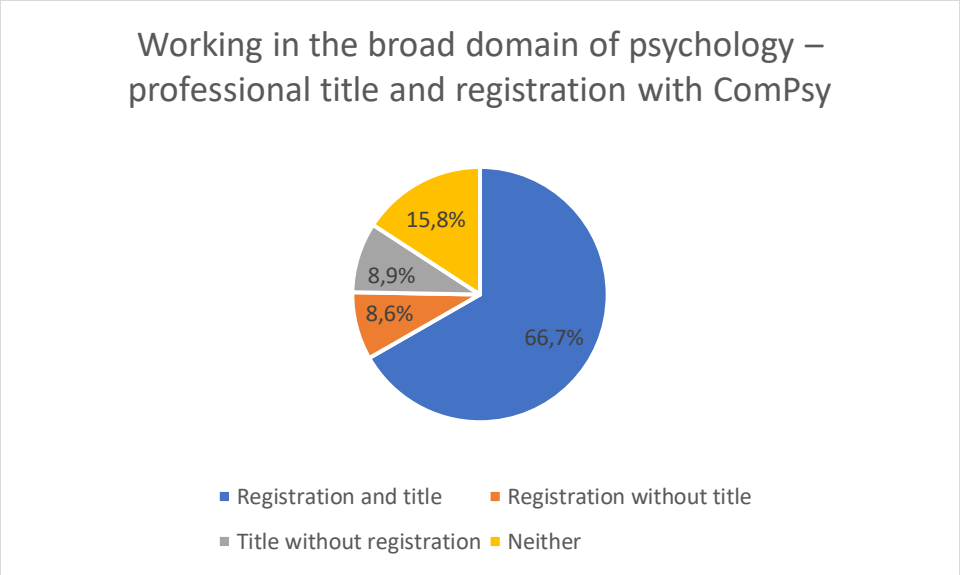

Figure 41. Relationship between registration with the Commission of Psychologists and use of the professional title of "psychologist" (n = 3,347).

Use of the professional title of psychologist was slightly more common among participants from the French or German Community than from the Flemish Community, but this difference did not reach the threshold for a small effect-size (n = 3,886, $\chi^2(1) = 10.79$, $\varphi = .05$, $p < .01$). Participants with an MSc in clinical psychology more often used the title than psychologists with another **educational background** (n = 3,894, $\chi^2(1) = 402.95$, $\varphi = .32$, $p < .001$). Further, use of this professional title was more relevant in psychologists who worked in **self-employment** as a primary or a secondary occupation, compared with psychologists who worked exclusively in salaried employment (n = 3,894, $\chi^2(1) = 675.39$, $\varphi = –.42$, $p < .001$). Figure 42 shows these group differences.

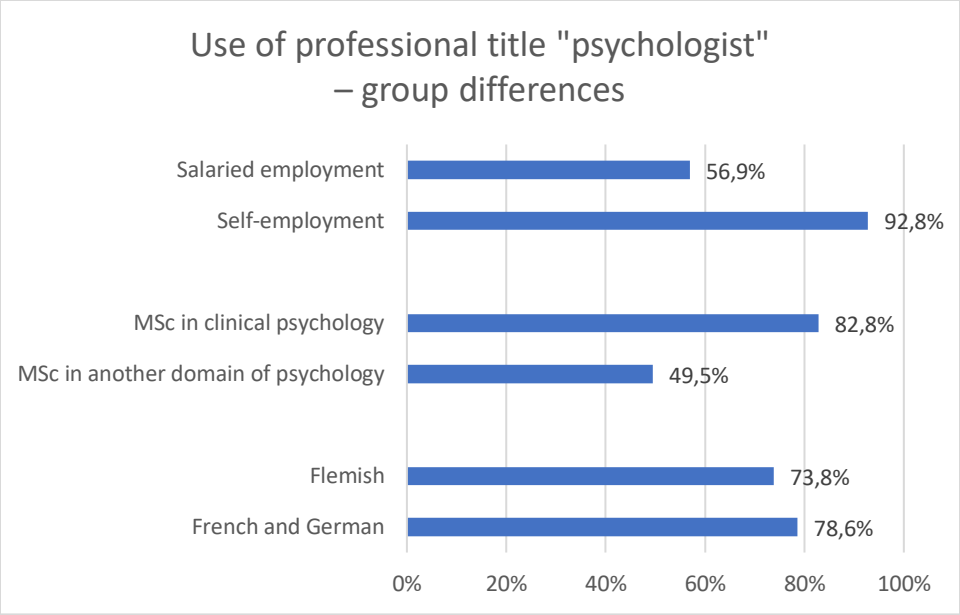

Figure 42. Group differences in the use of the professional title of "psychologist".

The correlation between professional title and **age** showed a significant relationship with age, indicating that use of the title increased somewhat with age, but this difference did not reach the threshold for a small effect-size (n = 3,893, ρ = .06, p < .001). Follow-up analyses showed that psychologists younger than 30 years of age used the title least often (70.1%).

As participants provided information regarding their professional title(s) per job, we further explored job title for the main job in salaried employment (n = 3,025) and their professional title(s) in self-employment (n = 2,020)[44]. Figure 43 shows the results for the **main job in salaried employment**. Most participants working in the field of psychology indicated that they had one job title (93.6%), 3.7% reported having more than one title in their contract, and 2.8% did not know their title(s). The job title of "psychologist" was most frequent, but other titles were common. Analyses of open-ended answers showed that these titles were often related to the specific function, such as coordinator, consultant, director, lector, or therapeutic assistant.

[44] Information on professional titles in self-employment were gathered for all self-employed jobs combined, and not for each job separately.

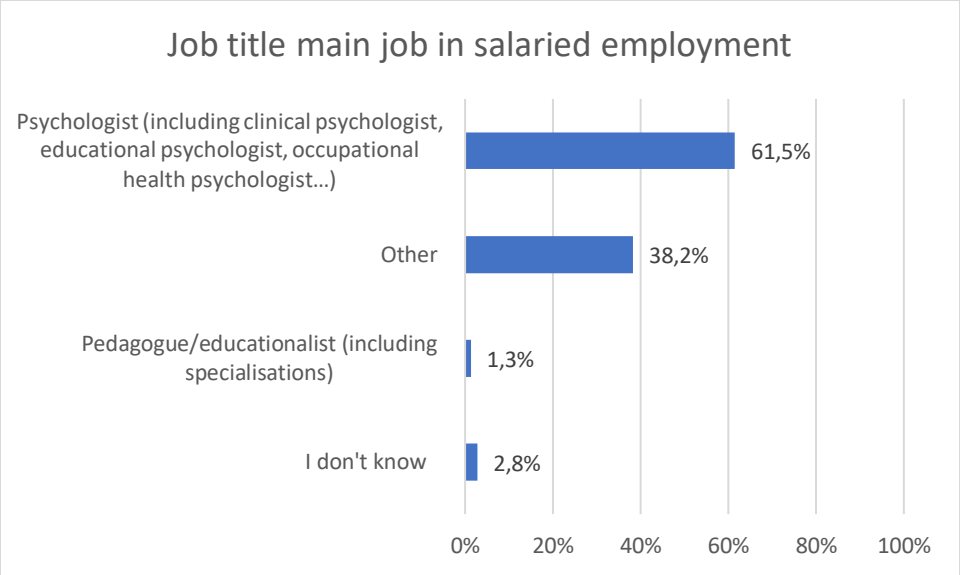

Figure 43. Job title of the main job in salaried employment.

For those in **self-employment**, we specifically inquired about the use of the titles "coach" and "psychotherapist". "Psychologist" was the professional title most often used, including specializations such as clinical psychologist, followed by" psychotherapist". The title "coach" was less commonly used, but was still used by 7% of psychologists. Analyses of open-ended answers showed that other titles were often related to a specific function (e.g. coordinator, mediator, supervisor) and to specifications of a title (e.g. behavioural therapist, psychoanalyst). Self-employed participants often used multiple titles: 49.8% used two titles, and 7.0% more than two.

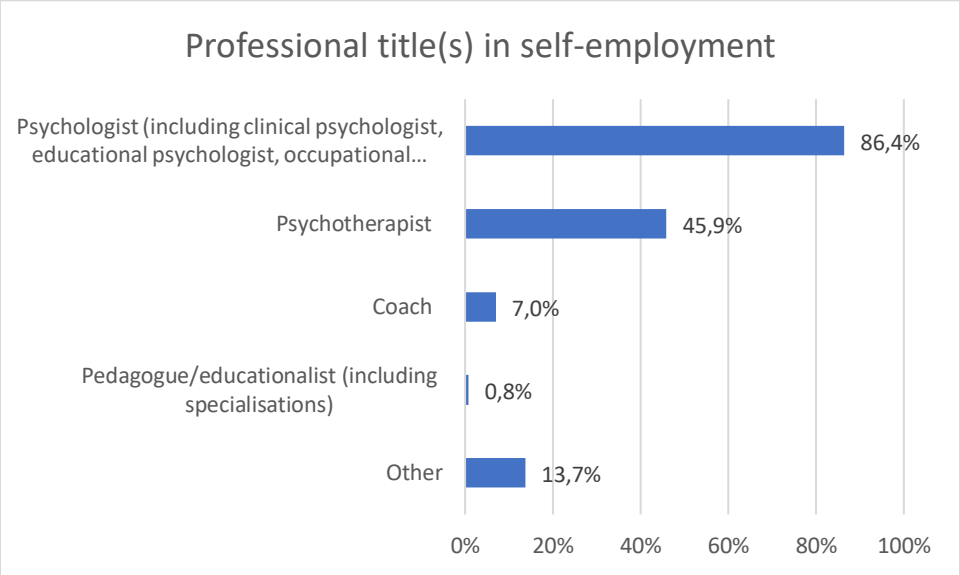

Figure 44. Professional title(s) used by self-employed psychologists.

Around half of self-employed psychologists used the title "psychotherapist" (45.9%); 43.5% also used the title "psychologist" and 2.4% used the title "psychotherapist" without the title of "psychologist". As for the participants that indicated that they used the title "coach" (7.0% of self-employed psychologists), the majority used it in conjunction with the title "psychologist" (5.9% of self-employed psychologists); 1.1% of self-employed psychologists used the job title "coach" without referring to their title of 'psychologist.

3.3.4 Membership of a professional organization

An important feature of the further professional development of (clinical) psychologists, besides continuing education, relates to **membership of professional organization** as a means of keeping up with new developments in the field.

Of the 4,304 study participants with an MSc in psychology, 3,691 reported whether they were a member of a general professional association for psychologists and/or membership of a specific psychotherapy organization (14.2% missing data). About half (55.3%) reported such a membership. Next, participants were offered a list of representative professional associations and psychotherapy associations; 40.8% reported being member of a listed professional organization and 19.8% reported being a member of a psychotherapy association (see also Table 20).

Table 20. Membership of a professional or psychotherapy organization among MSc in psychology

	MSc in psychology
Membership	%
Any membership	55.3
Only (representative) professional association	26.5
Only psychotherapy association	5.5
Professional and psychotherapy	14.3
Only other[45]	9.0

We compared membership of any professional or psychotherapy association in the different subgroups. Membership of an association was higher in the **Flemish**-speaking sample (58.9%) than the French- and German-speaking sample (47.4%) (n = 3,686, $\chi^2(1) = 42.48$, $\varphi = -.11$, $p < .001$). Membership was markedly higher among **self-employed** psychologists (76.4%) than psychologists who worked only in salaried employment (34.9%) (n = 3,691, $\chi^2(1) = 639.65$, $\varphi = -.42$, $p < .001$). Membership was also higher among those with an **MSc in clinical psychology** (62.5%) compared with those with an MSc in another domain of psychology (32.5%) (n = 3,691, $\chi^2(1) = 246.14$, $\varphi = .26$, $p < .001$)[46]. Membership was lower in younger **age**

[45] Organization that was not listed.

[46] The Flemish professional association for clinical psychologists ("Vlaamse Vereniging voor Klinisch Psychologen") is the largest professional organization for psychologists in Belgium and was over-represented in the sample.

cohorts (n = 3,691, $\chi^2(4) = 84.22$, Cramer's $V = .15$, $p < .001$), ranging from 43.9% among participants younger than 30 years to 65.1% among those aged 60 years and older.

Overall, 55.3% of participants with an MSc in psychology reported membership of a professional or psychotherapy association; among participants with an MSc in clinical psychology, the proportion was 62.5%. For membership of at least one **listed** professional association, the rate was 40.8% of participants with an MSc in psychology. Based on membership information of professional associations, in the population of psychologists in Belgium as a whole, current membership of professional associations is estimated to be 21.1% of psychologists (i.e., the number of people working as a psychologist according to the LFS, which is in itself only a subset of the number of graduates in psychology). Thus, in our sample, membership of professional associations seems to be higher than the national average.

3.3.5 Conclusion on professional situation

Although the majority of people holding an MSc in psychology are **employed full-time**, part-time employment is frequent (39%); on average psychologists work 90% FTE. This probably reflects certain features of the employment sector, the demographic profile of people with an MSc in psychology (about 83% female), and sociohistorical trends. Part-time employment is characteristic of the sector Human health and social work activities, and women are more likely to work part-time. These features were also apparent in our study sample: Mental healthcare, healthcare, social welfare (and education) were the most relevant sectors in which people with an MSc in psychology are employed, especially those with an MSc in clinical psychology.

A significant proportion of work in the broad domain of psychology is conducted by **self-employed** people. According to official statistics, 38.5% of holders of an MSc in psychology work in self-employment, either as their primary (16.5%) or a secondary (22%) occupation. In the current study, rates of self-employment were somewhat higher: 49.7% of participants reported working in self-employment (19.8% as primary occupation, 29.9% as a secondary occupation or semi-retirement).

In our sample, 71.8% of individuals with an MSc in psychology were currently **registered with the Commission of Psychologists**, whereas 91.6% of participants with an MSc in psychology reported they were working in the field of psychology. Acquaintance with the **code of ethics** seems quite poor, as only 20.3% of participants indicated that they were (fairly) familiar with the code and 11.1% reported they had never read it. On the other hand, 55.3% of participants reported holding a membership of a **professional or psychotherapy association**. Both the Commission of Psychologists and professional or psychotherapy associations provide support in matters of ethics.

There is no one-on-one relation between working in the field of psychology and the **job title** of psychologist; 75.3% reported using this professional title, despite working in the field of psychology. The title was more established in participants with an MSc in clinical psychology and in self-employed psychologists. Self-employed psychologists often combine their professional title of 'psychologist' with the title of 'psychotherapist', and sometimes with the title of 'coach'.

In the next section, we explore our results on further education of psychologists.

3.4. Further education of psychologists in Belgium

3.4.1 Types of education

Table 21 shows that after obtaining an MSc in psychology, more than half of the psychologists who participated in our study enrolled in programmes focused on further professional **training with a duration of at least 1 year**. Around one-third of participants enrolled in a **postgraduate psychotherapy training** with a typical duration of **3–4 years**. As we will discuss later in this section, these proportions were substantially higher among those with an MSc in clinical psychology. About 5% of participants had obtained a **PhD** in the broad domain of psychology or educational sciences. There were no differences between the Flemish- and the French- and German-speaking participants.

Table 21. Further education in the broad domain of psychology or educational sciences

Further education (%)	**Flemish (*n*=2,847)**	**French and German (*n* = 1,448)**	**All (*n* = 4,304)**	**$\chi^2(1)$**	**Cramer's *V***
Further professional training of at least 1 year	58.7	55.1	57.4	4.94	–.03
Further education of 1 or 2 years	42.4	39.8	41.5	2.64	–.03
Further education of 3 or 4 years (postgraduate psychotherapy training)	34.4[47]	34.5[48]	34.5[49]	0.22	–.01
PhD	4.4	4.8	4.5	0.51	.01

Note. *p < .01, **p <.001.

To explore the effects of **age**, we compared the levels of further education in the different age cohorts. As previous analyses did not indicate meaningful differences between the language of participants, we conducted these analyses on the full sample of participants with an MSc in psychology.

[47] Valid percent; Missing information on duration of psychotherapy training in *n*= 21.
[48] Valid percent ; Missing information on duration of psychotherapy training in *n* = 36.
[49] Valid percent: Missing data on duration of psychotherapy training in *n* = 57.

Table 22. Effects of age cohort in further education

	Age cohort					Test statistics	
Further education (%)	<30 (*n* =1,096)	30–39 (*n* = 1,529)	40–49 (*n* = 913)	50–59 (*n* = 521)	≥60 (*n* = 244)	$\chi^2(4)$	Cramer's *V*
Further professional training of at least 1 year	33.7	61.5	70.2	68.9	65.6	357.89**	.29**
Further education of 1 or 2 years	25.9	41.7	49.4	55.9	50.0	185.09**	.21**
Further education of 3 or 4 years (postgraduate psychotherapy training)	13.9	38.3	45.0	40.1	44.3	280.38**	.26**
PhD	2.1	5.4	6.1	3.6	6.1	25.31**	.08**

Note. n = 4,303, *p < .01, **p <.001. For ease of analysis, 57 cases (1.3%) with missing information regarding duration of psychotherapy training were counted as not having undertaken psychotherapy training of 3 or 4 years. LHCP, Law on the Practice of Healthcare Professions.

Table 22 shows that the level of **further education** differs in different **age cohorts**, especially for overall further education of at least 1 year and for psychotherapy training. Not surprisingly, levels of further education are lowest in the youngest two cohorts, and particularly in those younger than 30 years of age. There is a marked increase in uptake of further education between the youngest cohort and participants aged 30–40, suggesting that many individuals with an MSc in psychology choose this time in their life to continue their training. This may be related to the entrance criteria for educational programmes in psychology who offer further training, which often require substantial clinical experience as a criterion to be admitted. Likewise, as many psychologists need to fund their own training, financial factors may also play a role.

Next, we explored differences according to the **type of MSc in psychology**. As previous analyses did not indicate meaningful differences between the language of participants, again, we conducted these analyses on the full sample of psychologists. As shown in Table 23, participants with an MSc in clinical psychology more often enrolled in education programmes of at least one year (62.7% versus 40.8%)), and more specifically in psychotherapy training (40.7% versus 13.5%), compared with psychologists with another type of MSc. Effect sizes were typically small, however. Furthermore, the number of participants with a PhD was somewhat higher in those with an MSc in another domain of psychology (7.9% versus 3.4%).

Table 23. Effects of type of MSc in psychology in further education

Further education (%)	MSc clinical psychology (*n* = 3,253)	Other MSc psychology (*n* = 1,051)	$\chi^2(1)$	φ
Professional training of at least 1 year	62.7	40.8	156.13**	.19**
Further education of 1 or 2 years	43.3	35.9	18.13**	.07**
Further education of 3 or 4 years[50] (= Postgraduate Psychotherapy training)	40.7	13.5	261.48**	.25**
PhD	3.4	7.9	36.44**	–.09**

Note. *p < .01, **p < .001.

In addition, we compared further training between psychologists who only worked in **salaried employment** and psychologists who worked in **self-employment** as a primary or secondary occupation. Self-employed participants with an MSc in psychology more often enrolled in programmes of at least one year (71.8% versus 45.2 compared with participants who only worked in salaried employments. This was the case for training of one or two years and, to a larger extent, for psychotherapy training (51.5% versus 18.7%). The number of participants with a PhD did not differ meaningfully according to type of employment.

Table 24. Effects of type of employment in further education

Further education (%)	Only salaried employment (*n* = 2,087)	Self-employment as a primary or secondary occupation (*n* = 2,058)	$\chi^2(1)$	φ
Professional training of at least 1 year	45.2	71.8	300.36**	–.27**
Further education of 1 or 2 years	35.4	48.9	77.72**	–.14**
Further education of 3 or 4 years[51] (= Postgraduate Psychotherapy training)	18.7	51.5	487.83**	–.34**
PhD	5.4	3.6	7.58	.04

Note. *p < .01, **p < .001.

As Table 25 shows, a significant number of individuals holding an MSc in psychology (14%) had also obtained a degree at some level in a subject area **outside the broad domain of psychology** and educational sciences.

[50] *N* = 4,247, missing information on length of therapy training in *n* = 57.
[51] *N* = 4247, missing information on length of therapy training in *n* = 57.

Table 25. Additional diplomas outside the broad domain of psychology and educational sciences

Additional diploma (%)	Flemish (*n*=2,847)	French and German (*n* = 1,448)
Bachelor's or master's	**13.8**	**14.1**
Health sciences	1.6	1.7
Political sciences and law	2.5	3.4
Religion, culture, and history	1.5	0.9
Management	2.3	3.3
Economics and finances	2.4	1.0
Other	3.6	3.8
PhD	**0.7**	**–***
Health sciences	0.5	–*

Note. Percentages are in relation to the total number of psychologists (per language). * $n < 5$.

3.4.2 Content of training

When we look more closely at the content of training, the majority of further training is **related to the activities described in the LHCP** (see Table 26 and Table 27). In terms of the type of psychotherapy training, *systemic/family psychotherapy* is most popular (12.7% of participants), followed by the three other major conceptual frameworks of psychotherapy: *(cognitive) behavioural psychotherapy* (8.1% of participants), *psychoanalytic/psychodynamic psychotherapy* (6.5%), and *humanistic and client-centred therapy*, including *Gestalt psychotherapy* (6.0%). Of participants with an MSc in psychology who obtained training in psychotherapeutic care (*n* = 1,466), 13.2% followed more than one training in psychotherapeutic care.

Looking at the different **language communities** (Table 26), behavioural psychotherapy and humanistic/client-centred psychotherapy were slightly more popular in the Flemish-speaking sample than in the French-speaking sample, while the reverse is true for psychoanalytic/psychodynamic psychotherapy and systemic/family psychotherapy, both of which were less popular among the Flemish-speaking participants.

Other types of psychotherapy training also attract a sizeable subgroup of participants belonging to both language groups. Many of the small observed differences may be related to sociocultural regional differences and differences in the number of programmes offered and the number of candidates that are allowed in each programme. Regardless of these explanations, the diversity in types of evidence-based treatments is reflected in the diversity in training options in Belgium, which seems to be an in important strength of the current system, also in terms of capacity.

Table 26. Language differences in content of training

	Flemish (*n* = 2,847)	French and German (*n* = 1,448)	All (*n* = 4304)	χ^2	φ
Further education of 1 or 2 years (%)	42.4	39.8	41.5	2.64	–.03
Training in psychological activities related to the LHCP (e.g., prevention, diagnostics/ assessment, counselling, treatment)	28.4	30.5	29.1	2.14	.02
Training in other psychological activities (e.g., mediation, consultancy)	4.2	8.1	5.5	28.12**	.08**
Specific teacher training course	17.8	11.3	15.6	30.60**	–.08**
Psychotherapy training (%)	34.4	34.5	34.5	0.22	–.01
Humanistic/client-centred therapy	6.1	3.6	5.3	11.57**	–.05**
Psychoanalytic/psychodynamic therapy	4.8	9.8	6.5	37.65**	.09**
(Cognitive) Behavioural therapy	9.8	4.7	8.1	32.28**	–.09**
Systemic/family therapy	11.5	15.0	12.7	10.51**	.05**
Gestalt therapy	0.8	0.4	0.7	3.03	–.03
Integrative or eclectic therapy	3.4	3.8	3.5	0.43	.01
Other	2.2	5.3	3.3	28.40**	.08**

Note. *p < .01, **p < .001. Percentages are in relation to the total number of psychologists (per language). Training in psychological activities related to the LHCP includes postgraduate training and advanced master's-level programmes related to prevention, diagnostics/assessment, counselling, and treatment of psychological or psychosomatic suffering. Training in other psychological activities includes postgraduate training and advanced bachelor's-level programmes related to mediation, consultancy and (clinical) education. Other psychotherapy training included, e.g., solution-focused psychotherapy training. There was missing information regarding psychotherapy training (orientation and/or duration) for 65 participants.

As for differences in **educational background** (Table 27), further training related to the LHCP is more prevalent in participants with an MSc in clinical psychology, whether it's short (31.8% versus 20.9%) or long (i.e. psychotherapy training) (40.7% versus 13.5%, as already mentioned), and regardless of the orientation of the psychotherapy training.

Table 27. Comparison between types of education in psychology and content of further education

	MSc clinical psychology (*n* = 3,253)	Other MSc psychology (*n* = 1,051)	$\chi^2(1)$	φ
Further education of 1 or 2 years (%)	43.3	35.9	18.13**	.07**
Training in psychological activities related to the LHCP (e.g. prevention, diagnostics/assessment, counselling, treatment)	31.8	20.6	48.89**	.11**
Training in other psychological activities (e.g. mediation, consultancy)	5.3	6.0	0.70	–.01
Teacher training	14.8	18.1	6.54	–.04
Psychotherapy training (%)	40.7	13.5	261.48**	.25**
Humanistic/Client centred therapy	6.2	2.1	26.99**	.08**
Psychoanalytic/Psychodynamic therapy	7.7	2.2	41.03**	.10**
(Cognitive) Behavioural therapy	9.7	2.9	49.92**	.11**
Systemic/Family therapy	14.9	4.9	74.02**	.13**
Gestalt therapy	0.8	0.1	6.64	.04
Integrative or eclectic therapy	4.1	1.5	15.65**	.06**
Other	3.2	3.2	0.00	.00

Note. *p < .01, **p < .001. Percentages are in relation to the total number of psychologists (per language). Training in psychological activities related to the LHCP includes postgraduate training and advanced master's-level programmes related to prevention, diagnostics/assessment, counselling, and treatment of psychological or psychosomatic suffering. Training in other psychological activities includes postgraduate training and advanced bachelor's-level programmes related to mediation, consultancy and (clinical) education. Other psychotherapy training included, e.g., solution-focused psychotherapy training. There was missing information regarding psychotherapy training (orientation and/or duration) for 65 participants.

Figure 45 shows the distribution of types of psychotherapy training in participants with an MSc in clinical psychology. Again, systemic/family psychotherapy is most popular, followed by the three other major conceptual frameworks of psychotherapy.

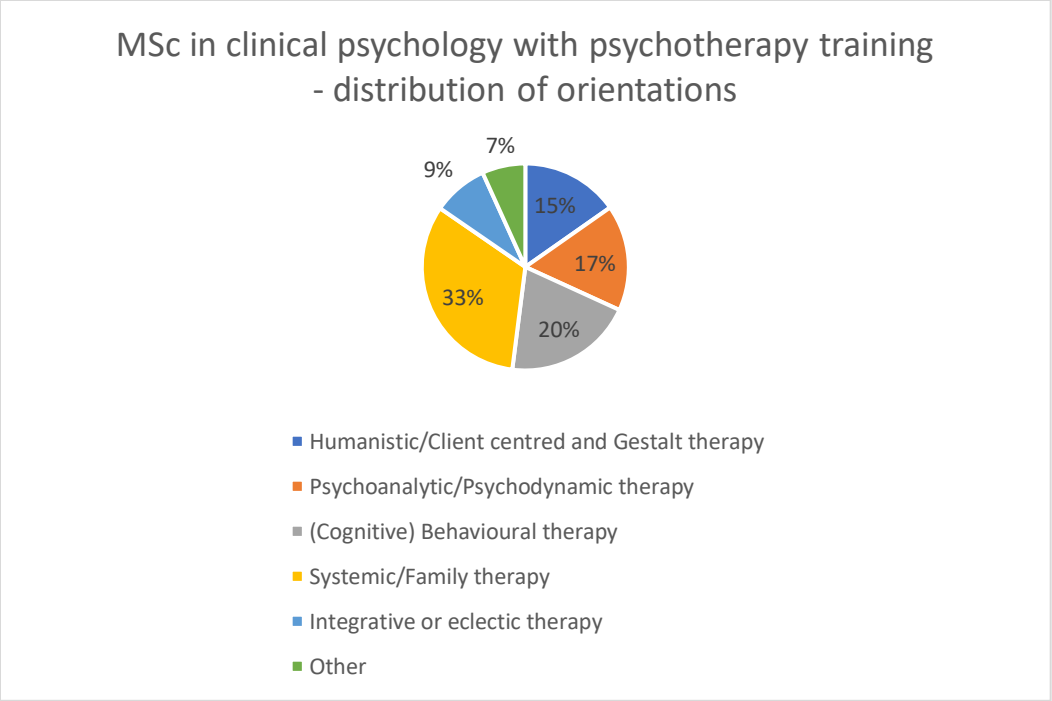

Figure 45. Type of psychotherapy training obtained by psychologists with an MSc in clinical psychology who obtained psychotherapy training[52].

3.4.3 Level of specialization related to the LHCP

Table 28 shows the distribution of **training related to the LHCP**, more specifically, whether those with an MSc in psychology combine shorter education programmes in psychological activities related to the LHCP and longer psychotherapy training. Differences between the language communities were not significant ($\chi^2(3) = 5.89$, $p > .05$). Hence, 14.2% of participants with an MSc in psychology seem to be highly specialized, having completed both 1–2 year and longer (3–4 year) additional education programmes[53].

[52] Percentages are in relation to the total number of training in psychotherapeutic care followed by participants with an MSc in clinical psychology (n = 1,461 for n = 1,324 who obtained training in psychotherapeutic care); 12.5% of participants with an MSc in clinical psychology that obtained training in psychotherapeutic care, followed more than one training in psychotherapeutic care.

[53] Follow-up analyses with level of specialization as a predictor and features of the field of work as outcome did not suggest that the highly specialized subgroup of psychologists who obtained both psychotherapy training and shorter training related to the LHCP, was a distinct cluster from those who only obtained psychotherapy training. The field of work of psychologists who obtained psychotherapy training did differ from psychologists without this type of training. Features of the group with short training are situated in between the characteristics of those without any training related to the LHCP and those who obtained psychotherapy training.

Table 28. Additional training related to the LHCP in the different language communities

Additional training related to the LHCP (%)	Flemish (*n*=2,847)	French and German (*n* = 1,448)	All (*n* = 4,304)
Additional training related to the LHCP of at least 1 year	49.2	48.7	49.0
Only education of 1 or 2 years related to the LHCP	14.8	15.1	14.9
Only education of 3 or 4 years (postgraduate psychotherapy training)	20.8	18.2	19.9
Both	13.6	15.5	14.2

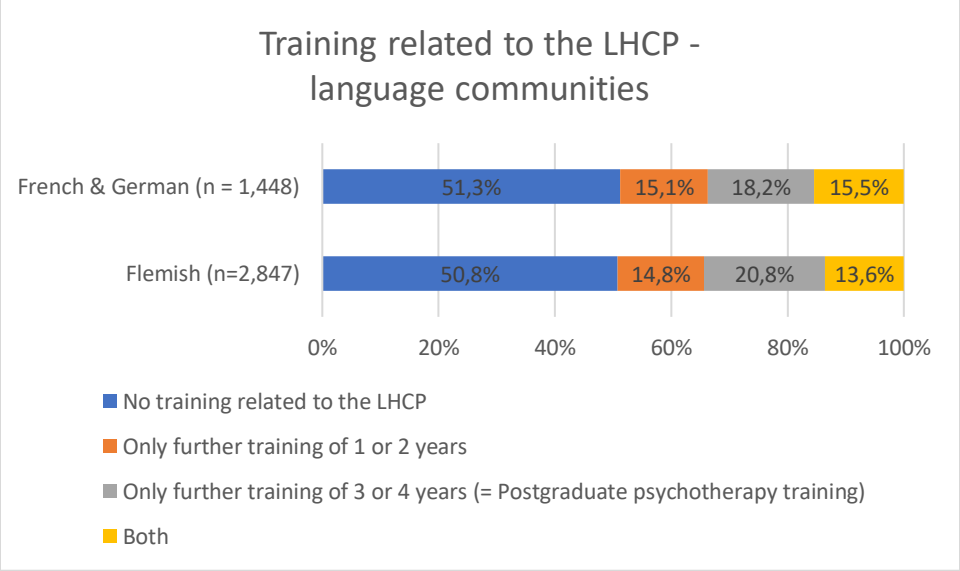

Figure 46. Community differences in training related to the LHCP.

As shown in Table 29, participants with an **MSc in clinical psychology** invested differently in training related to the LHCP compared with those with an MSc in a different domain of psychology (n = 4,304, $\chi^2(3)$ = 308.62, Cramer's V = .27, p < .001). Specifically, those with an MSc in clinical psychology more often completed training related to the LHCP (including psychotherapy training), whereas those with an MSc in another domain of psychology, in almost half of cases, completed training of 1 or 2 years' duration maximum. Again, 16.5% of participants with an MSc in clinical psychology seem to be highly specialized, having completed both a 1–2 year additional training and 3–4 year psychotherapy training.

Table 29. Additional training related to the LHCP in the different domains of psychology

Additional training related to the LHCP (%)	MSc clinical psychology (*n* = 3,253)	Other MSc psychology (*n* = 1,051)	All (*n* = 4,304)
Additional training related to the LHCP of at least 1 year	56.0	27.0	49.0
Only education of 1 or 2 years related to the LHCP	15.3	13.5	14.9
Only education of 3 or 4 years (postgraduate psychotherapy training)	24.2	6.5	19.9
Both	16.5	7.0	14.2

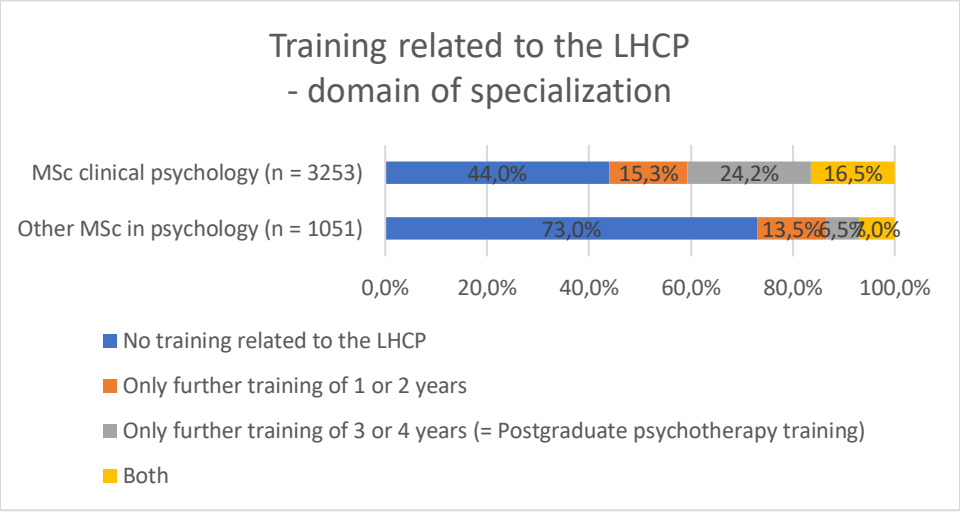

Figure 47. Training related to the LHCP among participants holding an MSc in clinical psychology and an MSc in another domain of psychology.

Involvement in further training related to the LHCP differed between **salaried psychologists**, and those who worked in **self-employment** (as a primary or secondary occupation) (n = 4,145, $\chi^2(3) = 532.27$, Cramer's $V = .36$, $p < .001$). Self-employed psychologists more often completed additional training related to the LHCP (66.1% compared with 34.2%), more specifically postgraduate psychotherapy training (51.5% compared with 18.7%) (see Table 30). Of working participants with an MSc in psychology who did not continue their training in domains of psychology related to the LHCP (n = 2,071), 66.3% worked only in salaried employment.

Table 30. Additional training related to the LHCP in the different types of employment

Additional training related to the LHCP (%)	Only salaried employment (*n* = 2,087)	Self-employment as a primary or secondary occupation (*n* = 2,058)	All (*n* = 4,145)
Additional training related to the LHCP of at least 1 year	34.2	66.1	50.0
Only education of 1 or 2 years related to the LHCP	15.5	14.6	15.1
Only education of 3 or 4 years (postgraduate psychotherapy training)	11.8	29.2	20.4
Both	6.9	22.3	14.5

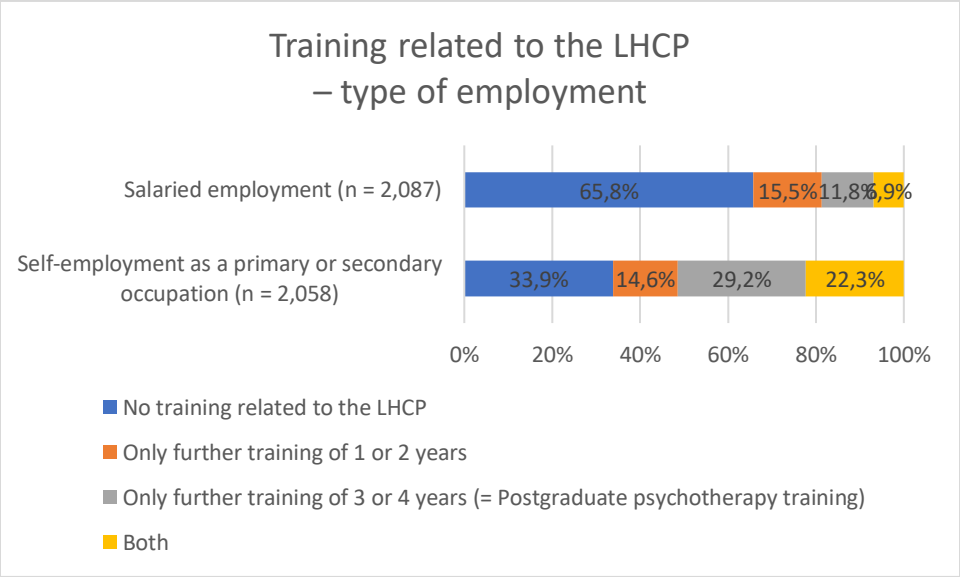

Figure 48. Training related to the LHCP among participants working in salaried employment and participants working in self-employment as a primary or secondary occupation.

Follow-up analyses showed small differences between psychologists who worked in self-employment as a primary occupation and those who combined their self-employment with a salaried job (n = 2,030, $\chi^2(3) = 21.32$, Cramer's $V = .10$, $p < .001$) (see Table 31).

Table 31. Additional training related to the LHCP in the different types of self-employment

Additional training related to the LHCP (%)	Self-employment as a primary occupation (*n* = 821)	Self-employment as a secondary occupation (*n* = 1,209)	Self-employment as a primary or secondary occupation (*n* = 2,030)
Additional training related to the LHCP of at least 1 year	61.6	68.7	65.9
Only education of 1 or 2 years related to the LHCP	15.5	14.1	14.7
Only education of 3 or 4 years (postgraduate psychotherapy training)	23.9	32.8	29.2
Both	22.3	21.8	22.0

Note. Semi-retired participants were not included in this analysis.

Level of specialization related to the LHCP differed according to the **age** of the participants (n = 4,303, $\chi^2(12) = 343.90$, Cramer's $V = .16$, $p < .001$). As shown in Table 32, as would be expected, a lower percentage of psychologists younger than 30 years old had completed psychotherapy training or a combination of psychotherapy training and shorter training related to the LHCP.

Table 32. Additional training related to the LHCP in the different age groups

	Age cohort				
Additional training related to the LHCP (%)	<30 (*n* = 1,096)	30–39 (*n* = 1,529)	40–49 (*n* = 913)	50–59 (*n* = 521)	≥60 (*n* = 244)
Additional training related to the LHCP of at least 1 year	27.8	52.6	60.5	57.2	60.2
Only education of 1 or 2 years related to the LHCP	14.0	14.3	15.4	17.1	16.0
Only education of 3 or 4 years (postgraduate psychotherapy training)	8.4	24.2	26.1	19.6	22.1
Both	5.5	14.1	18.9	20.5	22.1

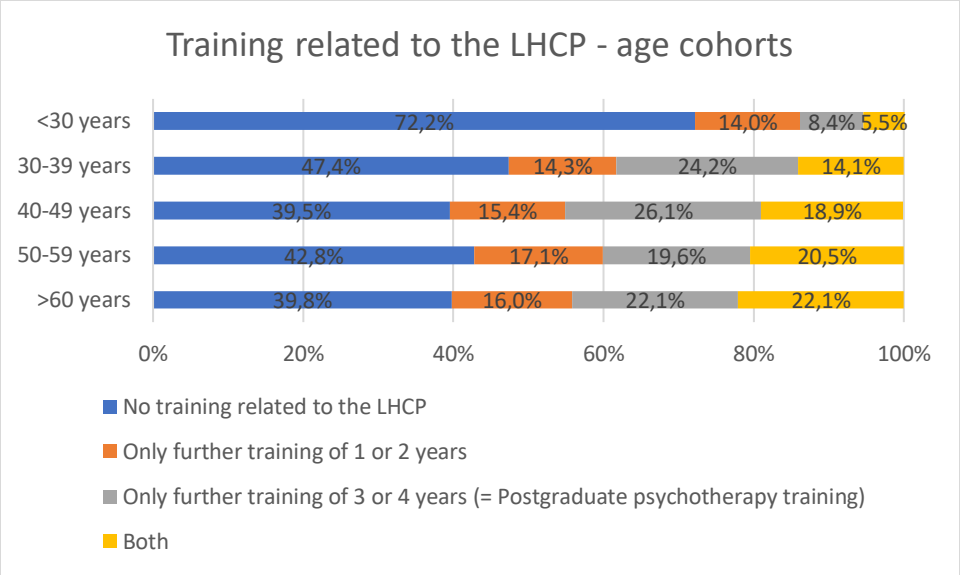

Figure 49. Age differences in training related to the LHCP among participants with an MSc in psychology (*n* = 4,303).

Follow-up analyses exploring age differences in level of specialization for the different types of employment showed that in every type of employment, additional training related to the LHCP was least prevalent in the youngest age group (see Table 33-35). Among employed participants with an MSc in psychology who were younger than 30 years old, 21.2% of participants working exclusively in salaried employment, 34.4% of participants working in self-employment as a primary occupation, and 48.7% of participants working in self-employment as a secondary occupation had completed training related to the LHCP [54].

[54] When focusing on participants with an MSc in psychology who indicated that client care was their primary task (*n* = 2,585), these percentages were 30.4%, 27.4%, and 48.1%, respectively. Thus, the majority of young psychologists in our sample who provided client care as a primary task in at least one of their jobs did not have additional training related to the LHCP, and this was also the case among young self-employed psychologists.

Table 33. Additional training related to the LHCP in the different age groups, among psychologists working in salaried employment

	Age cohort				
Additional training related to the LHCP (%)	<30 (*n* = 676)	30–39 (*n* = 796)	40–49 (*n* = 360)	50–59 (*n* = 204)	≥60 (*n* = 50)
Additional training related to the LHCP of at least 1 year	21.2	28.7	42.2	40.2	58.0
Only education of 1 or 2 years related to the LHCP	13.5	16.6	14.7	18.6	18.0
Only education of 3 or 4 years (postgraduate psychotherapy training)	4.6	14.9	17.8	9.3	28.0
Both	3.1	7.2	9.7	12.3	12.0

Note. *n* = 2,086.

Table 34. Additional training related to the LHCP in the different age groups, among psychologists working in self-employment as a primary occupation

	Age cohort				
Additional training related to the LHCP (%)	<30 (*n* = 128)	30–39 (*n* = 253)	40–49 (*n* = 201)	50–59 (*n* = 153)	≥60 (*n* = 86)
Additional training related to the LHCP of at least 1 year	34.4	68.8	70.6	59.5	64.0
Only education of 1 or 2 years related to the LHCP	10.2	15.0	17.9	17.6	15.1
Only education of 3 or 4 years (postgraduate psychotherapy training)	14.1	29.2	26.9	21.6	19.8
Both	10.2	24.5	25.9	20.3	29.1

Note. *n* = 821.

Table 35. Additional training related to the LHCP in the different age groups, among psychologists working in self-employment as a secondary occupation

	Age cohort				
Additional training related to the LHCP (%)	<30 (*n* = 236)	30–39 (*n* = 458)	40–49 (*n* = 338)	50–59 (*n* = 151)	≥60 (*n* = 26)
Additional training related to the LHCP of at least 1 year	48.7	69.9	75.1	79.5	84.6
Only education of 1 or 2 years related to the LHCP	19.5	10.5	14.8	15.2	15.4
Only education of 3 or 4 years (postgraduate psychotherapy training)	18.2	38.4	35.2	32.5	38.5
Both	11.0	21.0	25.1	31.8	30.8

Note. *n* =1,209.

3.4.4 Conclusion on educational profile

The educational profile of individuals with an MSc in psychology shows that the **majority of participants continued** their education after obtaining their MSc; 57.4 % followed training courses of at least 1 year related to the broad field of psychology and educational sciences, and 4.5% obtained a PhD in psychology or educational sciences. Furthermore, 14% of those with an MSc in psychology obtained a BA or MSc outside the broad domain of psychology and educational sciences, in areas such as health sciences, political sciences and law, religion, culture, and history, economics and finance, and management.

Out of the 57.4%, about 49% involves training of at least 1 year's duration in psychological activities **related to the LHCP** (e.g. prevention, diagnostic assessment, counselling, treatment, or psychotherapy). A subgroup of about 15% of those with an MSc in Psychology can be seen as highly specialized, as they followed shorter training as well as a postgraduate in psychotherapy training. This group constitutes about 20% of participants in older age cohorts (age 40 and older).

Individuals with an **MSc in clinical psychology** more often followed a psychotherapy training programme compared with those holding an MSc in another domain of psychology; 40.7% of those with an MSc in clinical psychology followed a psychotherapy training. More specifically, 24.2% of those with an MSc in clinical psychology followed a psychotherapy training course only, and 16.5% also followed a shorter training of 1 or 2 years (the highly specialized subgroup).

Training related to the LHCP was more prevalent in psychologists who worked in **self-employment**, as a primary occupation or as a secondary occupation (66.1%), compared with psychologists who only worked in salaried employment (34.1%). This was especially the case for **psychotherapy training**: 51.5% of self-employed psychologists reported having completed psychotherapy training, compared with only 18.7% of psychologists who exclusively worked in salaried employment.

Training related to the LHCP was **lowest in psychologists younger than 30 years old**. Age effects were more pronounced regarding psychotherapy training compared with shorter training related to the LHCP, and in self-employment compared with salaried employment.

Continuing professional development is discussed in Section 4.6, where we discuss the use of intervision[55] and supervision, and personal therapy.

[55] Intervision = supervision in a group.

3.5. Availability of mental healthcare as offered by MSc in psychology

3.5.1 Aspects of mental healthcare as offered by psychologists

In this section, we document the **availability of (preventative or curative) mental healthcare** as offered by people with an **MSc in psychology**[56]. In the current study (*n* = 4,304), 47.7% reported to be (self-) employed in the mental healthcare sector (i.e., they indicated that they worked this sector in one or more jobs; sectors were not mutually exclusive). Working in the mental healthcare sector is one way to delineate the availability of mental healthcare. However, mental healthcare can also be offered in other sectors. We asked participants to report on their job responsibilities and several features related to the availability of mental healthcare. For each job, they reported **whether they contributed to people's wellbeing or development** in that particular job (choosing between "Yes, a bit or a lot" and "No, not at all"). This was used an indicator of the **field of work of clinical psychology**. If they answered in the affirmative to this question:

(a) They reported on several **responsibilities**, including "supporting people or their environment", on a 5-point Likert scale ranging from "never" to "very often". This item was used to delineate **work with clients**. They also considered the overall orientation of their job responsibilities, and could choose a maximum of two options from a list, which included "client work".
   i. When client work was part of their job responsibilities (at least "rarely" on the 5-point scale), they reported on the focus of their job, and could indicate several fields, which included "psychological wellbeing". The fields were not mutually exclusive.
   ii. They were asked whether their work involved preventive or care tasks for people with (sub)clinical problems or disorders in the DSM diagnostic categories[57]. They indicated the categories they covered in an average working week.

(b) They indicated whether their **tasks** included **prevention, diagnostic assessment, counselling, and treatment**, each on a 5-point Likert scale ranging from "never" to "very often".
   i. When the participant provided treatment (at least "rarely" on the 5-point scale), a follow-up question inquired whether this treatment included **psychotherapeutic care**, defined "as a coherent set of psychological treatment techniques, which goes beyond guidance or supportive conversations". This question had a "yes" or "no" answer format.

[56] The 4,304 participants with an MSc in psychology included 74 participants (1.7%) who obtained their MSc in psychology in Belgium, but worked exclusively outside Belgium. In the subsample of participants who contribute to wellbeing or development of people (*n* = 3,758), 63 participants worked exclusively outside Belgium (again 1.7%). As this small group was not expected to meaningfully affect conclusions on mental health care availability in Belgium, they were not excluded from the analyses.

[57] The Diagnostic and Statistical Manual for Mental Disorders (5th ed.; American Psychiatric Association, 2013) is a standard classification system for mental disorders published by the American Psychiatric Association.

Figure 50 describes how these **job characteristics related to the provision of psychological care** in Belgium, are present in the survey, and how they are represented in the sample of participants with an MSc in psychology (*n* = 4,304). We compare these characteristics between participants based on (a) the **domain of specialization** in psychology, (b) the **language** of the participants, and (c) participants' **age**.

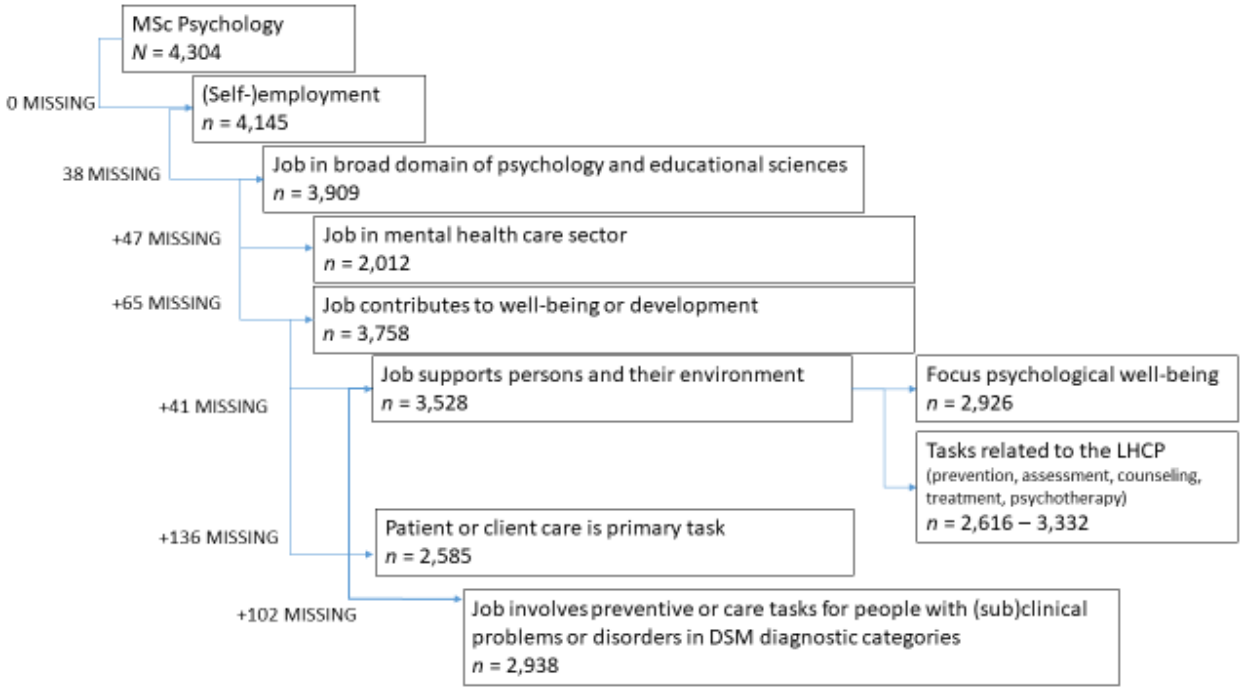

Figure 50. Job characteristics related to the provision of psychological care in the study participants.

In most cases, and in order of relative importance, participants with an MSc in psychology described (at least one of) their job(s) as (see Table 36):

(a) Contributing to people's wellbeing or development (i.e. our indicator of working in the **field of clinical psychology**) (89.4%);
(b) Involving supporting people and their environment (i.e. those with an MSc in psychology reporting working with clients) (84.8%); **client care** is a main task for 64.1% of participants;
(c) This client work focuses mainly on improving the **psychological wellbeing** of the client (72.0%) and on **problems related to the DSM** (72.4%).

Table 36. Relationship between job characteristics related to the availability of mental healthcare in the total sample of participants with an MSc in psychology

Job characteristics	*n*	Missing	Valid *n*	% of participants
General				
(Self-)employed	4,145	0	4,304	96.3
Domain of psychology	3,909	38	4,266	91.6
Related to availability of mental healthcare				
Mental healthcare sector	2,012	85	4,219	47.7
Contributes to wellbeing (clinical field)	3,758	103	4,201	89.4
Supports people (client care)	3,528	144	4,160	84.8
Focus on psychological wellbeing	2,926	239	4,065	72.0
Client care as primary task	2,585	269	4,035	64.1
DSM-related problems	2,938	246	4,058	72.4

Note. (Self-)employed, employed in self- or salaried employment; Domain of psychology, at least one job in the broad domain of psychology or educational sciences; Mental healthcare sector, at least one job in the mental healthcare sector; Contributes to wellbeing, at least one job that contributes to wellbeing or development of people (i.e. the indicator of a clinical field of work); Supports people, at least one job involves client care; Focus on psychological wellbeing, at least one job that focuses on people's psychological wellbeing; Client care as primary task, at least one job with patient or client care as its main task; DSM-related problems, at least one job involves preventive or care tasks for people with (sub)clinical problems or disorders as defined in DSM.

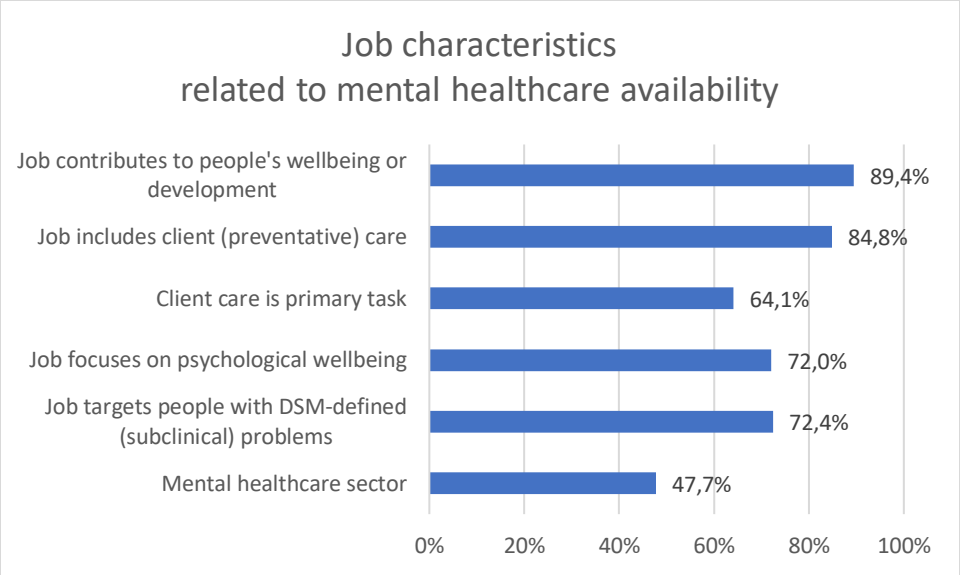

Figure 51. Job characteristics related to mental healthcare availability in participants with an MSc in psychology.

Table 37 compares the same job characteristics for participants who reported that they had obtained an **MSc in clinical psychology** (*n* = 3,253) and those with an **MSc in another domain** of psychology (*n* = 1,051). All these characteristics are more present in the jobs of participants with an MSc in clinical psychology than those with an MSc in another domain of psychology. For example, client care is a main task in the jobs of 74.8% of participants with an MSc in clinical psychology, compared with only 31.1% of participants with an MSc in another domain of specialization. On the other hand, aspects of psychological care are also highly relevant for those with a non-clinical MSc in psychology. Differences are small to medium. This shows that the provision of psychological care is not limited to those with an MSc in clinical psychology.

Table 37. Comparison between participants with an MSc in clinical psychology and participants with an MSc in another domain of specialization of psychology in terms of main job characteristics related to the availability of mental healthcare

	MSc clinical psychology *n* = 3,253	**Other MSc psychology** *n* = 1,051	***n***	**$\chi^2(1)$**	**φ**
Job characteristics of MSc in psychology (%)					
General					
(Self-)employed	97.1	93.9	4,304	22.42**	.07**
Domain of psychology	94.0	84.2	4,266	99.96**	.15**
Related to availability of mental healthcare					
Mental healthcare sector	57.4	17.9	4,219	487.49**	.34**
Contributes to wellbeing	92.9	78.7	4,201	166.57**	.20**
Supports people	90.1	68.5	4,160	280.58**	.26**
Focus on psychological wellbeing	80.8	45.1	4,065	477.37**	.34**
Client care as primary task	74.8	31.1	4,035	620.81**	.39**
DSM-related problems	82.5	41.4	4,058	638.20**	.40**

Note. *$p < .01$, ** $p < .001$. (Self-)employed, employed in self- or salaried employment; Domain of psychology, at least one job in the broad domain of psychology or educational sciences; Mental healthcare sector, at least one job in the mental healthcare sector; Contributes to wellbeing, at least one job that contributes to wellbeing or development; Supports people, at least one job involves client care; Focus on psychological wellbeing, at least one job that focuses on people's psychological wellbeing; Client care as primary task, at least one job with patient or client care as its main task; DSM-related problems, at least one job involves preventive or care tasks for people with (sub)clinical problems or disorders as defined in DSM; Other MSc psychology, MSc in school or educational psychology, neuropsychology, theory and research, organizational psychology, or a non-listed option.

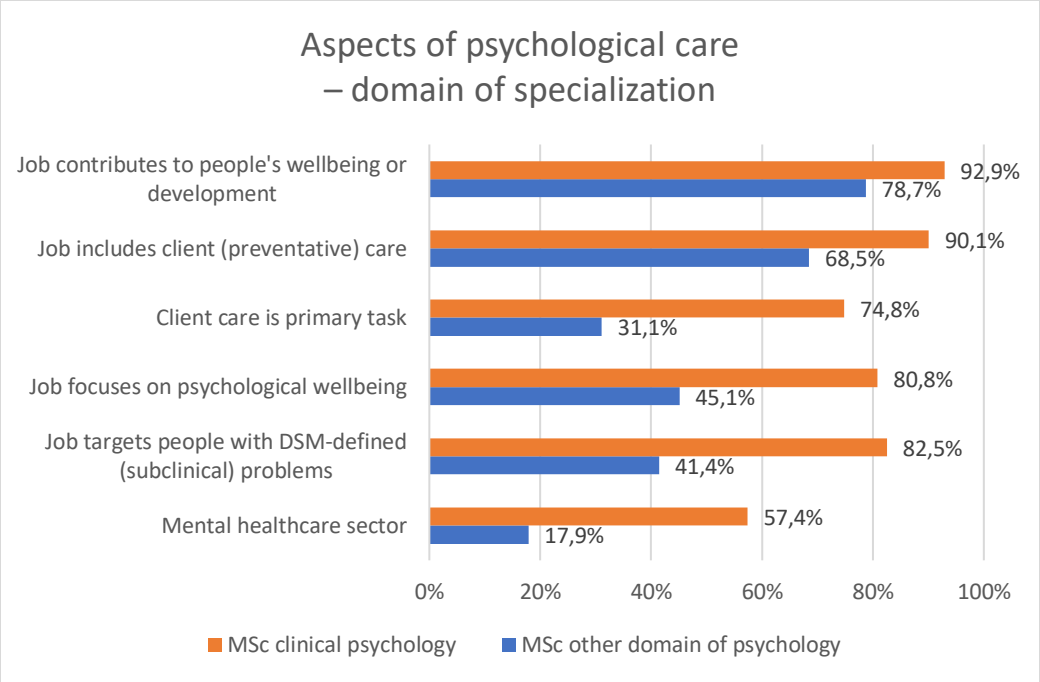

Figure 52. Job characteristics related to mental healthcare availability in participants with an MSc in clinical psychology and participants with an MSc in another domain of psychology.

Table 38 describes these characteristics in **Flemish-speaking** (*n* = 2,847) and **French- and German-speaking** participants (*n* = 1,448) separately. There were some differences between the two groups, but effect sizes were small. Flemish-speaking participants were somewhat more likely to be (self-)employed, to have a job in the broad field of psychology or educational sciences, to be (self-)employed in the mental healthcare sector in the strict sense, and to focus on psychological wellbeing in client work than their French/German speaking counterparts. Interestingly, there were no differences between Flemish- and French/German-speaking participants in terms of whether their work contributed to wellbeing, focused on client care, or focused on DSM-related problems.

Table 38. Comparison between Flemish- and French/German-speaking participants in terms of main job characteristics related to the availability of mental healthcare

	Flemish (n = 2,847)	**French and German** (n = 1,448)	***n***	**$\chi^2(1)$**	**φ**
Job characteristics of MSc in psychology (%)					
General					
(Self-)employed	97.4	94.3	4,295	25.99**	–.08**
Domain of psychology	92.5	89.9	4,257	8.75*	–.05*
Related to availability of mental healthcare					
Mental healthcare sector	52.9	37.4	4,211	90.30**	–.15**
Contributes to wellbeing	90.3	87.9	4,193	5.45	–.04
Supports people	85.0	84.5	4,152	0.23	–.01
Focus on psychological wellbeing	73.4	69.2	4,058	7.95*	–.04*
Client care as primary task	64.7	62.9	4,028	1.33	–.02
DSM-related problems	72.9	71.4	4,051	0.96	–.02

Note. *p < .01; **p < .001. (Self-)employed, employed in self- or salaried employment; Domain of psychology, at least one job in the broad domain of psychology or educational sciences; Mental healthcare sector, at least one job in the mental healthcare sector; Contributes to wellbeing, at least one job that contributes to wellbeing or development; Supports people, at least one job involves client care; Focus on psychological wellbeing, at least one job that focuses on people's psychological wellbeing; Client care as primary task, at least one job with patient or client care as its main task; DSM-related problems, at least one job involves preventive or care tasks for people with (sub)clinical problems or disorders as defined in DSM.

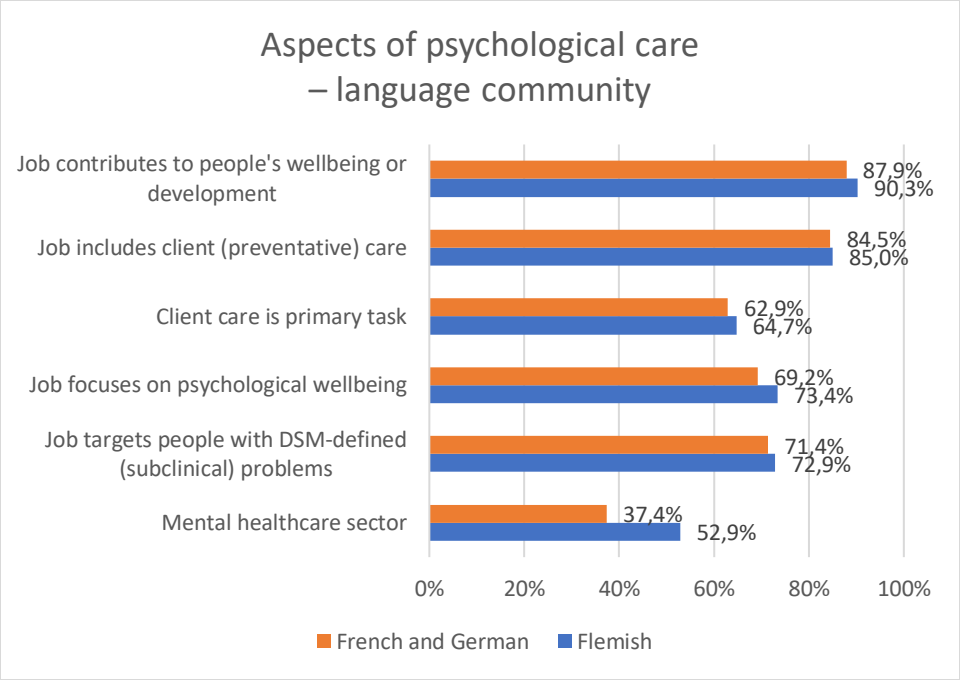

Figure 53. Job characteristics related to mental healthcare availability in Flemish-speaking participants and in French- or German-speaking participants.

Table 39 shows that aspects of psychological care are more often a feature of work for those in **self-employment** (in a primary or secondary occupation) compared with participants who work exclusively in **salaried employment**. Effect sizes are small to medium.

Table 39. Comparison between participants who work exclusively in salaried employment and participants who also work in self-employment, in terms of job characteristics

	Self-employment *n* = 2,032	**Exclusively salaried employment** *n* = 2,075	***n***	**$\chi^2(1)$**	**φ**
Job characteristics of MSc in psychology (%)					
General					
Domain of psychology	98.9	91.6	4,107	119.29**	–.17**
Related to availability of mental healthcare					
Mental healthcare sector	74.8	25,1	4,060	1004.79**	–.50**
Contributes to wellbeing	98.5	87.6	4,042	185.63**	–.21**
Supports people	97.2	79.5	4,001	300.00**	–.27**
Focus on psychological wellbeing	90.5	60.1	3,906	479.94**	–.35**
Client care as primary task	88.5	45.9	3,876	790.83**	–.45**
DSM-related problems	90.1	61.3	3,899	435.03**	–.33**

Note. *p < .01, **p < .001. (Self-)employed, employed in self- or salaried employment; Domain of psychology, at least one job in the broad domain of psychology or educational sciences; Mental healthcare sector, at least one job in the mental healthcare sector; Contributes to wellbeing, at least one job that contributes to wellbeing or development; Supports people, at least one job involves client care; Focus on psychological wellbeing, at least one job that focuses on people's psychological wellbeing; Client care as primary task, at least one job with patient or client care as its main task; DSM-related problems, at least one job involves preventive or care tasks for people with (sub)clinical problems or disorders as defined in DSM.

Spearman correlations with **age cohort** of (self-)employed MScs in psychology (<30 years; 30–39 years; 40–49 years; 50–59 years; ≥60 years) showed significant, but very small, correlations between age and (a) working in the mental healthcare sector (ρ = .05, p < .001), (b) contribution to wellbeing (ρ = .05, p < .001), and (c) client care (but not as primary task) (ρ = .06, p < .001). Other correlations were not significant at p < .01.

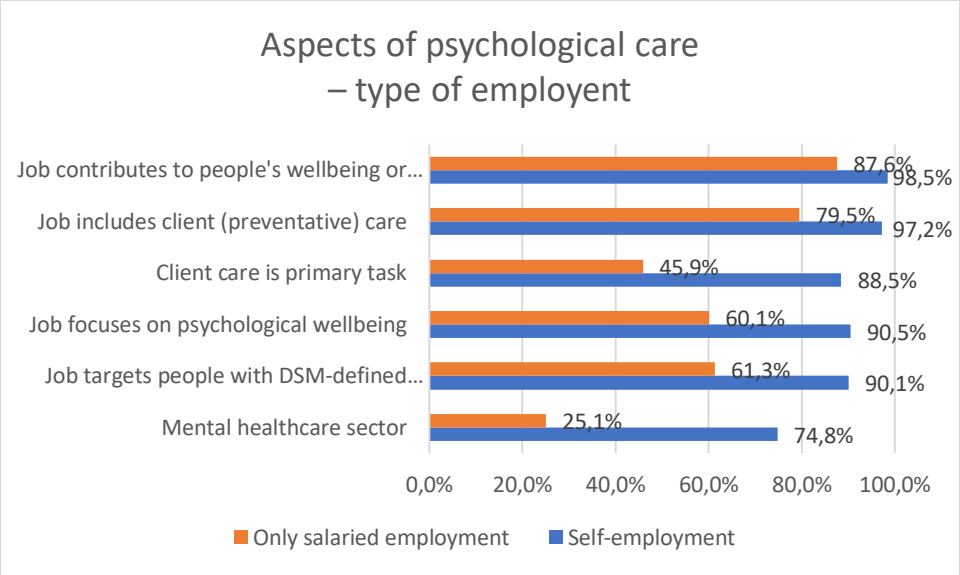

Figure 54. Job characteristics related to mental healthcare availability in participants with an MSc in psychology working exclusively in salaried employment and in self-employed participants.

3.5.2 Field of work of clinical psychology – jobs that contribute to wellbeing or development

Demographic characteristics and educational background

In the future, among those with an MSc in psychology, only clinical psychologists will be able to perform tasks related to the LHCP on a regular basis. In the meantime, many other types of psychologists are active in mental healthcare provision in Belgium. In this part of the survey, we investigated the involvement of psychologists in mental healthcare in a narrower sense (i.e., provision of mental healthcare by those with an MSc in clinical psychology) and in a broader sense (i.e., based on participants' self-reported involvement in mental healthcare).

In the survey, psychologists with a job in the broad domain of psychology and educational sciences were asked **whether they contributed to people's wellbeing and development**. They were instructed to interpret this broadly – for example, physical and mental health, cognitive development, and psychosocial wellbeing in the family, at work, at school, in society, and so on. This question was used as an indicator of a **clinical field of work.**

Of psychologists in (self-)employment who participated in this survey, 3,758 (92.9% of valid cases) responded in the affirmative to this question.[58] Considering only the subset of psychologists with a job in the broad domain of psychology and educational sciences (n = 3,844), this represents 97.7% of valid cases. These respondents had a mean FTE of 0.9 (i.e. on average, they worked 4.5 days per week). Table 40 shows that most jobs (89.5–98.7%) related to peoples' wellbeing and development. Further analyses on

[58] Valid cases: n = 4,044.

mental healthcare availability include only participants in those jobs. Table 41 describes the characteristics of this subsample.

Table 40. Contribution to people's wellbeing and development

	n	Valid percentage	FTE Mean
Contribution to wellbeing in ≥1 job	**3,758**	**97.7**	**0.90**
Jobs in salaried employment			
Job 1	2,900	96.8	0.81
Job 2	2,29	89.5	0.36
Job 3[59]	--	--	
Jobs in self-employment			
Job 1	1,840	98.7	0.55
Job 2	401	96.4	0.38
Job 3	85	89.5	0.32

Note. Valid percentage refers to the division between participants who replied "yes" versus "no" to this question. FTE, Full-time equivalent.

Table 41. Demographic characteristics and educational background of the subsample that contributes to the wellbeing or development of people

	n	%
Age cohort		
<30 years	918	24.4
30–39 years	1,389	37.0
40–49 years	823	21.9
50–59 years	457	12.2
≥60 years	171	4.6
Gender		
Male	614	16.3
Female	3,144	83.7
Language		
Flemish	2,522	67.1
French	1,203	32.0
German	27	0.7
English	6	0.2

[59] There is no information on this question about Job 3 in salaried employment (all 33 cases had dropped out by that point in the survey).

Work region[60]		
Flanders	2,415	64.3
Wallonia	931	24.8
Brussels	678	18.0
Type of MSc in psychology		
Clinical	2,948	78.4
Other	810	21.6
Further training		
No additional training related to the LHCP	1,764	46.9
Only education of 1 or 2 years related to the LHCP	593	15.8
Only education of 3 or 4 years (postgraduate psychotherapy training)	819	21.8
Both	582	15.5

Employment status

About half of individuals with an MSc in psychology who contribute to the wellbeing or development of people in at least one of their jobs, works exclusively in **salaried employment**, the other half works (also) in **self-employment** (see Table 42). As shown in Table 43, younger psychologists tend to work only in salaried employment more often, whereas the likelihood of being self-employed as a primary occupation is higher in **older cohorts**. These results are similar to those found in the general sample of psychologists (see section 3.3.1).

Table 42. Employment status of the subsample that contributes to the wellbeing or development of people

Employment status	***n***	**%**
Exclusively salaried employment	1,799	47.9
Self-employment as a primary occupation	754	20.1
Self-employment as a secondary occupation	1,179	31.4
Self-employment after retirement	26	0.7

[60] Participants could be employed in more than one Belgian region, as was the case in 302 participants in (self-) employment (8.0%); 63 participants only worked outside Belgium (1.7%).

Table 43. Age differences in employment status of the subsample that contributes to wellbeing or development of people

	Age cohort (years)					$\chi^2(8)$	Cramer's *V*
	<30	30–39	40–49	50–59	≥60	209.61**	.17**
Employment status (%)							
Exclusively salaried employment	61.4	50.6	38.3	37.4	26.9		
Self-employment as a primary occupation	13.2	17.3	21.7	30.4	43.9		
Self-employment as a secondary occupation or after retirement	25.4	32.1	40.0	32.2	29.2		
n	918	1389	823	457	171		

Note. * p < .01, **p < .001.

There were some small differences in (self-)employment between **Flanders**, the **Brussels-capital region** and **Wallonia**, but none of these differences reached the threshold for a small effect size (Table 44).

Table 44. Regional differences in professional situation

	Region			$\chi^2(4)$	Cramer's *V*
	Flanders	Wallonia	Brussels-capital	17.32*	.04*
Professional situation (%)					
Exclusively salaried employment	47.4	39.4	45.6		
Self-employment as a primary occupation	20.2	23.5	21.4		
Self-employment as a secondary occupation or after retirement	32.5	37.1	33.0		
n	2,415	931	678		

Note. * p < .01, **p < .001. Psychologists could be employed in more than one region.

Sectors and settings

Sectors

We asked participants to indicate the sectors and settings in which they were working. These analyses were done on participants' main job in salaried employment (*n* = 2,900) and their main job in self-employment (*n* = 1,840).[61]

Table 45. Sectors of main job in salaried employment

	Language community			**Test statistics**	
Sector (%)	Flemish (*n* = 1,967)	French and German (*n* = 929)	All (*n* = 2,900)	$\chi^2(1)$	φ
Social welfare, social services and interest groups	14.5	21.5	16.6	20.52**	.08**
Mental healthcare	36.1	25.4	32.7	33.09**	–.11**
Healthcare	12.6	19.7	14.9	25.04**	.09**
Education, training and student counselling	24.9	28.5	26.0	4.40	.04
Forensic sector	5.4	7.0	5.9	2.94	.03
Public administrations/government	5.0	6.6	5.5	3.05	.03
Commercial services	3.3	1.9	2.9	4.24	–.04
Industrial sector	1.7	1.1	1.5	1.56	–.02
Research sector	7.6	6.1	7.2	1.98	–.03
Leisure, culture and sport	0.4	0.5	0.4	0.51	.01

Note. *$p < .01$, **$p < .001$.

[61] Participants could report on up to three jobs in salaried employment and up to three jobs in self-employment. For each set, they were asked to start with the job that takes most of their time. Analyses were run on the first job in salaried employment they reported on, and on the first job in self-employment.

Table 46. Sectors of main job in self-employment

	Language community			Test statistics	
Sector (%)	Flemish (*n* = 1,200)	French and German (*n* = 638)	All (*n* = 1,840)	$\chi^2(1)$	φ
Social welfare, social services and interest groups	7.1	8.5	7.6	1.14	.03
Mental healthcare	85.7	52.7	74.2	237.05**	–.36**
Healthcare	9.3	37.5	19.0	215.03**	.34**
Education, training and student counselling	9.0	9.7	9.2	0.26	.01
Forensic sector	2.8	2.8	2.8	0.00	.00
Public administrations/government	1.6	1.1	1.4	0.71	–.02
Commercial services	5.3	2.2	4.2	9.69*	–.07*
Industrial sector	1.4	1.6	1.5	0.07	.01
Research sector	1.1	1.9	1.4	1.98	.03
Leisure, culture and sport	1.3	0.5	1.0	3.03	–.04

Note. *$p < .01$, **$p < .001$.

Not surprisingly, most jobs that contribute to people's wellbeing and development were linked to the **sectors** mental healthcare, healthcare, education and student counselling, and social welfare. The mental healthcare sector was more prominent among participants in **self-employment** (74.2%) than among those in **salaried employment** (32.7%).

Psychologists in the Flemish **community** were more often employed in the mental healthcare sector compared with their colleagues from the French or German community, and less often in social welfare and healthcare, although effect sizes were small (see Table 46). Self-employed psychologists in the Flemish community mainly identified with the mental healthcare sector, whereas self-employed psychologists in the French and German community also identified strongly with the healthcare sector.

Although participants could indicate that their job was situated in different sectors, most participants indicated that their job was related to only **one sector** (87.0% for the main job in salaried employment; 77.5% for the main job in self-employment) (see Figures 55 and 56).

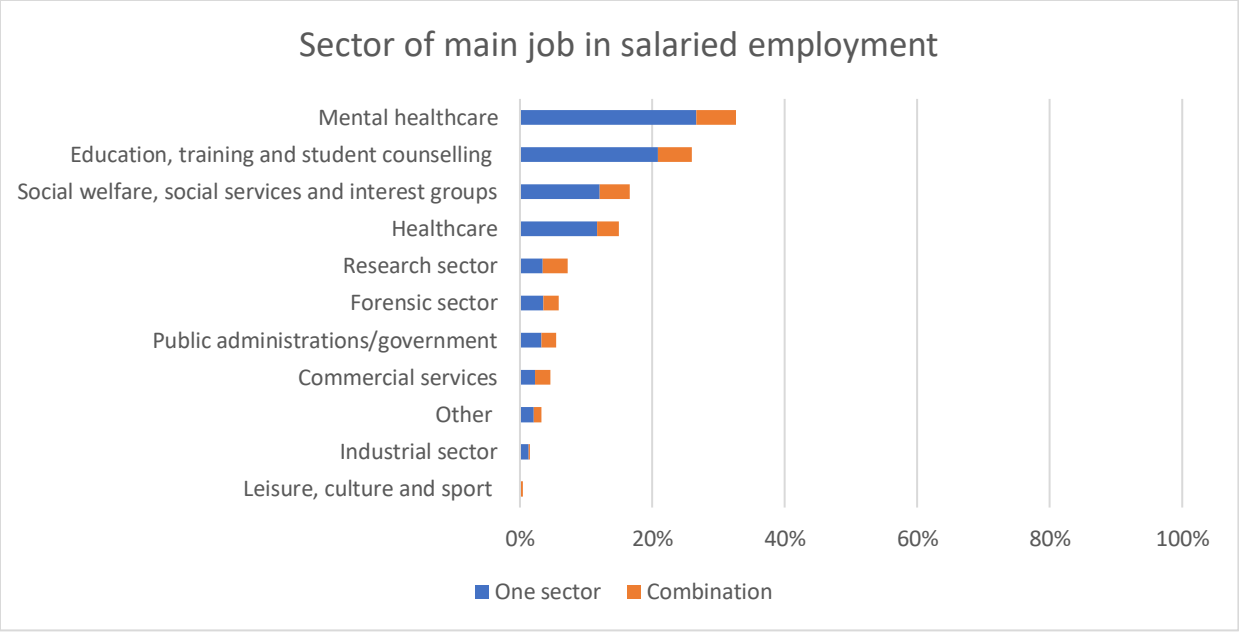

Figure 55. Sector(s) of main job in salaried employment[62].

[62] Participants were invited to specify their choice for "another sector". This showed that most responses were specific settings, that fitted in one of the sectors that was predefined. Despite our efforts to give an extensive list of settings for each sector, several participants could not identify their sector, or did not notice their setting was listed as an example of one of the sectors.

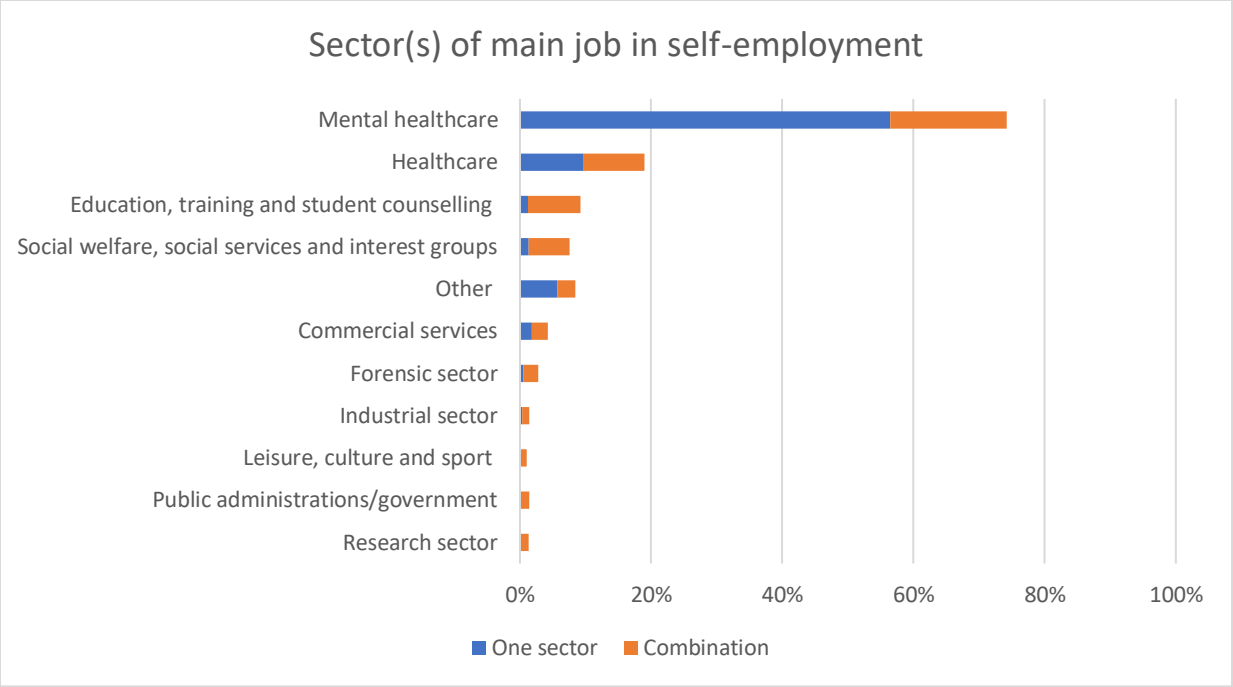

Figure 56. Sector(s) of main job in self-employment[63].

When participants did indicate that their job was related to different sectors (13% for the main job in salaried employment, 22.5% for the main job in self-employment), combinations with the mental healthcare sector were common both in salaried employment and in self-employment. Mental healthcare was relevant in 46.5% and 79% of combinations in salaried employment and self-employment, respectively.

Settings

There is a global trend for psychologists to work in different **settings across the different tiers of healthcare.** Whereas in the past psychologists were typically mainly employed in specialist, high-intensity care settings (e.g. psychiatric hospitals), there has been a notable shift, with psychologists now being employed across the different tiers of (mental) healthcare. Here, we investigate to what extent this trend is also observable among psychologists educated or employed in Belgium.

Settings in salaried employment

As shown in Figure 55, 33% of participants with an MSc in psychology who reported on their main salaried job that contributes to wellbeing or development indicated that they worked in the mental healthcare

[63] The relatively high percentage of "other" sectors can be explained by the difficulty for self-employed psychologists to categorize their private practice in a sector, as sectors are often defined in the context of salaried employment. Several psychologists who chose this option, specified they were working in a private practice.

sector (*n* = 947). Clearly, within the **mental healthcare sector**, psychiatric hospitals are still the most important work setting (33%), followed by mental healthcare centres (Centra Geestelijke Gezondheidszorg/Services de Santé Mentale) (28%). Both of these are specialized mental healthcare settings that primarily focus on second- and third-tier care. Only 8% of participants placed their job in a primary care setting (*n* = 80).

As previous analyses indicated **language community** differences in the mental healthcare sector, we further explored the effect of language community in the mental healthcare settings (see Table 47).

Table 47. Settings of the main job in salaried employment in the mental healthcare sector

	Language community			**Test statistics**	
Setting (%)	Flemish (*n* = 711)	French or German (*n* = 236)	All (*n* = 947)	$\chi^2(1)$	φ
Primary care	6.8	13.6	8.4	10.62*	.11*
Mental Healthcare Centre (~ "CGG/SSM/BTZ"")	26.7	30.1	27.6	1.00	.03
Subsidized therapy centre (e.g. for addictions)	3.5	8.5	4.8	9.63*	.10*
Centre for psychological/psychiatric rehabilitation	2.4	2.5	2.4	0.02	.00
Centre for outpatient rehabilitation	7.2	4.7	6.5	1.83	–.04
Psychiatric department of a general hospital	6.0	14.8	8.2	18.08**	.14**
Psychiatric hospital	36.4	22.0	32.8	16.64**	–.13**
Psychiatric nursing home	1.5	2.1	1.7	0.35	.02
Psychiatric home care	0.8	1.7	1.1	1.23	.04
Mobile team/outreach service	8.3	9.7	8.7	0.47	.02
Sheltered accommodation	1.4	1.3	1.4	0.02	–.01
Hired by an independent practice	1.3	0.8	1.2	0.27	–.02

Note. *$p < .01$, **$p < .001$.

Psychologists in the Flemish **community** were more often employed in psychiatric hospitals than psychologists in the French or German communities. The latter were more often employed in psychiatric departments of general hospitals and in subsidized therapy centres. The importance of employment in psychiatric departments of general hospitals in the French and German communities can partly explain

community differences in sectors (e.g. Table 46), as this setting can relate to both the mental healthcare sector and the healthcare sector, and participants were allowed to indicate multiple sectors per job. Furthermore, French- or German-speaking psychologists more often indicated that they provided primary care in the mental healthcare sector. However, all effect sizes were small.

Of those working in a **primary care setting** (*n* = 80), 46% work only in primary care, and 54% also work in second- or third-tier care. This means that, as far as the main job in salaried employment in the mental healthcare sector is concerned, 3.9% of participants work only in primary care, 4.5% work in both primary and second- or third-tier care, and 91.6% work only in second- or third-tier care.

Further, of those working in a primary care setting in the mental healthcare sector (*n* = 80), 55% also work in other sectors (*n* = 44), especially the social welfare, healthcare, and education, training and student counselling sectors.

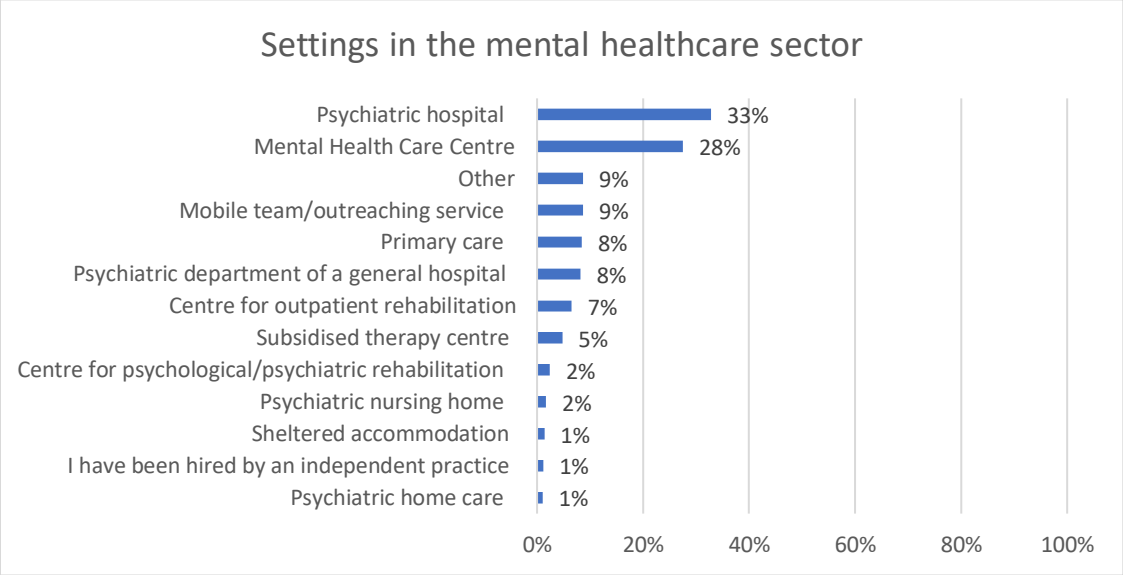

Figure 57. Settings in the mental healthcare sector[64].

In the **social welfare sector** (17%, *n* = 482), the most important settings are facilities for people with disabilities (25%), special youth care (22%), and social services (22%). In addition, 15% of respondents working in this sector work in social welfare/integration, and 11% in an organization that focuses on wellbeing and health promotion (Figure 58). Descriptive information on combinations of sectors showed that psychologists working in a social welfare/integration or social services setting more often indicated

[64] Inspection of the specifications showed that many settings listed as "other" mental healthcare settings could be categorized as one of the settings that were already listed as an option. Further, several "other" mental healthcare settings were social welfare settings or healthcare settings. This is perhaps unsurprising, as mental healthcare is often also offered in social welfare and healthcare settings.

that the sector of their job was also related to mental healthcare compared with other settings in the social welfare sector.

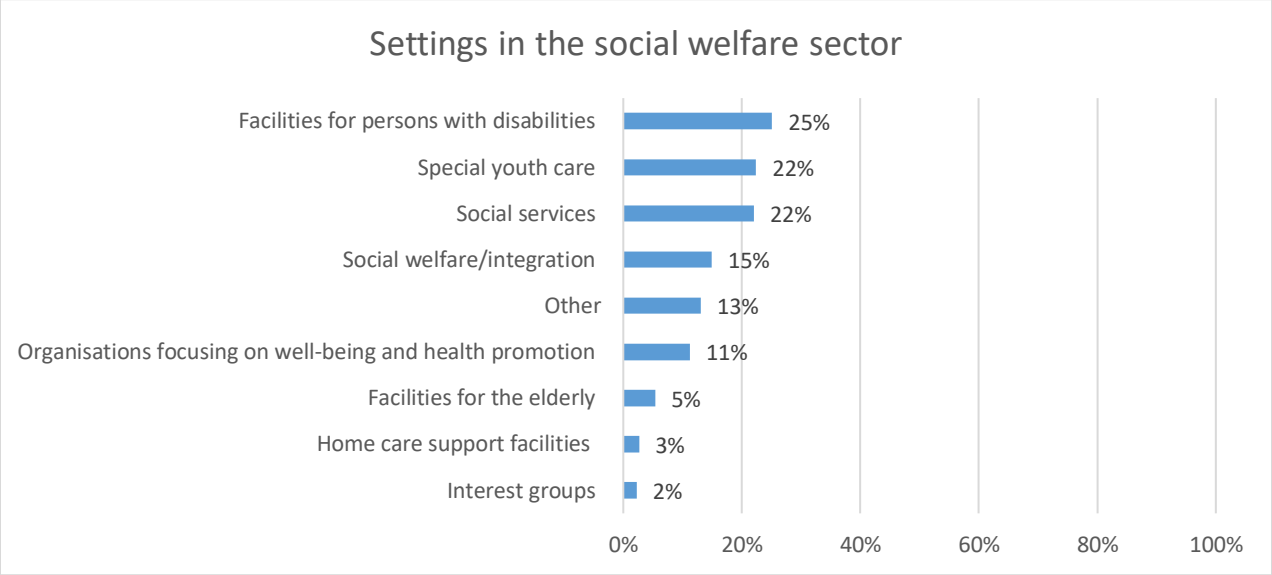

Figure 58. Settings in the social welfare sector.[65]

As previous analyses indicated language **community differences** in the social welfare sector, we explored the effect of language community in the social welfare settings (see Table 48). However, the distribution across the settings was similar in both language communities.

[65] Inspection of the specification of "other" settings in the social welfare sector showed that most options could be categorized in one of the settings listed by the researchers. Part of the classification in "other" settings was an artefact of the previous question on sector of the job: participants had the possibility to classify one job in multiple sectors. For example, pupil guidance centres were often mentioned as an "other" setting in the social welfare sector. However, pupil guidance centres were listed as a setting in the sector "education, training and student counselling".

Table 48. Settings of the main job in salaried employment in the social welfare sector

	Language community			Test statistics	
Setting (%)	Flemish (n = 285)	French or German (n = 197)	All (n = 482)	$\chi^2(1)$	φ
Social welfare/integration	13.3	17.3	14.9	1.41	.05
Social services	23.2	20.3	22.0	0.55	–.03
Special youth care	24.2	19.8	22.4	1.31	–.05
Facilities for the elderly	6.3	4.1	5.4	1.16	–.05
Facilities for people with disabilities	23.9	26.9	25.1	0.57	.04
Home care support facilities	2.8	2.5	2.7	0.03	–.01
Interest groups	1.4	3.6	2.3	2.41	.07
Organizations focusing on wellbeing and health promotion	11.6	10.7	11.2	0.10	–.01

Note. *p < .01, **p < .001.

In the **forensic sector** (n = 171, 6%), 43% of respondents indicated that they worked in a prison, as part of the psychosocial services provided in prisons. Psychologists working in forensic settings in a centre for mental healthcare (8%), a psychiatric hospital (18%), or an outreach team (5%) more often indicated that their job also related to the mental healthcare sector compared with other settings in the forensic sector.

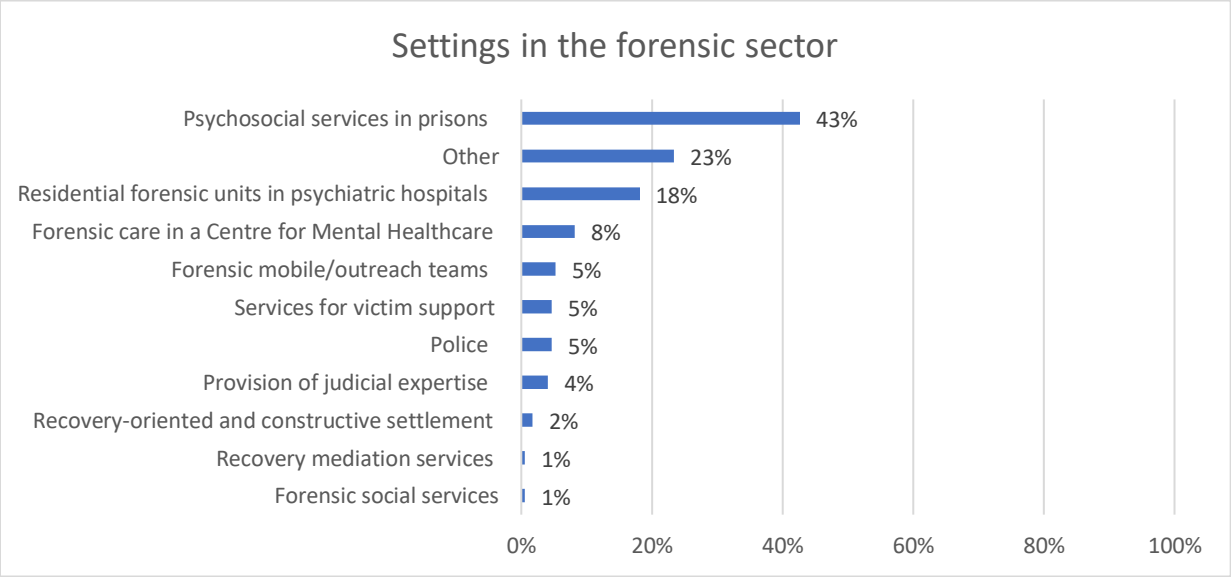

Figure 59. Settings in the forensic sector[66].

[66] Specifications of "other" forensic settings included forensic psychiatric centres, juvenile prisons, facilities for illegal immigrants, and reintegration services.

In the **healthcare sector** (*n* = 432, 15%), 71% indicated that they worked in a non-psychiatric department of a general hospital, 7% in a district healthcare centre, and 24% in another setting[67]. As previous analyses indicated language community differences in the healthcare sector (see Table 46), we explored the effect of language community in the healthcare settings. As shown in Table 49, working as a psychologist at a district health centre is not a common practice in the Flemish community. Working at a non-psychiatric department of a general hospital is more prevalent in the Flemish community. However, some participants interpreted a "general hospital" as a non-academic hospital, so these findings have to be interpreted with caution.

Table 49. Settings of the main job in salaried employment in the health sector

	Language community			**Test statistics**	
Setting (%)	Flemish (*n* = 248)	French or German (*n* = 183)	All (*n* = 432)	$\chi^2(1)$	φ
District Health Centre	0.4	15.8	7.0	38.78**	.30**
Non-psychiatric department of a general hospital	80.2	57.4	70.5	26.49**	–.25**
Other	19.8	30.6	24.4	6.72	.13

Note. *p < .01, **p < .001.

In the **education, training and student counselling sector** (*n* = 754, 26%), 38.5% work in a pupil guidance centre (CLB/CPMS); the majority of respondents working in this sector work in a school/educational setting, e.g. primary school, university (college) (63.1%).

In **government/public administration** (*n* = 159), 38.4% of participants work for a public service for wellbeing or mental health, 13.2% work for a public service for education, and 54.7% work for another public service[68].

Hence, it seems that individuals with an MSc in psychology who are employed in the mental healthcare sector primarily work in second- or third-tier care. However, a smaller group is employed in primary care and outreach care. In addition, employment related to wellbeing or development is not limited to the

[67] Inspection of the specifications showed that many settings listed as "other" healthcare settings could be categorized as one of the settings that were already listed as an option (e.g. further specifications of the setting, e.g. rehabilitation). Some psychologists specified they worked at a university or academic hospital (in contrast to a "general" hospital", which in the context of the questionnaire referred to a non-psychiatric hospital). Further, several "other" healthcare settings were social welfare settings or mental healthcare settings, or even education and student counselling settings (pupil guidance centres have a medical task too in Belgium).

[68] Other public services included the Immigration Office and the Federal Public Service "Employment, Labour and Social Dialogue".

mental healthcare sector, but is also related to other sectors, such as social welfare, healthcare, education, the forensic sector, and government.

Settings in self-employment

For those in **self-employment** (*n* = 1,840), the mental healthcare sector (74%) is very dominant in their main self-employed job that relates to wellbeing or development. Of self-employed participants, nearly half indicated that they work in an individual private practice (45%), 19% work in a monodisciplinary group practice, and 24% indicate that they work in a multidisciplinary group practice.

These proportions are similar for those working in the mental healthcare sector (*n* = 1,345) (Figure 60).

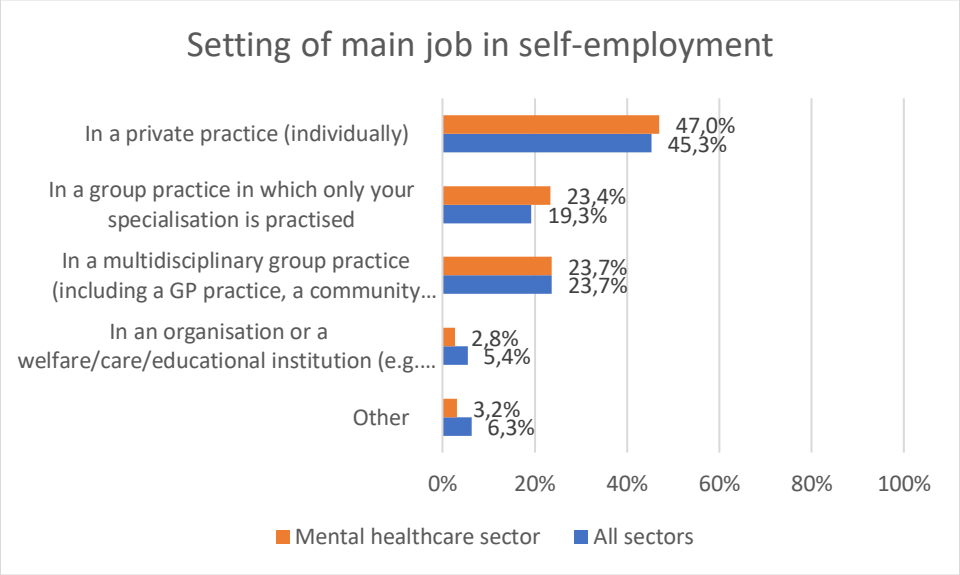

Figure 60. Setting of main job for psychologists in self-employment[69].

[69] "Other" settings of main job in self-employment included working in a private practice of a psychiatrist, working in different settings, working for a business company, delivering psychological care at the patient's home etc. Several participants gave a specification of a setting that was listed.

There were **language community** differences in setting (n = 1,838, $\chi^2(4)$ = 183.26, Cramer's V = .32). Working individually, in a private practice, appeared to be a more common practice in the French or German language community compared with the Flemish community, whilst in Flanders work in a monodisciplinary group practice was more common.

Table 50. Language community differences in work setting of the main job in self-employment

	Language community			Test statistics	
	Flemish (n =1,200)	French or German (n =638)	All (n =1,840)	$\chi^2(4)$	Cramer's V
Setting (%)				183.26**	.32**
In a private practice (individually)	38.2	58.6	45.3		
In a monodisciplinary group practice	27.0	4.9	19.3		
In a multidisciplinary group practice	25.3	20.8	23.7		
In an organization or a welfare/ care/educational institution	3.1	9.9	5.4		
Other[70]	6.5	5.8	6.3		

Note. *p < .01, **p < .001.

For psychologists working in a private or group practice[71] in the mental healthcare sector (n = 1,284), we also asked whether they considered their work to situated at the **primary care and/or second-tier level** of mental health care. The vast majority (90.5%) indicated that their practice was situated at the primary care level, with 20.1% situating their practice at the primary care level only. Only a very small proportion (<10%) indicated that their practice was situated at the second tier of mental healthcare. These findings are in line with the report from the Flemish Association of Clinical Psychologists (VVKP, 2017) on clinical psychologists in private practice, arguing that the distinction between primary and second-tier care is not meaningful in the practice of most self-employed clinical psychologists.

[70] The specifications of the "other" settings provided by the participants showed this category was not easily interpretable, as it included participants who work working alone (and for example chose this category because they made house calls) as well as participants who worked in a group context (e.g. they worked in multiple settings in the same job).

[71] The remaining 81 self-employed psychologists working in the mental healthcare sector (6.0%) indicated they were self-employed in an institution or a welfare/care/educational institution, or in a setting that was not listed (option "other"). The specific circumstances of their (self-)employment are unknown.

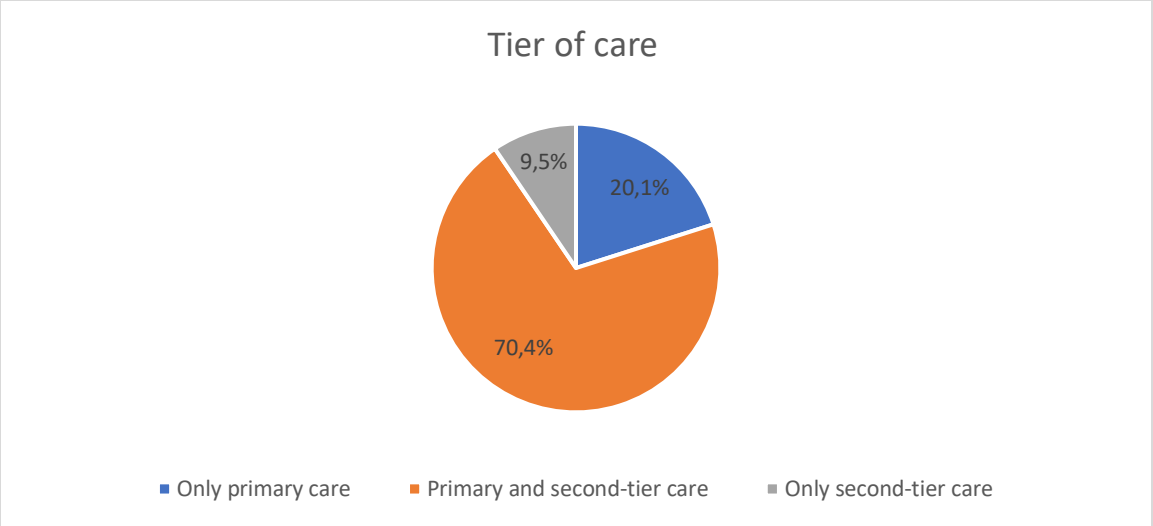

Figure 61. Tier of care provided by psychologists working in self-employment in healthcare practices in the mental healthcare sector.

There were small **language community** differences in level of care (n = 1,283, $\chi^2(2) = 60.57$, Cramer's V = .22, $p < .001$). In self-employment, primary care seems more common in the Flemish community (see Table 51), whereas in the main job in salaried employment, a higher percentage of psychologists in the French and German community reported to provide primary care compared with Flemish-speaking psychologists (see Table 47). The distinction between primary and secondary care also seems less relevant in the Flemish community.

Table 51. Language community differences in tier of care of the main self-employed job

	Language community		**Test statistic**	
	Flemish (n = 975)	French or German (n = 308)	$\chi^2(2)$	Cramer's V
Tier of care (%)			60.57**	.22**
Only primary care	21.4	15.9		
Primary and second-tier care	72.6	63.3		
Only second-tier care	5.9	20.8		

Note. * $p < .01$, ** $p < .001$.

Furthermore, there were significant but very small effects of **type of MSc in psychology** (n = 1,284, $\chi^2(2) = 9.26$, Cramer's V = .09, $p < .01$). The distinction between primary and second-tier seemed somewhat less relevant in participants with an MSc in clinical psychology compared with those with an MSc in another domain of psychology.

Table 52. Language community differences in tier of care of the main self-employed job

	Type of MSc in psychology		Test statistic	
	Clinical psychology (*n* = 1,164)	Another domain of psychology (*n* = 120)	$\chi^2(2)$	Cramer's *V*
Tier of care (%)			9.26*	.09*
Only primary care	19.8	22.5		
Primary and second-tier care	71.4	60.8		
Only second-tier care	8.8	16.7		

Note. * $p < .01$, ** $p < .001$.

Finally, as shown in Table 53, **younger** psychologists seemed to focus more on primary care activities (n = 1,284, $\chi^2(4) = 37.84$, Cramer's $V = .12$, $p < .001$). Yet, a similar effect of age cohort was not found for the identification with primary care in the main salaried job (n = 947, $\chi^2(4) = 1.60$, $p > .05$).

Table 53. Age group differences in tier of care of the main self-employed job

	Age cohort					Test statistics	
	<30 (*n* = 249)	30-39 (*n* = 473)	40-49 (*n* = 324)	50-59 (*n* = 167)	≥60 (*n* = 71)	$\chi^2(4)$	Cramer's *V*
Tier of care (%)						37.84**	.12**
Only primary care	31.3	18.6	16.7	16.8	14.1		
Primary and second-tier care	64.3	73.4	71.0	70.1	70.4		
Only second-tier care	4.4	8.0	12.3	13.2	15.5		

Note. *$p < .01$ (Bonferroni correction), **$p < .001$.

It seems that self-employed individuals with an MSc in psychology who contribute to wellbeing in their job usually work in the mental healthcare sector. As most self-employed participants indicated that they are involved in both primary care and second-tier care, the distinction in between tiers seems to be less relevant in self-employment. Furthermore, a multidisciplinary work setting is not standard for those in self-employment, with about 1 out of 4 reporting this work setting for their main self-employed job, whereas about half report working in an individual private practice.

3.5.3 Tasks of (clinical) psychologists involved in fostering wellbeing and development

Introduction

Participants with an MSc in psychology who were involved in fostering psychological wellbeing and development (i.e., working in a clinical field) were requested to **report on the way they contribute to people's wellbeing** and development in their job, with the following options:

- Supporting individuals and their environment (including diagnosis and treatment of individuals or groups of individuals, in various settings)
- Supporting organizations (e.g. schools, institutions, child daycare centres)
- Managerial tasks
- Supervision of colleagues or trainees
- Policy and governance (e.g. writing policy papers, quality assurance)
- Training and education
- Scientific research
- Administrative tasks.

We focused on tasks for those with a main job in salaried employment and a main job in self-employment. Figure 62 shows the percentages per category for the **main job in salaried employment** (*n* = 2,872; information was missing for 28 participants). Figure 63 shows the results for the main job in self-employment (*n* = 1,773 – 1,818; 11-67 missing).

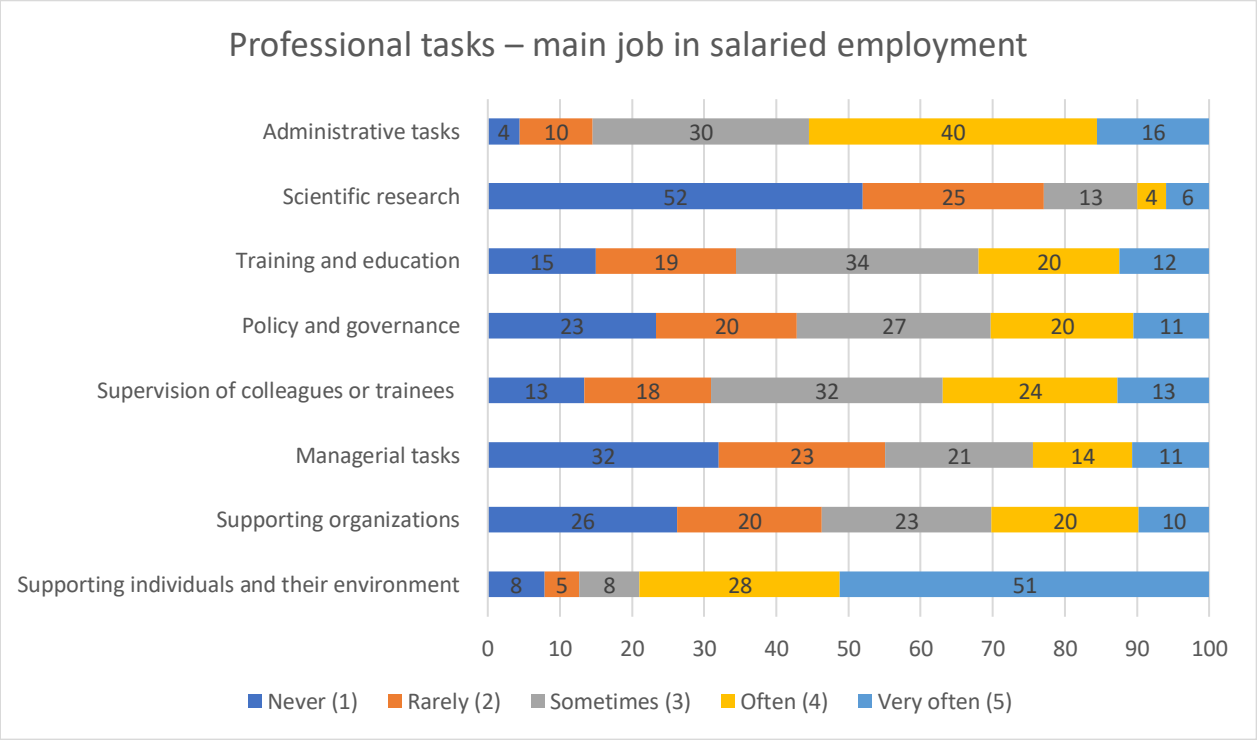

Figure 62. Percentages of professional tasks for the main job in salaried employment.

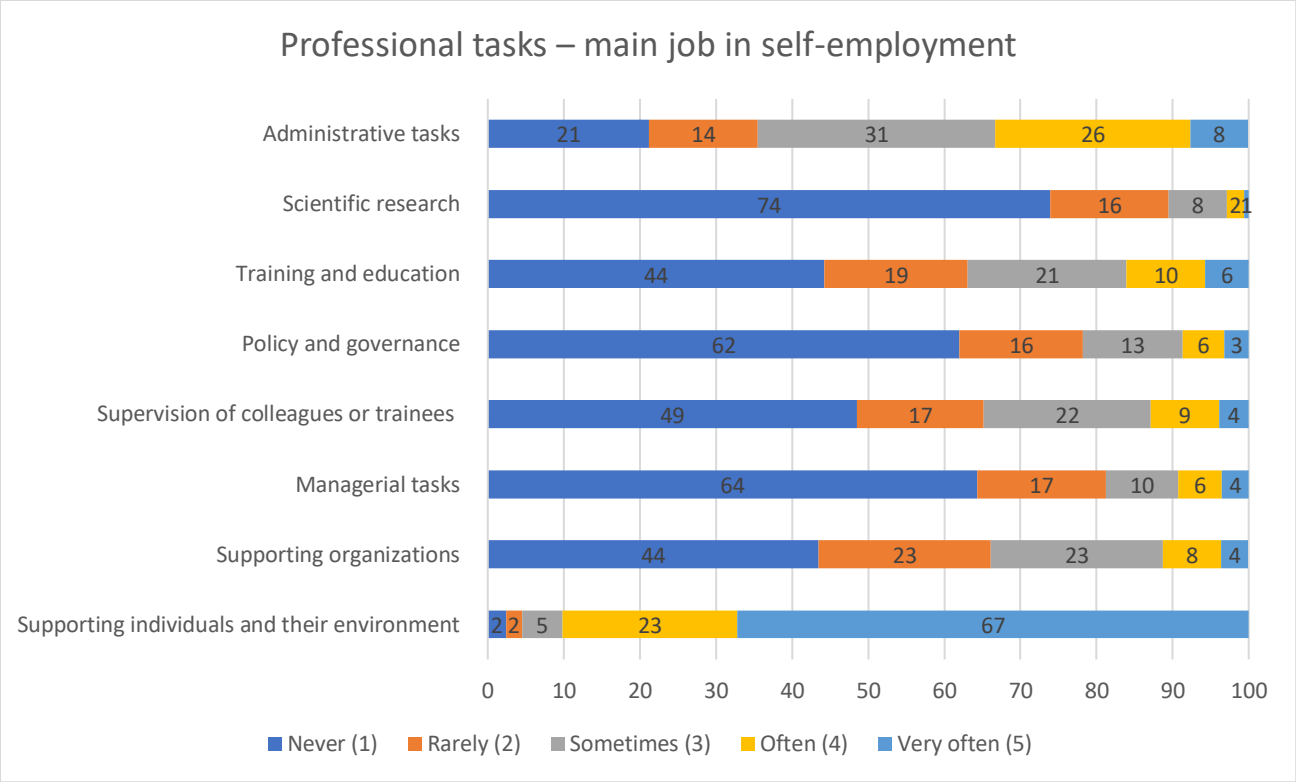

Figure 63. Percentages of professional tasks for the main job in self-employment.

It is not surprising that **supporting individuals and their environment** is the **most important task** for those in salaried employment who contribute to people's wellbeing in their job (n = 2,872); 92% performed this task at least rarely. Close to four out of five psychologists indicate that they perform this task often to very often (79%). This is even more so for those in self-employment (n = 1,818), where 97.6% identify this task as relevant and nine out of 10 indicate that they perform this task often to very often (90.2%) ($\chi^2(4)$ = 153.30, Cramer's V = .18, n = 4,690, p <.001).

Administrative tasks seem to be the second most prevalent task, both for those in salaried employment (95.6%; n = 2,872) and those in self-employment (78.8%; n = 1,779). In self-employment, 64.4% of psychologists indicate that they perform administrative tasks at least sometimes in their main self-employed job related to people's wellbeing; for those in salaried employment, this increases to 85.5%, with 55.5% indicating they perform this task often to very often. Hence, the administrative workload is higher for those in salaried employment compared with those in self-employment ($\chi^2(4)$ = 424.23, Cramer's V = .30, n = 4,651, p <.001).

Scientific research seems **least relevant** for jobs contributing to wellbeing. Half of the psychologists in salaried employment indicate they are never involved in research (52.0%; n = 2,872), and almost three-quarters of those who are self-employed indicate that they are never involved in research (73.9%; n = 1,773) ($\chi^2(4)$ = 252.62, Cramer's V = .23, n = 4,645, p <.001).

Training and education and **supervision** are third in the hierarchy of tasks in **salaried employment**, with two out of three psychologists engaging in this task at least sometimes; i.e. 65.6% for training and education (n = 2,872) and 69.1% (n = 2,872) for supervision. **Policy and governance** (57.1%), **managerial tasks** (44.9%), and **supporting organizations** (53.7%) are carried out at least sometimes in around half of psychologists in salaried employment.

Figures 62 and 63 also show that the task profile is **more diverse in salaried employment** compared with self-employment. After client care and administration, all the other tasks seem relevant (i.e. performed at least "rarely") to only around half of the psychologists with a (main) job in self-employment.

Client work

In the previous section, we gave an overview of the different tasks and responsibilities of participants with an MSc in psychology who are involved in fostering wellbeing or development. In the next analysis, we focus on one of these responsibilities: **"Supporting people or their environment"** (hereafter referred to as "**client work**"). In the introduction (section 3.5.1, Table 37), we showed that participants with an MSc in clinical psychology more often perform client work (90.1%) compared with those with an MSc in a different area of psychology (68.5%; n = 4,160). When we repeated this analysis for participants involved in supporting people's wellbeing or development, this was also the case: 97.0% of participants with an MSc in clinical psychology are involved in client work, compared with 87.2% of those with another MSc in psychology ($\chi^2(1) = 127.54$, $\varphi = .19$, n = 3,717, $p < .001$). When looking at the total amount of client work, psychologists with an MSc in clinical psychology account for 80.2% of client work. However, we have to take into account that participants with an MSc in clinical psychology are somewhat overrepresented in our sample.

We further explored relationships with **educational background** (i.e. type of MSc in psychology). Educational background consisted of the following categories:

- Clinical or health psychology (including clinical neuropsychology and clinical forensic psychology)
- School or educational psychology
- Neuropsychology
- Theoretical and experimental psychology
- Personnel management and industrial/organizational psychology
- Other or no information
- More than one master's degree in psychology.

As displayed in Table 54, most psychologists, regardless of their background, perform client work to some extent (i.e. at least rarely, in at least one of their jobs) (94.9%). The prevalence of client work ranges between 72.4% and 98.2%. The prevalence of client work differs according to educational background (n = 3,717, $\chi^2(6) = 258.07$, Cramer's $V = .26$, $p < .001$). Descriptive analyses show that psychologists with a background in theoretical psychology or in organizational psychology seem to work with clients less often (72.4% and 79.9%). The highest rate of client work is found in psychologists with a background in clinical psychology and neuropsychology (97.1% and 98.2%).

Table 54. Differences in involvement in client work according to educational background

	Client work				
	Yes (%)	No (%)	*n*	$\chi^2(6)$	Cramer's *V*
Education				258.07**	.26**
Clinical or Health Psychology (including clinical neuropsychology and clinical forensic psychology)	97.1	2.9	2,796		
School or educational Psychology	94.3	5.7	175		
Neuropsychology	98.2	1.8	55		
Theoretical and Experimental Psychology	72.4	27.6	76		
Personnel Management and Industrial/Organizational Psychology	79.9	20.1	314		
Other or no information	97.0	3.0	164		
More than one master's degree in psychology	93.4	6.6	137		
Total	94.9	5.1	3,717		

Note. * $p < .01$, ** $p < .001$.

Follow-up analysis of variance (see Table 55) with the 5-point Likert score (ranging from never (1) to very often (5)) for the main job in salaried employment (n = 2,872, information was missing for 15 cases) and the main job in self-employment (n = 1,818; 46 missing) showed lower scores on this task in participants with an MSc in theoretical psychology or organizational psychology for the main job in salaried employment ($F(6, 480.08) = 42.87$, $p < .001$, $\eta^2 = .10$), and lower scores in participants with an MSc in organizational psychology for the main job in self-employment ($F(6, 244.55) = 10.46$, $p < .001$; $\eta^2 = .04$) (Games-Howell post-hoc comparisons).

Table 55. Relationship between educational background and client work, separately for psychologists' main job in self-employment and their main job in salaried employment

	Main job in salaried employment			Main job in self-employment		
	n	*M*	*SD*	*n*	*M*	*SD*
Education						
Clinical or Health Psychology	2,147	4.26	1.10	1,455	4.55	0.83
School or educational Psychology	151	3.93	1.20	54	4.52	0.80
Neuropsychology	39	4.31	0.95	31	4.52	0.93
Theoretical and Experimental Psychology	59	2.98	1.65	29	4.31	1.17
Personnel Management and Industrial/Organizational Psychology	245	3.00	1.44	96	3.75	1.32
Other or no information	133	4.14	1.17	78	4.54	0.73
More than one master's degree in psychology	98	4.04	1.28	75	4.56	0.78

Patient or client care as primary task

Participants who contributed to people's development or wellbeing (*n* = 3,758) were asked to consider the **overall orientation** of their job responsibilities, and indicate their **primary task** (with a maximum of two tasks out of a predefined list). Of these, *n* = 3,592 reported on this question (information was missing for 166 cases), and *n* = 2,585 indicated that patient or client care was a primary task in at least one of their jobs (72%). The majority had an **MSc in clinical psychology** (*n* = 2,277; 88.1% of the group with client care as primary task). Chi-squared analyses showed a relationship of medium effect size between client care as primary task and type of MSc in psychology ($\chi^2(1) = 501.26$, $p < .001$, $\varphi = .37$).

Table 56. Relationship between client care as primary task and type of MSc in psychology

Client care as primary task (%)	MSc in clinical psychology (*n* = 2,820)	Other type of MSc in psychology (*n* = 772)	MSc in psychology (any type of MSc) (*n* = 3,592)
Yes	80.7	39.9	72.0
No	19.3	60.1	28.0

The focus on client care differs somewhat per **work region** ($\chi^2(2) = 65.59$, $p < .001$, Cramer's $V = .13$). As shown in Table 57, the focus on client care is central for about three out of four psychologists in Flanders and Wallonia (73.7% and 73.9%, respectively), in Brussels, this is the case in about three out of five psychologists (59.7%).

Table 57. Relationship between client care as primary task and work region[72]

Client care as primary task (%)	Flanders (*n* = 2,326)	Wallonia (*n* = 880)	Brussels (*n* = 650)	$\chi^2(2)$	Cramer's *V*
Yes	73.7	73.9	59.7	69.59**	.13**
No	26.3	26.1	40.3		

Note. *p < .01, **p < .001. Participants could be employed in more than one region.

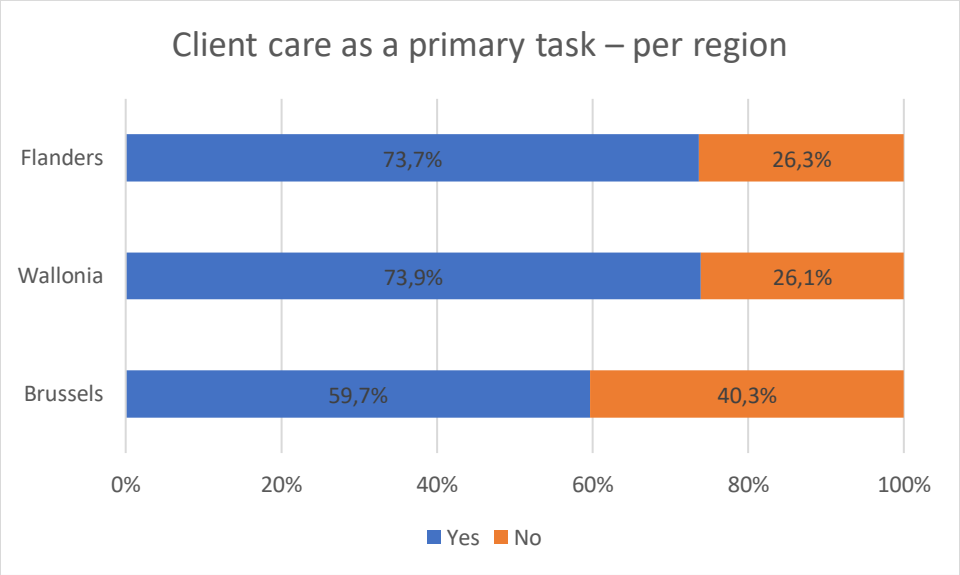

Figure 64. Psychologists indicating that client care is their primary task in participants working in the clinical field in Flanders, Wallonia, or Brussels.

We also looked into possible effects of **age** cohort, but no significant effects were found (($\chi^2(4) = 6.43$, $p > .05$, Cramer's $V = .04$; $\rho = .00$, $p > .05$, $n = 3{,}591$).

The focus on client care differed per **type of employment** ($\chi^2(2) = 625.30$, Cramer's $V = .42$, $p < .001$), with client care being more central in self-employment compared with salaried employment.

[72] See supplementary results in Appendix C on regional differences in field of work and client care.

Table 58. Relationship between client care as primary task and type of employment.

Client care as primary task (%)	Only salaried employment (*n* = 1,713)	Self-employment as a primary occupation (*n* = 727)	Self-employment as a secondary occupation (*n* = 1,134)
Yes	52.7	85.8	92.5
No	47.3	14.2	7.5

3.5.4 Target age group

We asked participants to indicate **the age group(s) they worked with** (i.e. toddlers, children, adolescents, young adults, adults, and elderly; see Table 59). Participants could indicate multiple age groups. The vast majority reported having more than one target group (70.2% and 90.6% for the first job in salaried employment and the first job in self-employment, respectively).

In general, the number of psychologists fostering wellbeing or development increases with the age of the target group, with a small decline in the oldest age group. Most participants with an MSc in psychology say they focus on (young) adults (66.3% for young adults and 70.2% for adults; see Table 59, "combined"). This pattern is similar for jobs in salaried employment and self-employment.

Table 59. Target age group for psychologists that contribute to wellbeing based on main job in salaried employment and main job in self-employment

Age groups	Salaried employment		Self-employment		Combined (%)
	n	%	*n*	%	
Toddlers (up to 3 years of age)	344	12.6	187	10.5	11.7
Children (3–12 years of age)	845	30.9	625	35.1	32.5
Young people (12–18 years of age)	978	35.7	907	50.9	41.7
Young adults (18–25 years of age)	1,584	57.9	1,413	79.2	66.3
Adults (25–65 years of age)	1,701	62.1	1,472	82.6	70.2
The elderly (65+)	727	26.6	718	40.3	31.9
n	2,737		1,783		4,520[73]
	134 missing, 29 not applicable		43 missing 14 not applicable		

Note. % is in relation to the number of jobs in salaried employment and jobs in self-employment (*n* = 2,737 + 1,783 = 4,520); combined = main job in salaried employment and main job in self-employment

[73] In this set of analyses, each participant who reported working in one of the age groups is counted as "1".

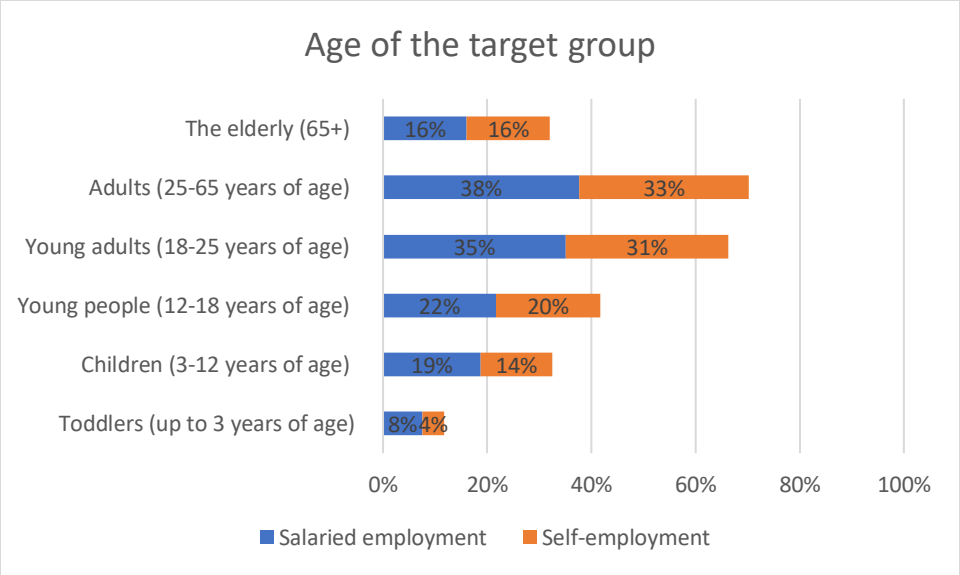

Figure 65. Relative contribution of salaried and self-employment per age group for main jobs that contribute to wellbeing.

Figure 66 shows the age distribution of the population of Belgium in the year 2018[74]. Although the age categories do not perfectly match the age groups in our sample, it seems that those with an MSc in psychology in our sample more often report working with adolescents and young adults as a target group than one could expect based on the age distribution of the Belgian population. Yet, on the other hand, the onset of psychological problems typically occurs in adolescence and young adulthood, and thus a greater focus on this group in psychological care is in line with epidemiological findings concerning the onset of psychological problems.

[74] See https://statbel.fgov.be/nl/themas/bevolking/structuur-van-de-bevolking

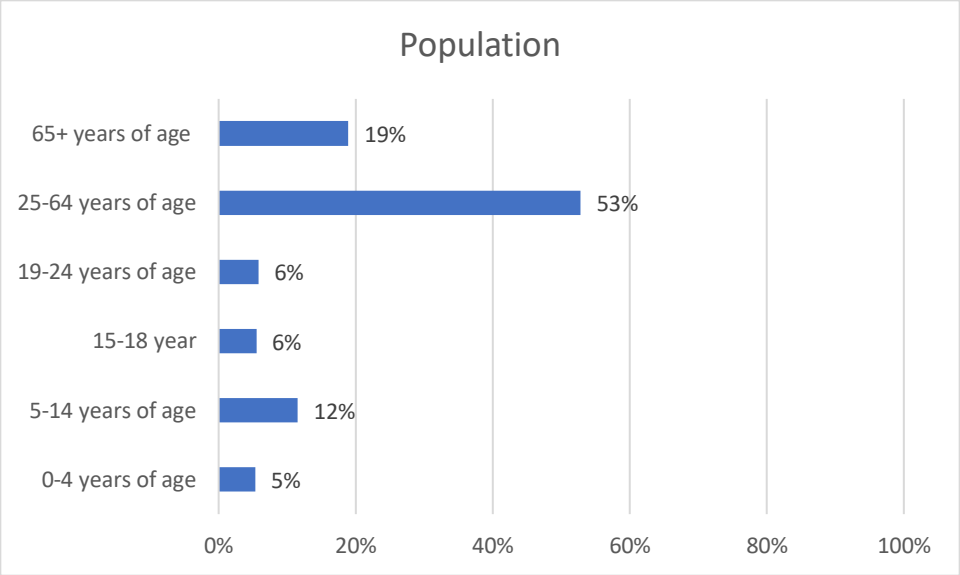

Figure 66. Age distribution of Belgian population (Statbel).

We **differentiated** between psychologists (a) working only with *children and adolescents* (age younger than 18 years), (b) working only with *adults*, and (c) working with *both*. As shown in Table 60, 23.1% of psychologists indicated working with both groups in their main job in salaried employment, and 44.1% did so in their main self-employed job. Hence, despite the fact that university training and clinical services often offer programmes focusing on children and adolescents versus adults specifically, in practice, psychologists often see patients in both age groups.

Table 60. Target age group for psychologists that contribute to wellbeing based on main job in salaried employment and main job in self-employment

Target age group (%)	Main job in salaried employment (*n* = 2,739)	Main job in self-employment (*n* = 1,784)
Children and adolescents (<18 years)	21.7	9.0
Adults (18+ years)	55.3	46.9
Both	23.1	44.1

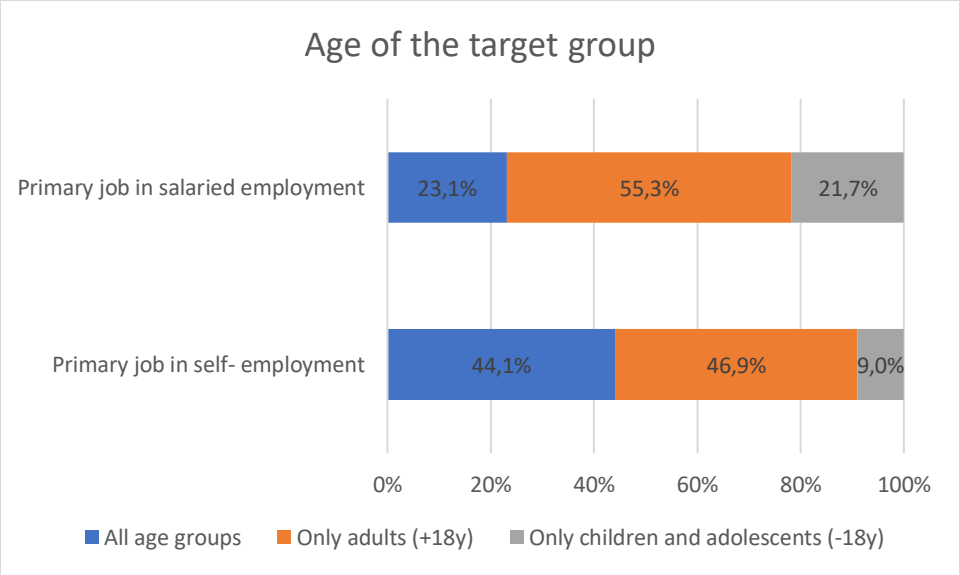

Figure 67. Age of the target group in the main job in salaried employment and the main job in self-employment.

We also gathered information regarding **working with families**. Among psychologists fostering wellbeing, 42.1% worked with families in at least one of their jobs (n = 3,684; data were missing for 74 participants). As working with families can have an effect on information regarding the age of the target group (i.e. it can imply working with multiple age groups or the inclusion of children), we explored the relationship between these features of the target group.

Psychologists who fostered wellbeing in their main job in salaried employment reported working with families or couples in 32.8% of the cases. This differed according to the **age of the target group** ($\chi^2(2)$ = 133.79, Cramer's V = .22, p < .001, n = 2,739). Psychologists who indicated that they worked with children and adults worked with families or couples most often, with 50.5% of them reporting working with this target group.

Table 61. Relationship between age of the target group and working with families or couples, in the main job in salaried employment

		Age of the target group	
Working with families or couples (%)	<18 years (n = 593)	18+ years (n = 1,514)	Both (n = 632)
Yes	34.4	24.8	50.5
No	65.6	75.2	49.5

Psychologists who fostered wellbeing in their main job in self-employment reported working with families or couples in 48.1% of the cases. Again, this differed according to the age of the target group ($\chi^2(2) = 79.51$, Cramer's $V = .21$, $p < .001$, $n = 1{,}784$). Psychologists who indicated that they worked with children and adults worked with families or couples most often, with 59.7% of them reporting working with this target group.

Table 62. Relationship between age of the target group and working with families or couples, in the main job in self-employment

	Age of the target group		
Working with families or couples (%)	<18 years (n = 161)	18+ years (n = 837)	Both (n = 786)
Yes	31.7	40.4	59.7
No	68.3	59.6	40.3

Regarding differences between the **language communities**, psychologists in the French- and German-speaking communities more often worked with children and adults in the main job in salaried employment ($\chi^2(2) = 72.48$, Cramer's $V = .16$, $p < .001$, $n = 2{,}736$) and in the main job in self-employment ($\chi^2(2) = 87.93$, Cramer's $V = .22$, $p < .001$, $n = 1{,}782$). Working with couples or families was also slightly more common in the French and German communities (47.6%) than in the Flemish community (39.4%), although this difference did not reach the threshold for a small effect-size ($\chi^2(1) = 22.31$, $\varphi = .08$, $p < .001$, $n = 3{,}679$).

Table 63. Community differences in target age group for psychologists who contribute to wellbeing based on the main job in salaried employment

Target age group (%)	**Flemish community (n = 1,866)**	**French and German communities (n = 870)**
Children and adolescents (<18 years)	23.0	18.9
Adults (18+ years)	58.6	48.0
Both	18.4	33.1

Table 64. Community differences in target age group for psychologists who contribute to wellbeing based on the main job in self- employment

Target age group (%)	**Flemish community (n = 1,168)**	**French and German communities (n = 614)**
Children and adolescents (<18 years)	10.0	7.2
Adults (18+ years)	53.9	33.6
Both	36.1	59.3

3.5.5 Diversity of the target group

Psychologists who worked with clients were asked whether a significant portion of their **clients belonged to a minority or a group with specific needs**. They could indicate multiple options.

In the main job in salaried employment, 30.7% did not work with any of these target groups. When they did, the majority (64.1%) worked with more than one target group (*M* = 2.27, *SD* = 1.33, *n* = 1,766).

In the main self-employed job, 65.4% did not work with any of these target groups. When they did, half of them (50.3%) worked with more than one target group (*M* = 1.94, *SD* = 1.19, *n* = 612).

Table 65. Target group for psychologists who provide client care based on the main job in salaried employment and the main job in self-employment.

Target groups	Salaried employment		Self-employment	
	n	%	*n*	%
People with a disability	914	36.0	255	14.6
People with refugee status	383	15.1	62	3.6
People with an immigration background	790	31.2	174	10.0
People with low socioeconomic status (SES)	1,478	58.3	334	19.2
People with a homosexual or bisexual orientation	315	12.4	276	15.8
People with a non-binary gender identity	131	5.2	84	4.8
Not applicable	778	30.7	1,140	65.4
n	2,536		1,744	
	109 missing		31 missing	

Thus, working with minority groups is more common in salaried employment ($\chi^2(1) = 502.79$, $p < .001$; Cohen's $d = 0.73$)[75]. Except for gender and sexual minorities, minority groups are better represented in the target population of psychologists working in **salaried employment** compared with those in **self-employment** (see Figure 68).

[75] Based on "applicable/not applicable".

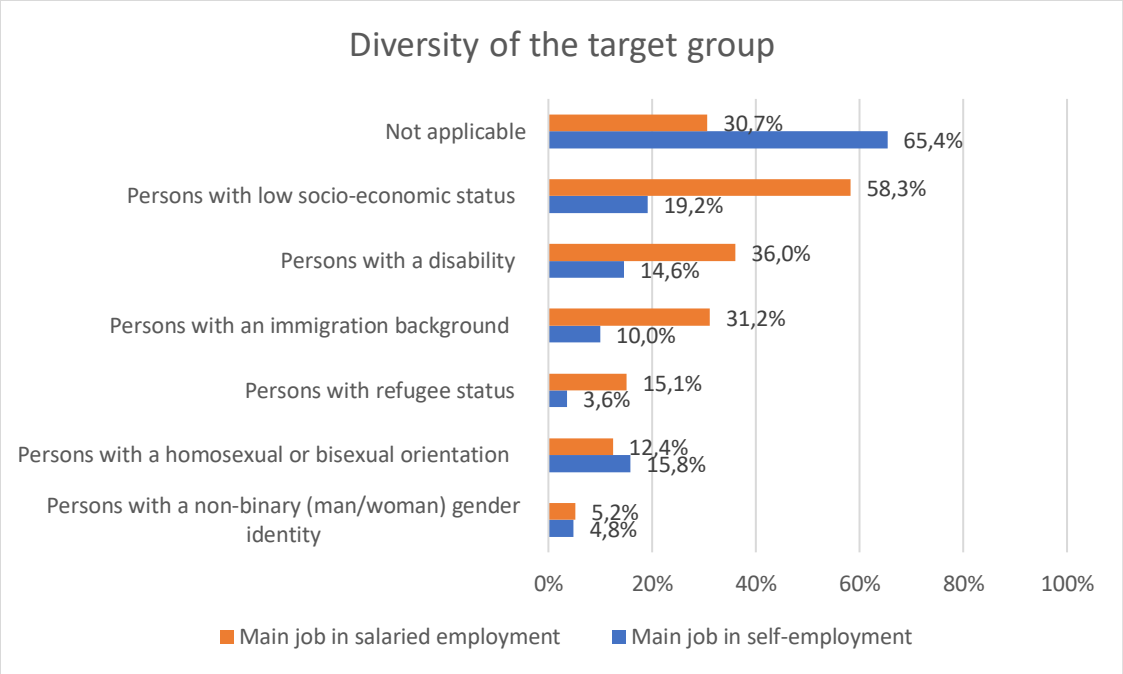

Figure 68. Diversity of the target group in the main job in salaried employment and the main job in self-employment.

3.5.6 Problems focused on by (clinical) psychologists

Psychologists with a job that contributes to wellbeing or development (*n* = 3,758) were asked to report on the **focus of their job**. Information was missing for 136 participants. Participants could indicate multiple problems.

We asked participants to indicate whether they focused on any of the **problem areas** listed in Figure 69. We also asked participants to indicate whether their work focused on specific **problems as defined in the DSM**; these results are discussed in the next section.

As information on job focus was gathered per job, the following series of analyses explored potential **group differences** in job focus in the main job in salaried employment and in the main job in self-employment, and the several problem areas that were provided in the response options are included in the analyses.

More than 96% of psychologists with a job that contributed to wellbeing indicated that their job focused on at least one of the predefined **problem areas** (96.3% concerning the main job in salaried employment and 98.8% concerning the main job in self-employment). The majority of the participants indicated that their most important focus was on the broad category of psychological wellbeing (74.3% of participants in salaried employment and 91.5% participants in self-employment; 80.8% of psychologists with a job that contributed to wellbeing reported this focus in one of their jobs). The next two most frequently reported were behavioural difficulties (56.8% and 60.1% for paid and self-employment, respectively) and relational wellbeing and relationship problems (46.0% and 65.8%, respectively).

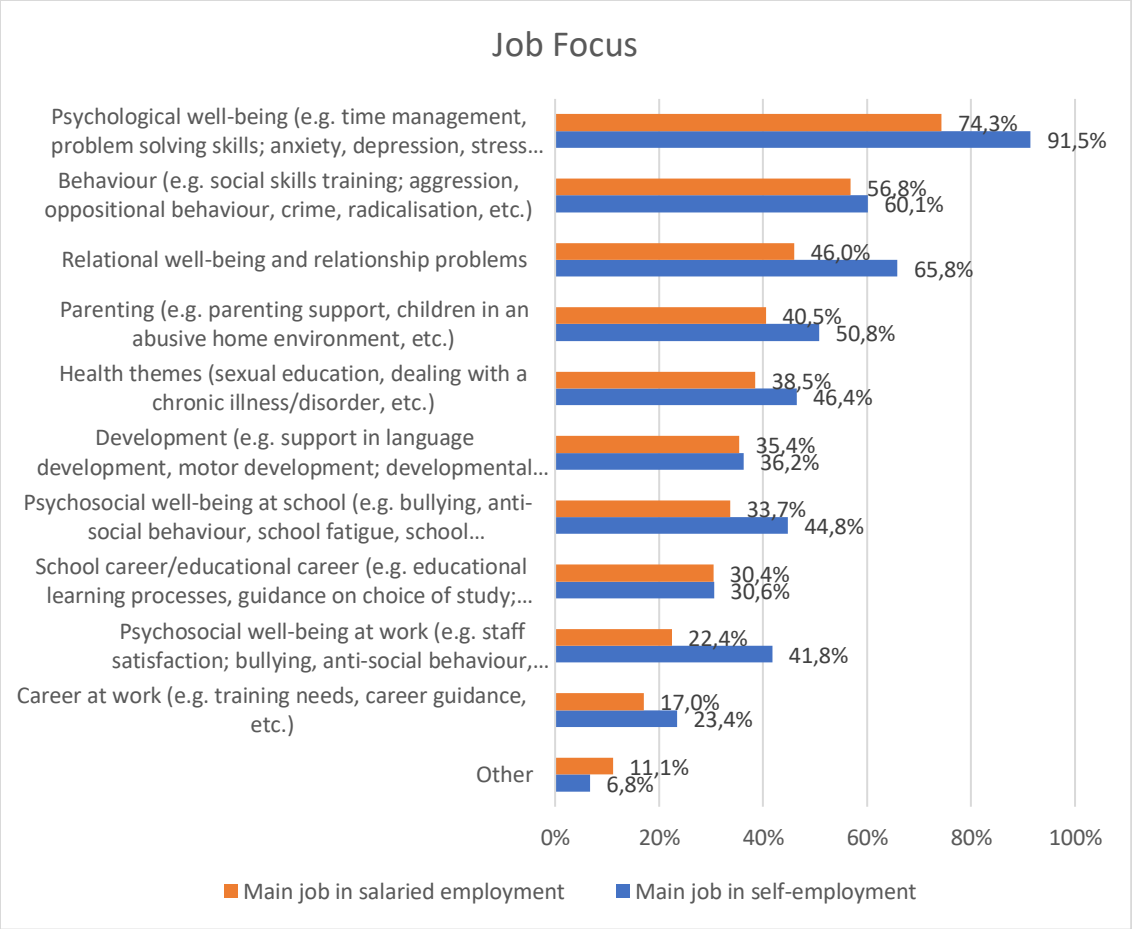

Figure 69. Focus of jobs that contribute to wellbeing for participants in self-employment (*n* = 1,803; 37 missing) and salaried employment (*n* = 2,786; 114 missing).

Table 66 shows group differences in job focus according to educational background for the **main job in salaried employment** (*n* = 2,786). Effect sizes are small (Cramer's *V* ranging between .20 and .28 when job focus was predefined), except for differences in educational background related to jobs focusing on "career at work (training needs, career guidance etc."), which has a medium effect size (Cramer's *V* = .39). Descriptive statistics show the following patterns[76]. Relative to participants with other educational backgrounds:

- Psychologists with a background in **clinical or health psychology** score highest on "**psychological wellbeing**" (80.7%). They also score higher relative to participants with

[76] We performed a χ^2 -analysis with the categorical variable that included all 7 educational backgrounds (MSc in clinical or health psychology; MSc in school or educational psychology; MSc in neuropsychology; MSc in theoretical and experimental psychology; MSc in another domain of psychology (Special education, disability studies, and behavioural disorders; a general degree in psychology and educational sciences; no information on domain of specialization; non-listed domain of specialisation); psychologists with more than one MSc in psychology, in multiple domains of psychology), which showed significant differences based on educational background.

educational backgrounds in neuropsychology, theoretical psychology, and organizational psychology on "behaviour", "parenting", "health themes", and "relational wellbeing".

- Psychologists with a background in **school or educational psychology** tend to focus most on "school/educational career" (81.0%), "psychological wellbeing at school" (78.2%), "parenting" (61.2%) and "development" (59.2%) . Psychologists with this educational background report a similar focus on "behaviour" as psychologists with an education in clinical psychology.
- Psychologists with a background in **neuropsychology** score higher than most backgrounds (except for school or educational psychology) on "development" (52.6%) and "school/educational career" (42.1%). Psychologists with this background also report a higher focus on "psychological wellbeing" (52.6%), "behaviour" (42.1%) and "health themes" (31.6%) compared with psychologists with educational backgrounds in theoretical psychology and organizational psychology. Further, they report a higher focus on "other job focus" (21.1%) than most other backgrounds, which suggests that the categories offered do not fully capture the scope of their job focus.
- On the majority of predefined themes, psychologists with a background in **theoretical and experimental psychology** report a lower job focus than psychologists with a background in clinical psychology, school or educational psychology and neuropsychology. Nonetheless, "psychological wellbeing" is a job focus in 43.1% of psychologists with this background. Further, psychologists with a background in theoretical psychology report a higher focus on parenting (22.4%), development (24.1%), school/educational career (36.2%), and psychological wellbeing at school (22.4%), health themes (17.2%) and relational wellbeing (29.3%) than those with a background in organizational psychology. However, relative to other backgrounds, they have the highest score in "other job focus" (27.6%), again suggesting that the categories offered do not fully capture the scope of their job focus.
- Psychologists with a background in **personnel management and industrial/organizational psychology** tend to focus most on "career at work" (64.8%) and "psychological wellbeing at work" (55.1%). On the majority of other predefined themes, they report a lower job focus compared with psychologists with other educational backgrounds, although there is a similar focus as psychologists with a background in theoretical psychology on "psychological wellbeing" (44.5%) and "behaviour" (26.7%).

Table 66. Comparison of job focus according to educational background for the main job in salaried employment

	Education									
	Clin.	**Edu.**	**Neuro.**	**Theo.**	**Org.**	**Other**	**More degrees**	**Total**	**$\chi^2(6)$**	**Cramer's *V***
n	2,086	147	38	58	236	138	91	2,786		
Job focus (%)										
Psychological wellbeing	80.7	59.9	52.6	43.1	44.5	64.6	72.5	74.3	215.97**	.28**
Parenting	43.8	61.2	26.3	22.4	5.5	40.8	40.7	40.5	166.38**	.24**
Behaviour	61.6	61.2	42.1	27.6	26.7	51.5	51.6	56.8	133.53**	.22**
Development	37.5	59.2	52.6	24.1	5.9	31.5	31.9	35.4	139.38**	.22**
School/ educational career	28.1	81.0	42.1	36.2	14.0	34.6	30.8	30.4	217.19**	.28**
Psychosocial wellbeing at school	33.9	78.2	26.3	22.4	8.5	33.1	33.0	33.7	202.09**	.27**
Career at work	12.0	12.2	13.2	6.9	64 .8	19.2	22.0	17.0	427.84**	.39**
Psychosocial wellbeing at work	19.9	10.9	10.5	12.1	55.1	23.1	25.3	22.4	170.72**	.25**
Health themes	44.0	26.5	31.6	17.2	6.8	40.0	27.5	38.5	152.58**	.23**
Relational wellbeing and relationship problems	50.5	27.9	42.1	29.3	18.6	56.9	39.6	46.0	121.86**	.21**
Other	10.3	3.4	21.1	27.6	15.7	13.1	13.2	11.1	35.80**	.11**

Note. *$p < .01$, **$p < .001$; Clin., MSc in clinical or health psychology; Edu., MSc in school or educational psychology; Neuro., MSc in neuropsychology; Org., MSc in theoretical and experimental psychology; Other, MSc in another domain of psychology (Special education, disability studies, and behavioural disorders; a general degree in psychology and educational sciences; no information on domain of specialization; non-listed domain of specialisation); More degrees, psychologists with more than one MSc in psychology, in multiple domains of psychology.

Psychologists with an MSc in clinical psychology (whether or not they had also obtained an MSc in another domain of psychology) who had also completed a **training in psychotherapeutic care** more often reported a job focus on psychological wellbeing (n = 2,165, ρ = 18, $p < .001$) and relational wellbeing and relationship problems (ρ = 20, $p < .001$) in their main salaried job than clinical psychologists who had not obtained training in psychotherapeutic care, and less often reported a focus on school/educational career (ρ = –.12, $p < .001$).[77]

[77] Previous analyses showed that participants with an MSc in clinical psychology more often obtained a training in psychotherapeutic care than participants with an MSc in another domain of psychology. Therefore, we added this analysis for psychologists with an MSc in clinical psychology.

Table 67 shows group differences in job focus according to educational background for **the main job in self-employment** (*n* = 1,803). Except for psychological wellbeing, where there is a medium effect size of type of MSc in psychology (Cramer's *V* = .34), effect sizes are small, ranging between .09 and .25 when job focus was predefined. Participants with an MSc in clinical psychology most often reported their job focused on psychological wellbeing.

It is noteworthy that the focus on psychological wellbeing is more pronounced in the main job in self-employment compared with the main job in salaried employment (*n* = 4,589, $\chi^2(1) = 211.30$, $\varphi = .21$, $p < .001$): 91.5% of self-employed psychologists report this focus in their job. Psychological wellbeing is the most reported focus for every educational background (ranging between 71.0% and 94.9%), except for neuropsychology (36.7%), where development is the most reported job focus (80.0%).

Table 67. Chi squared analyses between educational background and job focus for main job in self-employment

	Education									
	Clin.	**Edu.**	**Neuro.**	**Theo.**	**Org.**	**Other**	**More degrees**	**Total**	**$\chi^2(6)$**	**Cramer's *V***
n	1,446	56	30	29	93	77	72	1,803		
Job focus (%)										
Psychological wellbeing	94.9	80.4	36.7	89.7	71.0	83.1	90.3	91.5	202.92**	.34**
Parenting	53.5	64.3	46.7	37.9	16.1	53.2	36.1	50.8	61.42**	.19**
Behaviour	64.4	55.4	30.0	37.9	30.1	45.5	54.2	60.1	71.72**	.20**
Development	37.5	42.9	80.0	20.7	11.8	29.9	31.9	36.2	55.86**	.18**
School/ educational career	30.6	50.0	56.7	20.7	9.7	33.8	31.9	30.6	40.49**	.15**
Psychosocial wellbeing at school	48.1	55.4	16.7	27.6	11.8	45.5	30.6	44.8	68.64**	.20**
Career at work	21.2	14.3	3.3	20.7	67.7	28.6	20.8	23.4	116.66**	.25**
Psychosocial wellbeing at work	41.7	33.9	16.7	34.5	51.6	48.1	43.1	41.8	14.83	.09
Health themes	50.3	35.7	13.3	55.2	11.8	45.5	33.3	46.4	75.06**	.20**
Relational wellbeing and relationship problems	68.5	53.6	36.7	72.4	38.7	70.1	61.1	65.8	52.10**	.17**
Other	5.7	5.4	6.7	20.7	22.6	5.2	5.6	6.8	49.18**	.17**

Note. *$p < .01$, **$p < .001$; Clin., MSc in clinical or health psychology; Edu., MSc in school or educational psychology; Neuro., MSc in neuropsychology; Org., MSc in theoretical and experimental psychology; Other, MSc in another domain of psychology (Special education, disability studies, and behavioural disorders; a general degree in psychology and educational sciences; no information on domain of specialization; non-listed domain of specialisation); More degrees, psychologists with more than one MSc in psychology, in multiple domains of psychology.

When we look at group differences, similar patterns emerge as in the main job in salaried employment. Compared with psychologists with other educational backgrounds:

- Psychologists with a background in **clinical or health psychology** score highest of all groups on "psychological wellbeing" (94.9%) and "behaviour" (64.4%). They report a higher focus than most backgrounds (and similar to the reports of psychologists with a background in theoretical psychology) on "relational wellbeing" (68.5%).
- Psychologists with a background in **school or educational psychology** tend to focus most on "parenting" (64.3%) and "psychosocial wellbeing at school" (55.4%).
- Psychologists with a background in **neuropsychology** report a higher focus than all other educational backgrounds on "development" (80.0%) and "school/educational career" (56.7%).
- Relative to other backgrounds, psychologists with a background in **theoretical and experimental psychology** tend to focus most on "relational wellbeing" (72.4%) and "health themes"(55.2%). This pattern is different from that in salaried employment. However, this group of participants is small (n = 29), so conclusions should be made with caution. Further, 20.7% reports they focus on one or more different themes, suggesting that the categories offered do not fully capture the scope of their job focus.
- Psychologists with a background in **personnel management and industrial/organizational psychology** report the highest job focus on "career at work" (67.7%), "psychological wellbeing at work" (51.6%), and "other job focus" (22.6%), which also suggests that the categories offered do not fully capture the scope of their job focus.

Again, psychologists with an MSc in clinical psychology (whether or not they had also obtained an MSc in another domain of psychology) who had also completed a **training in psychotherapeutic care** more often reported a job focus on psychological wellbeing (n = 1,539, ρ = .11, p < .001) and relational wellbeing and relationship problems (ρ = .12, p < .001) in their main self-employed job than clinical psychologists without such additional training.

Finally, we explored differences in job focus according to the **target age group** of the psychologist's job (see Table 68). For the main job in salaried employment, results showed strong effects of clients' age for jobs focusing on parenting, development, school/educational career, and psychosocial wellbeing at school. Hence, these findings suggest that psychologists working with children typically have a broader "transthematic" focus. Work-related problems were more relevant to psychologists working with adults, although these themes were generally selected less often, which resulted in less marked differences between target age groups. Psychological wellbeing, health themes, and relational issues were relevant in both young people and adults, and psychologists who worked with both age groups most often indicated focusing on these problem domains.

In **self-employment**, we have to consider the fact that few self-employed psychologists focus uniquely on young people. Parenting, development, and school themes were again more relevant for those working with children and adolescents, and work themes were more relevant in work with adults. Health themes and relational wellbeing seemed to be, relatively speaking, less relevant for psychologists who focused on children and adolescents in their self-employed job compared with psychologists who (also) worked with adults.

Table 68. Job focus: differences in target age group

	Target age group				
	Children and adolescents (<18 y ears)	**Adults (18+ years)**	**Both**	**$\chi^2(2)$**	**Cramer's *V***
Main job in salaried employment					
n	593	1514	632		
Job focus (%)					
Psychological wellbeing	68.0	75.2	79.3	21.39**	.09**
Parenting	82.1	13.1	68.2	1095.24**	.63**
Behaviour	77.1	48.0	60.3	150.84**	.24**
Development	79.4	13.9	46.8	842.68**	.56**
School/educational career	67.5	11.5	41.9	677.35**	.50**
Psychosocial wellbeing at school	72.8	9.5	55.9	939.08**	.59**
Career at work	3.5	23.6	13.8	127.40**	.22**
Psychosocial wellbeing at work	5.9	29.1	21.4	132.42**	.22**
Health themes	29.7	37.1	50.3	57.94**	.15**
Relational wellbeing and relationship problems	34.9	44.6	60.6	84.62**	.18**
Main job in self-employment					
n	161	837	786		
Job focus (%)					
Psychological wellbeing	73.3	94.0	93.4	82.04**	.21**
Parenting	84.5	25.7	71.0	412.49**	.48**
Behaviour	77.6	52.7	64.9	47.39**	.16**
Development	87.0	16.1	47.3	367.43**	.45**
School/educational career	54.7	13.0	44.3	235.08**	.36**
Psychosocial wellbeing at school	69.6	20.9	65.3	366.21**	.45**
Career at work	0.6	29.4	21.1	66.08**	.19**
Psychosocial wellbeing at work	0.6	48.5	42.9	128.15**	.27**
Health themes	11.8	48.3	51.8	87.78**	.22**
Relational wellbeing and relationship problems	27.3	68.8	71.2	120.13**	.26**

Note. *$p < .01$, **$p < .001$.

3.5.7 DSM-defined problems

General findings

Participants who indicated that their work focused on supporting individuals or their environment (*n* = 3,528) were given a list of 20 DSM-5 diagnoses and asked **whether their work involved prevention, counselling, or treatment focusing on people with (sub)clinical problems or disorders** in these **diagnostic categories** in an **average working week**. In total, 3,426 participants responded to this question (information was missing for 102 participants), and 2,938 participants (85.8%) indicated that working with people with DSM-related problems was relevant in at least one of their jobs. On average, psychologists who worked with DSM-related problems worked 4.5 days in a regular working week (FTE: *M* = 0.89, *SD* = 0.23). Table 69 shows their type of employment.

Table 69. Type of employment of psychologists who work with people with DSM-related problems

Professional situation	***n***	**%**
Only salaried employment	1,225	41.7
Self-employment as a primary occupation	639	21.7
Self-employment as a secondary occupation	1052	35.8
Self-employment after retirement	22	0.7

There were differences between psychologists in **salaried employment and those in self-employment** in terms of whether they perceived themselves as focusing on DSM-related problems. Self-employed psychologists more often indicated that they worked with people with DSM-related problems (92.8%; 90.0% in self-employment as a primary occupation, 94.5% in self-employment as a secondary occupation) compared with psychologists in salaried employment (77.5%) (χ *(1)* = 169.75, Cramer's *V* = .22, $p < .001$). However, the average number of diagnoses listed was similar for those with a main job in salaried employment (7.09, *SD* = 4.62) and for the main job in self-employment (7.34, *SD* = 3.95; *t*(4,290.8) = -1.90, $p > .05$).

Table 70. Relationship between working with people with DSM-related problems and type of employment

Working with people with DSM-related problems (%)	Only salaried employment (*n* = 1,580)	Self-employment as a primary occupation (*n* = 710)	Self-employment as a secondary occupation (*n* = 1,136)
Yes	77.5	90.0	94.5
No	22.5	10.0	5.5

The vast majority of those reporting that their work involved a focus on individuals with a DSM (subclinical) diagnosis had an **MSc in clinical psychology** (*n* = 2,524, 85.9%). Chi-squared analyses showed a relationship of medium effect size between provision of care related to DSM diagnostic categories and type of MSc ($\chi^2(1) = 421.98$, $p < .001$, $\varphi = .35$), with those with an MSc in clinical psychology being far more likely to work with people with DSM-related problems than those with another type of MSc.

Table 71. Relationship between working with people with DSM-related problems and MSc in psychology

Working with people with DSM -related problems (%)	MSc clinical psychology (*n* = 2,748)	Other MSc in psychology (*n* = 678)	MSc in psychology (any type of MSc) (*n* = 3,426)
Yes	91.8	61.1	85.8
No	8.2	38.9	14.2

Furthermore, the average **number of diagnoses** psychologists encountered in their patient population reported by participants with an MSc in clinical psychology ($M = 7.37$, $SD = 4.60$) in their main job in salaried employment was significantly higher than for those with another MSc in psychology ($M = 5.42$, $SD = 4.36$) ($t(2059) = 6.80$, Cohen's $d = 0.43$, $p < .001$). A similar (small) effect was found in the main job in self-employment ($M_D = 1.33$, $SD_D = 0.30$, $t(1601) = 4.40$, Cohen's $d = 0.33$, $p < .001$).

Clinical psychologists who had obtained training in psychotherapeutic care reported working with the highest number of DSM-defined problems (for salaried employment: $M_D = –1.87$, $SD_D = 0.22$, $t(1674.06) = –8.66$, Cohen's $d = 0.42$, $p < .001$; for self-employment: $M_D = –1.40$, $SD_D = 0.21$, $t(1269.00) = –6.73$, Cohen's $d = 0.36$, $p < .001$).

Provision of care related to DSM-defined problems differed per **work region** ($\chi^2(2) = 73.44$, Cramer's $V = .14$, $p < .001$). As shown in Table 72, 82.9% and 83.1% of psychologists in Flanders and Wallonia, respectively, reported providing care related to DSM diagnostic categories, whereas in Brussels, only 68.4% of psychologists reported providing this type of care. We do not know whether this difference is due to real differences in individuals seeking help or differences in the interpretation and/or attitude towards DSM categories, or a combination of both factors.

Table 72. Relationship between working with people with DSM-defined problems and work region

Working with people with DSM-related problems (%)	Flanders (*n* = 2,340)	Wallonia (*n* = 885)	Brussels (*n* = 652)	$\chi^2(2)$	Cramer's *V*
Yes	82.9	83.1	68.4	73.44**	.14**
No	17.1	16.9	31.6		

Note. *p < .01, **p < .001; Psychologists could work in more than one region.

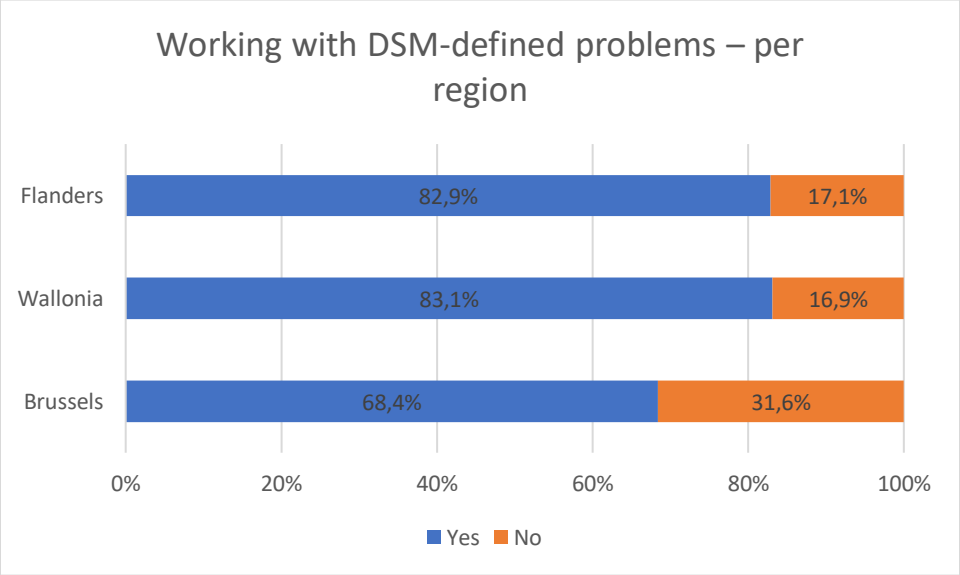

Figure 70. Psychologists indicating that they worked with DSM-defined problems in Flanders, Wallonia, or Brussels.

Interestingly, there were no effects of **language** of the participants (Flemish versus French or German) (n = 3,422, $\chi^2(1) = 0.67$, $p > .05$) in whether they reported working with individuals with DSM-defined problems in general, nor in the number of diagnoses they reported (($t(2,056) = –0.23$, $p > .05$, in the main job in salaried employment; ($t(1,024.05) = –0.35$, $p > .05$, in the main job in self-employment).

There were no overall effects of **age** of psychologists ($\chi^2(4) = 6.28$, Cramer's $V = .04$, $p > .05$) in whether they reported working with individuals with DSM-defined problems in general. However, there were small age differences in the number of diagnoses they reported working with in their main job in salaried employment (F (4, 554) = 5.46, $R^2 = .01$, $p < .001$)[78] and in their main job in self-employment ($F(4) = 7.03$, $R^2 = .02$, $p < .001$). Games-Howell pairwise comparisons showed a lower number of DSM diagnoses reported by the youngest age cohort (<30 years; $M = 6.32$, $SD = 4.25$) compared with the next two age cohorts (30–39 years, $M = 7.26$, $SD = 4.79$, $d = 0.21$, $p < .01$; 40–49 years, $M = 7.46$, $SD = 4.65$, $d = 0.26$, $p < .001$) in the main job in salaried employment. In the main job in self-employment, Hochberg pairwise comparisons again showed a smaller number of different diagnoses in the two youngest age cohorts (<30

[78] Brown-Forsythe robust F-test.

years, *M* = 6.62, *SD* = 3.83, *d* = 0.46, *p* < .001; 30–39 years, *M* = 7.26, *SD* = 3.81, *d* = 0.30, *p* <.01) compared with psychologists between 50 and 60 years old (*M* = 8.41, *SD* = 3.88).

Finally, we explored whether their work involving individuals meeting DSM diagnostic criteria (in full or partially) differed per **target age group** (children/adults). As shown in Table 73, psychologists who work with children (whether or not they also work with adults) more often indicated that their work involved patients meeting criteria for at least one DSM-diagnostic category than psychologists who work exclusively with adults. Follow-up analyses showed that this might relate to the predominance of neurodevelopmental problems (such as Attention Deficit Hyperactivity Disorder) reported by those working with young people. On the other hand, those working with adults reported a higher number of different diagnoses (see Table 74): the number of diagnostic categories was lower for psychologists whose job focused exclusively on children or adolescents compared with psychologists who worked with adults (Games-Howell pairwise comparisons, *p* < .001).

Table 73. Relationship between working with people with DSM-related problems and target age group

	Target age group				
	Children and adolescents (<18 years)	**Adults (18+ years)**	**Both**	**χ^2(2)**	**Cramer's *V***
Job includes working with people with DSM-related problems (%)					
Main job in salaried employment (*n* = 2,529)	86.5	76.6	84.9	33.72**	.12**
Main job in self-employment (*n* = 1,734)	95.5	88.1	95.6	33.62**	.14**

Note. *p < .01, **p < .001.

Table 74. Number of DSM-related problems in patient population per target age group

	Target age group				
	Children and adolescents (<18 years)	**Adults (18+ years)**	**Both**	***F*†**	***df***
Number of diagnoses in patient population (*M*(*SD*))					
Main job in salaried employment (*n* = 2,044)	5.52 (4.19)	7.78 (4.65)	7.21 (4.60)	43.49**	2, 1644.48
Main job in self-employment (*n* = 1,597)	4.92 (3.35)	7.33 (3.75)	7.82 (4.08)	38.55**	2, 803.64

Note. *p < .01, **p < .001. †The assumption of homogeneity of variance was violated; hence, the robust Brown-Forsythe *F*-test was reported.

Diagnostic categories

As shown in Table 75 and Figure 71, the **most prevalent reported diagnoses (≥50%)** in the main job in salaried employment were depressive disorders, anxiety disorders, trauma- and stressor-related disorders, neurodevelopmental disorders (e.g. autism spectrum disorder (ASD), attention deficit and hyperactivity disorder (ADHD)), and personality disorders. **Between 30% and 50%** of psychologists who reported working with patients with DSM-defined problems furthermore listed addiction, somatic symptom disorders, obsessive-compulsive disorders (OCD), conduct disorders, bipolar disorders, psychotic disorders, or eating disorders. **Less than 30%** reported working with individuals with neurocognitive disorders, dissociative disorders, sleep-wake disorders, sexual dysfunctions, elimination disorders (enuresis and encopresis), gender dysphoria, paraphilic disorders, or disorders related to medication use.

In self-employment, the **most prevalent diagnoses (≥50%)** were depressive disorders, anxiety disorders, trauma- and stressor-related disorders, OCD, and somatic symptoms. **Between 30% and 50%** reported working with patients with personality disorders, neurodevelopmental disorders, eating disorders, bipolar disorders, addiction, or sleep-wake disorders. **Less than 30%** reported working with conduct disorders, dissociative disorders, sexual dysfunctions, psychotic disorders, neurocognitive disorders, elimination disorders, gender dysphoria, paraphilic disorders, or disorders related to medication use (see Table 75 and Figure 71). Overall, the pattern looked fairly similar to those in salaried employment, with the exception of schizophrenia spectrum disorders, which were reported twice as often in salaried employment compared with self-employment.

Table 75. Frequency of DSM-related problems in psychologists' patient population in the main job in salaried employment and the main job in self-employment, per diagnostic category

Diagnostic category (%)	Main job in salaried employment	Main job in self-employment
Depressive disorders	73.6	88.6
Anxiety disorders	72.6	88.2
Trauma- and stressor-related disorders	65.7	77.6
Neurodevelopmental disorders (e.g. ASD, ADHD, intellectual disability, learning disorder)	59.7	46.0
Personality disorders	49.8	48.8
Substance-related and addiction disorders	42.0	36.4
Somatic symptom and related disorders	39.1	50.5
Obsessive-compulsive and related disorders	39.0	56.4
Disruptive, impulse-control and conduct disorders	38.0	29.4
Bipolar and related disorders	37.9	38.2
Schizophrenia spectrum and other psychotic disorders	35.3	17.2
Feeding and eating disorders	30.6	38.7
Neurocognitive disorders	24.8	14.0
Dissociative disorders	24.7	23.1
Sleep-wake disorder	23.0	31.1

Sexual dysfunctions	13.1	17.8
Elimination disorders (enuresis, encopresis)	12.0	11.9
Gender dysphoria	11.4	11.3
Paraphilic disorders	8.9	5.2
Medication-induced movement disorders and other adverse effects of medication	8.2	3.4

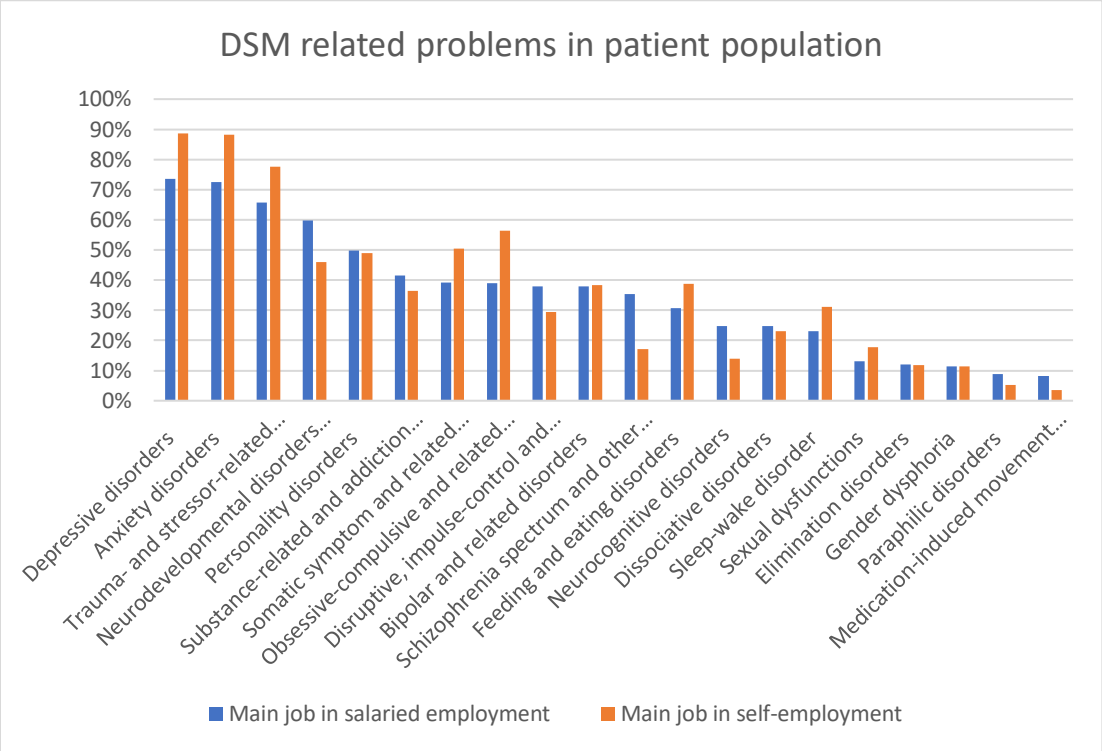

Figure 71. DSM diagnoses reported as being part of the work of those with an MSc in psychology in salaried and self-employment.

Next, we explored differences in DSM diagnostic categories in psychologists' target patient population according to the **age of the target group** (see Table 76). Most diagnostic categories showed significant effects of age of the target group, usually indicating a higher reported prevalence of DSM diagnostic categories in those working with adults. Only neurodevelopmental disorders and elimination disorders were reported as being more prevalent in jobs focusing on children and adolescents than in jobs focusing on adults; effect sizes were medium. For those diagnostic categories that showed medium effect size differences as a function of the age of the target group, those working with adults reported a greater focus on personality disorders (in the main job in salaried employment), substance-related and addiction disorders (in the main job in salaried employment), bipolar and related disorders (in the main job in salaried employment), and depressive disorders (in the main job in self-employment).

Table 76. DSM diagnostic categories: differences in target age group

	Target age				
	Children and young people (<18 years)	**Adults (18+ years)**	**Both**	**$\chi^2(2)$**	**Cramer's *V***
Main job in salaried employment					
n	498	1039	507		
Diagnostic category (%)					
Depressive disorders	54.2	82.0	75.1	134.44**	.26**
Anxiety disorders	59.4	77.9	74.6	58.75**	.17**
Trauma- and stressor-related disorders	53.8	69.0	70.2	40.79**	.14**
Neurodevelopmental disorders (e.g. ASD, ADHD, intellectual disability, learning disorder	90.6	42.5	64.7	329.66**	.40**
Personality disorders	24.5	64.0	45.8	214.68**	.32**
Substance-related and addiction disorders	16.7	55.3	37.3	212.31**	.32**
Somatic symptom and related disorders	26.3	43.5	42.4	45.05**	.15**
Obsessive-compulsive and related disorders	27.9	44.0	39.8	36.73**	.13**
Disruptive, impulse-control and conduct disorders	42.0	36.4	37.5	4.54	.05
Bipolar and related disorders	14.3	50.6	34.9	191.76**	.31**
Schizophrenia spectrum and other psychotic disorders	18.9	44.1	33.3	94.79**	.22**
Feeding and eating disorders	31.5	26.9	37.5	17.98**	.09**
Neurocognitive disorders	16.7	30.3	21.5	37.58**	.14**
Dissociative disorders	12.7	32.1	21.3	72.98**	.19**
Sleep-wake disorder	17.1	25.1	24.3	13.01*	.08*
Sexual dysfunctions	4.0	17.1	13.8	51.12**	.16**
Elimination disorders	25.7	2.5	18.1	194.94**	.31**
Gender dysphoria	9.0	11.3	14.0	6.18	.06
Paraphilic disorders	2.0	13.1	7.1	53.67**	.16**
Medication-induced movement disorders and other adverse effects of medication	4.6	10.0	7.5	13.49*	.08*

Main job in self- employment					
n	148	708	741		
Diagnostic category (%)					
Depressive disorders	58.1	93.9	89.6	156.91**	.31**
Anxiety disorders	73.0	90.3	89.3	36.84**	.15**
Trauma- and stressor-related disorders	45.3	82.6	79.5	101.14**	.25**
Neurodevelopmental disorders (e.g. ASD, ADHD, intellectual disability, learning disorder	91.2	26.4	55.6	258.70**	.40**
Personality disorders	10.1	61.2	44.7	136.89**	.29**
Substance-related and addiction disorders	4.1	43.9	35.6	84.42**	.23**
Somatic symptom and related disorders	26.4	49.9	55.9	43.19**	.16**
Obsessive-compulsive and related disorders	35.8	55.5	61.1	32.47**	.14**
Disruptive, impulse-control and conduct disorders	29.7	23.9	34.5	19.91**	.11**
Bipolar and related disorders	6.1	44.2	38.9	75.65**	.22**
Schizophrenia spectrum and other psychotic disorders	7.4	16.9	19.2	12.00*	.09*
Feeding and eating disorders	29.7	33.6	45.2	25.98**	.13**
Neurocognitive disorders	13.5	11.4	16.5	7.63	.07
Dissociative disorders	2.7	26.1	24.4	38.97**	.16**
Sleep-wake disorder	20.9	32.1	32.3	7.88	.07
Sexual dysfunctions	1.4	20.8	18.1	31.76**	.14**
Elimination disorders	30.4	1.4	18.2	150.87**	.31**
Gender dysphoria	3.4	11.2	13.0	11.33*	.08*
Paraphilic disorders	0.7	5.6	5.7	6.77	.07
Medication-induced movement disorders and other adverse effects of medication	2.0	2.4	4.7	6.86	.07

Note. *$p < .01$, **$p < .001$.

Overall, the following **patterns** seemed to emerge:

- The vast **majority of psychologists** who provide client care report working with individuals with DSM diagnoses (full or partial) in their job: around 77.5% in salaried employment and 90–94% in self-employment.
- DSM-defined problems were considered as **relevant for all target age groups** (children/adolescents and adults). The number of different reported diagnoses was somewhat higher in adult populations.
- Participants with an **MSc in clinical psychology** are more likely to work with individuals with DSM-defined problems (92%) than their counterparts with another MSc in psychology (61%).
- Most psychologists work with a **patient population with different diagnoses**; this means they reported to either work with individuals that typically meet criteria for several diagnostic categories (reflecting high levels of "co-morbidity") or they tend to see a wide variety of patients with different types of psychopathology, or a combination of both.
- Psychologists with an MSc in a domain other than clinical psychology, report working with a patient population with a smaller number of different diagnoses compared with those with an MSc in clinical psychology. Thus, participants with an **MSc in clinical psychology** appear to work with a patient population that is more varied or has higher comorbidity compared with participants with another MSc in psychology, and this is even more pronounced in clinical psychologists who have completed a **training in psychotherapeutic care**.
- Combining jobs in salaried employment and self-employment, it seems that psychologists most often work with **problems** related to depression, anxiety, trauma, neurodevelopmental disorders, and personality disorders.
- The relevance of diagnoses differs depending on the **age of the patient population**. Problems related to DSM diagnostic categories are usually considered to be more relevant for adult clients, except for neurodevelopmental disorders and elimination disorders, which are considered to be more prevalent in work with young people.
- Psychologists in **self-employment** account for an **important part** of prevention, counselling, and treatment of individuals with DSM-defined psychological problems.

3.5.8 Conclusion on availability of psychological care

Mental healthcare, broadly defined, is at the core of the domain of **clinical psychology**. Consistent with this view, the vast majority of psychologists reported that they **contributed to people's wellbeing and development**, regardless of their educational background.

Analyses of **sectors and settings** in the clinical field of work show that there are differences between the availability of psychological care in salaried employment and in self-employment. Psychologists in salaried employment who work in a job in the mental healthcare sector tend to work in specialized second- or third-tier settings. Preventive and primary care is offered in other sectors, such as social welfare and education (student counselling). Psychologists in self-employment more frequently situate their job in the mental healthcare sector, and they clearly are involved in primary care. Only a small minority indicate that they offer second-tier care only.

Most psychologists focus on **client care**. "Supporting people and their (social) environment" is the most important task for most psychologists: almost four out of five psychologists with a job in salaried employment engage in this task often or very often, and nine out of 10 with a job in self-employment. Psychological wellbeing is the focus of 74.3% of (main) jobs in salaried employment and 91.5% of (main) jobs in self-employment. The administrative workload seems higher in salaried employment compared with self-employment.

Client care (i.e., "supporting people and their (social) environment") is **not limited to participants with an MSc in clinical psychology**. Depending on the educational background of psychologists, the prevalence of client care ranges between 72.4% and 98.2%. The highest rates of client care are found in participants with an MSc in clinical psychology and neuropsychology (97.1–98.2%), and the lowest rates in participants with an MSc in theoretical psychology and organizational psychology (72.4–79.9%). Differences are more pronounced in jobs in salaried employment than in jobs in self-employment.

When considering the overall orientation of their job responsibilities, 72% of psychologists working in the clinical field chose **client care as their most important task**. This percentage was higher in participants with an MSc in clinical psychology (80.7%). Nonetheless, 39.9% of participants with an MSc in another domain of psychology also chose client care as their primary task.

The availability of psychological care generally increases with client age, and then drops again for the elderly. The highest availability is for (young) adults and the lowest for (young) children.

When we look at the **job focus** of psychologists in the clinical field, psychological wellbeing is a relevant focus in 80.8% of them. The focus on psychological wellbeing was more prevalent in participants with an MSc in clinical psychology and in clinical psychologists with a training in psychotherapeutic care. Notably, the focus on psychological wellbeing was also more pronounced in self-employment.

Among psychologists working in the clinical field, 85.8% indicated that their work involved preventative or care tasks for people with **(sub)clinical problems or disorders** as defined by **the DSM**. This percentage was higher in participants with an MSc in clinical psychology (91.8%), but a substantial proportion of] those with another MSc in psychology also provided care for people with DSM-defined problems (61.1%).

Psychologists usually worked with a **patient population** with more than one diagnosis. The average number of diagnoses psychologists worked with was seven. Participants with an MSc in clinical psychology worked with a greater **number of different diagnoses** than those with MSc in another domain of psychology, and clinical psychologists with a training in psychotherapeutic care reported working with the highest number of different DSM-defined problems in their population. Work with a higher number of DSM-defined problems could reflect more interpersonal variation in the psychological difficulties of clients, higher intrapersonal psychological comorbidity, or a combination of both. DSM-defined problems related to depression and anxiety were reported most often, both in jobs in salaried employment and in jobs in self-employment. Other problems that were frequently reported (by more than 50% of respondents in either a self-employed or a salaried job) were trauma- and stressor-related disorders, OCD, somatic symptoms, neurodevelopmental disorders, and personality disorders. Analyses including the age of the target group showed that neurodevelopmental disorders, impulse control and conduct disorders,

and elimination disorders (i.e. enuresis and encopresis) are more relevant in children and adolescents. Furthermore, care related to DSM-defined problems in children and adolescents seems to rely more on jobs in salaried employment, as few jobs in self-employment focus (solely) on young people.

In terms of **minority populations and populations with specific needs** (e.g. migration background, low SES, people with disabilities), the target population is more diverse for jobs in salaried employment than in self-employment. This might indicate that the mental healthcare offered by self-employed psychologists is less targeted towards, or less accessible for, minority groups and populations with specific needs.

3.6. Types of professional activities

3.6.1 Introduction

The **LHCP** focuses on **prevention, diagnostic assessment, counselling, and treatment** as the central tasks of clinical psychologists, and views psychotherapeutic care as a specialized form of psychological care.

As explained in section 3.5.1, participants indicated whether their tasks included prevention, assessment, counselling, or treatment, each on a 5-point Likert scale ranging from "never" to "very often". When participants provided treatment (defined as at least "rarely" on the 5-point Likert scale), a follow-up question inquired whether this treatment included psychotherapeutic care, defined as "a coherent set of psychological treatment techniques, which goes beyond counselling or providing support". This question had a "yes" or "no" answer format.

As shown in Table 77, prevention, assessment, counselling, and treatment are part of 70–80% of the work as reported by participants; psychotherapeutic care is provided by slightly more than 50% of participants.

Table 77. LHCP tasks in jobs that support people and their environment among individuals with an MSc in psychology

LHCP task	*n*	Missing	Valid *n*	% of participants
Prevention	2,927	167	4,137	70.8
Diagnostic assessment	3,039	167	4,137	73.5
Counselling	3,332	169	4,135	80.6
Treatment	2,973	169	4,135	71.9
Provision of psychotherapeutic care	2,216	184	4,120	53.8

This section will first further explore the central tasks of clinical psychologists: prevention, diagnostic assessment, counselling, and treatment. We will consider potential group differences in the prevalence

and the frequency of these tasks (e.g. differences as a function of type of MSc in psychology, type of employment, language cohort, or age).

The LHCP attaches great importance to **continuing professional development** (CPD) and **interdisciplinary collaboration** in mental healthcare practitioners (Superior Health Council, 2015). We therefore also include data concerning CPD and interdisciplinary collaboration. We report data for those with an MSc in psychology and, in the final section, specifically for those psychologists who also provide psychotherapeutic care.

3.6.2 Prevention, diagnostic assessment, counselling and treatment

Group differences in overall prevalence of prevention, diagnostic assessment, counselling and treatment

Table 78 describes the prevalence of prevention, assessment, counselling, and treatment (i.e., they engaged in this task at least "rarely" in at least one of their jobs) in participants with an MSc in psychology and subsamples who foster people's wellbeing or who work with clients. Participants reported on each separate task (i.e. tasks were not mutually exclusive).

Table 78. Prevalence of prevention, diagnostic assessment, counselling, and treatment in participants with an MSc in psychology and subsamples who foster people's wellbeing or who work with clients

LHCP task (%)	In full sample of participants with an MSc in psychology (*n* = 4,135–4,137)	In those with jobs contributing to wellbeing or development (*n* = 3,696)	In those with jobs supporting people or their environment (*n* = 3,502)
Prevention	70.8	81.8	83.8
Diagnostic assessment	73.5	83.9	86.9
Counselling	80.6	93.7	95.3
Treatment	71.9	81.3	85.0

We explored group differences in the full sample of participants with an MSc in psychology.

As shown in Table 79, the LHCP is even more relevant for those with an **MSc in clinical psychology**, for which the LHCP has been designed, compared with those holding an MSc in another domain of psychology. Prevention, assessment, counselling, and treatment are part of the work of 75–86% of those with an MSc in clinical psychology. However, these tasks are also present in the jobs of participants with an MSc in another domain of psychology: 51.4–64.0% are involved in prevention, assessment, or counselling, and 43.9% provide treatment.

Table 79. Comparison between MSc in clinical psychology and other MSc in psychology on LHCP tasks

LHCP task (%)	MSc clinical psychology	Other MSc psychology	*n*	$\chi^2(1)$	φ
Prevention	75.1	57.2	4,137	118.66**	.17**
Diagnostic assessment	80.6	51.4	4,137	334.87**	.29**
Counselling	85.9	64.0	4,135	235.20**	.24**
Treatment	81.0	43.9	4,135	520.86**	.36**

Note. *p < .01, **p < .001. Other MSc psychology; MSc in school or educational psychology, neuropsychology, theory and research, organizational psychology, or a non-listed option.

Differences in terms of LHCP tasks between the different **language communities** were not significant and/or did not reach the threshold for a small effect-size (see Table 80).

Table 80. Comparison between Flemish-speaking and French- or German-speaking participants in terms of LHCP tasks

LHCP task (%)	Flemish	French and German	*n*	$\chi^2(1)$	φ
Prevention	71.5	69.5	4,130	1.72	–.02
Diagnostic assessment	73.1	74.3	4,130	0.65	.01
Counselling	81.6	78.8	4,128	4.60*	–.03*
Treatment	70.3	75.3	4,128	11.23**	.05**

Note. *p < .01, ** p < .001.

Participants with an MSc in psychology who (also) worked in **self-employment** were more involved in tasks directly relevant to the LHCP compared with those who worked only in salaried employment. Effects were strongest for treatment, with a medium effect size. This difference partly reflects the difference between participants with an MSc in psychology in salaried and in self-employment in terms of direct client contact.

Table 81. Comparison between participants who only work exclusively in salaried employment and those who also work in self-employment in terms of LHCP tasks

LHCP task (%)	Self-employment	Exclusively salaried employment	*n*	$\chi^2(1)$	φ
Prevention	81.3	66.2	3,978	117.14**	–.17**
Diagnostic assessment	85.9	67.3	3,978	189.94**	–.22**
Counselling	92.8	75.1	3,976	228.85**	–.24**
Treatment	92.2	58.0	3,976	615.41**	–.39**

Note. *p <.01, **p < .001.

Spearman correlations with **age cohort** of (self-)employed in those with an MSc in psychology (<30 years; 30–39 years; 40–49 years; 50–59 years; ≥60 years) showed a significant correlation between age and (a) counselling (ρ = .05, p < .01) and (b) treatment (ρ = .06, p < .001), but these correlations did not reach the threshold for a small effect-size. Other correlations were not significant at p < .01.

As the LHCP describes acts aimed at the prevention, diagnostic assessment, counselling, and treatment of psychological or psychosomatic suffering as core tasks of clinical psychologists, we analysed the proportion of participants with an MSc in clinical psychology for each of these tasks, and compared this proportion between the **language communities**. Between 80.3% and 85.1% of participants who carried out the tasks described in the LHCP had an MSc in clinical psychology. This proportion was higher in the Flemish-speaking sample compared with French- or German-speaking participants, although effect sizes were small.

Table 82. Proportion of participants with an MSc in clinical psychology in the exercise of LHCP tasks

LHCP task (%)	Flemish	French and German	Full sample	*n*	$\chi^2(1)$	φ
Prevention	84.8	70.9	80.3	2,924	79.11**	–.16**
Diagnostic assessment	87.4	74.1	82.9	3,035	84.70**	–.17**
Counselling	85.5	70.5	80.6	3,329	104.93**	–.18**
Treatment	90.9	74.2	85.1	2,971	149.28**	–.22**

Note. *p <.01, **p < .001.

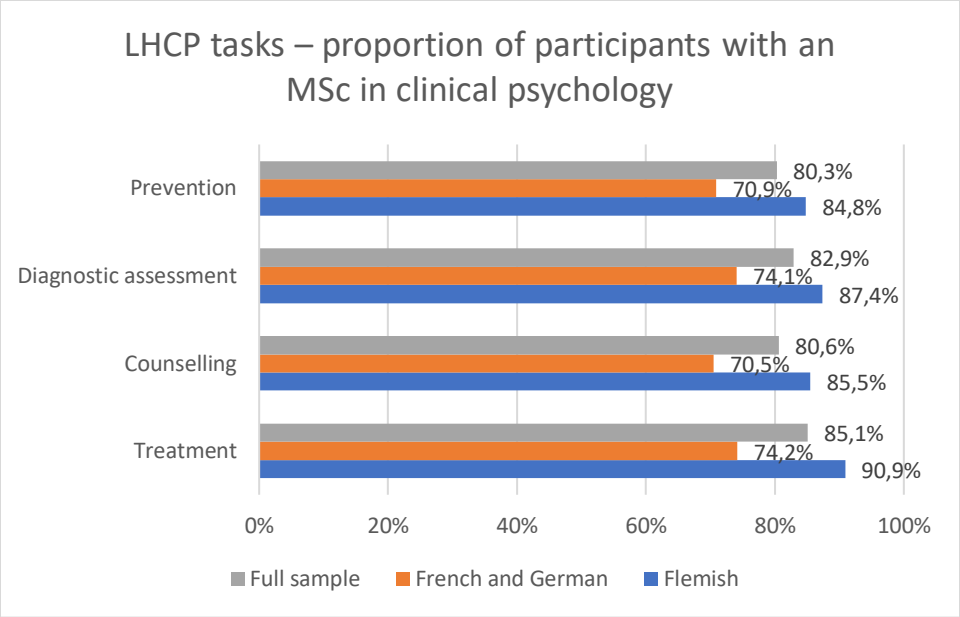

Figure 72. Proportion of participants with an MSc in clinical psychology engaged in the exercise of LHCP tasks.

Frequency of prevention, diagnostic assessment, counselling, and treatment tasks in participants' main job

As described in the previous section (see Table 81), psychologists who (also) worked in self-employment were more involved in tasks directly relevant to the LHCP compared with those with an MSc in psychology who worked only in salaried employment.

Figures 73 and 74 show the **frequency** of these tasks for the main job in salaried employment (n = 2,853, information was missing for 47 participants) and the main job in self-employment (n = 1,819, information was missing for 21 participants) in participants with an MSc in psychology. Frequencies of prevention and diagnostic assessment showed (very) small differences between the main job in salaried employment and the main job in self-employment Cramer's V = .11 and .09, respectively, p < .001). Differences in counselling did not reach the threshold for a small effect-size (Cramer's V = .05, p < .05). Frequencies differed significantly and meaningfully between the main job in salaried employment and the main job in self-employment only for treatment, with a medium effect-size (n = 4,672, $\chi^2(4) = 709.11$, Cramer's V = .39, p < .001); treatment was more frequent in the main self-employed job compared with the main salaried job.

In **salaried employment** (see Figure 73), the most important task is **counselling**, with 67% engaged in this task often or very often. Prevention is practised least often, with 44% of psychologists never or rarely involved in prevention. It is noteworthy that 27% of psychologists indicate that they never offer treatment.

In **self-employment** (see Figure 74), **treatment** is the most important task, with 86% indicating that they offer treatment often to very often. Prevention is again practised the least frequently, with 52% never or rarely engaged in this task.

With regard to assessment, psychologists vary greatly in the extent to which they are involved in this task. This diversity is apparent in both salaried employment and self-employment.

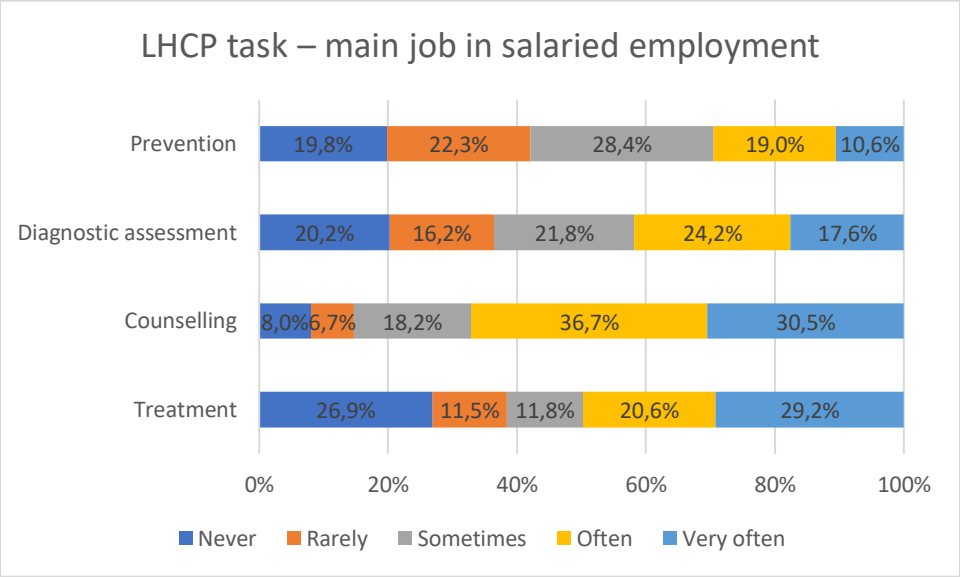

Figure 73. LHCP tasks for the main job in salaried employment in participants with an MSc in psychology.

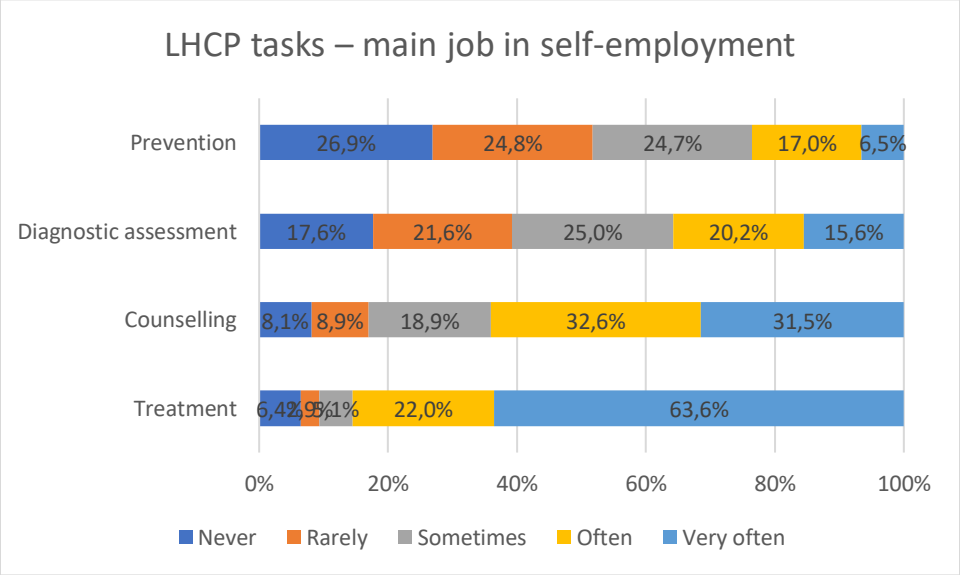

Figure 74. LHCP tasks for the main job in self-employment in participants with an MSc in psychology.

In the previous analyses, we did not stipulate whether or not these tasks were carried out in the context of **client work**. Psychologists who, for example, supported organizations were also included. As the LHCP describes clinical psychology as acts of professionals that involve humans/people, in the following series of analyses, participants with an MSc in psychology who contribute to wellbeing are selected when they

provide prevention, diagnostic assessment, counselling or treatment in one of their jobs, and if they support people in this job.

Correlations between the tasks are in the small to moderate range (Spearman's ρ = .28–.49, p < .001, n = 3,692–3,694). The correlation between prevention and treatment is lowest (Spearman's ρ = .28), followed by the correlation between prevention and diagnostic assessment (ρ = .34). The bivariate correlations between diagnostic assessment, counselling, and treatment range between .45 and .49, and the correlation between prevention and counselling is also in this range (ρ = .46).

The majority of participants who are involved in one of these tasks are also involved in the other task(s): even for prevention and treatment, which show the smallest correlation, 86.2% of those involved in prevention also provide treatment, and 84.8% of those providing treatment are also involved in prevention.

We explored the relationship with **educational background** (orientation of MSc in psychology), defined as the following categories:

- Clinical or health psychology (including clinical neuropsychology and clinical forensic psychology)
- School or educational psychology
- Neuropsychology
- Theoretical and experimental psychology
- Personnel management and industrial/organizational psychology
- Other or no information
- More than one master's degree in psychology.

For each task, we conducted a chi-squared analysis comparing participants who reported the task in at least one of their jobs with participants who did not report this task in any of their jobs. As shown in Table 83, the majority of psychologists with a background in **clinical psychology, school or educational psychology, and neuropsychology** provide prevention, diagnostic assessment, counselling, or treatment while working with people or their environment, with proportions ranging between 69.5% and 92.8%. The prevalence of the tasks differs according to educational background (all tasks significant at p < .001). Descriptive statistics suggest that lower scores on these tasks are reported by psychologists with a theoretical psychology or organizational psychology master's degree, ranging between 30.8% and 73.3%. Group differences are strongest regarding treatment, with a medium effect size (Cramer's V = .41), and lowest regarding prevention.

When looking at the total amount of LHCP tasks in our sample, psychologists with a master's degree in clinical psychology account for 80.2% (prevention) to 85.1% (treatment) of LHCP tasks.

Table 83. Educational background and provision of prevention, diagnostic assessment, counselling or treatment of people in MSc in psychology involved in supporting wellbeing or development

	Prevention				
	%	***n***	***missing***	**$\chi^2(6)$**	**Cramer's *V***
Education				76.11*	.14*
Clinical or health psychology	80.9				
School or educational psychology	87.4				
Neuropsychology	78.2				
Theoretical and experimental psychology	60.5				
Personnel management and industrial/organizational psychology	63.3				
Other or no information	81.6				
More than one master's degree in psychology	78.4				
Total	79.2	3,694	64		
	Diagnostic assessment				
Clinical or health psychology	86.8			320.42*	.30*
School or educational psychology	81.0				
Neuropsychology	81.8				
Theoretical and experimental psychology	55.3				
Personnel management and industrial/organizational psychology	48.4				
Other or no information	81.6				
More than one master's degree in psychology	83.6				
Total	82.3	3,694	64		
	Counselling				
Clinical or health psychology	92.8			182.84*	.22*
School or educational psychology	91.4				
Neuropsychology	90.9				
Theoretical and experimental psychology	64.5				
Personnel management and industrial/organizational psychology	73.3				
Other or no information	92.6				
More than one master's degree in psychology	85.8				
Total	90.2	3,692	66		

	Treatment				
Clinical or health psychology	87.3			612.05**	.41**
School or educational psychology	69.5				
Neuropsychology	83.6				
Theoretical and experimental psychology	55.3				
Personnel management and industrial/organizational psychology	30.8				
Other or no information	81.0				
More than one master's degree in psychology	79.9				
Total	80.5	3,692	66		

Note. *p <.01, **p <.001.

3.6.3 Personal and professional development

Membership of a professional organization

Participants were asked whether or not they were a **member of a professional or a psychotherapy association.** As reported in section 3.3.4, 55.3% of participants with an MSc in psychology reported such a membership, with 19.8% being member of a psychotherapy association. Membership of at least one professional organization was higher in (a) Flemish-speaking participants compared with French- and German-speaking participants, (b) participants with an MSc in clinical psychology compared with those with an MSc in another domain of psychology, (c) psychologists who worked in self-employment compared with those who worked only in salaried employment, and (d) older psychologists compared with younger psychologists. In this section, we explore differences according to field of work (contribution to wellbeing or development) and between participants with an MSc in psychology who provide psychotherapeutic care and those who do not.

Of psychologists who indicated that their **work contributed to wellbeing** (n = 3,324), 59.2% reported membership of a professional/psychotherapy organization, compared with 18.7% of participants with an MSc in psychology who indicated that their job(s) did not contribute to people's wellbeing or development (n = 359) ($\chi^2(1) = 215.41$, $\varphi = .24$, $p < .001$). The majority (49.8%) reported holding membership of at least one organization that was listed by the researchers (i.e. a list of recognized/representative professional associations and psychotherapy organizations). Membership of at least one professional organization was significantly higher among psychologists who provide psychotherapeutic care (n = 2,012; 75.5%) compared with psychologists who contributed to wellbeing but did not provide psychotherapeutic care (n = 1,312; 34.1%) ($\chi^2(1) = 563.57$, $\varphi = .41$, $p < .001$). Differences between the language communities also appeared in the subsample of participants with an MSc in psychology who contribute to the wellbeing or development of people (n = 3,320, $\chi^2(1) = 51.19$, $\varphi = –.12$, $p < .001$) and in the subsample of participants who provide psychotherapeutic care ($\chi^2(1) = 77.78$, $\varphi = –.20$, $p < .001$), showing that Flemish-speaking participants reported higher levels of membership of professional organizations.

Table 84 gives an overview of membership of a (predefined) general professional association or psychotherapy association, in the full sample and separately per language group.

Table 84. Membership of a general professional or psychotherapy association

Membership (%)	Psychologists who contribute to wellbeing	Psychologists who provide psychotherapy
Full sample	(*n* = 3,324; 434 missing)	(*n* = 2,012; 204 missing)
Any membership	59.2	75.5
Only professional association	28.3	31.6
Only therapy association	6.0	9.1
Professional and therapy association	15.6	25.4
Only other[79]	9.4	9.4
Flemish-speaking participants	(*n* = 2,281; 241 missing)	(*n* = 1,396; 105 missing)
Any membership	63.3	81.2
Only professional association	32.2	35.2
Only therapy association	6.1	9.5
Professional and therapy association	19.0	31.2
Only other	5.8	5.3
French- and German-speaking participants	(*n* = 1,039; 191 missing)	(*n* = 616; 98 missing)
Any membership	50.1	62.8
Only professional association	19.5	23.4
Only therapy association	5.9	8.3
Professional and therapy associations	7.7	12.5
Only other	17.0	18.7

Continuing professional development

Participants who were (self-)employed were requested to report on the **CPD** they had done **since they graduated** with an MSc in psychology.

The following set of analyses does not include participants who reported that they worked in student counselling (*n* = 547, 12.7% of the full sample of 4,304 participants with an MSc in psychology). For the analyses on CPD for this specific subgroup, we refer to the report by Spilt et al., 2021. These participants received a specific and more elaborate set of questions more closely related to school settings and school or educational psychology.

This set of questions was analysed for 3,046 participants with an MSc in psychology who fully completed the questionnaire[80]. Table 85 shows the prevalence of the **various forms of CPD** in the full sample. This

[79] Organization that was not listed.

[80] There was very little drop-out from this point on in the survey (almost all participants who started the section on CPD, completed every question assigned to them).

shows that conferences and *short training courses* are the most frequent forms of CPD (undertaken by 82.3–84.0% of participants with an MSc in psychology), followed by *intervision and supervision* (46.0–61.1%), *personal or didactic psychotherapy* (38.6% had either of those), and *teaching* (17.5–18.5%). As this list was not exhaustive, 12.3% of participants indicated that they also engaged in other forms of CPD[81]. Around 2% did not engage in any of the forms of CPD listed, and 1.2% did not feel that CPD was applicable to them.

Table 85. Forms of continuing professional development in participants with an MSc in psychology

Form of continuing professional development since graduation	%
Attend conferences	84.0
Follow short training courses (1 day to a few days)	82.3
Participate in intervision (with the focus on the professional actions of yourself and colleagues)	61.1
Get supervision (with the focus on your own professional actions, individually or in small groups)	46.0
Didactic therapy (~"leertherapie, thérapie d'apprentissage") (with a duration of at least 6 months)	17.1
(Voluntary) Personal therapy	30.9
Teaching in a short training programme (programme <1year)	17.5
Teaching in a long training programme (programme >1 year)	18.5
None of the above	2.2
Other forms of CPD	12.3
Not applicable	1.2

Based on the nature of CPD, we combined information from the several response options and distinguished **four types** of CPD:

1. Short training (conferences and short training courses)
2. Participation in intervision or supervision
3. Personal therapy (either on a voluntary basis or in a didactic context)
4. Teaching (in short or long training programmes).

On average, participants with an MSc in psychology had taken part in two of these four categories since their graduation (n = 3,046, M= 2.34, SD = 1.05). However, 3.9% of participants had not been not involved in any of these types of CPD at any point in time; 14.3% had been involved in all four types of CPD.

[81] Participants were asked to specify this response. Other forms of CPD included further education of one or more years (which is discussed in previous sections), voluntary work, or keeping up with professional literature.

Table 86. Forms of continuing professional development in participants with an MSc in psychology

Form of continuing professional development since graduation	%
Short training	93.7
Attend conferences	84.0
Follow short training courses (1 day to a few days)	82.3
Participation in intervision or supervision	71.4
Participate in intervision (with the focus on the professional actions of yourself and colleagues)	61.1
Get supervision (with the focus on your own professional actions, individually or in small groups)	46.0
Personal therapy	38.6
Didactic therapy ("leertherapie, thérapie d'apprentissage") (with a duration of at least 6 months)	17.1
(Voluntary) Personal therapy	30.9
Teaching	30.2
Teaching in a short training programme (programme <1year)	17.5
Teaching in a long training programme (programme >1 year)	18.5
Other options	
None of the above	2.2
Other forms of CPD	12.3
Not applicable	1.2

In Table 87, we compare engagement in these types of CPD between participants with an **MSc in clinical psychology** (n = 2,390) and those with an MSc in another domain of psychology (n = 656). These comparisons show that participants with an MSc in clinical psychology were more involved in most of the forms of CPD compared with their counterparts from other domains of psychology, except for teaching activities, which did not differ. Effect sizes were small. Furthermore, participants with an MSc in clinical psychology were involved in more types of CPD (M = 2.47, SD = 0.98) compared with individuals with an MSc in another domain of psychology (M = 1.88, SD = 1.13) (t(942.29) = 12.13, Cohen's d = 0.52, p < .001).

Table 87. Comparison of types of CPD between participants with an MSc in clinical psychology and participants with an MSc in another domain of psychology

Types of CPD (%)	MSc in clinical psychology (*n* = 2,390)	MSc in another domain of psychology (*n* = 656)	MSc in psychology (*n* = 3,046)	$\chi^2(1)$	φ
Short training	95.2	88.3	93.7	42.52**	.12**
Intervision or supervision	77.9	47.7	71.4	229.04**	.27**
Personal therapy	43.3	21.3	38.6	104.80**	.19**
Teaching	30.2	30.3	30.2	0.01	.00

Note. *p < .01, **p < .001.

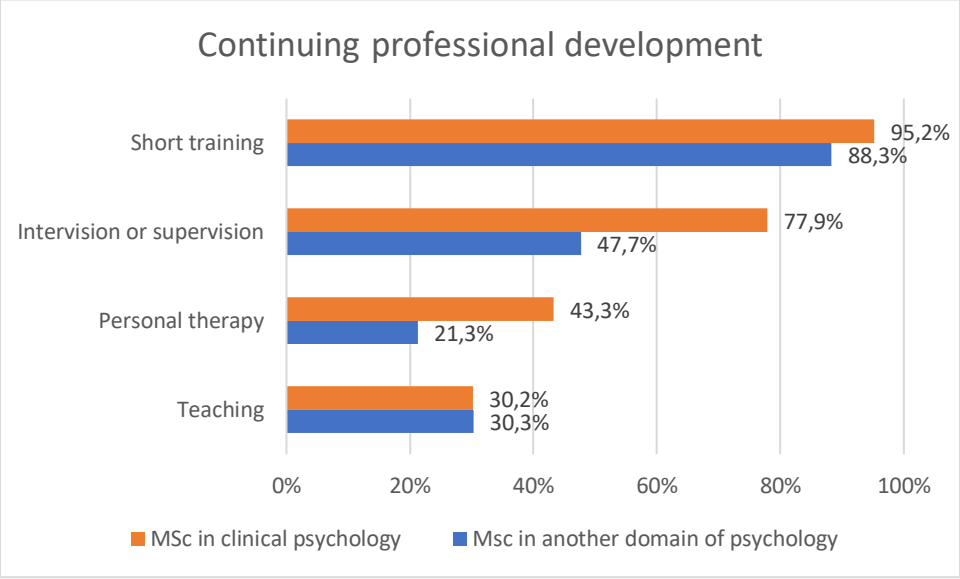

Figure 75. Types of CPD according to domain of specialization.

We also compared types of CPD between **Flemish-speaking participants** (*n* = 2,115) **and French- and German-speaking participants** combined (*n* = 927) (see Table 88). Participants from the French and German language communities were involved in more types of CPD (*M* = 2.62, *SD* = 1.15) than their Flemish counterparts (*M* = 2.22, *SD* = 0.97) (*t*(1,533.60) = –9.36, *d* = 0.37, *p* < .001). Whereas short training and participation in either intervision or supervision did not differ according to participants' language, having followed personal therapy and involvement in teaching activities were more frequent among the French- and German-speaking participants. Differences in teaching activities had a moderate effect size. Follow-up-analyses showed that French- and German-speaking participants were more involved in teaching activities than their Flemish counterparts, both when teaching took place in a short or a long

training programme, but only the latter difference had a medium effect size (φ = .43, p < .001); the former had a small effect size.

Table 88. Comparison of forms of CPD between Flemish-speaking participants and French- and German speaking participants

Types of CPD (%)	Flemish-speaking participants (n = 2,115)	French- and German -speaking participants (n = 927)	$\chi^2(1)$	φ
Short training	94.1	93.0	1.34	–.02
Intervision or supervision	72.2	69.6	2.25	–.03
Personal therapy	35.5	45.6	27.87**	.10**
Teaching	19.9	53.9	354.81**	.34**

Note. *p < .01, **p < .001.

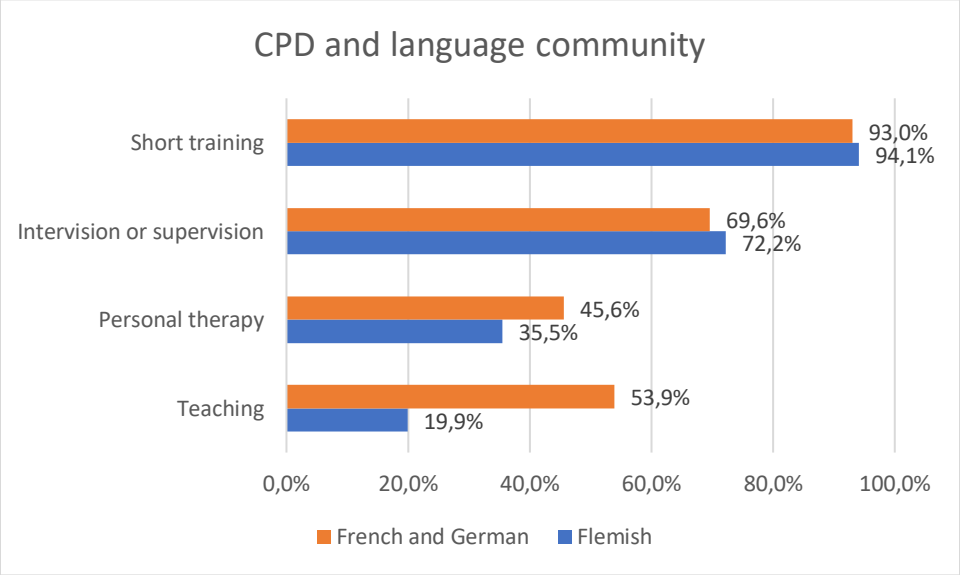

Figure 76. Types of CPD according to language community.

Age of (self-)employed participants with an MSc in psychology (<30 years; 30–39 years; 40–49 years; 50–59 years; ≥60 years) showed significant but small Spearman correlations with (a) short training (ρ = .11, p < .001), (b) participation in intervision or supervision (ρ = .10, p < .001), (c) personal therapy (ρ = .12, p < .001), and (d) teaching (ρ = .19, p < .001). Older participants also participated in more different types of CPD (ρ = .20, p < .001).

Next, we compared types of CPD between **participants in self-employment** (n = 1,498) and participants who worked exclusively in **salaried employment** (n =1,548). Participants with an MSc in psychology who

were self-employed (as a primary or secondary occupation) were more involved in all types of CPD. Effect sizes were small and ranged between φ = .11 - .31 (see Table 89). Self-employed participants were also involved in more different types of CPD (M = 2.71, SD = 0.92) compared with their colleagues who worked exclusively in salaried employment (M = 1.98, SD = 1.03) (t(3,024.37) = 20.76 , Cohen's d = 0.75, p < .001).

Table 89. Comparison of forms of CPD between participants in self-employment and participants who work exclusively in salaried employment.

Type of CPD (%)	Self-employment (n = 1,498)	Exclusively salaried employment (n = 1,548)	$\chi^2(1)$	φ
Short training	96.4	91.1	35.64**	–.11**
Intervision or supervision	85.6	57.6	293.98**	–.31**
Personal therapy	51.3	26.2	202.48**	–.26**
Teaching	37.9	22.8	81.74**	–.16**

Note. *p < .01, **p < .001.

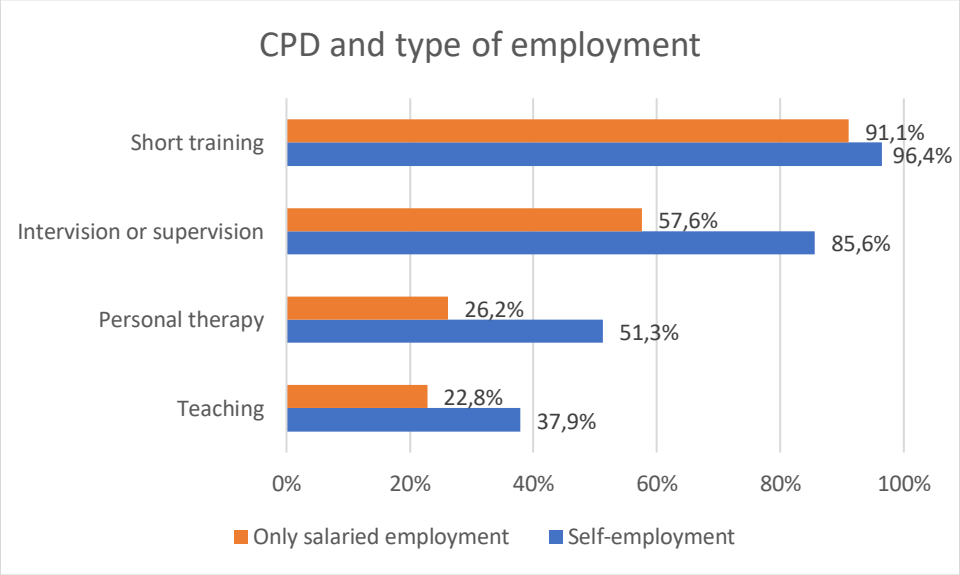

Figure 77. Types of CPD in participants with an MSc in psychology according to type of employment.

Finally, we explored differences between (a) participants who **foster people's wellbeing** or development in their job(s) (n = 2,792) (i.e., clinical field of work) and those who do not (n = 246), and (b) those who **provide psychotherapeutic care** (n = 1,798) and those who do not report this type of care (n = 994) in the subsample that reported fostering wellbeing. Not surprisingly, most types of CPD were more prevalent in participants whose job(s) fostered wellbeing compared with those with other types of jobs (see Table 90), and this was even more pronounced when psychologists also provided psychotherapeutic care (see Table 91). This also translated into more different types of CPD in participants who fostered people's wellbeing

(*n* = 2,792, *M* = 2.45, *SD* = 0.98) than those with other types of jobs (*n* = 246, *M* = 1.11, *SD* = 0.97; *t*(290.81) = –20.63, Cohen's *d* = 1.37, *p* < .001), and in those who provided psychotherapeutic care (*n* = 1,798, *M* = 2.74, *SD* = 0 .88) compared with those who did not provide this type of care (*n* = 994, *M* = 1.92, *SD* = 0.92; *t*(2790) = –23.13, Cohen's *d* = 0.91, *p* < .001).

Table 90. Comparison of forms of CPD between participants who contribute to the wellbeing or development of people and participants with other types of jobs

Type of CPD (%)	Job contributes to wellbeing or development (*n* = 2,792)	Other type of job (*n* = 246)	$\chi^2(1)$	φ
Short training	95.9	69.1	275.10**	.30**
Intervision or supervision	76.1	18.3	369.61**	.35**
Personal therapy	40.8	13.0	73.69**	.16**
Teaching	31.9	11.0	46.87**	.12**

Note. *p < .01, **p < .001.

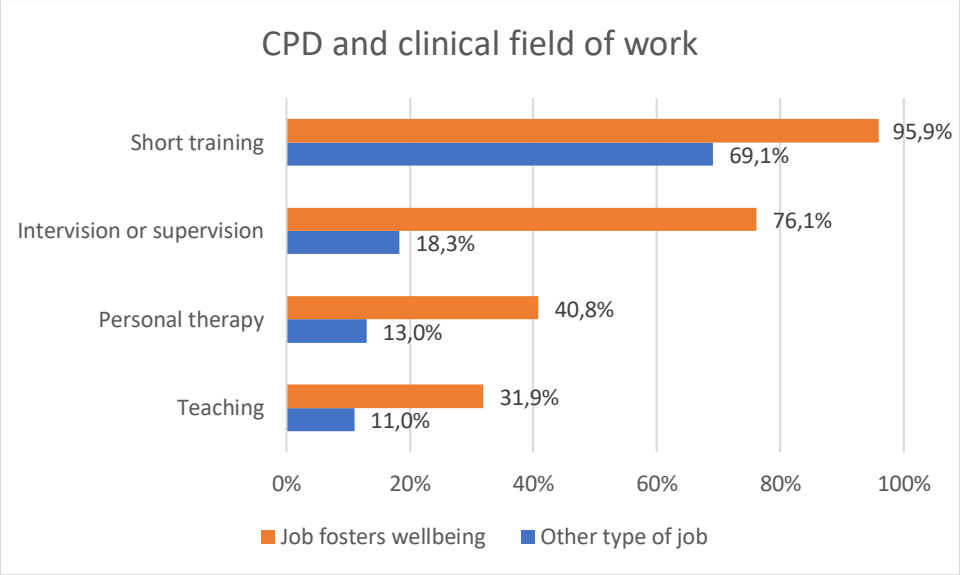

Figure 78. Types of CPD in psychologists who work in the clinical field and in those who work in another field.

Table 91. Comparison of forms of CPD between participants who contribute to wellbeing and provide psychotherapeutic care and participants who do not provide psychotherapeutic care

Type of CPD (%)	Provision of psychotherapeutic care (*n* = 1,798)	No provision of psychotherapeutic care (*n* = 994)	$\chi^2(1)$	φ
Short training	96.8	94.3	10.20*	.06*
Intervision or supervision	88.2	54.1	408.57**	.38**
Personal therapy	52.6	19.4	292.08**	.32**
Teaching	36.3	23.9	44.73**	.13**

Note. *p < .01, **p < .001.

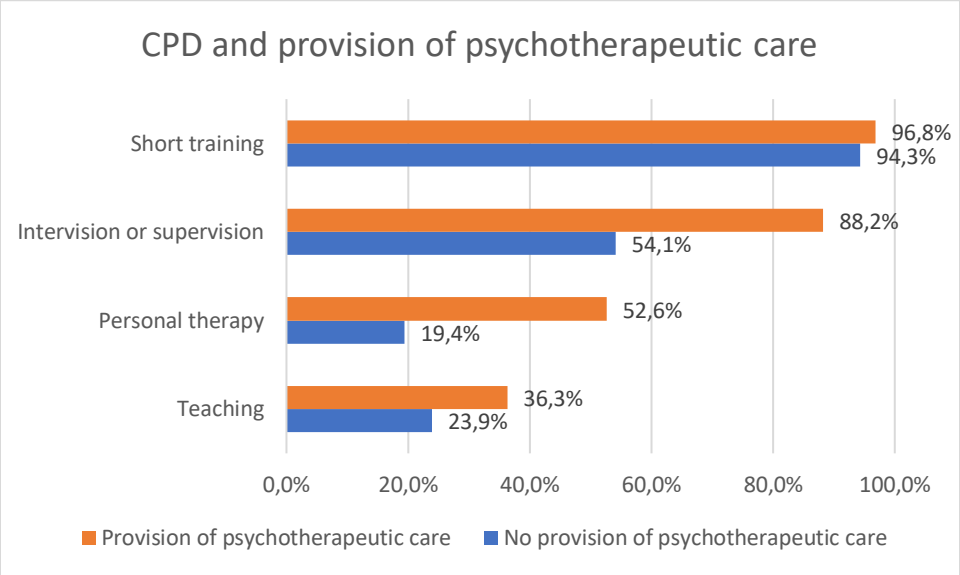

Figure 79. Types of CPD in psychologists who work in the clinical field and provide psychotherapeutic care and those who do not provide this type of care.

3.6.4 Intervision and supervision

One important feature of CPD is participation in **intervision or supervision**[82]. As intervision and supervision are especially relevant in the context of the LHCP, we focus on participants with an MSc in psychology whose work contributes to the wellbeing or development of people, and those who indicate that they provide psychotherapeutic care[83]. As shown in Table 92, intervision and supervision are more

[82] To clarify the difference between intervision and supervision, "participation in intervision" was followed by the specification "with the focus on the professional actions of yourself and colleagues"; "getting supervision" was followed by the specification "with the focus on your own professional actions, individually or in small groups".
[83] In line with the previous analyses on CPD, these analyses included participants who fully completed the survey, i.e. they answered every question assigned to them based on the logic of the survey; provision of psychotherapeutic care does not necessarily imply that the participant acquired training in psychotherapeutic care.

prevalent among participants whose **job contributes to wellbeing** or development (*n* = 2,792) compared with those with other types of jobs (*n* = 246). The same is true for participants who **provide psychotherapeutic care** (*n* = 1,798) compared with those who do not (*n* = 1,240) (see Table 93). Nonetheless, 23.9% of psychologists who contribute to wellbeing reported never participating in intervision or supervision. Among those who provide psychotherapeutic care, 11.8% indicated that they never participated in intervision or supervision.

Table 92. Comparison of intervision and supervision between participants who contribute to wellbeing or development of people and participants with other types of jobs

Type of CPD (%)	Job contributes to wellbeing or development (*n* = 2,792)	Other type of job (*n* = 246)	$\chi^2(1)$	φ
Intervision or supervision	76.1	18.3	369.61**	.35**
Intervision	65.2	15.4	235.45**	.28**
Supervision	49.1	10.2	138.04**	.21**

Note. *p < .01, **p < .001.

Table 93. Comparison of intervision and supervision between participants who provide psychotherapeutic care and participants who do not provide psychotherapeutic care in their job(s)

Type of CPD (%)	Provision of psychotherapeutic care (*n* = 1,798)	No provision of psychotherapeutic care (*n* = 1,240)	$\chi^2(1)$	φ
Intervision or supervision	88.2	47.0	609.77**	.45**
Intervision	75.0	41.0	356.70**	.34**
Supervision	61.9	22.8	451.27**	.39**

Note. *p < .01, **p < .001.

In a follow-up question, participants were requested to provide information on the frequency with which they had participated in intervision and supervision **in the past year**. Figure 80 shows the frequency of intervision in the subset of participants who indicated that they had taken part in intervision in the past year (1,767 participants who contribute to wellbeing or development of people, and 1,315 participants who provide psychotherapeutic care). Figure 81 shows these frequencies for supervision (*n* = 1,248 and *n* = 1,010 for both respective subsamples). The median time between intervision sessions was 2 months (median = “every 2 months”), although there was clear variability in the time between intervisions, with a considerable proportion reporting that they attended intervision and supervision sessions at least every month.

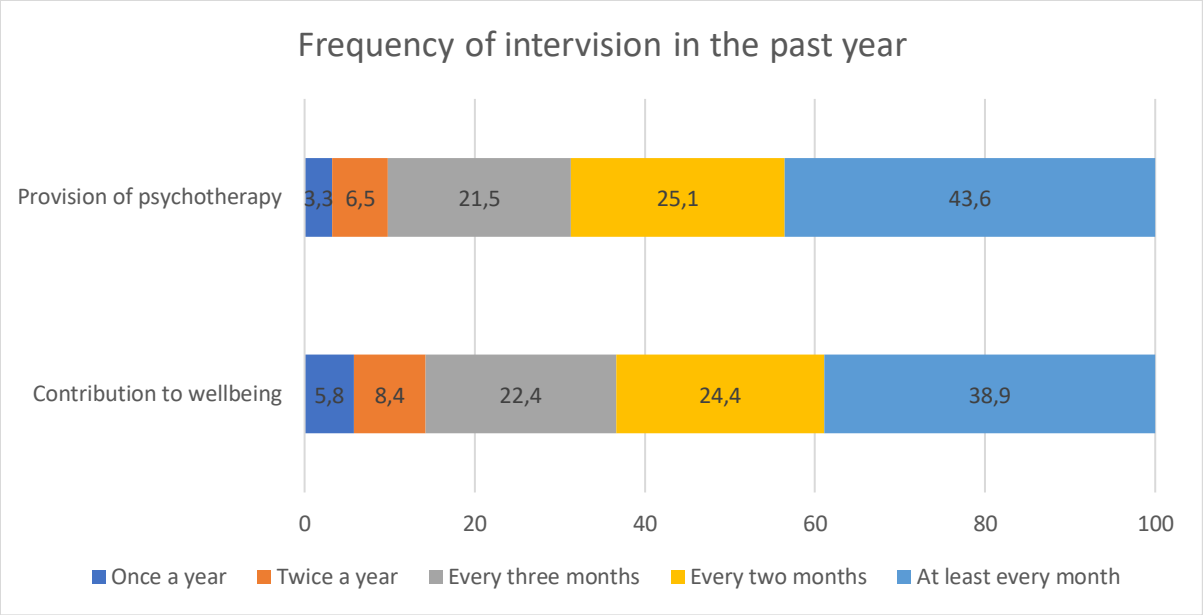

Figure 80. Frequency of intervision (%) in participants with an MSc in psychology who participated in intervision in the past year.

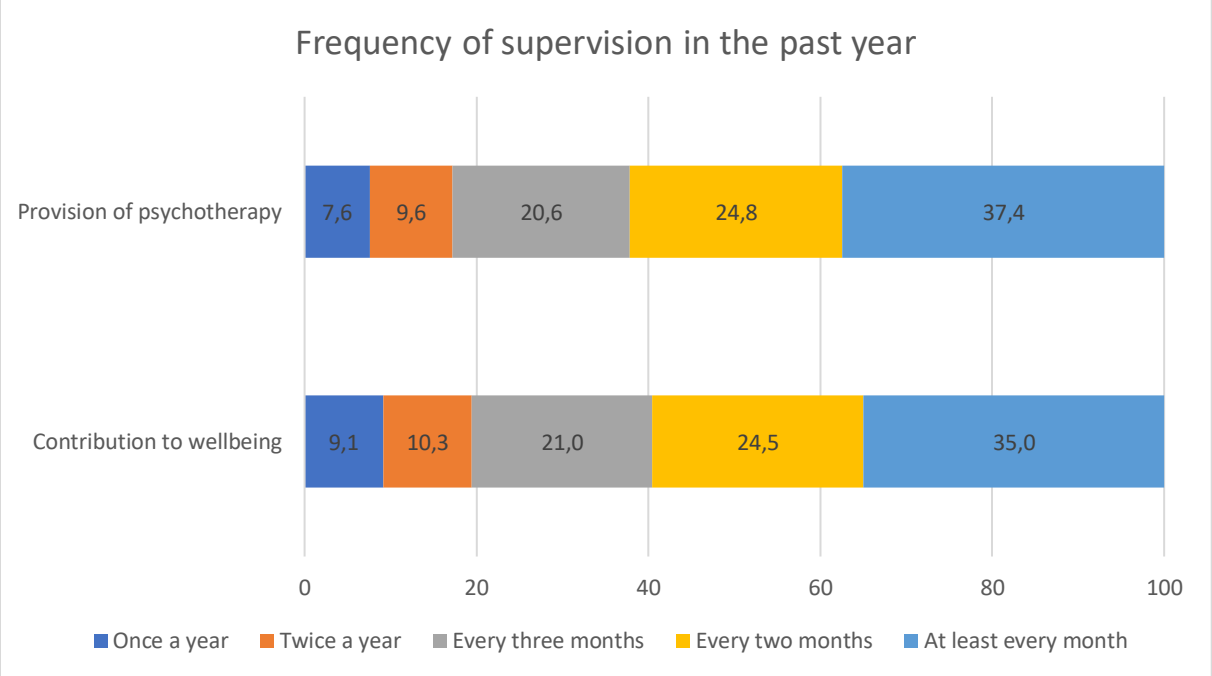

Figure 81. Frequency of supervision (%) in participants with an MSc in psychology who participated in supervision in the past year.

Tables 94 and 95 show the **frequencies of supervision and intervision** in participants with an MSc in psychology who contribute to wellbeing (*n* = 2,792) and in those who provide psychotherapeutic care (*n* = 1,798). These ratios take **into account the numbers of participants who reported that they never participated** in these activities.

Table 94. Prevalence and frequency of intervision in psychologists who contribute to wellbeing and in those who provide psychotherapeutic care

	Never (%)	Past year (if ever) (%)					
		None	Once	Twice	Every 3 months	Every 2 months	At least every month
Psychologists who contribute to wellbeing (*n* = 2,792)	34.8	1.9	3.7	5.3	14.2	15.5	24.6
Flemish-speaking participants (*n* = 1,939)	28.3	1.1	3.5	5.5	15.0	17.6	29.0
French- and German-speaking participants (*n* = 850)	49.5	3.6	4.0	4.9	12.5	10.7	14.7
MSc in clinical psychology (*n* = 2,269)	30.3	1.9	3.0	5.2	14.5	17.1	28.1
Psychologists who provide psychotherapeutic care (*n* = 1,798)	25.0	1.9	2.4	4.8	15.7	18.4	31.9
Flemish-speaking participants (*n* = 1,264)	18.0	1.0	2.0	4.3	16.5	20.7	37.6
French- and German-speaking participants (*n* = 534)	41.6	3.9	3.4	6.0	14.0	12.7	18.4
MSc in clinical psychology (*n* = 2,269)	24.1	1.6	2.1	4.6	15.4	18.7	33.4

Participation in intervision since graduation ($\chi^2(1) = 117.89$, $\varphi = -.21$, $p < .001$) and the subsequent frequency of intervision ($t(617.05) = 6.28$, Cohen's $d = 0.26$, $p < .001$) in the past year were **higher in Flemish-speaking participants** compared with French- and German-speaking participants who contribute to wellbeing or development. These effects of language community were also found in psychologists who provide psychotherapeutic care (($\chi^2(1) = 111.73$, $\varphi = -.25$ $p < .001$; ($t(423.86) = 6.59$, Cohen's $d = 0.34$, $p < .001$).

Participation in intervision since graduation and the subsequent frequency of intervision in the past year were **higher in participants who worked in independent practice** (n = 1,469) than in participants who worked exclusively in paid employment (n = 1,323) ($\chi^2(1) = 104.38$, $\varphi = -.19$, $p < .001$); $t(1{,}481.86) = 5.37$, Cohen's $d = 0.20$, $p < .001$). These effects of employment were no longer significant in psychologists who provide psychotherapeutic care: participants in self-employment (n = 1,261) were no more likely to be involved in intervision since graduation than their counterparts who worked exclusively in paid employment (n = 537), nor did sessions occur more frequently($\chi^2(1) = 5.61$, $\varphi = -.06$, $p > .01$; ($t(1{,}347) = 1.56$, $p > .05$).

Table 95. Prevalence and frequency of supervision in psychologists who contribute to wellbeing and in those who provide psychotherapeutic care

	Never (%)	**Past year (if ever) (%))**					
		None	**Once**	**Twice**	**Every 3 months**	**Every 2 months**	**At least every month**
Psychologists who contribute to wellbeing (*n* = 2,792)	50.9	4.4	4.1	4.6	9.4	11.0	15.6
Flemish-speaking participants (*n* = 1,939)	56.4	3.5	3.4	4.8	8.6	9.9	13.4
French- and German-speaking participants (*n* = 850)	38.2	6.5	5.6	4.2	11.3	13.3	20.8
MSc in clinical psychology (*n* = 2,269)	47.6	4.5	3.7	4.8	10.0	11.8	17.6
Psychologists who provide psychotherapy (*n* = 1,798)	38.1	5.7	4.3	5.4	11.6	13.9	21.0
Flemish-speaking participants (*n* = 1,264)	44.3	4.8	3.7	5.7	10.8	12.7	18.0
French- and German-speaking participants (*n* = 534)	23.4	7.9	5.6	4.7	13.5	16.7	28.3
MSc in clinical psychology (*n* = 1,658)	38.7	5.4	3.9	5.5	11.5	13.9	21.1

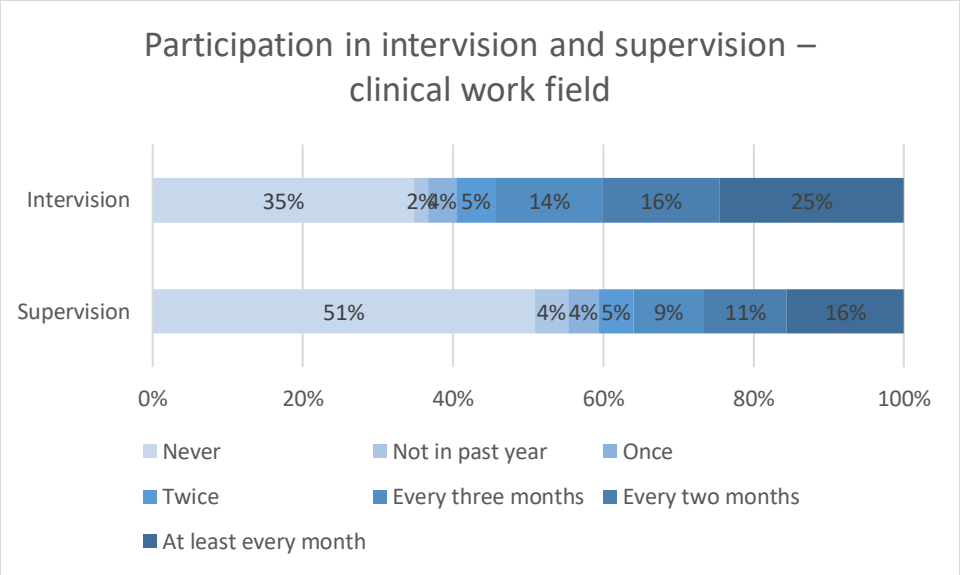

Figure 82. Frequency of intervision and supervision during the past year in psychologists who contribute to wellbeing.

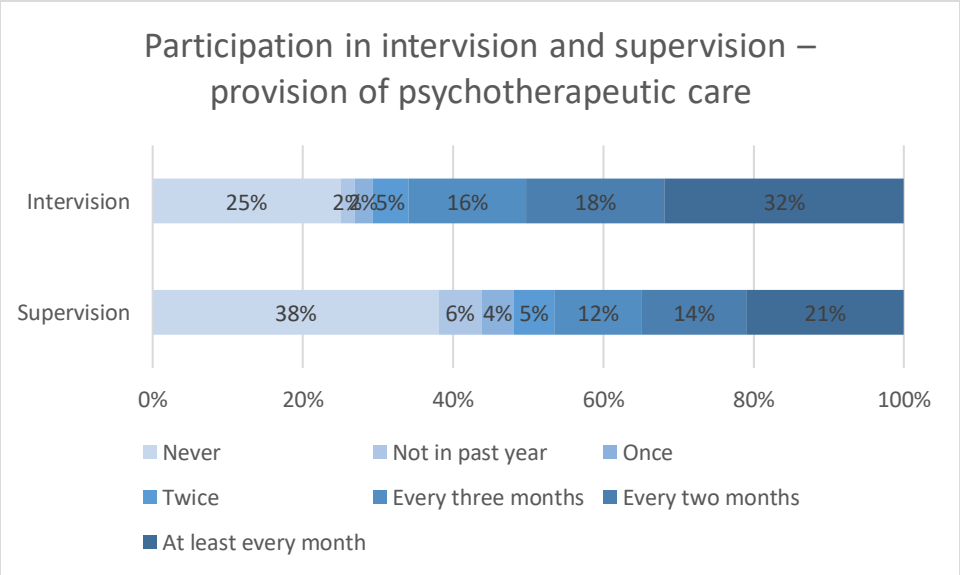

Figure 83. Frequency of intervision and supervision during the past year in psychologists who provide psychotherapeutic care.

Participation in supervision since graduation was **higher in French- and German-speaking participants** compared with Flemish-speaking participants who contribute to wellbeing or development ($\chi^2(1) = 78.20$, $\varphi = .17$, $p < .001$). The frequency of supervision in the past year in those who were involved in supervision since graduation did not differ between the language communities ($t(1,368) = 0.12$, $p > .05$). The same

patterns were true in psychologists who provide psychotherapeutic care (($\chi^2(1) = 69.50$, $\varphi = .20$, $p < .001$; ($t(1,111) = –0.62$, $p > .05$).

Participation in supervision since graduation was **higher in participants who worked in independent practice** ($n = 1,469$) than in participants who worked exclusively in salaried employment ($n = 1,323$) ($\chi^2(1) = 177.36$, $\varphi = –.25$, $p < .001$). Differences in the frequency of supervision in the past year related to type of employment did not reach the threshold for a small effect-size ($t(877.74) = 4.20$, Cohen's $d = 0.16$, $p < .001$). These effects of type of employment also appeared, to a lesser extent, in psychologists who provide psychotherapeutic care: participants in self-employment ($n = 1,261$) were more likely to be involved in supervision since graduation than their counterparts who worked exclusively in paid employment ($n = 537$) ($\chi^2(1) = 29.76$, $\varphi = –.13$, $p < .001$; these sessions occurred somewhat more frequently, but not enough to reach the threshold for a small effect-size ($t(429.67) = 2.81$, Cohen's $d = 0.15$, $p < .01$).

Thus, the following patterns emerge:

- The number of MScs in psychology who contribute to wellbeing or development and who **are not involved** in intervision and supervision is generally surprisingly **high**: 34.8% report that they have never been involved in intervision, and 50.9% report never having been involved in systematic supervision since they graduated. When participants do engage in intervision or supervision, on average, they do so **every 2 months**.
- In the past year, and taking into account participants who had never been involved in intervision or supervision, 24.6% of participants with an MSc in psychology who are involved in supporting wellbeing or development reported at least monthly participation in intervision, and 15.6% received monthly supervision. Among MScs in clinical psychology, these proportions were 28.1% and 17.6%, respectively.
- In **Flemish**-speaking participants, **intervision** is a more common practice compared with the French and German-speaking participants, whereas the opposite is true for supervision.
- When psychologists indicate they provide **psychotherapeutic care**, the engagement in intervision and supervision increases. However, the number of psychologists who provide psychotherapeutic care and who have never participated in intervision or supervision is still high, at 25.0% and 38.1%, respectively; 11.8% participated in neither.
- Psychologists in **self-employment** are more involved in intervision and supervision than their counterparts who work only in salaried employment. These differences in type of employment diminish when job characteristics are more similar, that is, in psychologists who provide psychotherapeutic care.

3.6.5 Interdisciplinary collaboration

Interdisciplinary consultation

Participants who worked with clients (i.e. those who "supported people and their environment") were asked to report on the frequency of **interdisciplinary consultation**; 3,479 participants with an MSc in psychology reported on this variable, data were missing for 49 participants. They were asked how often they participated, on average, in interdisciplinary consultation regarding (the coordination of) patient/client care, and to report this for each job they carried out. The frequency of interdisciplinary consultation was rated on a 5-point Likert scale ranging from "less than quarterly" to "daily". Participants could also indicate that the question was not applicable to their job. Figure 84 shows the frequency of interdisciplinary consultation in participants' main job in salaried employment (n = 2,606) and in their main job in self-employment (n = 1,762). Based on the median (50th percentile), the average frequency of interdisciplinary consultation was "monthly" in the main job in self-employment and "weekly" in the main job in salaried employment. Thus, interdisciplinary consultation appeared to be more frequent in jobs in salaried employment (Cramer's V = .21). Notably, 10–17% of participants indicated this was not applicable to them, and 4–13% rarely consulted with colleagues from another discipline.

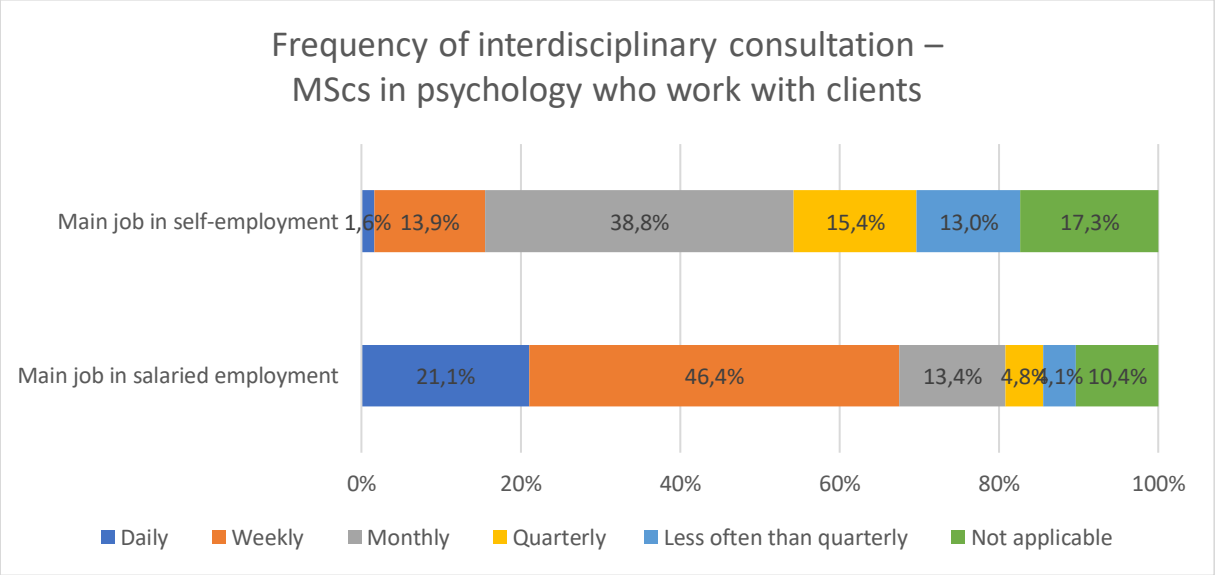

Figure 84. Frequency of interdisciplinary consultation in psychologists who work with clients, in their main job in salaried employment and their main job in self-employment.

Figure 85 shows the frequency of interdisciplinary consultation in the subsample that also provided psychotherapeutic care. The frequency of interdisciplinary collaboration/ consultation was again higher in participants in salaried employment than those in self-employment (Cramer's V = .21). The median frequency of interdisciplinary consultation for the main job in salaried employment was "weekly", while 24.9% reported "daily" interdisciplinary consultations. In self-

employment, the median frequency was “monthly”, and 29.4% reported hardly ever being involved in interdisciplinary collaboration/consultation (“less often than quarterly” or “not applicable”).

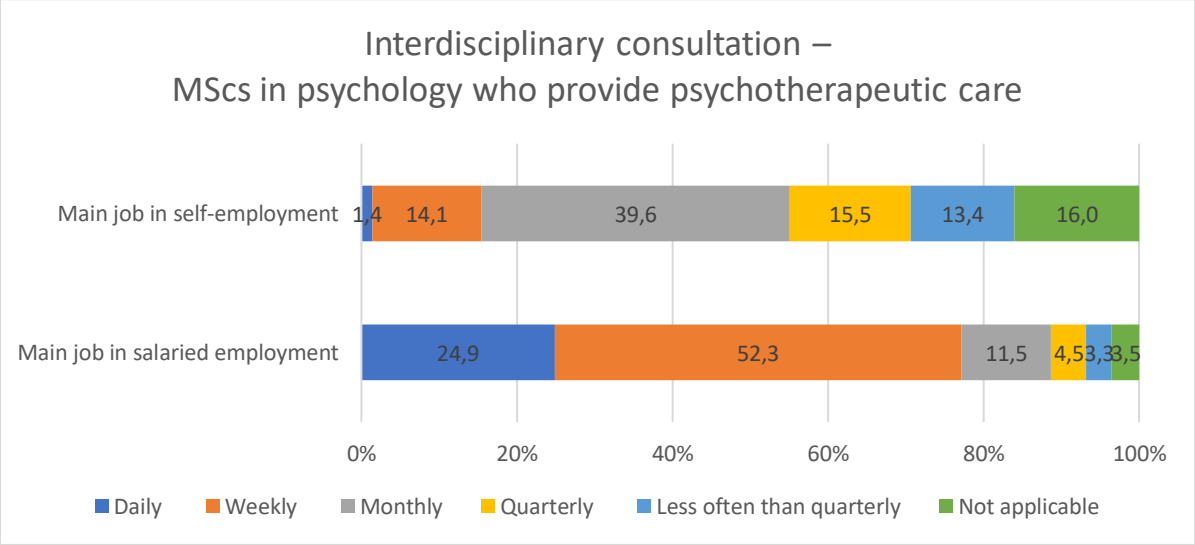

Figure 85. Frequency of interdisciplinary consultation in psychologists who provide psychotherapeutic care, in their main job in salaried employment and their main job in self-employment.

We created a **binary variable** to distinguish psychologists who participated in interdisciplinary consultation **in one or more jobs at least quarterly** from those who did not (combining the categories “less than quarterly” and “not applicable”), and explored several group differences. In the full sample of MScs in psychology who worked with clients (n = 3,479), the vast majority (84.5%) reported participation in interdisciplinary consultation at least quarterly. This participation was slightly more common in psychologists who reported providing **psychotherapeutic care** (90.2%) compared with those who did not provide this type of care (74.7%; $\chi^2(1) = 146.49$, $\varphi = .21$; $p < .001$), and in participants with an **MSc in clinical psychology** (88.3%) compared with participants with an MSc in another domain of psychology (68.8%) ($\chi^2(1) = 159.85$, $\varphi = .21$, $p < .001$). There was also a very small effect of age; younger psychologists were somewhat more likely than their older counterparts to participate in interdisciplinary collaboration ($\rho = -.09$, $p < .001$). Differences in interdisciplinary consultation between **Flemish-speaking participants** (85.7%) and French- or German-speaking participants (82.0%) did not reach the threshold for a small effect-size ($\chi^2(1) = 8.13$, $\varphi = -.05$; $p < .01$).

Interdisciplinary consultation was least common in psychologists who work only in **self-employment** (n = 718 in the subsample of psychologists involved in client work)) compared with other types of employment (1,600 participants who work only in salaried employment and 1,161 participants who combine salaried employment and self-employment). Table 96 shows the prevalence of interdisciplinary consultation in participants with an MSc in psychology who work with clients (n = 3,479) and in the subsample that also provides psychotherapeutic care (n = 2,204), taking into account language and employment status.

Table 96. Prevalence of interdisciplinary consultation in participants with an MSc in psychology who work with clients and in those who provide psychotherapeutic care, in relation to type of employment and language

Interdisciplinary consultation (%)	Only salaried employment (*n* = 1,600)	Self-employment as a primary occupation (*n* = 718)	Self-employment as a secondary occupation (*n* = 1,161)	All	$\chi^2(2)$	Cramer's *V*
Psychologists who work with clients (*n* = 3,479)	83.5	76.6	90.8	84.5	70.45**	.14**
Flemish-speaking participants (*n* = 2,329)	84.0	79.5	92.2	85.7	43.18**	.14**
French- and German-speaking participants (*n* =1,146)	82.5	71.1	88.2	82.0	30.82**	.16**
Psychologists who provide psychotherapeutic care (*n* = 2,204)	96.1	80.0	92.5	90.2	98.68**	.21**
Flemish-speaking participants (*n* = 1,492)	97.6	84.9	94.3	92.8	53.80**	.19**
French- and German-speaking participants (*n* = 711)	92.0	70.2	89.1	84.5	43.78**	.25**

Note. * $p < .01$, ** $p < .001$.

Follow-up analyses with the **frequency of interdisciplinary consultation** (ranging from "daily" to "not applicable") in the main job in salaried employment (*n* = 2,606) and the main job in self-employment (*n* = 1,762) confirmed most of the results found with the binary variable that combined information for all jobs.

Language differences were not found in the main job in salaried employment (*n* = 2,603, $\chi^2(5) = 7.71$, $p > .05$), with a median "weekly" frequency in both Flemish-speaking participants and French- and German-speaking participants, but were significant in the main job in self-employment (*n* = 1,761, $\chi^2(5) = 66.06$, Cramer's $V = .20$, $p < .001$). The median frequency was "monthly" in the Flemish-speaking participants and "quarterly" in the French- and German-speaking participants.

Domain of specialization in psychology was relevant in both salaried employment ($\chi^2(5) = 156.39$, Cramer's $V = .25$, $p < .001$) and self-employment ($\chi^2(5) = 29.68$, Cramer's $V = .13$, $p < .001$). The median frequency of interdisciplinary consultation was higher in participants with an MSc in clinical psychology ("weekly" in salaried employment and "monthly" in self-employment) compared with participants with another domain of specialization ("monthly" in salaried employment and "quarterly" in self-employment).

A linear **age effect** appeared in the main job in self-employment, indicating that younger MScs in psychology participated more frequently in interdisciplinary consultation than their older colleagues ($\rho = –.20$, $p < .001$), but this age effect did not appear in salaried employment ($\rho = .00$, $p > .05$).

The frequency of interdisciplinary consultation is also higher in **participants who provide psychotherapeutic care** compared with those who do not provide this type of care, both in salaried employment ($\chi^2(5) = 224.89$, Cramer's $V = .29$, $p < .001$) and self-employment ($\chi^2(5) = 18.44$, Cramer's $V = .10$, $p < .01$). The median frequency was "weekly" in salaried employment, regardless of the provision of psychotherapeutic care, but in those who provide psychotherapeutic care, 52.3% reported weekly consultations, compared with 38.4% of those who did not provide this type of care. In self-employment, the median frequency of interdisciplinary consultation was "monthly" in those who provide psychotherapeutic care and "quarterly" in those who did not.

Thus, the majority of psychologists who work with clients seem to participate in interdisciplinary consultation to some extent, with 84.5% of this group reporting participating in these consultations in at least one of their jobs, at least once in 3 months. These consultations seem to be more embedded in salaried employment settings, where psychologists tend to participate in these consultations on a weekly basis, compared with self-employment settings, where the usual frequency is monthly. The participation in interdisciplinary consultation also differs according to the psychologists' demographic characteristics, their educational background, and job characteristics: interdisciplinary consultations seem to be a slightly more common practice in younger psychologists and in the Flemish community. Furthermore, psychologists with a background in clinical psychology and psychologists who indicate that they provide psychotherapeutic care more often participate in interdisciplinary consultations than their counterparts.

Interdisciplinary work setting

Related to the issue of interdisciplinary consultation is the issue of multidisciplinary versus individual private practice. Previous analyses showed that around half of psychologists work individually in a private practice in their main self-employed job that contributes to wellbeing or development (45.3%), 19.3% work in a group practice of psychologists, and 23.7% work in a multidisciplinary group practice (see 3.5.2).

In this section, we explore this distribution in psychologists **who work with clients**, and discuss several group differences (e.g. differences in participants' language, type of MSc in psychology, age effects, and type of care provided).

Figure 86 shows the **work setting** of psychologists' main job in **self-employment** that relates to client work (n = 1,775) and the work setting of self-employed psychologists who work with clients when information

on several jobs is combined (i.e. they work in this setting in at least one job)[84] (*n* = 1,823). This shows that in both analyses, the most prevalent work setting is alone in a private practice, followed by an interdisciplinary group practice, and a group practice of only psychologists. Other settings were less frequently reported, and are not as easy to interpret. Subsequent comparisons were carried out with the variable that combined information on several jobs and limited to the comparison between the three groups of interest: those working alone in a private practice, in a monodisciplinary (i.e. only psychologists) group practice, or in a multidisciplinary group practice (*n* = 1,617) (see Figure 87).

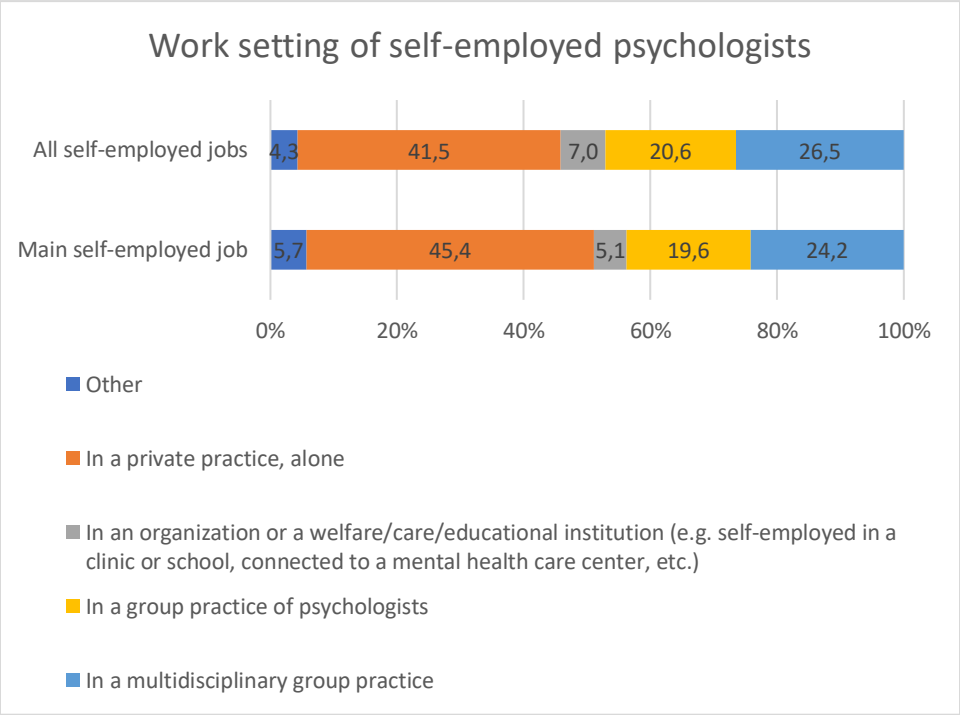

Figure 86. Work setting of participants with an MSc in psychology who work with clients, separately for their main job in self-employment and when information on work setting of other self-employed jobs is included.

[84] In order to assign each participants to one setting when combining information on several jobs, we chose the following hierarchy: (1) psychologists working in a multidisciplinary group practice, (2) psychologists working in a group practice of only psychologists, (3) psychologists who work in a healthcare or welfare institution (although they have a self-employed status), (4) psychologists who work alone, in a private practice, and (5) psychologists who work only in other settings. The specifications of the "other" settings provided by the participants showed that this category was not easily interpretable, as it included participants who work alone (and, for example, chose this category because they made house calls) as well as participants who worked in a group context (e.g. they worked in multiple settings in the same job).

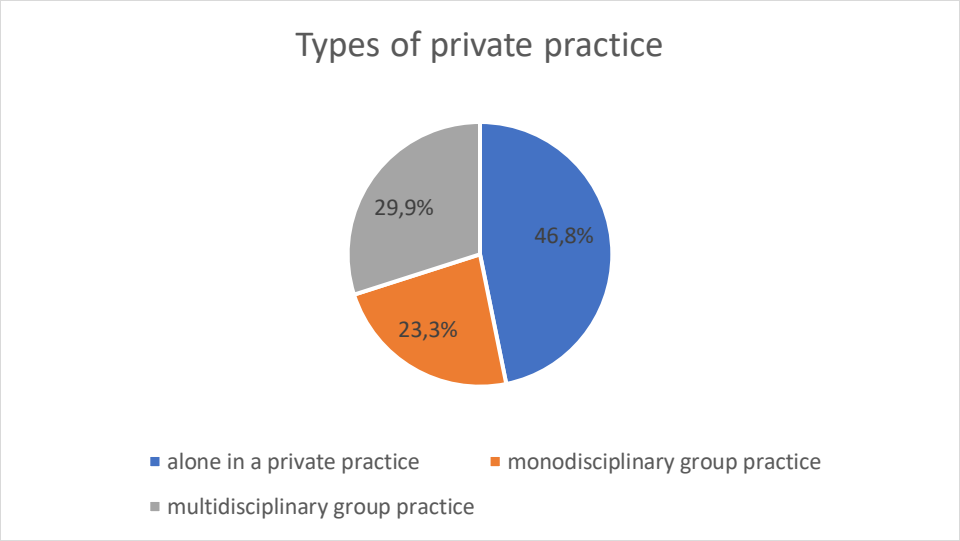

Figure 87. Work setting of participants with an MSc in psychology (%) who work with clients and work in a private practice (*n* = 1,617).

As shown in Table 97, **Flemish-speaking** participants worked alone in a private practice less often than their French- and German-speaking colleagues, and more often in a group practice, especially a monodisciplinary group practice. Follow-up analyses showed that working in a multidisciplinary group practice did not differ according to participants' language (n = 1,616, $\chi^2(1) = 1.96$, $p > .05$).

Table 97. Comparison of work setting between language communities

Work setting (%)	**Flemish-speaking participants (*n* = 1,078)**	**French- and German-speaking participants (*n* = 538)**	**$\chi^2(2)$**	**Cramer's *V***
			132.15**	.29**
Private practice, alone	38.1	64.1		
Monodisciplinary group practice	30.8	8.2		
Multidisciplinary group practice	31.1	27.7		

Note. * $p < .01$, ** $p < .001$.

Psychologists with a **clinical education** worked alone in a private practice less often than psychologists with another type of education, and more often in monodisciplinary group practice. Follow-up-analyses showed that working in a multidisciplinary group practice did not differ according to type of MSc in psychology (n = 1,617, $\chi^2(1) = 1.00$, $p > .05$).

Table 98. Comparison of work setting between participants with an MSc in clinical psychology and those with an MSc in another domain of psychology

Work setting (%)	MSc in clinical psychology (*n* = 1,385)	MSc in another domain of psychology (*n* = 232)	$\chi^2(2)$	Cramer's *V*
			43.17**	.16**
Private practice, alone	43.9	64.2		
Monodisciplinary group practice	25.7	8.6		
Multidisciplinary group practice	30.4	27.2		

Note. * $p < .01$, ** $p < .001$.

Work setting differed slightly between psychologists who **provided psychotherapeutic care** and those who did not ($p < .05$), but the effect size did not reach the threshold of a small effect.

Table 99. Comparison of work setting between providers of psychotherapeutic care and those who provide other types of client work

Work setting (%)	Providers of psychotherapeutic care (*n* = 1,417)	Other types of client work (*n* = 192)	$\chi^2(2)$	Cramer's *V*
			8.95	.08
Private practice, alone	46.8	46.4		
Monodisciplinary group practice	24.3	16.1		
Multidisciplinary group practice	28.9	37.5		

Note. * $p < .01$, ** $p < .001$.

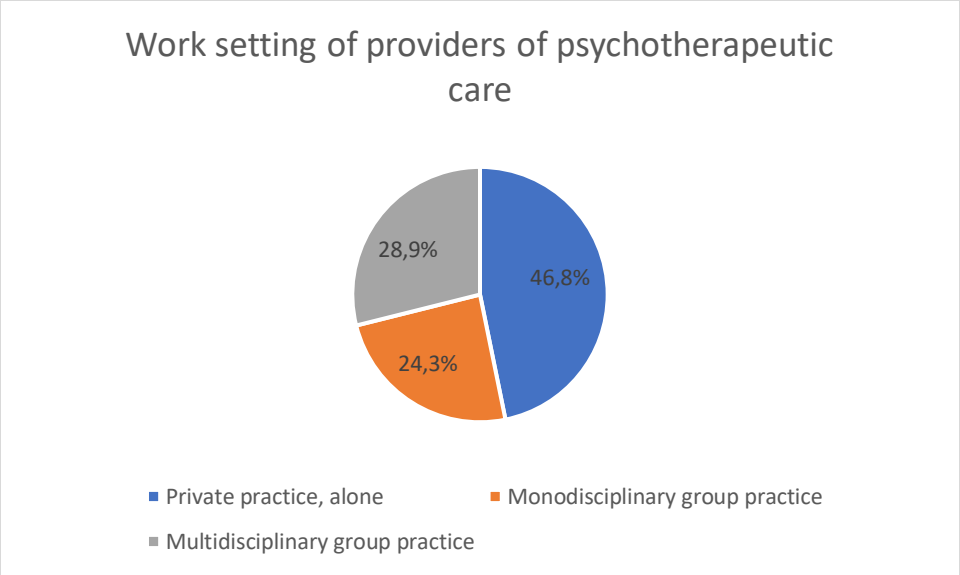

Figure 88. Work setting of participants with an MSc in psychology who provide psychotherapeutic care and work in a private practice.

There were clear **age** effects (with a linear-by-linear association of 224.60, Cramer's V = .39, p < .001), indicating that younger psychologists worked in a group practice more often than older psychologists; this was the case for both types of group practice. Psychologists younger than 40 years were more likely to work in a group practice than alone in a private practice. Among psychologists younger than 30 years who worked with clients in a private practice, the most likely setting was a multidisciplinary group practice (see Table 100).

Table 100. Comparison of work setting between age cohorts

Work setting (%)	**<30 years (*n* = 304)**	**30–39 years (*n* = 573)**	**40–49 years (*n* = 420)**	**50–59 years (*n* = 219)**	**60+ years (*n* = 101)**	**χ^2(8)**	**Cramer's *V***
						240.24**	.39**
Private practice, alone	17.4	41.0	54.0	73.5	80.2		
Monodisciplinary group practice	30.3	27.2	20.5	14.2	10.9		
Multidisciplinary group practice	52.3	31.8	25.5	12.3	8.9		

Note. * p < .01, ** p < .001.

The type of work setting differed slightly between psychologists who were **self-employed as a primary occupation** and those who were self-employed as a **secondary occupation**, but the effect did not reach the threshold of a small effect size (see Table 101).

Table 101. Comparison of work setting between types of employment

Work setting (%)	Self-employment as a primary occupation (*n* = 624)	Self-employment as a secondary occupation (*n* = 993)	$\chi^2(2)$	Cramer's *V*
			10.92*	.08*
Private practice, alone	45.0	47.9		
Monodisciplinary group practice	20.5	25.0		
Multidisciplinary group practice	34.5	27.1		

Note. * $p < .01$, ** $p < .001$.

Thus, among psychologists who work with clients in a private practice, slightly less than half work alone in a private practice (46.8%), and slightly more than half work in a group practice (53.2%), of which more than half are multidisciplinary practices (29.9%). When including other work settings of self-employed psychologists, 26.5% work in a multidisciplinary group practice.

Psychologists who work in a group practice (monodisciplinary or multidisciplinary) are typically from the Flemish community, obtained an MSc in clinical psychology, and are younger than psychologists who work alone in a private practice.

3.6.6 Psychotherapeutic care

Group differences in participants who provide psychotherapeutic care

The LHCP defines psychotherapy as an activity – that is, psychotherapeutic care – and views psychotherapeutic care as a specialized form of psychological care. Participants with an MSc in psychology who indicated that they provided treatment to patients were asked whether this treatment included psychotherapeutic care, "as a coherent set of psychological treatment techniques, which goes beyond counselling or providing support". This was true for 2,216 participants, or 63.3% of participants with an MSc in psychology involved in client care (see Table 102).

Table 102. Prevalence of psychotherapeutic care in participants with an MSc in psychology

	In full sample of participants with an MSc in psychology (*n* = 4,120)	In those with jobs contributing to wellbeing or development (*n* = 3,677)	In those with jobs supporting individuals or their environment (*n* = 3,483)
Provision of psychotherapeutic care (%)	53.8	60.3	63.6

There were no differences in the provision of psychotherapeutic care between the different **language** communities. Thus, previously reported (small) differences between language communities in providing treatment in general were no longer significant when treatment was specified as the provision of psychotherapeutic care.

Table 103. Comparison between Flemish-speaking and French/German-speaking participants in terms of provision of psychotherapeutic care

	Flemish (*n* = 2,748)	French and German (*n* = 1,365)	*n*	$\chi^2(1)$	φ
Provision of psychotherapeutic care (%)	54.6	52.3	4,113	1.96	–.02

Note. *$p < .01$, ** $p < .001$.

Participants with an MSc in psychology who (also) worked in **self-employment** were more involved in the provision of psychotherapeutic care than those who worked only in salaried employment, with a strong effect size ($\varphi = –.53$). We previously reported similar (medium) differences in the provision of treatment. As with differences in treatment in general, this can be linked to the difference between psychologists in salaried and in self-employment in terms of direct client contact.

Table 104. Comparison of provision of psychotherapeutic care between participants with an MSc in psychology who only work in salaried employment versus participants with an MSc in psychology who also work in self-employment

	Self-employment (*n* = 1,941)	Only salaried employment (*n* = 2,020)	*n*	$\chi^2(1)$	φ
Provision of psychotherapeutic care (%)	82.5	30.4	3,961	1091.79**	–.53**

Note. *$p < .01$, ** $p < .001$.

Older individuals with an MSc in psychology appeared to be more involved the provision of psychotherapeutic care compared with their younger counterparts. Spearman correlation with age cohort of (self-) employed psychologists (<30 years; 30–39 years; 40–49 years; 50–59 years; 60+ years) showed a significant but small correlation between age cohort and provision of psychotherapeutic care (ρ = .14, p < .001).

Participants with an **MSc in clinical psychology** more often reported that they provided psychotherapeutic care than participants with an MSc in another area of psychology, with 64.3% of participants with an MSc in clinical psychology being providers of psychotherapeutic care (see Table 105).

Table 105. Comparison of provision of psychotherapeutic care between participants with an MSc in clinical psychology and participants with an MSc in another domain of psychology

	Other MSc in psychology (*n* = 1,009)	**MSc in clinical psychology (*n* = 3,111)**	***n***	**$\chi^2(1)$**	**φ**
Provision of psychotherapeutic care (%)	21.5	64.3	4,120	560.16**	.37**

Note. *p < .01 ,** p < .001. Other MSc in psychology = MSc in school or educational psychology, MSc neuropsychology, MSc Theory and research, MSc organizational psychology, non-listed option.

Thus, 60.3% (n = 2,216) of participants with an MSc in psychology who contribute to people's wellbeing (n = 3,677) indicated they provided psychotherapeutic care, which is quite similar to the 64.3% (n = 1,999) of participants with an MSc in clinical psychology (n = 3,111). Providers of psychotherapeutic care (n = 2,216) are typically self-employed and older than those who do not provide psychotherapeutic care. The vast majority of them (90.2%) have an MSc in clinical psychology. In the future, only those with an MSc in clinical psychology with an additional training will be allowed to provide psychotherapeutic care (as well as those with an MSc in Educational Sciences (Special education, disability studies, and behavioural disorders[85]) and Medicine with an additional psychotherapy training). In the next section, we look at further education in those who provide psychotherapeutic care related to the LHCP.

Further education

Figure 89 shows the distribution of short (<2 years) and long (>2 years) **training related to domains defined in the LHCP** in participants with an MSc in psychology who also provide psychotherapeutic care. **This shows that 57.6% of MScs in psychology who indicated that they currently provide psychotherapeutic care had followed an additional postgraduate psychotherapy training.** This percentage did not differ according to the language of the participant: in Flemish-speaking participants, 58.6% of participants with an MSc in psychology who provided psychotherapeutic care had completed a psychotherapy training; in French- and German speaking participants, the proportion was 55.3% ($\chi^2(1)$ =

[85] Orthopedagogiek/orthopédagogie Clinique.

2.16, $p > .05$). A subgroup of 24.1% had completed a postgraduate psychotherapy training as well as shorter training.

Of the 42.4% who provided psychotherapeutic care without having completed a psychotherapy training, one in three (13.5%) had completed a shorter training (e.g. training in the treatment of specific psychological problems). Close to 30% (28.9%) of the participants who provided psychotherapeutic care did not report having followed training courses related to treatment or psychotherapy. Differences between the language communities were not significant ($n = 2{,}215$, $\chi^2(3) = 5.57$, $p > .05$).

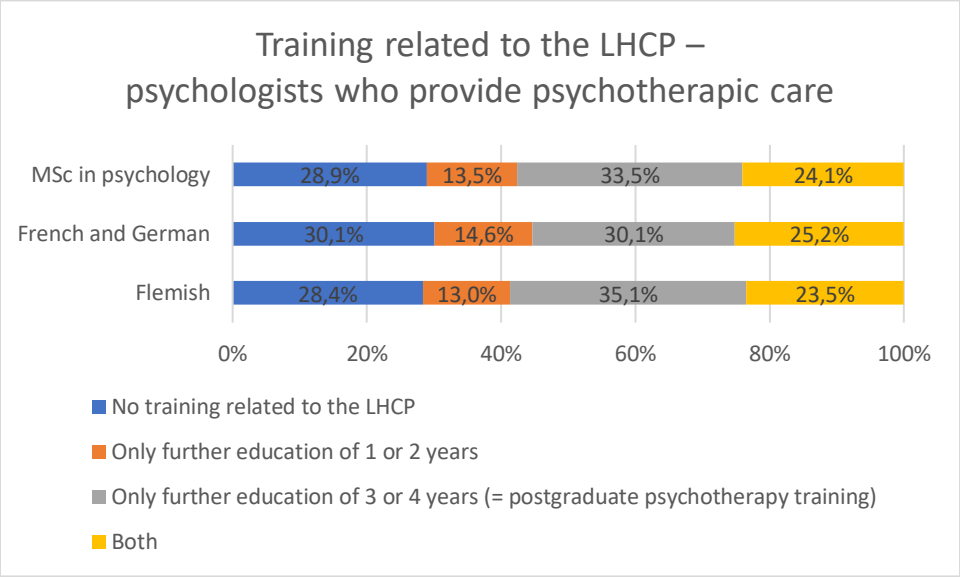

Figure 89. Further education in participants with an MSc in psychology who indicated they provide psychotherapeutic care.

We also looked at differences according to **type of MSc in psychology in participants who provided psychotherapeutic care**. Further education differed according to type of MSc in psychology, but this difference did not reach the threshold for a small effect-size ($\chi^2(3) = 12.16$, Cramer's $V = .07$, $p < .01$): 58.2% of participants with an MSc in clinical psychology who provided psychotherapeutic care had followed psychotherapy training compared with 51.6% of those with an MSc in another domain of psychology who provided psychotherapeutic care, and this difference was not significant ($\chi^2(1) = 3.51$, $p > .05$). More importantly, of participants with an MSc in psychology who indicated that they provided psychotherapeutic care, 52.5% ($n = 1{,}164$) had obtained an MSc in clinical psychology and additional psychotherapy training. **Thus, at the moment, only half of those with an MSc in psychology who provide psychotherapeutic care would meet the criteria set by the LHCP.**

Table 106. Relationship between type of MSc in psychology and further education in participants who indicated that they provided psychotherapeutic care

Type of additional training related to the LHCP (%)	Other MSc in psychology (*n* = 217)	MSc in clinical psychology (*n* = 1,999)	MSc in psychology (any type of MSc) (*n* = 2,216)
No postgraduate psychotherapy training	48.4	41.8	42.4
No further training related to the LHCP	29.5	28.9	28.9
Only short training (1 or 2 years)	18.9	12.9	13.5
Postgraduate psychotherapy training	51.6	58.2	57.6
Only further education of 3 or 4 years (= postgraduate psychotherapy training)	24.4	34.5	33.5
Both short (<2 years) and long (>2 years) training	27.2	23.7	24.1

Note. Continued education in psychological activities related to the LHCP includes postgraduate training and advanced masters related to prevention, diagnostics/assessment, counselling, and treatment of psychological or psychosomatic suffering.

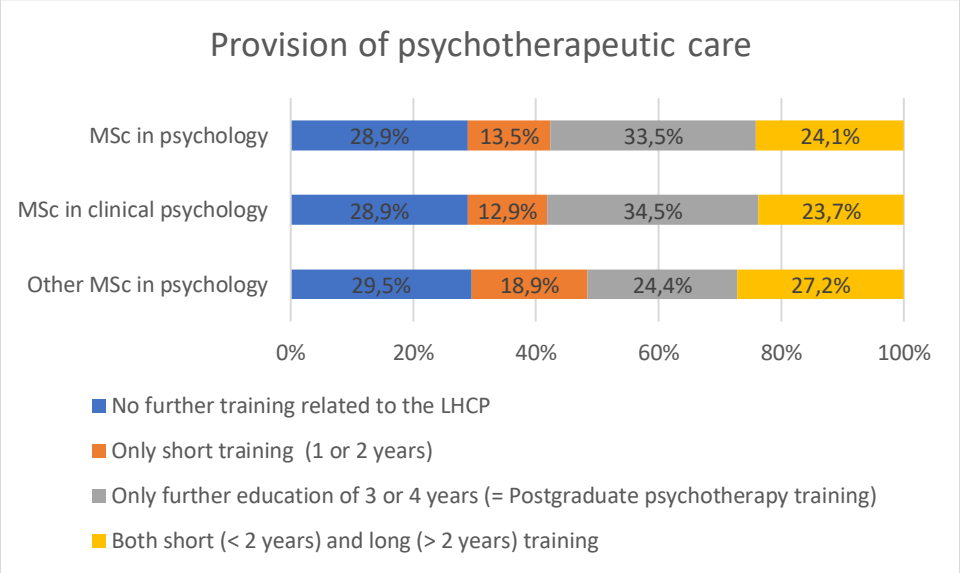

Figure 90. Further education in participants with an MSc in psychology who indicated that they provide psychotherapeutic care.

Hence, overall, about 60% of participants with an MSc in psychology who work with clients indicate that they provide psychotherapeutic care. The majority of them (90%) have an MSc in clinical psychology. This is in line with the LHCP, which describes the provision of psychotherapeutic care as a specialized type of treatment provided by certain healthcare professionals, such as clinical psychologists. However, according

to the law, the provision of psychotherapeutic care requires additional training of at least 70 ECTS and 2 years of full-time supervised practice, which tend to be covered by psychotherapeutic training programmes of 3 or 4 years. Only **58%** of participants with an **MSc in clinical psychology** who provide psychotherapeutic care had acquired additional training that would meet this standard, resulting in only **52.5%** of participants with an **MSc in psychology** who provide psychotherapeutic care having the required training to do this work according to the criteria set out by the LHCP (i.e. an MSc in clinical psychology and a postgraduate psychotherapy training)[86].

Profile of psychologists who provide psychotherapeutic care

We explored the characteristics of **psychologists who provide psychotherapeutic care** (*n* = 2,216). Previous analyses showed that, in general, psychologists who indicate that they provide psychotherapeutic have the following characteristics:

- 90.2% had obtained an MSc in clinical psychology
- 57.6% have completed a psychotherapy training
- 28.9% of self-employed psychologists work in a multidisciplinary group practice; 46.8% work alone in private practice
- 90.2% participate in interdisciplinary consultation (at least quarterly)
- 88.2 participate in intervision or supervision (at least once in the past year)
- 52.6% reported having had personal therapy
- 75.5% hold membership of a general professional association or a psychotherapy organization.

We compared these characteristics between **providers of psychotherapeutic care who had obtained a psychotherapy training (of at least 3 years, *n* = 1,276) and those who had not obtained such training (*n* = 940)**. Table 107 gives an overview of the characteristics of psychologists with or without psychotherapy training in terms of the type of MSc in psychology, interdisciplinary collaboration (either by consultations set up for this purpose or by work setting), type of employment, and CPD. This shows that psychologists who had obtained training in psychotherapeutic care (of at least 3 years) work somewhat less often in a multidisciplinary group setting when self-employed, combine salaried and self-employment somewhat more, are more engaged in CPD (i.e. they participate more in intervision or supervision), more often report having been in personal therapy (which is often required as part of psychotherapy training), and are more often a member of a professional or psychotherapy association.

[86] This percentage does not include participants with an MSc in Special education, disability studies, and behavioural disorders (as domain of specialization in psychology). When taking into account the 20 participants who provided psychotherapeutic care with this educational background, *n* = 8 obtained psychotherapy training. This would increase the percentage of participants with an MSc in psychology who provide psychotherapeutic care having the required training to do this work, with 0.36%.

Table 107. Characteristics of psychologists with and without psychotherapy training

Characteristic (%)	Without psychotherapy training (*n* = 940)	With psychotherapy training (*n* = 1,276)	$\chi^2(1)$	φ	*n*
Type of MSc in psychology					
MSc in clinical psychology	88.8	91.2	3.51	.04	2,216
Interdisciplinary collaboration					
Interdisciplinary consultation	89.5	90.6	0.76	.02	2,204
Work setting: alone in a private practice	41.3	43.7	0.89	.02	1,563
Work setting: multidisciplinary group practice	30.7	23.4	10.18*	–.08*	1,563
Type of employment[87]					
Only salaried employment	33.3	23.6	25.47**	–.11**	2,216
Self-employment as a primary occupation	27.7	26.7	0.24	–.01	2,216
Self-employment as a secondary occupation	39.0	49.7	24.76**	.11**	2,216
Continuing professional development					
Intervision or supervision	81.9	92.7	49.50**	.17**	1,798
Personal therapy	44.6	58.4	33.16**	.14**	1,798
Professional or psychotherapy association	64.4	83.6	97.82**	.22**	2,012

Note. *$p < .01$, ** $p < .001$.

Language differences between providers of psychotherapeutic care with and without psychotherapy training were not significant (n = 2,215, $\chi^2(1) = 2.16$, $p > .05$). Not surprisingly, psychologists who have completed a psychotherapy training are on average older than psychologists who do not (yet) have such an additional training ($\chi^2(4) = 188.48$, Cramer's $V = .29$, $p < .001$). Among psychologists without psychotherapy training who provide psychotherapeutic care, 34.6% are younger than 30 years, compared with only 10.8% of psychologists with a psychotherapy training. This also means that in the youngest cohort, more psychologists who report they provide psychotherapeutic care do this without specialized training (see Table 108). In each of the subsequent age cohorts, psychologists with a specialized training outnumber those who provide psychotherapeutic care without having done this training. Spearman

[87] This table focuses on the distribution of type of employment in psychotherapists with and without psychotherapy training. For the distribution of psychotherapy training per type of employment, see supplementary data in Appendix C.

correlations indicated a small linear relationship between age cohort and psychotherapy training (ρ = .21, p < .001).

Table 108. Age characteristics of participants who provide psychotherapeutic care with and without psychotherapy training (*n* = 2,216)

	Without psychotherapy training (*n* = 940) (%)	With psychotherapy training (*n* = 1,276) (%)
Age cohort		
<30 years	70.3	29.7
30–39 years	35.1	64.9
40–49 years	33.0	67.0
50–59 years	39.3	60.7
60+ years	33.6	66.4

Next, we compared characteristics of self-employed providers of psychotherapeutic care who worked **individually** in a private practice with those who worked in a private **group practice** (*n* = 1,425)[88]. As shown in Table 109, there were few differences. Those in individual practice are less involved in intervision or supervision and in interdisciplinary cooperation, and more often combine their self-employed job with a job in salaried employment. Other characteristics did not differ significantly.

[88] In this series of analyses, we excluded 138 participants who did not work in a private practice (they either worked in self-employment in a healthcare or social welfare institution, or chose the category "other work setting", which covered a variety of individual and group settings).

Table 109. Characteristics of providers of psychotherapeutic care in individual and group private practice

Characteristic (%)	Individually in a private practice (*n* = 668)	Group practice (mono- or multidisciplinary) (*n* = 757)	$\chi^2(1)$	φ	*n*
Education					
MSc in clinical psychology	84.1	92.9	27.16**	.14**	1425
Training in psychotherapeutic care	62.6	60.1	0.91	–.03	1425
Interdisciplinary collaboration					
Interdisciplinary consultation	80.6	93.5	54.01**	.20**	1422
Type of self-employment					
self-employment as a primary occupation	35.8	39.9	2.55	.04	1425
self-employment as a secondary occupation	64.2	60.1	2.55	.04	1425
Continued professional development					
Intervision or supervision	85.7	93.7	20.65**	.13**	1159
Personal therapy	60.8	53.3	4.63	–.08	1159
Professional or therapy association	80.3	84.4	3.87	.05	1314

Note. *p < .01, ** p < .001.

As in the larger sample of psychologists who worked with clients (see section 3.6.5), in the subsample of psychologists who provide psychotherapeutic care (*n* = 1,425) there were differences in work setting between the **language** communities and **age** cohorts. Flemish-speaking providers of psychotherapeutic care (*n* = 959) more often worked in a group practice (62.6%), whereas French- and German-speaking participants (*n* = 465) more often worked individually in a private practice (66.2%) ($\chi^2(1) = 104.33$, $\varphi = .27$, $p < .001$). Spearman correlations indicated a moderate linear relationship with age, indicating that older providers of psychotherapeutic care were more likely to work individually in a private practice ($\rho = .39$, $p < .001$).

Finally, we explored how many providers of psychotherapeutic care who worked in a private practice (*n* = 1,425) did not engage in any form of collaboration – that is, they were (a) working individually in a private practice, (b) did not participate in interdisciplinary consultation (“less than quarterly”), and (c) had not

participated in intervision or supervision in the past year. This resulted in 26 participants, or 1.9% of those who worked in private practice (*n* = 1,404, information was missing for 21 participants). Of these 26 participants, 17 participants (65.4%) did not have a psychotherapy training.

3.6.7 Conclusion on the work of psychologists related to the LHCP

The **tasks** attributed to the exercise of clinical psychology according to the LHCP –that is, prevention, diagnostic assessment, counselling, and treatment – appeared relevant to the majority of participants with an MSc in psychology. Prevention, diagnostic assessment, and treatment were part of the tasks of about **four out of five psychologists who worked in the clinical field** (i.e. they contributed to people's wellbeing or development and/or provided client care), and more than nine out of 10 provided counselling. The LHCP-defined tasks were even more relevant for those with an **MSc in clinical psychology**, for whom the LHCP has been designed, compared with those holding an MSc in another domain of psychology. Nonetheless, group differences in educational background were generally small; only differences in educational background pertaining to treatment showed a medium effect size.

When looking more closely at **educational background**, we see a different pattern in the exercise of LHCP tasks between participants with an MSc in clinical psychology, school or educational psychology, and neuropsychology on the one hand (69.5–92.8% are involved in the LHCP tasks), and participants with an MSc in theoretical psychology and organizational psychology on the other hand (30.8–73.3% are involved in the LHCP tasks), with the former providing each of these tasks more often than the latter. Group differences are lowest regarding prevention and strongest regarding treatment.

Previous sections showed a stronger focus on client care in **self-employed jobs** compared with salaried jobs. In terms of LHCP tasks, this translated into differences in the involvement in and frequency of **treatment**, which was also higher in self-employed jobs. Differences in prevention, diagnostic assessment, or counselling between types of employment were usually small. In self-employment, treatment is the most important LHCP task, with 86% reporting that they offer treatment often or very often. Of participants in salaried employment, 27% report never providing treatment in their main job, and counselling is the most important task, with 67% practising this task often or very often. Prevention is practised the least in both employment settings.

The LHCP requires clinical psychologists to invest in **activities** to ensure their **continued professional development (CPD)**. Participants with an MSc in psychology who were working at the time of the survey had engaged in several forms of CPD since graduation. We distinguished between (a) short training (conferences and short training courses), (b) participation in intervision or supervision, (c) personal therapy (either on a voluntary basis, or in a didactic context), and (d) teaching (in short or long training programmes). On average, participants with an MSc in psychology had taken part in two of these four categories since their graduation. The vast majority of participants with an MSc in psychology participated in CPD by means of short training (93.7%); CPD by means of teaching was least commonly reported (30.2%). All types of CPD were more prevalent among participants who worked in the clinical field (i.e. whose job(s) fostered wellbeing) compared with those with other types of jobs.

Since graduation, 71.4% of participants with an MSc in psychology had taken part in intervision or supervision. This prevalence was higher in participants with an MSc in clinical psychology (77.9%), participants working in a clinical field (i.e. “contributed to wellbeing or development in one of their jobs”) (76.1%), and self-employed participants (85.6%). Concerning psychologists working in the clinical field more specifically, 65.2% participated in **intervision** and 49.1% invested to some extent in receiving **supervision**. However, 23.9% never received intervision or supervision. Among those who had taken part in intervision or supervision in the past year, the median time between sessions was 2 months, although there was clear variability in the time between sessions, with a considerable group reporting attending intervision sessions and supervision at least every month.

About four out of 10 clinical psychologists had **received psychotherapeutic care** themselves since graduation, in either a personal or a didactic context: 40.8% of psychologists working in the clinical field (i.e. “contributed to wellbeing or development in one of their jobs”) and 43.3% of participants with an MSc in clinical psychology. The prevalence of engaging in personal therapy was higher in psychologists who provide psychotherapeutic care (52.6%) and in psychologists who (also) work in self-employment (51.3%). Furthermore, 59.2% reported **membership of a professional or psychotherapy organization**. Based on registration information provided by several professional organizations, membership is overrepresented in our sample. This is not unexpected, as professional associations helped to disseminate the survey.

Participants who provided client care (“supporting people and their environment”) reported on the frequency of **interdisciplinary consultation** (i.e. with a focus on coordinating patient/client care). This showed that 84.5% of psychologists involved in client care participate in interdisciplinary consultation at least quarterly (i.e. every 3 months). This prevalence is lower in psychologists who work only in self-employment (76.6%). The frequency of interdisciplinary consultation is higher in **salaried employment** (median = “weekly”) compared with self-employment (median = “monthly”). On the other hand, as shown earlier, psychologists in self-employment are somewhat more involved in intervision and supervision.

Of self-employed psychologists who work with clients in a **private practice**, slightly less than half work alone in a private practice (46.8%) and slightly more than half work in a group practice (53.2%), of which more than half are multidisciplinary practices (29.9%). When including other work settings of self-employed psychologists, 26.5% work in a multidisciplinary group practice. Psychologists who work in a group practice (monodisciplinary or multidisciplinary) are typically from the Flemish-speaking community, obtained an MSc in clinical psychology, and are younger compared with psychologists who work alone in a private practice.

Psychologists who reported that they provided treatment were asked whether this treatment included **psychotherapeutic care**, “as a coherent set of psychological treatment techniques, which goes beyond guidance or supportive conversations”. This was true for 60% of psychologists who work in the clinical field (i.e. they contribute to people’s wellbeing in at least one of their jobs) and 64% of participants with an MSc in clinical psychology. In our sample, the majority of participants who provide psychotherapeutic care (90%) have an MSc in clinical psychology; 57.6% have completed a psychotherapy training of 3 or 4 years; and 52.5% obtained both an MSc in clinical psychology and a psychotherapy training, and thus had the required training to provide psychotherapeutic care according to the LHCP.

Furthermore, psychologists who indicated that they provide psychotherapeutic care have the following **characteristics**:

- 28.9% of self-employed psychologists work in a multidisciplinary setting
- 90.2% participate in interdisciplinary consultation at least quarterly
- 88.2 had participated in intervision or supervision since graduation; 26.9% had not participated in intervision in the past year, and 43.8% had not taken part in supervision in the past year. When they did, the median time between sessions was 2 months
- 52.6% reported having received personal therapy
- 75.5% hold membership of a general professional association or a psychotherapy organization.

Thus, professional and personal development and interdisciplinary collaboration are more prevalent among psychologists who provide psychotherapeutic care than among those who do not provide this type of care. Participants who had obtained training in psychotherapeutic care were generally more involved in personal and professional development than providers of psychotherapeutic care without this type of training. Differences in interdisciplinary collaboration were not significant or did not reach the threshold for a small effect.

3.7. Career development of psychologists

3.7.1 First employment in the broad domain of psychology and educational sciences

Of the 3,794 participants who responded to the questions about their **first (self-)employment in the broad domain of psychology or educational sciences**, only 3.4% indicated that they either had not found a job or had not looked for one in the domain.[89] By contrast, more than half of participants reported finding a job within 3 months after graduation; only 16.3% of the participants reported that it took more than 1 year to find (self-) employment within the broad domain of psychology and educational sciences.

[89] The question was: "How long after graduating did you find salaried employment or became self-employed in the broad domain of psychology or educational sciences?".

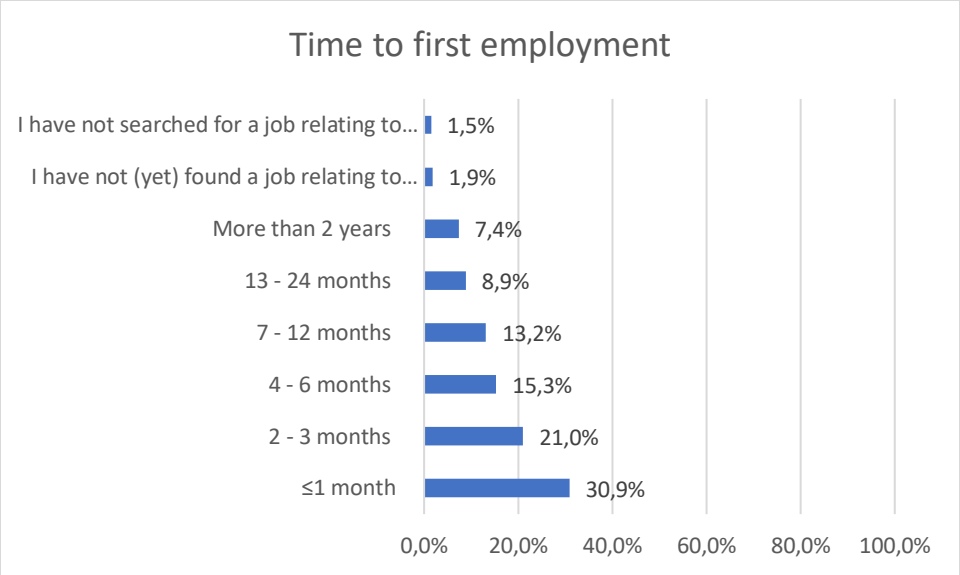

Figure 91. Time to first employment in the broad domain of psychology and educational sciences.

Psychologists who indicated that they either had not found a job or had not looked for a job in this domain were not included in the further analyses.

Of the 3,655 participants who provided information on the **duration** of their first job, 32.6% indicated that their first employment lasted less than a year.

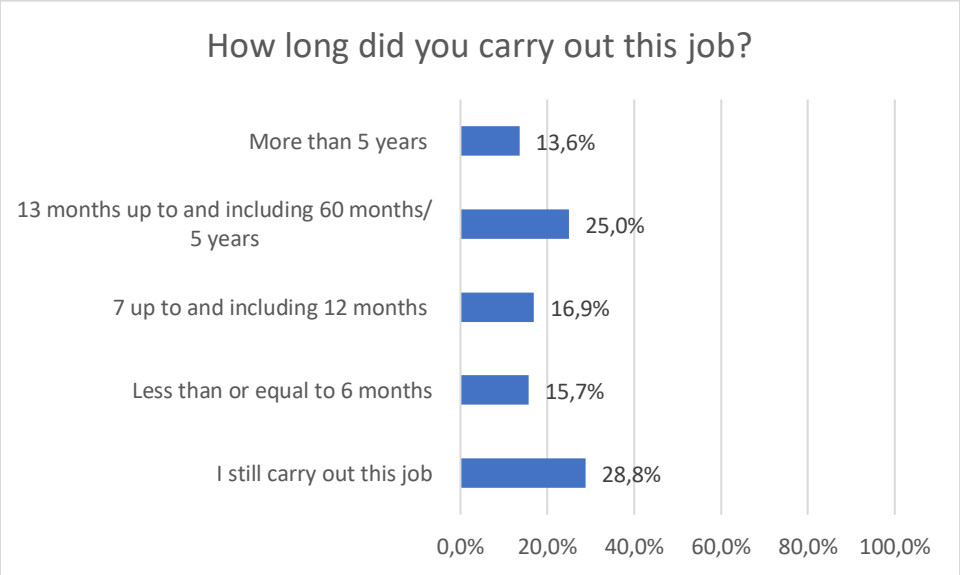

Figure 92. Duration of first employment.

Of the 3,655 participants who provided information on the **content** of their job, the vast majority (79.4%) indicated that this job related to (one of) their domain(s) of specialization in psychology (Figure 94).

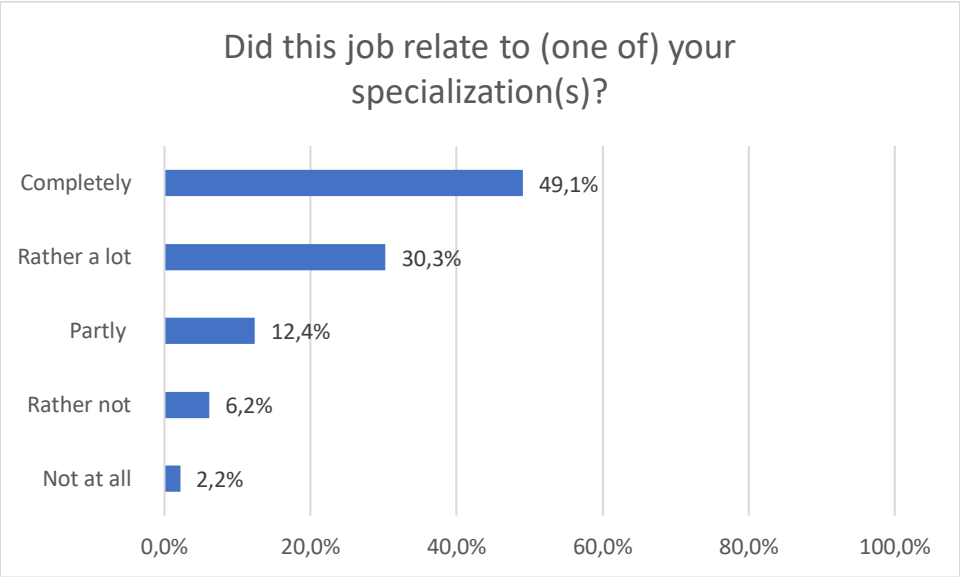

Figure 93. Relationship between content of first employment and domain of specialization.

Regarding **full-time and part-time employment** (*n* = 3,642 respondents), 90.3% of first jobs were salaried and 86.5% reported at least a half-time (self-)employment. Whereas 71.9% of respondents were satisfied with their employment percentage, 25.9% wanted to have a higher employment percentage. The level of remuneration was at the pay grade of a Master of Sciences (or a PhD) for 70.7% of respondents.

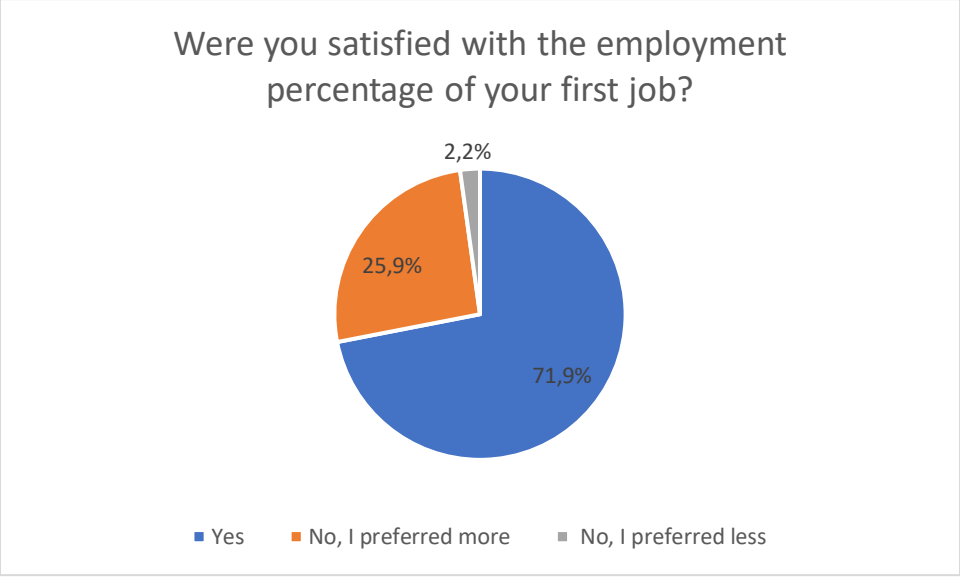

Figure 94. Satisfaction with full-time or part-time employment of first (self-)employment.

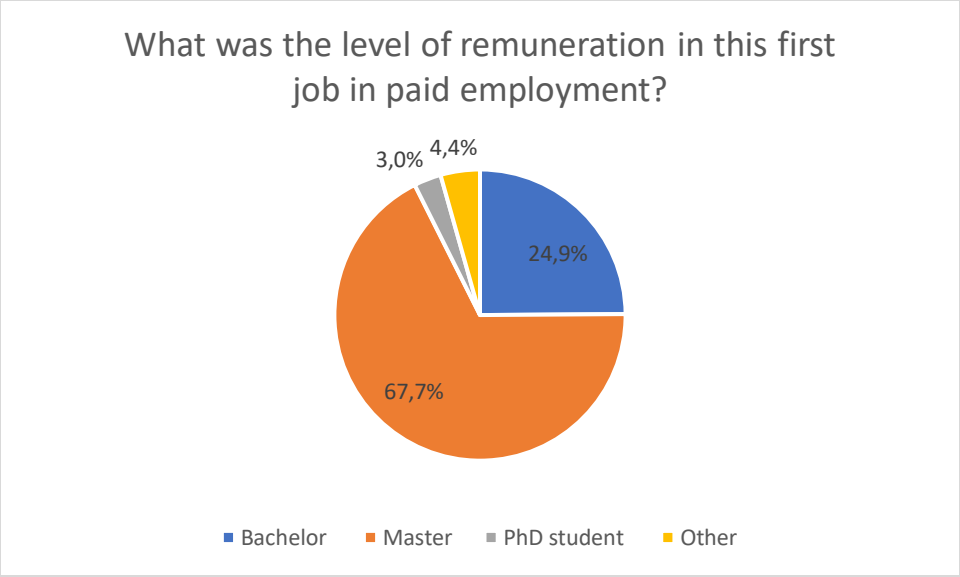

Figure 95. Remuneration level of first (self-)employment[90].

Of the 3,771 participants with an MSc in psychology who responded to these questions, 31.6% (n = 1,191) met all of the following **criteria**:

1. Found a job in salaried employment
2. Found this employment within 6 months
3. Were remunerated at the pay grade of a Master of Sciences (or as a PhD student)
4. This job was at least half-time employment
5. This job at least partly related to their domain(s) of specialization
6. This job lasted for at least 6 months.

The proportion of participants **meeting all six criteria** was slightly but significantly lower in participants with an **MSc in clinical psychology** (29.1%) compared with those with an MSc in another domain of specialization of psychology (39.5%) (n = 3,771, $\chi^2(1) = 34.69$, $\varphi = -.10$, $p < .001$). It was also lower in the French- and German-speaking subsample (27.5%) than in the Flemish-speaking subsample (33.5%) (n = 3,764, $\chi^2(1) = 13.51$, $\varphi = -.06$, $p < .001$), although this difference did not reach the threshold for a small effect-size.

We also compared the percentage of participants who met these criteria in the different **age** cohorts[91]. Except for participants between 50 and 59 years of age, of whom only 27.3% had found a job that met all the criteria within 6 months, older cohorts had a slightly higher chance of finding a job within 6 months

[90] Specifications of the category "other" were not at MSc level, and quite often referred to voluntary work (unpaid).

[91] For the relationship with age, we excluded psychologists younger than 25 (n = 134), as a large number of them indicated that they were still working in their first job (which resulted in an unusually large number of respondents who met the criteria), which biased the interpretation of age effects.

than younger cohorts (n = 3,634, $\chi^2(4) = 19.39$, $\varphi = .07$, $p < .01$), or at least reported that this had been easier for them at the start of their career.

Table 110. First job within 6 months per age cohort

	Age cohort				
	25–29 y	**30–39 y**	**40–49 y**	**50–59 y**	**≥60 y**
First employment within 6 months (%)	27.3	31.9	34.9	27.3	38.2
n of age cohort	810	1,343	806	455	220

Note. y, Years.

Participants were also asked whether they had worked in **jobs that were not related to the broad domain of psychology** and educational sciences **before** their first (self-)employment in this domain. Of the 3,584 respondents, 1,043 (29.1%) responded in the affirmative to this question, and almost two-thirds of them (66.2%) indicated that one of the reasons was that they had found it difficult to find a job in the domain of psychology and educational sciences (Figure 96).

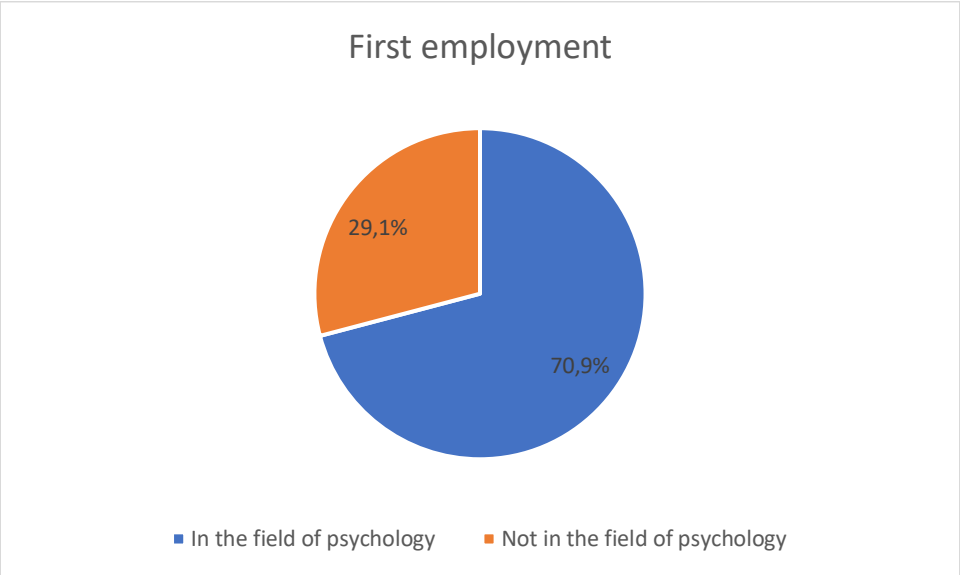

Figure 96. Field of work of first employment

There was a significant relationship between finding a job in the domain of psychology and educational sciences according to the above criteria and having had a job outside the field of psychology (n = 3,584, $\chi^2(1) = 156.59$, $\varphi = .21$, $p < .001$). The group who reported having a job outside the domain of psychology/educational sciences before finding a job in the domain (n = 1,043) were mostly participants who did not meet all six of the criteria listed above (n = 859; 82.4%). Furthermore, of the group of

participants who had not found a job that met these criteria (*n* = 2,402), 35.8% (*n* = 859) had accepted a job outside the domain (compared with 15.6% (*n* = 184) of those who had found an acceptable job within their domain within 6 months (*n* = 1,182)).

3.7.2 First self-employment

In our sample, 49.7% of employed psychologists were in self-employment (whether or not in combination with salaried employment). Psychologists who worked in self-employment at the time of the study were asked to provide information on their **reasons for being self-employed** and to report at what point in their career they **started to work in independent practice**. These questions were answered by 1,901 (of 2,058; 157 missing).

As shown in Figure 97, a wish for more **autonomy** was the main reason for participants to start working in independent practice, with 71.7% of those in independent practice indicating this reason. Greater **diversity** in tasks was the second most commonly mentioned reason (43.6%), followed by the importance of personal **recognition** and a better **work/life balance** (37%). It is noteworthy that 25.2% also indicated that they were offered the opportunity to join a group practice. Financial reasons were mentioned by only 18.9% of respondents as a reason to start working in independent practice.

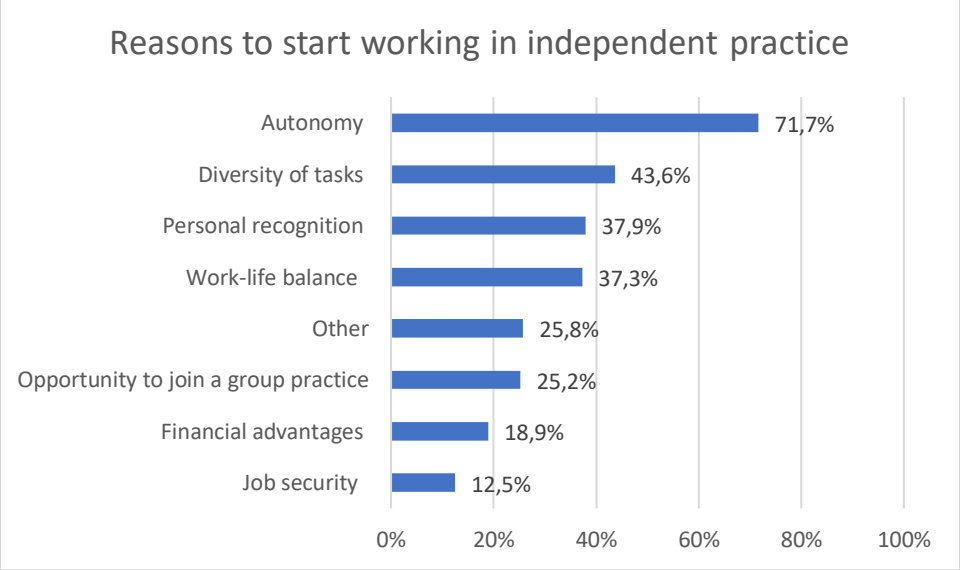

Figure 97. Reasons to start working in independent practice.

Figure 98 shows data on psychologists' **time and experience** before they started working in independent practice (whether or not in combination with a salaried job). Although more than half reported having had at least 2 years of experience in the broad domain of psychology and educational sciences (55.8%), 33% indicated that they had started in independent practice with less than 1 year of experience, and 24.4% had started in independent practice with only 6 months or less of work experience in the field.

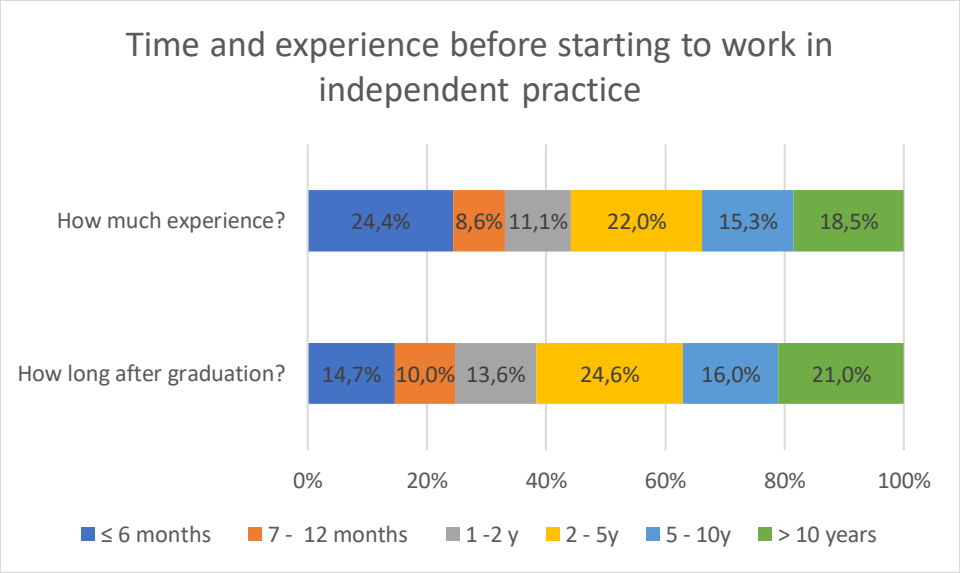

Figure 98. Time and experience before psychologists start working in independent practice.

Keeping in mind the reasons participants gave for starting in independent practice, follow-up analyses explored whether starting with less experience may be related to job security and/or to employment in a group practice (as more and more group practices emerge, and the support offered in terms of supervision and guidance in general in a group practice can potentially be similar to the support offered in a salaried employment setting).

There was indeed a relationship between **experience** in the broad domain of psychology and starting in independent practice as a way to ensure **job security**. Among participants who started in independent practice after either less than 6 months or less than 12 months of experience, 21.5% and 23.2%, respectively, indicated that job security was a reason for their choice to start in independent practice. For those with 1 year or more of experience, job security was mentioned much less frequently as a reason for starting in independent practice (i.e., between 5.7% and 13.3% (n = 1,902, $\chi^2(5) = 84.57$, Cramer's $V = .21$, $p < .001$). A similar linear trend was found for joining a group practice. Around 30% of psychologists with less than 2 years of experience indicated that the opportunity to join a group practice motivated them to start in independent practice, whereas this was true for only around 20% of psychologists with more than 2 years of experience (n = 1,902, $\chi^2(5) = 37.50$, Cramer's $V = .14$, $p < .001$).

Table 111. Motivation for starting in independent practice in relation to experience in the broad domain of psychology

	Experience in the broad domain of psychology					
	≤6 months	**7–12 months**	**1–2 years**	**2–5 years**	**5–10 years**	**>10 years**
Motivation (%)						
Job security	21.5	23.2	13.3	6.7	8.2	5.7
Group practice	32.5	31.7	29.9	21.7	22.3	16.5
n	464	164	211	419	291	352

3.7.3 Clinical experience

Participants were also asked to report on their **years of experience in different sectors** related to the broad domain of psychology and educational sciences since the start of their career. These responses provide more insight into (a) the overall variability in the career of individuals holding an MSc in psychology and (b) the extent to which psychologists have experience in the mental healthcare sector and related sectors, which is immediately relevant to the law on mental healthcare professions.

We also explored possible effects of the type of MSc in psychology (clinical orientation or other) held by participants, their language, and their age.

Experience per sector

Throughout their career, individuals with an MSc in psychology develop considerable experience in the **mental healthcare, education, social welfare, and healthcare sectors**, as can be expected. Between 42.0% and 68.6% of psychologists report at least some experience in (mental) healthcare, social work, or education and student counselling (see Table 112). The most relevant sector is mental healthcare; 68.6% of psychologists report at least some experience in this sector, and 51.5% have at least 2 years of experience in this sector. However, 31.4% of those with an MSc in psychology report having no experience in this sector. Around one in four psychologists have experience in the research sector (23.1%). The other sectors are relevant for less than 20% of psychologists (see also Figure 99).

Table 112. Work experience of participants with an MSc in psychology, per sector

	Experience (years)						
	0	**≤1**	**1–2**	**2–5**	**5–10**	**10–20**	**>20**
Sector (%)							
Social welfare, social services, and interest groups	52.5	9.7	6.8	9.6	8.8	8.6	3.9
Mental healthcare	31.4	9.8	7.3	13.6	13.4	14.5	10.0
Healthcare	58.0	7.7	5.7	7.9	8.9	7.9	3.9
Education, training, and student counselling	42.2	12.9	7.7	10.8	10.9	10.4	5.1
Forensic sector	85.3	4.1	2.1	2.3	2.7	2.6	0.8
Public administration/government	80.3	4.9	2.8	4.0	3.3	3.5	1.3
Commercial services	83.8	4.5	2.6	3.6	2.2	1.8	1.4
Industrial sector	93.2	1.8	0.7	1.2	1.1	1.2	0.9
Research sector	76.9	6.7	4.3	5.6	3.7	1.9	0.9
Leisure, culture, and sport	94.4	2.0	1.0	1.2	0.5	0.4	0.5

Note. Of the 4,304 psychologists who participated in this study, 3,584 answered this question; 177 were excluded based on the logic of the questionnaire as they had no work experience in the broad domain of psychology or educational sciences at the time of the survey; 543 were missing.

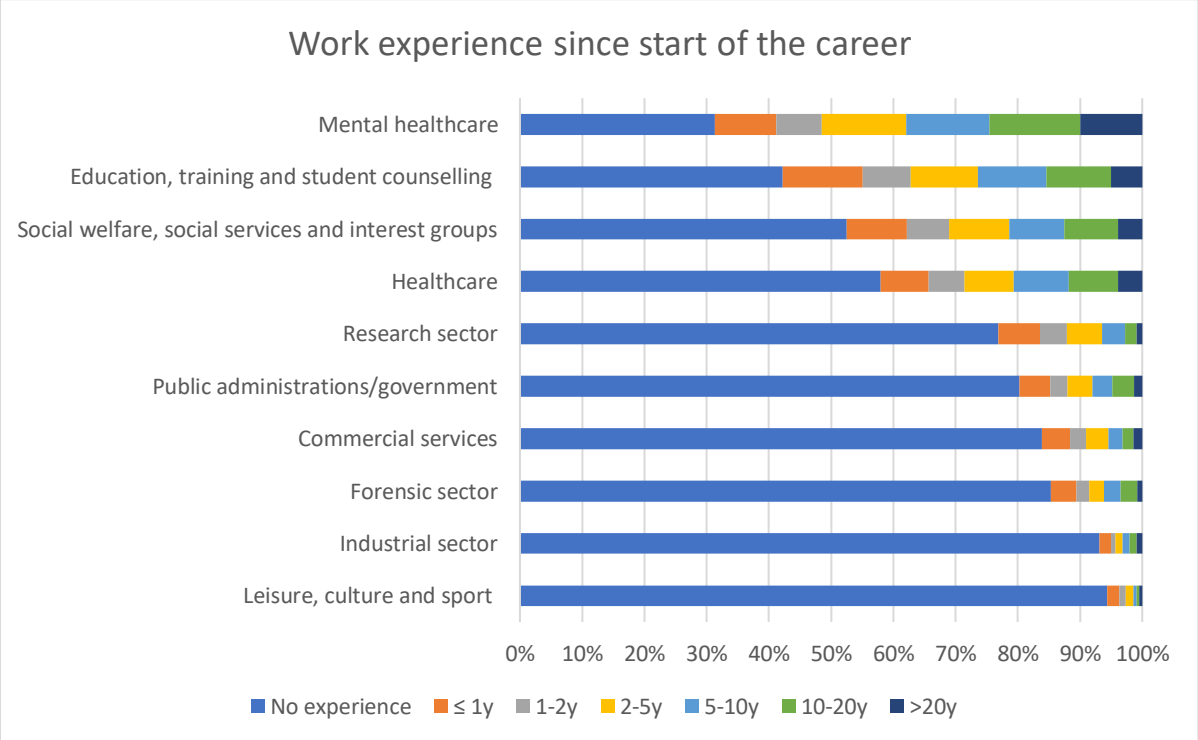

Figure 99. Work experience since the start of the career for participants with an MSc in psychology.

We repeated these analyses separately for those with an MSc in clinical psychology and those with an MSc in another domain of psychology. Table 113 shows the results for participants with an MSc in clinical psychology.

Table 113. Work experience of participants with an MSc in clinical psychology, per sector

	Experience (years)						
	0	**≤1**	**1–2**	**2–5**	**5–10**	**10–20**	**>20**
Sector (%)							
Social welfare, social services, and interest groups	49.1	10.5	7.1	10.1	9.7	9.4	4.2
Mental healthcare	20.3	10.9	8.5	16.1	15.7	17.2	11.4
Healthcare	53.3	8.6	6.3	8.7	9.8	8.8	4.5
Education, training, and student counselling	44.1	13.6	7.8	10.6	10.4	9.2	4.4
Forensic sector	83.2	4.8	2.5	2.8	2.8	3.1	0.8
Public administration/government	82.8	4.3	2.4	2.8	3.1	3.3	1.2
Commercial services	88.3	4.1	2.2	2.4	1.5	0.8	0.7
Industrial sector	96.3	1.5	0.5	0.6	0.4	0.5	0.3
Research sector	79.6	6.3	4.0	4.9	3.0	1.6	0.7
Leisure, culture, and sport	94.4	1.9	1.0	1.4	0.4	0.3	0.4

Note. Of the 3,253 participants in this study who held an MSc in clinical psychology, 2,748 reported on this question.

Similar to the general sample, throughout their career, participants with an **MSc in clinical psychology** most often have experience in the mental healthcare, education, social welfare, and healthcare sectors, ranging from 46.7% to 79.7% of those with an MSc in clinical psychology. Less than 20% of participants with an MSc in clinical psychology have work experience in the other sectors.

The overwhelming importance of the mental healthcare sector is more pronounced among participants with an MSc in clinical psychology compared with the general sample: 79.7% of those with an MSc in clinical psychology have experience in the mental healthcare sector, and 60.4% report at least 2 years of experience in this sector.

As shown in Table 114, the most relevant sector for participants with an **MSc in another domain of psychology** is education, with 64% of participants with an MSc in another domain of psychology reporting some experience in this sector. Next is social welfare, with 36.2% reporting some experience. Mental healthcare, research, commercial services, public administration, and healthcare follow closely, with between 26.7% and 32.4% reporting some experience in these sectors. All other sectors are relevant for 5.7–16.2% of participants with an MSc in another domain of psychology. Relevant to the LHCP, 26.0% of those with an MSc in another domain of psychology have at least 2 years of experience in the mental healthcare sector.

Table 114. Work experience of participants with an MSc in another domain of psychology, per sector

	Experience (years)						
	0	**≤1**	**1–2**	**2–5**	**5–10**	**10–20**	**>20**
Sector (%)							
Social welfare, social services, and interest groups	63.8	6.9	6.1	8.0	6.0	6.1	3.1
Mental healthcare	67.6	6.5	3.3	5.3	6.0	5.9	5.5
Healthcare	73.3	4.9	3.7	5.4	5.7	4.8	2.2
Education. Training, and student counselling	36.0	10.8	7.5	11.7	12.7	14.2	7.1
Forensic sector	92.3	2.0	0.6	0.6	2.5	1.0	1.0
Public administration/government	72.1	6.7	3.8	7.9	3.8	3.8	1.8
Commercial services	69.3	5.9	4.1	7.5	4.5	5.1	3.6
Industrial sector	83.8	3.0	1.6	3.0	3.5	3.3	2.6
Research sector	67.9	8.0	5.4	7.9	6.2	3.0	1.6
Leisure, culture, and sport	94.3	2.2	1.0	0.5	0.8	0.7	0.6

Note. Of the 1,051 participants with an MSc in another domain in psychology, 836 reported on this question.

Those with an **MSc in clinical psychology** more often reported having experience in the mental healthcare sector (medium effect size) and the social welfare, healthcare, and forensic sectors (small effect sizes). Participants with an MSc in another domain of psychology more often reported experience in education, public administration, commercial services, industry, and research, although all effect sizes were small (Table 115).

Table 115. Differences in work experience between participants with an MSc in clinical psychology and those with an MSc in another domain of psychology

	MSc in clinical psychology	MSc in another domain of psychology	$\chi^2(1)$	φ
Sector (%)				
Social welfare, social services, and interest groups	50.9	36.2	55.29**	.12**
Mental healthcare	79.7	32.4	662.38**	.43**
Healthcare	46.7	26.7	105.39**	.17**
Education, training, and student counselling	55.9	64.0	17.09**	–.07**
Forensic sector	16.8	7.7	43.19**	.11**
Public administration/ government	17.2	27.9	46.40**	–.11 **
Commercial services	11.7	30.7	171.27**	–.22 **
Industrial sector	3.7	17.0	176.37**	–.22 **
Research sector	20.4	32.1	49.21**	–.12 **
Leisure, culture, and sport	5.7	5.6	0.04	.00

Note. n = 3,584; * $p < .01$, ** $p < .001$.

In terms of the different **language communities**, throughout their career, **Flemish-speaking psychologists** most often have experience in the mental healthcare, education, social welfare, and healthcare sectors. Between 46.7% and 69.3% of Flemish psychologists have experience in these sectors (Table 116). The most relevant sector is mental healthcare: 69.3% of Flemish psychologists have experience in this sector, and 52.4% have at least 2 years of experience in this sector. Next is the research sector, with around 20% of psychologists having experience in this sector. The other sectors are relevant for less than one in five Flemish psychologists.

Table 116. Work experience of participants with an MSc in psychology, per sector, in the Flemish-speaking subsample

	Experience (years)						
	0	**≤1**	**1–2**	**2–5**	**5–10**	**10–20**	**>20**
Sector (%)							
Social welfare, social services and interest groups	53.3	9.8	6.9	9.9	8.8	8.4	3.0
Mental healthcare	30.7	9.6	7.2	14.4	13.7	15.2	9.1
Healthcare	62.6	7.0	5.3	7.3	7.6	7.1	3.1
Education, training and student counselling	46.1	12.9	6.8	10.2	10.1	10.0	3.9
Forensic sector	86.9	4.1	2.0	2.0	2.4	2.2	0.5
Public administration/ government	81.3	4.5	3.1	3.7	3.1	3.2	1.1
Commercial services	81.9	5.2	2.8	4.1	2.4	2.0	1.5
Industrial sector	93.0	1.8	0.8	1.2	1.1	1.2	0.8
Research sector	78.4	5.8	3.9	5.7	3.8	1.9	0.5
Leisure, culture and sport	95.0	1.7	0.9	1.0	0.5	0.4	0.4

Note. Of the 2,847 Flemish-speaking participants with an MScs in psychology, 2,459 reported on this question; 89 were excluded based on the logic of the questionnaire; 299 were missing.

In the **French- and German-speaking sample**, participants most often have career experience in the mental healthcare, education, social welfare, and healthcare sectors, similar to the Flemish-speaking participants. Between 49.3% and 67.3% of participants have experience in these sectors (Table 117).

Table 117. Work experience of participants with an MSc in psychology, per sector, in the French- and German-speaking subsample

	Experience (years)						
	0	**≤1**	**1–2**	**2–5**	**5–10**	**10–20y**	**>20**
Sector (%)							
Social welfare, social services, and interest groups	50.7	9.3	6.7	9.1	8.9	9.2	6.1
Mental healthcare	32.7	10.2	7.3	11.7	13.0	13.1	12.0
Healthcare	47.8	9.2	6.6	9.2	11.6	9.7	5.9
Education, training, and student counselling	33.8	13.0	9.4	12.2	12.7	11.3	7.6
Forensic sector	81.7	4.3	2.2	3.0	3.6	3.7	1.5
Public administration/ government	78.2	5.7	1.9	4.6	3.6	4.1	1.9
Commercial services	88.4	2.9	2.1	2.5	1.8	1.2	1.1
Industrial sector	93.6	1.7	0.5	1.1	1.2	1.0	1.0
Research sector	73.6	8.7	5.2	5.5	3.6	1.9	1.6
Leisure, culture, and sport	92.9	2.5	1.3	1.7	0.5	0.4	0.5

Note. Of the 1,448 French- and German-speaking participants with an MSc in psychology, 1,119 reported on this question; 88 were excluded based on the logic of the questionnaire; 241 were missing.

The most relevant sector is mental healthcare: 67.3% of the French- and German-speaking subsample have experience in this sector, and 49.8% have at least 2 years of experience in this sector. Next, around one in four French- and German speaking psychologists have experience in the research sector (26.4%), and one in five have worked in public administration (21.8%). The other sectors are relevant for less than 20% of this subsample.

Overall, the Flemish-speaking sample reported more career experience in commercial services, and the French/German-speaking sample reported more experience in healthcare, education, and the forensic and research sectors. All effect sizes were small, suggesting that differences were small at best.

Table 118. Differences in work experience between Flemish-speaking participants and French- or German-speaking participants

Sector (%)	Flemish	French/German	$\chi^2(1)$	φ
Social welfare, social services, and interest groups	46.7	49.3	2.09	.02
Mental healthcare	69.3	67.3	1.44	–.02
Healthcare	37.4	52.2	68.91**	.14**
Education, training, and student counselling	53.9	66.2	47.66**	.12**
Forensic sector	13.1	18.1	16.72**	.07**
Public administration/government	18.7	21.8	4.67	.04
Commercial services	18.1	11.6	24.20**	–.08**
Industrial sector	7.0	6.4	0.33	–.01
Research sector	21.6	26.4	10.03*	.05*
Leisure, culture, and sport	5.0	7.1	6.39	.04

Note. n = 3,578. *p < .01, ** p < .001.

Number of sectors

We calculated the **number of different sectors** in which psychologists worked.[92] On average, participants (n = 3,550) reported working in or having worked in three sectors throughout their career (M = 3.01, SD = 1.53). Only 17.0% reported they had worked in only one sector, 25.1% had worked in two sectors, and 24.2% had worked in three sectors. Around one in three participants reported having worked (or currently working) in more than three sectors (33.6%).

Participants with an **MSc in clinical psychology** reported working in more sectors (n = 2,719, M = 3.08, SD = 1.49) than those with an MSc in another domain of psychology (n = 831, M = 2.80, SD = 1.63) (t(1279.07) = 4.38, Cohen's d = 0.18, p < .001). **Flemish**-speaking participants (n = 2,438, M = 2.91, SD = 1.51) reported working in significantly fewer different sectors than French- and German-speaking participants (n = 1,106, M = 3.24, SD = 1.55) (t(3542 = –5.93, Cohen's d = –.22, p < .001). There was a small linear effect of **age**, indicating that older psychologists had worked in a larger number of sectors (r = .16, p < .001). This may reflect cohort or age differences or a combination of both.

Regression analyses of the number of sectors with educational background and language dummy coded (clinical psychology = 1, Flemish = 1), and age as covariate, equally pointed to effects of the type of MSc and language spoken, but again effect sizes were small ($F(3)$ = 50.60, R^2 = .04) (Table 119).

[92] Participants who did not indicate any of the listed sectors (n = 20) and those who indicated more than eight sectors (n = 14) were excluded. Thus, these analyses were run for 3,550 participants.

Table 119. Regression analysis of variation in work sectors

	Coefficients	
	β	***t***
Predictors		
Age	.15**	9.33**
Educational background (clinical psychology = 1)	.10**	6.04**
Sample (Flemish = 1)	–.10**	–5.66**

Note. *p < .01, **p < .001.

3.7.4 Conclusion on career development and trajectory

The **transition from education to work** is relatively smooth for 31.6% of those with an MSc in psychology. Approximately one in three psychologists reported that their **first employment in the field of psychology** is a salaried job related to their diploma, which started within a reasonable time of 6 months after graduation, that is remunerated in accordance with their level of education (i.e. MSc), with an employment of half-time or more, and with a contract of at least 6 months. The remaining two thirds of psychologists typically take longer to find such a job, and they may take on a job in another field in the meantime (which was the case for 35.8%), start working as a self-employed psychologist (14.7% of self-employed psychologists started self-employment within 6 months after graduation), or take a job with remuneration at the BA level or jobs involving brief contracts. Several of these findings may also be a deliberate decision. For example, a proportion of graduated students accepting a first job in the field of psychology at BA level can have the feeling they must gain more experience in the field before they consider themselves ready to work as a psychologist.

The transition from education to work appeared to be slightly **more difficult** for those with an MSc in clinical psychology; the proportion of participants with a first employment meeting the criteria described above, was slightly but significantly lower in participants with an MSc in clinical psychology (29.1%) compared with those with an MSc in another domain of specialization in psychology (39.5%). Further, there were small age-effects between those with an MSc in psychology; 27.3% of psychologists in the youngest cohort (younger than 30 years old at the time of the survey) reported that their first employment in the field of psychology met these criteria, whereas this was higher than 30% in most other cohorts.

Potential issues with the transition from education to work were also clear in other analyses: 29% of psychologists who work in the field of psychology did not start their career in this field, and two-thirds of them attributed this at least partly to perceived difficulties in finding a job in the field. Among psychologists who started working as a self-employed psychologist after less than 6 months of experience, 21.5% indicated that job security was at least part of the motivation for their choice. These results indicate psychologists perceive some difficulties in finding a job that meets their criteria.

Job security was not the only motivation to **start working in self-employment**. The main reason psychologists gave for starting to working in self-employment was a need for greater autonomy. More than 70% of psychologists in independent practice reported this as their reason to begin independent practice, followed by a wish for greater diversity in their work tasks (indicated by 44%). Psychologists who

worked in self-employment usually had at least 2 years of experience in the domain of psychology before they took the step to become self-employed. However, one in three self-employed psychologists started in independent practice after less than 1 year of experience, and one in four started after less than 6 months of experience in the field. These findings may be a cause for concern, as these self-employed psychologists may not have the same levels of support and supervision as those in salaried employment. On the other hand, at least a subgroup of psychologists who started to work in independent practice with less than 2 years of experience (close to one in three) indicated that they began to work in independent practice because of the opportunity to join a group practice. This specific motivation was stronger in the group with less experience compared with psychologists with more than 2 years of experience in the field. A group practice may have similar characteristics to a setting in salaried employment in terms of the availability of supervision and support in general.

Throughout their career, psychologists most often have **experience** in the mental healthcare sector and other sectors where mental healthcare is often offered – that is, education and student counselling, social welfare, and healthcare. This pattern emerged in the full sample of psychologists and in the subsamples based on language. Compared with the Flemish-speaking subsample, the French- and German-speaking subsample included a higher proportion of psychologists with at least some experience in healthcare or education.

Regardless of educational background, 68.6% of psychologists have experience in the mental healthcare sector, and 51.5% have at least 2 years of experience in this sector. These proportions are higher among psychologists with an MSc in clinical psychology: 79.6% of these psychologists have some experience in the mental healthcare sector, and 60.6% have at least 2 years of experience in this sector. In contrast, 38.1% of individuals with an MSc in another domain of psychology report some experience in the mental healthcare sector, with 26.3% of this group having at least 2 years of experience in the mental healthcare sector and 19.3% having at least 5 years of experience.

Most psychologists gain **experience in more than one sector**. On average, psychologists work in three different sectors in the course of their career, with older psychologists working in a greater number of different sectors. Psychologists with an MSc in clinical psychology work, on average, in more sectors than those with an MSc in another domain of psychology, and French- and German-speaking psychologists work, on average, in a larger number of sectors than Flemish-speaking psychologists. However, these differences are all small. As previous analyses on current employment showed that most jobs fit into one sector (when looking at jobs contributing to wellbeing and development, 87.0% for the main job in salaried employment and 77.5% for the main job in self-employment), it seems that psychologists build up experience in several jobs in different sectors. This also demonstrates the variation in the career of psychologists. It could also partly reflect the trajectory from salaried employment to self-employment (or to a combination of salaried and self-employment), as jobs in salaried employment are situated in a variety of sectors, whereas jobs in self-employment are usually situated in the mental healthcare sector. Apart from psychologists' decision to start working in independent practice, it is unclear whether these changes in jobs/sectors reflect a deliberate choice – for example, to broaden their experience by working in different sectors – or whether it reflects problems in the field of work (e.g., related to the availability of long-term employment or job stressors).

3.8. Challenges

3.8.1 Work pressure

Participants who were in (self-)employment were requested to indicate the amount of **work pressure** they experienced on a 0 to 10 rating scale. The average work pressure was 7.26 (*SD* = 2.10, *n* = 3,563). Thus, on average, psychologists indicate that their work pressure is quite high.

Work pressure was higher in psychologists who worked only in salaried employment (*n* = 1,860, *M* = 7.51, *SD* = 1.87) compared with psychologists who (also) worked in self-employment (*n* = 1,703, *M* = 6.97, *SD* = 2.29) (*t* (3,296.08) = –7.64, Cohen's *d* = 0.26, *p* < .001).

Work pressure did not differ according to type of MSc in psychology (clinical psychology versus another domain of psychology; M_D= –0.06, SD_D = 0.08, *t*(3,561) = –0.74, *p* >.05), or language (Flemish versus French or German; M_D= 0.00, SD_D = 0.08, *t*(1,931.48) = 0.02, *p* >.05). There was a small negative relationship with age (in years) (*n* = 3,562, *r* = –.09, *p* < .001), indicating that work pressure decreases somewhat as psychologists become older or build more experience. Work pressure was slightly lower in psychologists whose primary task was client care (*M* = 7.20, *SD* = 2.12) compared with psychologists who did not work primarily with clients (*M* = 7.36, *SD* = 2.10) (*t*(3,553) = 2.12, *p* < .05), although after correcting for age this differences did not reach the threshold for a small effect size (β = –.03).

3.8.2 Work–life balance

Working participants also reported on their **work–life balance** on a 0 to 10 rating scale, with higher scores indicating a poorer work–life balance. The average score was 4.55 (*SD* = 2.57, *n* = 3,563). Thus, on average, psychologists feel quite neutral towards work–life balance, and feel that their work and life are neither totally in balance nor totally out of balance.

Work–life balance was somewhat poorer in psychologists who worked in self-employment (*n* = 1,703, *M* = 4.68, *SD* = 2.62) compared with psychologists who worked only in salaried employment (*n* = 1,860, *M* = 4.44, *SD* = 2.52), but this difference did not reach the threshold for a small effect-size (*t* (3,561) = 2.75, Cohen's *d* = 0.09, *p* < .01).

Work–life balance did not differ according to type of MSc in psychology (clinical versus other; M_D= –0.13, SD_D = 0.10, *t*(3,561) = –1.24, *p* > .05) or language (Flemish versus French or German; M_D= 0.08, SD_D = 0.10, *t*(1,990.15) = 0.82, *p* > .05). There was a very small negative relationship with age (in years) (*n* = 3,562, *r* = –.06, *p* < .001), indicating that work–life balance improves somewhat as psychologists become older or build more experience, and this correlation did not reach the threshold for a small effect-size. Work–life balance did not differ between psychologists whose primary task was client care and psychologists who did not work primarily with clients (M_D= 0.0, SD_D = 0.09, *t*(3,553) = –0.13, *p* > .05).

There was a strong positive relationship between work–life imbalance and work pressure, indicating that work–life balance was poorer when work pressure was higher (*n* = 3,563, *r* = .52, *p* < .001).

3.8.3 Coping strategies

Participants reported on their **coping strategies when they experienced work pressure or problems with work–life balance** (*n* = 3,563; 14% missing cases). They could indicate multiple options. Figure 100 shows that the most prevalent responses were to seek help from colleagues, family, or friends (62.9%) and to use self-help strategies (55.6%)[93]. The majority of participants (63.4%) reported two or more different coping strategies. A minority (8.2%) indicated that they ignored feelings of work pressure or work–life imbalance; usually this was not their only strategy, as 62.0% of participants who reported to rely on this strategy also reported using other strategies. About one in four participants reported seeking professional help.

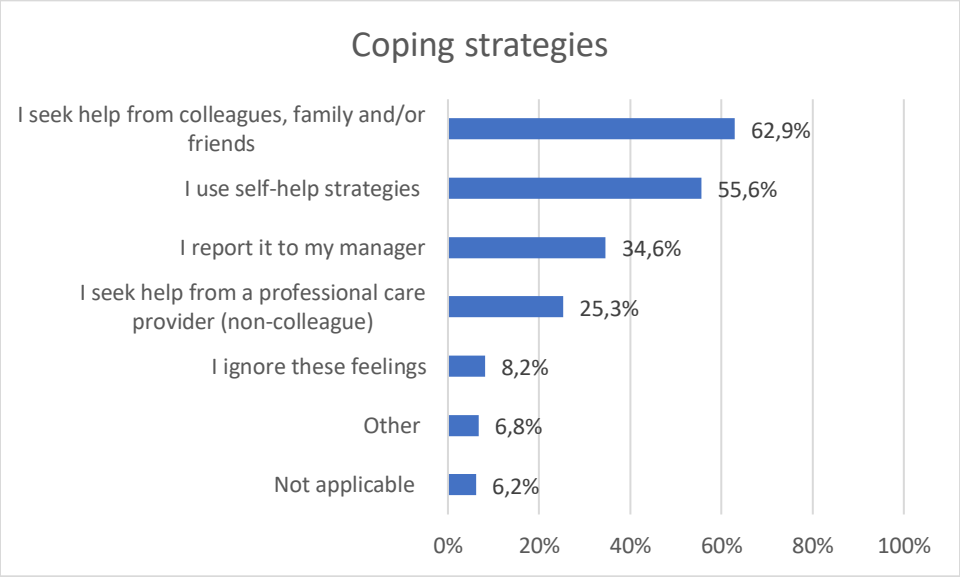

Figure 100. Coping strategies when dealing with work pressure or problems with work–life balance.

[93] We didn't provide examples of self-help strategies, but self-help strategies can include a variety of coping skills such as trying to change a problematic situation, reducing stress by exercise or relaxation techniques, venting one's emotions etc.

Figure 101. Coping strategies per language community when dealing with work pressure or problems with work–life balance.

Use of these coping strategies differed depending on the participants' **language** (Figure 101), although differences were usually small. Seeking professional help was a more common strategy among French- or German-speaking participants (n = 3,558, $\chi^2(1) = 70.70$, $\varphi = .14$, $p < .001$), whereas using self-help strategies ($\chi^2(1) = 200.10$, $\varphi = -.24$, $p < .001$), confiding in colleagues, friends, or family ($\chi^2(1) = 102.88$, $\varphi = -.17$, $p < .001$), and talking with a superior ($\chi^2(1) = 73.62$, $\varphi = -.14$, $p < .001$) were more often reported by Flemish-speaking participants. Participants from the French or German community also reported slightly more other, non-listed options ($\chi^2(1) = 18.26$, $\varphi = .07$, $p < .001$) or indicated that the need to seek help for these issues was not applicable to them ($\chi^2(1) = 44.06$, $\varphi = .11$, $p < .001$). On the other hand, previous analyses showed no significant differences between language communities in the amount of work pressure or work–life imbalance.

Type of employment also played a role in the coping strategies used, probably because some strategies are more readily available in settings in salaried employment. The results in Table 120 show that psychologists who (partially) work in salaried employment talk with their manager more often than psychologists who are fully self-employed and, to a lesser extent, more often confide in colleagues, family, or friends. Previous analyses showed that self-employed psychologists often work on their own in a private practice, and thus lack a context where a superior or a colleague is present in the work setting. On the other hand, self-employed psychologists more often seek professional help compared with psychologists who exclusively work in salaried employment.

Table 120. Coping strategies per type of employment when dealing with work pressure or problems with work–life balance

	Type of employment			Test statistics	
	Salaried employment (*n* = 1,860)	Self-employment as a primary occupation (*n* = 654)	Self-employment as a secondary occupation (*n* = 1,049)	$\chi^2(2)$	Cramer's *V*
Strategies (%)					
I ignore these feelings	8.80	9.30	6.50	6.00	0.04
I use self-help strategies	54.00	56.10	58	4.29	0.04
I report it to my manager	42.80	6.30	37.60	292.06**	0.29**
I seek help from colleagues, family, and/or friends	64.60	51.20	67.70	50.2**	0.12**
I seek help from a professional care provider (non-colleague)	18.20	31.50	34.20	107.37**	0.17**
Other	5.10	10.70	7.30	24.64**	0.08**
Not applicable	6.20	9.30	4.30	17.5**	0.07**

Note. *p < .01, **p < .001.

Spearman correlations showed that the tendency to turn to a manager (ρ = –.10) or a peer (colleague, friend, or family member) decreased with **age** (ρ = –.22), indicating that younger, less experienced psychologists use these strategies more often (p < .001). Other strategies did not show a linear trend with age.

3.8.4 Perceived challenges and concerns

We aimed to identify the perceived challenges in the domain of clinical psychology. To this end, we asked respondents working in Belgium how worried they were about several **structural and societal challenges, the implementation of new laws and decrees**, and concerning certain key **themes and topics related to the exercise of the profession of psychologist;** 2,755 psychologists who contributed to people's wellbeing or development responded to these questions[94]. Respondents rated their concerns on a 4-point rating scale ranging from 1 (*not at all concerned*) to 4 (*highly concerned*)[95].

[94] As psychologists active in the field of work of school or educational psychology received a specific set of questions on this topic, they are not included in these analyses.

[95] They could also indicate they did not know, or that the item was not applicable to them. This explains the variable number of respondents per item.

Structural and societal changes

As shown in Table 121, respondents indicated that their greatest concerns were about financial resources. They were also on average '**rather concerned '** (i.e., scale point close to 3.0) about pressure at work, waiting lists, and the complexity of the problems in their patients.

In addition, average scores were higher than 2.5 (indicating being **'more concerned than not'**) for the medicalization of the profession and the impact of social media use.

Perhaps somewhat surprisingly, respondents were on average **'rather not concerned'** about the digitalization of care, migration, extremism, and diversity in family composition.

Implementation of new laws and decrees

Psychologists raised the highest concerns about the LHCP. Mean scores indicated that they were **rather concerned** about the implications of this law (i.e., scale point close to 3.0).

They were **more concerned than not** (i.e., scale point higher than 2.5) about laws and decrees in the educational context, the European privacy legislation (the General Data Protection Regulation (GDPR)), the introduction of the classification system of the Institute for Job Classification (IFIC), and reorganization of primary care.

They were **rather not concerned** about the introduction of a disciplinary committee, the legal framework regarding insolvency[96], the obligatory professional liability insurance, and the law on patients' rights.

Important themes related to the profession of psychologist

Psychologists had the highest concerns about situations in which there was serious risk for the patient and/or the context (e.g. abuse or suicidal risk) and confidentiality of information (e.g., sharing information with other caregivers/the justice system), indicating that they were on average **rather concerned** about these themes. They were **more concerned than not** about the socioeconomic status of clients, policy on patients' rights, and professional liability. On average, psychologists were **rather not concerned** about the legal status of minors.

[96] Since 2017, liberal professions, including self-employed psychologists, are included as a profession in laws regarding insolvency, which include regulations to protect psychologists against financial risks associated with their professional activity. See https://www.compsy.be/nl/de-zelfstandig-psycholoog-en-insolventie or https://www.compsy.be/fr/le-psychologue-independant-et-linsolvabilite.

Table 121. Descriptive statistics of perceived challenges

	n	*M*	*SD*
Structural and societal challenges			
Pressure at work	2,635	3.14	0.83
Complexity of the problems one is confronted with	2,664	3.06	0.86
Financial resources	2,628	3.26	0.86
Waiting lists	2,442	3.12	0.98
Digitalization of healthcare	2,402	2.40	1.00
Medicalization of the profession	2,410	2.78	0.99
Migration (and thus more non-native newcomers, influx of refugees...)	2,449	2.24	0.91
Extremism and radicalization	2,402	2.41	1.00
Diversity in family composition	2,538	2.18	0.90
Use of (social) media (and thus internet and game addiction among children and young people, cyberbullying ...)	2,528	2.66	0.93
Further implementation of new laws and decrees			
Laws/decrees in the educational context (e.g. M Decree, Student Counselling, Support model, etc.)	2,009	2.67	1.03
Laws/decrees on youth care	1,693	2.46	0.99
Federal law on the practice of healthcare professions (LHCP/WUG/LEPSS)	1,889	2.88	0.96
European privacy legislation (General Data Protection Regulation, GDPR)	2,424	2.51	0.95
Introduction of the classification system of the Institute for Job Classification (IFIC)	1,711	2.72	1.15
Reorganization of primary care	1,984	2.69	0.99
Introduction of the disciplinary body	1,748	1.96	0.89
The legal framework regarding insolvency (financial risk of the professional activity)	1,548	2.26	1.09
Obligated profession liability insurance	2,020	1.84	0.91
Law on patients' rights	2,207	2.03	0.92
Important themes related to the profession of psychologist			
Confidentiality of information (e.g. sharing information with other caregivers/justice)	2,657	2.81	0.94
Professional liability	2,576	2.65	0.93
Situations with serious risk for the client and/or the context (e.g. abuse or suicidal risk)	2,527	2.99	0.87
Socioeconomic status of the clients (financial situation, refugee status...)	2,488	2.76	0.90
Legal status of minors	2,013	2.23	0.91
Policy on patients' rights	2,334	2.67	0.94

Note. Scale range: 1 (*not at all concerned*) to 4 (*highly concerned*); IFIC, Instituut voor Functieclassificatie/ l'Institut de Classification de Fonctions (IF-IC).

Group differences

We explored differences between the **language communities** and **types of employment** (salaried employment or self-employment) concerning perceived challenges.

Table 122 shows differences between the Flemish community (n = 1,924) and the French and German communities (n = 829). We limit the discussion to differences that reached the cut-off for a small effect (d ≥ .2).

In general, when differences occurred, participants from the French and German communities reported greater concerns than those from the Flemish community. Differences in concerns about societal changes were usually small, with the exception of concerns about waiting lists, which were markedly higher in the Flemish community. Differences in concerns about new laws and decrees were moderate to large, and differences in concerns about important themes related to the profession were small to moderate.

Compared with the French and German communities, the **Flemish community** reported more concerns about financial resources, waiting lists, the new job classification system (IFIC), and the legal framework regarding insolvency. Compared with the Flemish community, the **French and German communities** were more concerned about digitalization of health care, medicalization of the profession, the LHCP, the law on patients' rights, and all of the themes related to the profession of psychologist.

Table 122. Perceived challenges: Differences between language communities

	Flemish community *M* (*SD*)	**French and German communities *M* (*SD*)**	***t***	***df***	**Cohen's *d***
Structural and societal challenges					
Pressure at work	3.18 (0.79)	3.02 (0.92)	4.24**	1278.27	0.19**
Complexity of the problems one is confronted with	3.02 (0.85)	3.16 (0.86)	–3.83**	2660	–0.16**
Financial resources	3.34 (0.82)	3.07 (0.91)	7.61**	2624	0.33**
Waiting lists	3.33 (0.86)	2.57 (1.04)	16.83**	1066.16	0.82**
Digitalization of healthcare	2.32 (0.93)	2.62 (1.14)	–6.15**	1015.35	–0.31**
Medicalization of the profession	2.72 (0.95)	2.93 (1.05)	–4.47**	1215.44	–0.21**
Migration (and thus more non-native newcomers, influx of refugees...)	2.25 (0.87)	2.21 (1.02)	0.87	1123.85	0.04
Extremism and radicalization	2.37 (0.96)	2.51 (1.09)	–2.95*	1136.56	–0.14*
Diversity in family composition	2.13 (0.84)	2.30 (1.01)	–3.99**	1206.20	–0.19**
Use of (social) media (and thus internet and game addiction among children and young people, cyberbullying...)	2.62 (0.91)	2.73 (0.98)	–2.60*	1284.49	–0.12*

Further implementation of new laws and decrees					
Laws/decrees in the educational context (e.g. M Decree, Student Counselling, Support model, etc.)	2.71 (1.00)	2.59 (1.09)	2.35	1137.60	0.12
Laws/decrees on youth care	2.48 (0.98)	2.42 (1.01)	1.16	1691	0.06
Federal law on the practice of healthcare professions (LHCP/WUG/LEPSS)	2.78 (0.92)	3.07 (1.01)	–6.07**	1238.19	–0.30**
European privacy legislation (GDPR)	2.49 (0.92)	2.56 (1.02)	–1.58	1175.54	–0.07
Introduction of the classification system of the Institute for Job Classification (IFIC)	2.96 (1.09)	2.02 (1.02)	16.22**	806.53	0.87**
Reorganization of primary care	2.73 (0.94)	2.56 (1.09)	3.29*	821.67	0.18*
Introduction of the disciplinary body	1.95 (0.85)	2.00 (0.97)	–1.06	834.89	–0.06
The legal framework regarding insolvency (financial risk of the professional activity)	2.43 (1.10)	1.87 (0.93)	10.22**	1063.29	0.53**
Obligated profession liability insurance	1.79 (0.87)	1.93 (1.00)	–3.05*	1005.57	–0.16*
Law on patients' rights	1.84 (0.79)	2.46 (1.04)	–13.89**	1012.69	–0.72**
Important themes related to the profession of psychologist					
Confidentiality of information (e.g. sharing information with other caregivers/justice)	2.65 (0.91)	3.17 (0.91)	–13.56**	2653	–0.57**
Professional liability	2.47 (0.87)	3.05 (0.96)	–15.28**	2572	–0.65**
Situations with serious risk for the client and/or the context (e.g. abuse or suicidal risk)	2.93 (0.86)	3.13 (0.88)	–5.46**	1446.65	–0.24**
Socioeconomic status of the clients (financial situation, refugee status...)	2.68 (0.88)	2.95 (0.91)	–6.76**	1391.62	–0.30**
Legal status of minors	2.17 (0.85)	2.34 (1.00)	–3.71**	1056.95	–0.19**
Policy on patients' rights	2.58 (0.90)	2.87 (0.99)	–6.89**	2330	–0.31**

Note. *$p < .01$, **$p < .001$. Small effect: $d \geq 0.2$; medium effect: $d \geq 0.5$; large effect: $d \geq 0.8$.

Table 123 shows differences between psychologists working exclusively in **salaried employment** (*n* = 1,291) and **psychologists who are self-employed** either as a primary occupation (*n* = 578) or as a secondary occupation (*n* = 886). In general, effect sizes were either small or did not reach the threshold for a small effect size (i.e., $\eta^2 < .01$). Furthermore, concerns about themes related to the profession did not differ meaningfully between the two groups.

Concerns about work pressure were somewhat **higher in psychologists who worked in salaried employment** (either exclusively or in combination with self-employment) compared with psychologists who were self-employed as a primary occupation. The same pattern emerged for concerns about the complexity of problems, concerns about waiting lists, laws on youth care, and the introduction of IFIC.

Psychologists who worked in **self-employment**, either as a primary or a secondary occupation, reported greater concerns than psychologists who worked exclusively in salaried employment regarding financial resources, the digitalization of healthcare, medicalization of the profession, the LHCP, the reorganization of primary care, and legislation on insolvency. They were somewhat less concerned than psychologists in salaried employment about the law on patients' rights and the professional liability insurance.

Table 123. Perceived challenges: differences between salaried employment and self-employment

	Salaried employment *M* (*SD*)	**Self-employment as a primary occupation *M* (*SD*)**	**Self-employment as a secondary occupation *M* (*SD*)**	***F*†**	***df***	**η^2**
Structural and societal challenges						
Pressure at work	3.16 (0.79)	2.98 (0.92)	3.20 (0.83)	12.27**	(2, 2,632)	.01**
Complexity of the problems one is confronted with	3.16 (0.80)	2.82 (0.92)	3.07 (0.86)	29.41**	(2, 1,955.58)	.02**
Financial resources	3.16 (0.90)	3.34 (0.83)	3.35 (0.80)	15.81**	(2, 2,211.25)	.01**
Waiting lists	3.25 (0.94)	2.76 (1.02)	3.17 (0.96)	47.26**	(2, 1,897.99)	.04**
Digitalization of healthcare	2.22 (0.95)	2.52 (1.04)	2.56 (1.01)	31.17**	(2, 1,887.53)	.03**
Medicalization of the profession	2.59 (0.96)	2.95 (1.01)	2.93 (0.97)	38.51**	(2, 2,407)	.03**
Migration (and thus more non-native newcomers, influx of refugees...)	2.38 (0.93)	2.06 (0.89)	2.15 (0.87)	27.13**	(2, 1,976.18)	.02**

Extremism and radicalization	2.48 (1.01)	2.40 (1.03)	2.32 (0.97)	5.69*	(2, 1,848.31)	.01*
Diversity in family composition	2.19 (0.90)	2.19 (0.94)	2.18 (0.88)	0.02	(2, 2,535)	.00
Use of (social) media (and thus internet and game addiction among children and young people, cyberbullying...)	2.64 (0.92)	2.75 (0.95)	2.62 (0.92)	3.36	(2, 2,525)	.00
Further implementation of new laws and decrees						
Laws/decrees in the educational context (e.g. M Decree, Student Counselling, Support model, etc.)	2.67 (1.04)	2.64 (1.04)	2.69 (1.01)	0.26	(2, 2,006)	.00
Laws/decrees on youth care	2.48 (1.00)	2.32 (0.99)	2.52 (0.98)	4.64	(2, 1,690)	.01
Federal law on the practice of healthcare professions (LHCP/WUG/LEPSS)	2.70 (0.98)	3.01 (0.96)	3.01 (0.90)	24.97**	(2, 1,648.72)	.03**
European privacy legislation (GDPR)	2.47 (0.94)	2.56 (0.98)	2.53 (0.95)	1.91	(2, 2,421)	.00
Introduction of the classification system of the Institute for Job Classification (IFIC)	2.77 (1.13)	2.26 (1.13)	2.88 (1.12)	33.35**	(2, 1,708)	.04**
Reorganization of primary care	2.51 (0.97)	2.78 (1.01)	2.83 (0.96)	23.88**	(2, 1,981)	.02**
Introduction of the disciplinary body	1.89 (0.85)	1.99 (0.93)	2.02 (0.98)	3.84	(2, 1,745)	.00
The legal framework regarding insolvency (financial risk of the professional activity)	2.13 (1.03)	2.30 (1.11)	2.37 (1.11)	7.44*	(2, 1380.25)	.01*
Obligated profession liability insurance	2.03 (0.94)	1.72 (0.90)	1.74 (0.87)	26.01**	(2, 2,017)	.03**
Law on patients' rights	2.10 (0.90)	1.98 (0.94)	1.97 (0.91)	5.09*	(2, 2,204)	.01*

Important themes related to the profession of psychologist						
Confidentiality of information (e.g. sharing information with other caregivers/justice)	2.86 (0.94)	2.76 (0.95)	2.76 (0.92)	3.79	(2, 2,654)	.00
Professional liability	2.70 (0.94)	2.63 (0.96)	2.61 (0.90)	2.58	(2, 2,573)	.00
Situations with serious risk for the client and/or the context (e.g. abuse or suicidal risk)	3.00 (0.88)	2.98 (0.90)	2.97 (0.83)	0.28	(2, 2,524)	.00
Socioeconomic status of the clients (financial situation, refugee status...)	2.79 (0.90)	2.74 (0.92)	2.74 (0.89)	0.98	(2, 2,485)	.00
Legal status of minors	2.23 (0.91)	2.25 (0.93)	2.20 (0.88)	0.37	(2, 2,010)	.00
Policy on patients' rights	2.61 (0.96)	2.73 (0.96)	2.70 (0.90	3.27*	(2, 1918.14)	.00

Note. *$p < .01$, **$p < .001$. †When the assumption of homogeneity of variance was violated we report the robust Brown-Forsythe *F*-ratio for these variables. Small effect: $\eta^2 \geq .01$; medium effect: $\eta^2 \geq .06$; large effect: $\eta^2 \geq .14$.

3.8.5 Sources of support

Participants were asked to specify **where they looked for information or help to deal with difficult themes or challenges in their job**; 2,747 psychologists who contributed to people's wellbeing or development responded to this question. They could indicate multiple sources of support.

As shown in Figure 102, **colleagues** were the most important source of support and information, with 77.2% indicating that they turned to their colleagues in relation to professional issues or challenges. Close to 40% mentioned professional literature and intervision or supervision, while nearly 35% turned to the Code of Ethics and/or the Commission of Psychologists for help. Other reported sources of support included seeking further training on the topic or turning to a professional organization or their manager/employer. A small group (3.8%) did not look for support regarding these issues, and 6.8% reported that the question did to apply to them.

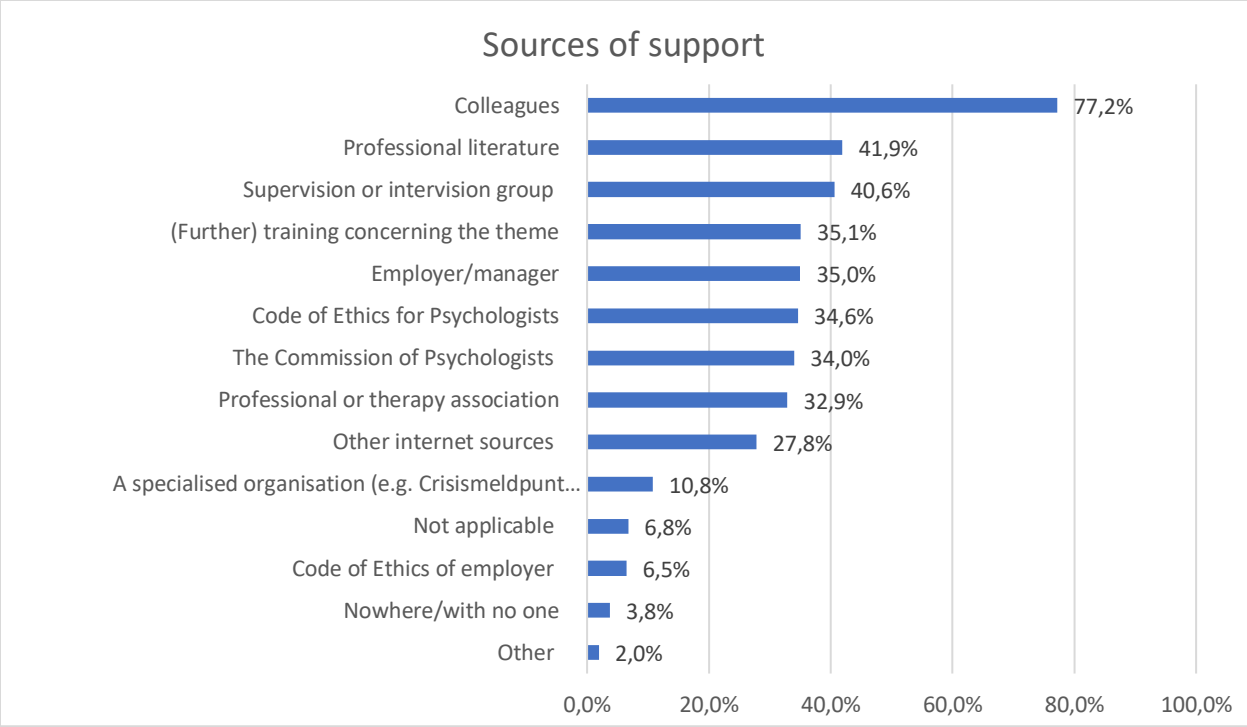

Figure 102. Sources of information or support to deal with difficult professional themes or challenges.

We compared these sources of support between the **language communities**. In general, differences were (very) small, and indicated that a higher percentage of psychologists in the Flemish community turned to the source of support in question compared with the French and German communities. In both language communities, colleagues were the most important source of support. Noteworthy, the Commission of Psychologists and the Code of Ethics for Psychologists were more important sources for the French and German communities (coming second after colleagues), compared with the Flemish community.

Table 124. Perceived challenges: Differences between language communities

Sources of support (%)	Flemish community (*n* = 1,920)	French and German communities (*n* = 827)	$\chi^2(1)$	φ
Not applicable	6.5	7.4	0.69	.02
Nowhere/with no one	3.4	4.7	2.81	.03
Professional literature	43.6	38.1	7.19*	–.05*
(Further) training concerning the theme	37.7	29.0	19.38**	–.08**
Colleagues	80.2	70.1	33.31**	–.11**
Employer/manager	37.7	28.9	19.48**	–.08**
Supervision or intervision group	41.8	37.7	4.02	–.04
Professional or psychotherapy association	34.4	29.7	5.48	–.05
Code of Ethics for Psychologists	31.0	43.0	37.13**	.12**
Code of Ethics of employer	6.6	6.2	0.19	–.01
The Commission of Psychologists	31.0	41.1	26.38**	.10**
A specialized organization (e.g. Crisis Reporting Centre for Integral Youth Help, Trust Centre for Child Abuse, etc.)	14.6	2.2[97]	92.00**	–.18**
Other internet sources	26.6	30.6	4.56	.04
Other	2.1	1.9	0.06	–.01

Note. * $p < .01$, ** $p < .001$.

We also explored differences in sources of support depending on **type of employment**, and found small to medium differences regarding several sources of support. We discuss the differences that reached the threshold for a small effect size (see Table 125).

There were differences between psychologists who worked exclusively in salaried employment and those who were self-employed to some extent. As can be expected, **psychologists in salaried employment**, whether or not this was in combination with self-employment, more often turned to their manager or employer for help, or consulted the Code of Ethics of their employer, compared with psychologists who worked only in self-employment. **Self-employed psychologists**, on the other hand, sought support through supervision or intervision, turned to a professional or therapy association, and consulted the Code of Ethics for Psychologists or the (website of) the Commission of Psychologists, to a larger extent than psychologists who worked in exclusively salaried employment.

[97] This low percentage possibly reflects a translation issue: the French translation of this item may have given rise to misunderstandings: “Une organization spécialisée (par ex. la ligne d’urgence d’Integrale Jeugdhulppoint [aide intégrale à la jeunesse], Vertrouwenscentrum Kindermishandeling [centre de confiance pour enfants maltraités], etc.)”.

Table 125. Sources of support: differences between salaried employment and self-employment

Sources of support (%)	Salaried employment (*n* = 1,151)	Self-employment as a primary occupation (*n* = 512)	Self-employment as a secondary occupation (*n* = 787)	$\chi^2(2)$	Cramer's *V*
Not applicable	9.4	6.9	2.8	36.17**	.12**
Nowhere/with no one	4.0	2.9	4.0	1.42	.02
Professional literature	40.0	44.5	43.1	4.09	.04
(Further) training concerning the theme	37.0	33.4	33.5	3.62	.04
Colleagues	76.5	72.1	81.5	18.15**	.08**
Employer/manager	48.4	8.7	32.7	279.36**	.32**
Supervision or intervision group	30.7	50.6	48.3	97.61**	.19**
Professional or therapy association	17.4	49.9	44.5	269.91**	.31**
Code of Ethics for Psychologists	23.7	49.2	41.1	138.87**	.23**
Code of Ethics of employer	8.9	1.0	6.4	41.13**	.12**
The Commission of Psychologists	20.9	49.4	43.1	191.33**	.26**
A specialized organization (e.g. Crisis Reporting Centre for Integral Youth Help, Trust Centre for Child Abuse)	10.4	11.3	11.2	0.44	.01
Other internet sources	26.4	28.4	29.6	2.78	.03
Other	1.4	3.3	2.1	7.22	.05

Note. * $p < .01$, ** $p < .001$.

3.8.6 Conclusion on challenges

We explored several challenges in the field of work of psychologists. First, it appears that **work pressure** is on average quite high, especially for psychologists who work in salaried employment, and participants expressed their concerns about work pressure. Work pressure was perceived to be higher when work–life balance was less optimal, but in general, psychologists judge their work–life balance to be fairly good.

To contextualize these findings, we compared them with information on work pressure and work-life balance in other job types and sectors. In Flanders, work circumstances of employees are monitored every 3 years[98] by the "Stichting Innovatie & Arbeid", which includes an assessment of work pressure and work-

[98] See https://www.serv.be/stichting/publicatie/werkbaarheidsmonitor-2019-werknemers

life balance. According to the report of 2019, work-life balance is problematic for 12.8% of employees in Flanders, and work pressure is problematic for 37.6% (Bourdeaud'hui, Janssens, & Vanderhaeghe, 2019). Thus, work-life balance seems to be evaluated as less problematic in general than work pressure. Looking at different types of jobs, no separate results were reported for psychologists, but healthcare workers, for instance, report relatively high levels of work pressure (42.7% is categorized as problematic, compared with 37.6% in the general population). The same is true when we focus on the jobs in the "human health and social work activities" sector (41.7% problematic) and in the education sector (41.1% problematic). With regard to work-life balance, this is again more problematic for individuals with a job as healthcare worker or with a teaching position (18.4%, compared with 12.8% in the general population) and those in the education sector (23.7%), but not in the "human health and social work activities" sector (10.1%). Our own analyses did not show group differences in work-life balance between clinical psychologists and other types of psychologists.

When asked about **concerns about societal changes, implementation of new laws, and specific themes related to the profession** of psychologist, psychologists raised the greatest concerns, aside from work pressure, about the availability of financial resources, waiting lists, the complexity of problems they are confronted with, the LHCP, and patient safety and confidentiality issues. Concerns about financial resources and waiting lists were more pronounced in the Flemish community, whereas the LHCP and patient safety and confidentiality issues seemed to be of greater concern in the French and German communities. As noted, psychologists in salaried employment expressed more concerns about work pressure, but also about waiting lists and the complexity of the cases they deal with, compared to those in self-employment. Self-employed psychologists, on the other hand, indicated to be more concerned than their colleagues in salaried employment about financial resources and the LHCP.

Most psychologists try to deal with work pressure in several ways, and they also use several **strategies** when dealing with other professional concerns and challenges. Peers (colleagues, friends, and family) are the main source of support, more so in participants from the Flemish community and in younger psychologists, compared with participants from the French/German speaking community and older psychologists. When dealing with work pressure, psychologists from the French and German communities more often seek professional help compared with Flemish psychologists. Furthermore, the Code of Ethics and the Commission of Psychologists are more relevant sources of information and support in the French and German communities, as well as in self-employed psychologists. Psychologists who work in salaried employment more readily have the opportunity to turn to a manager or employer when they have professional issues both with regard to work pressure and professional challenges and concerns.

Chapter 4: Discussion

This report is part of a broader study concerning the provision of psychological healthcare in Belgium. The present report focuses on the profile of psychologists and the provision of mental healthcare as offered by (clinical) psychologists in Belgium. This report presents results of a large-scale web survey on the professional activities and education of psychologists and educationalists/pedagogues in Belgium, focusing on participants with an MSc in psychology. A separate report presents the results on the field of work of school and educational psychology (Spilt et al., 2021). A future study will investigate mental healthcare needs in the Belgian population, focusing on the extent to which mental healthcare needs are met ("met needs") and whether mental health care is appropriately deployed for those who really need it ("unmet needs" and "overmet needs").

In this chapter, we summarize the key findings of this study, discuss its main limitations and propose directions for future research.

4.1. The population of psychologists in Belgium

4.1.1 Introduction

Based on information from the Belgian ministries of education and the Belgian universities, the total number of individuals with an MSc in psychology in Belgium in the working age population ranges between 38,481 and 40,167. Of these, at the time of the study, 14,245 were registered with the Belgian Commission of Psychologists and 17,295 indicated they worked as a psychologist according to the Labour Force Survey (LFS). Hence, the 4,304 participants in the current study represented approximately 11% of the total estimated population of those with an MSc in Psychology. The results of this study indicate that the **majority of participants with an MSc in psychology work in the broad field of psychology and support people's wellbeing** in their job. This shows that a greater number of workers in Belgium have a background in psychology than is captured or "visible" in official registrations of psychologists in Belgium, such as the LFS or the Commission of Psychologists (see 3.1.1). On the other hand, official numbers are in line with the Western-European average, as reported by the European Commission (2016); excluding outliers, the concentration of (registered) psychologists in Western-Europe varies between 100 and 150 per 100,000 inhabitants. Based on the number of individuals working as a psychologist according to the LFS[99], and the number of inhabitants according to Statbel[100], the concentration of psychologists in Belgium was 152 per 100,000 inhabitants in 2018.

[99] See https://statbel.fgov.be/nl/themas/werk-opleiding/arbeidsmarkt/beroepen-belgie#figures

[100] See https://statbel.fgov.be/nl/themas/bevolking/structuur-van-de-bevolking#panel-13. The number of inhabitants registered on 01/01/2018 was used.

4.1.2 The sociodemographic and employment profile of psychologists

Population statistics show that, overall, those with an MSc in psychology and registered psychologists are a **young** group of people, with up to almost 60% being younger than 40 years old. The vast majority (i.e., 93.4%) is born in Belgium, and is **female** (83%). The Flemish and French region each have a similar number MScs in psychology and registered psychologists. Although this study was not designed as a population-representative study, participants showed similar sociodemographic features (age, gender) as those in the population. Also, the fact that 66% of the participants were from the Flemish speaking community reflects the distribution of the Belgian population in general. Approximately 65–70% in the population of those with an MSc in psychology specialize in clinical psychology, approximately 25% specialize in social/organizational psychology, and less than 5% specialize in research. In the current sample, those with a specialization in clinical psychology were overrepresented. Importantly, the majority of MScs in psychology **continue** their training after graduation, with 57.4% following at least one additional training of at least 1 year (see 3.4.1).

In the current sample, 96.3% of MScs in psychology were employed (in salaried employment or in self-employment). On average, they worked **90% of a full-time equivalent**, with the majority working either four days out of five in a regular week or working full-time. Furthermore, the vast majority (91.6%) of those with an MSc in psychology reported to **work in the broad domain of psychology or educational sciences**. The most important sectors were mental healthcare, healthcare, social welfare, and education. Many working participants (42%) reported combining more than one job. **Self-employment** in particular is quite common. According to official registrations, 38.5% of psychologists work in self-employment as either a primary or a secondary occupation, but those numbers do not include psychologists who were already working in self-employment before 2009. In this study, 49.7% of working MScs in psychology were self-employed (see 3.3.1 and 3.3.2).

The **job title** of “psychologist” is used by 69.1% of those with MScs in psychology in our sample, and 76.9% are **registered** with the Commission of Psychologists or have been registered in the past. In light of the discrepancy between the number of MScs in the population and the number of psychologists registered with the Commission or captured in the LFS, these numbers are likely to be an overestimate. This is also the case for membership of a professional organization. Based on information on membership of professional associations, 21.1% of people working as a psychologist according to the LFS (i.e. representing the population of psychologists in Belgium as a whole) are estimated to hold a membership of a professional association. Membership rates in the study sample were higher, with 40.8% of MScs in psychology reporting membership of a representative professional association (see 3.3.3 and 3.3.4). Overrepresentation of registration with the Commission of Psychologists and of membership with professional organizations is not unexpected, as they helped to disseminate the survey.

There is no one-on-one relation between working in the field of psychology and using the job title of “psychologist”. Only 75.3% of psychologists who indicated that they were working in the field of psychology reported using this professional title. Use of the title was more established in participants with an MSc in clinical psychology and in self-employed psychologists. Self-employed psychologists also often use the title “psychotherapist” (45.9%) and sometimes use the title “coach” (7.0%); usually, they use these titles in combination with the title “psychologist” (see 3.3.3).

Acquaintance with the **Code of Ethics** for Psychologists seems quite poor, as only 20.3% of participants with an MSc in psychology indicated that they were (fairly) familiar with the code of ethics, and 11.1% reported they had never read it. Even psychologists who indicated familiarity with the Code of Ethics only consulted the code on a yearly basis. Group differences in field of work or type of employment were small (see 3.3.3).

4.1.3 Further education

The **majority** of individuals with an MSc in psychology **continued** their education after obtaining their MSc; 57.4% followed training courses of at least 1 year related to the broad field of psychology and educational sciences; 4.5% obtained a PhD in psychology or educational sciences. Furthermore, 14% of those with an MSc in psychology obtained a bachelor's or master's degree outside the broad domain of psychology and educational sciences, in areas such as health sciences; political sciences and law; religion, culture, and history; economics and finance; and management (see 3.4.1).

Further education in the broad field of psychology and educational sciences was often **related to the LHCP**, as 49% of holders of an MSc in psychology engaged in training of at least 1 year's duration in psychological activities related to the LHCP (e.g. prevention, diagnostics/assessment, counselling, treatment, or psychotherapy); 14.9% had completed training of 1 or 2 years related to the LHCP, 19.9% had completed a training in psychotherapeutic care of 3 or 4 years and 14.2% had completed both types of training. Thus, 34.1% of participants with an MSc in psychology had completed a training in psychotherapeutic care of 3 or 4 years. A subgroup of approximately 15% of participants with an MSc in psychology are **highly specialized** as they followed both additional trainings of at least one year duration as well as psychotherapy training (see 3.4.3). Training related to the LHCP, especially psychotherapy training, was more common in participants with an MSc in clinical psychology (40.7% had completed psychotherapy training), and in self-employed psychologists (51.5% reported completion of psychotherapy training). Findings concerning the high levels of additional training might reflect on the one hand the need for further specialization in those working in the domain of (clinical) psychology. On the other hand, this may also reflect expectations by employers and colleagues. As noted by some members in the **focus groups** discussions, high levels of further specialization might lead to a decrease in the perceived value of the basic diploma of an MSc in psychology by both students/graduates and employers, as there appears to be an expectation that psychologists will obtain further training after the MSc in psychology.

Finally, there was a high degree of **diversity in terms of the theoretical orientation of psychotherapy training**, with each of the major types of psychotherapy attracting a sizeable subgroup of psychologists. Systemic/family psychotherapy was the most popular type of psychotherapy of training, followed by the three other major theoretical approaches in psychotherapy: (cognitive-) behavioural psychotherapy, psychoanalytic and psychodynamic psychotherapy, and humanistic and client-centred therapy, including Gestalt psychotherapy, who attract a similar number of trainees (see 3.4.2).

4.2. The field of work of psychology

4.2.1 Availability of mental healthcare as offered by psychologists in Belgium

Introduction

Mental healthcare is not only offered by individuals with an MSc in clinical psychology or limited to the mental healthcare sector. In this study, we delineated a subgroup of participants who indicated that they contributed to people's wellbeing or development in their job(s) (89.4% of participants with an MSc in psychology; 78.4% of this group had an MSc in clinical psychology) as an indication of the field of work of clinical psychology.

Sociodemographic profile of psychologists working in the field of clinical psychology

Similar to the sociodemographic profile of the full sample of psychologists, participants working in the field of clinical psychology are typically **young** (61.4% is younger than 40 years) and mostly **female** (83.7% in the current study). More than half (52.1%) reported to be working in self-employment (either full-time or part-time), indicating the importance of **self-employed** psychologists in the availability of mental healthcare in Belgium (see 3.5.2).

Although there is not a one-on-one relationship between the field of work of clinical psychology and holding an MSc in clinical psychology, features of the clinical field of work were usually **more strongly** represented in participants with an **MSc in clinical psychology**. However, even in participants with an **MSc in another domain of psychology**, the majority contributed to wellbeing or development (i.e., our indicator of a clinical field of work in the broadest sense) (78.7%), and a substantial proportion also provided client care (68.5%) and/or focused on psychological wellbeing (45.1%) (see 3.5.1). More detailed analyses showed that participants with a specialisation in research and personnel management and industrial/organizational psychology were somewhat less involved in client care, and participants with an MSc in neuropsychology and school or educational psychology were involved in client care to a similar extent as participants with an MSc in clinical psychology. Differences in the provision of client care were more pronounced in salaried jobs than in self-employed jobs in that client care was a more central feature in self-employed jobs, regardless of characteristics of the psychologist, such as their domain of specialization (see 3.5.3).

Characteristics of the field of work/job features

The majority of participants with an MSc in psychology described (at least one of) their job(s) as (see 3.5.1):

(a) Contributing to people's wellbeing or development (89.4%)
(b) Involving supporting people and their (social) environment (i.e. an indicator of providing client care) (84.8%); client care was a main task for 64.1% of participants
(c) Focusing mainly on improving the psychological wellbeing of the client (72.0%) and on problems related to DSM-defined categories (72.4%).

Mental healthcare was the most important **sector** in the field of work of clinical psychology, and more so in self-employed jobs. In salaried employment, participants also reported to work in the sector of education, training and student counselling; in self-employment, the healthcare sector was the second most important sector, followed by social welfare, social services and interest groups (see 3.5.2).

Within the mental healthcare sector, in salaried employment (32.7% of jobs in salaried employment was situated in this sector), psychiatric hospitals are the most important work **setting** (33%) in mental healthcare, followed by mental healthcare centres (28%). Both of these are specialized mental healthcare settings that primarily focus on second tier- and third tier care. Only 8% of participants stated that their main salaried job in the mental healthcare sector was in a primary care setting. However, 16.6% of participants indicated that their main salaried job was situated in the social welfare, social services and interest groups sector, which also includes settings where primary (mental health) care is provided.

Within the mental healthcare sector, in self-employment (74.2% of jobs in self-employment was situated in this sector), the distinction between primary care and second-tier (specialized) care seems less relevant; 70.4% of participants working in this sector in self-employment indicated to be involved in both primary and second-tier care, and only 9.5% focused on second-tier care only (see 3.5.2). Hence, whereas in salaried employment, stepped care[101] organizational principles seem to determine the work of clinical psychologists, in self-employment matched care[102] appeared to be the guiding principle and the organizational division between tiers or care seemed less relevant.

Client care is the most important task in the field of work of clinical psychology, particularly, as can be expected, in self-employment. Administrative tasks, especially in salaried employment, also seem to take up a substantial amount of time, followed by supervision of colleagues or trainees, provision of training or education, contribution to policy, and supporting organizations, particularly in those in salaried employment. In self-employment, these latter tasks were only rarely indicated (see 3.5.3).

The majority of psychologists reported that their job involves working with either adults or children and adolescents. However, despite the fact that universities often offer clinical programmes focusing on a specific age group, in practice, a substantial group of psychologists sees **patients across both age groups**. The availability of psychological care is highest for adult patients; most psychologists work with (young) adults (66–70%), whether or not combined with work with other age groups. Psychologists who specifically work with children and adolescents work more often in salaried jobs than in self-employment (see 3.5.4). This was also the case for **minority groups and populations with specific needs**, such as individuals with a disability, people with an immigration background or refugee status, and people with a low socio-economic status. In salaried jobs, 58.3% of psychologists provides care for clients with a low socio-economic status, 36.0 % includes people with a disability, and 31.2% includes people with an immigration background in their target population. In self-employed jobs, the target population appears less diverse, with minority groups representing only a small subsample of the total group of patients seen

[101] Stepped care means applying low-intensity interventions where possible, followed by more intensive interventions when necessary.

[102] Matched care stands for tailoring the treatment to characteristics of the patient, such as the severity of the problem, mental and social skills, environmental factors and the patient's wishes and needs.

by self-employed psychologists (3.5.5). This finding is most likely related to the limited availability of reimbursement of psychological care offered by self-employed psychologists in Belgium, and (perceived) barriers to psychological treatment in minority groups. On the other hand, psychologists, and particularly those in self-employment, may feel that they lack specific knowledge and expertise required for mental healthcare in minority groups and populations with specific needs, and thus have less of a focus on these groups.

When we presented psychologists working in the clinical field with several possible problems their job could focus on, "**psychological wellbeing"** was the most important focus of their job, especially in self-employment, followed by "behavioural difficulties" and "relational wellbeing and relationship problems". MSc in clinical or health psychology were more likely than other MScs in psychology to focus on psychological wellbeing, relationship problems, behavioural difficulties and health themes in their job; psychologists with a background in neuropsychology more frequently focused on development; psychologists with a background in school or educational psychology scored highest on school/educational career and psychological wellbeing at school; and psychologists with a background in personnel management and industrial/organizational psychology focused on career and wellbeing at work. Differences in job focus according to educational background were again less pronounced in self-employment compared with salaried employment (see 3.5.6).

In terms of patients meeting criteria (partially or fully) for DSM diagnostic categories, the most frequent problems focused on by psychologists were depressive disorders, anxiety disorders, and trauma and stressor-related disorders. In children and adolescents, neurodevelopmental disorders were also frequently indicated. Participants who had also completed a postgraduate psychotherapy training, reported working with a more diverse (and likely to be more complex) patient population in terms of DSM-defined problems, as they reported working with a patient population with a greater number of different psychological problems than psychologists without this type of training (3.5.7).

4.2.2. The career of psychologists

The transition from university to work

Results of our survey indicated that the **transition** to the labour market is not always smooth. Although 67.2% of participants with an MSc in psychology started a job in the field within 6 months after they graduated, this job was often for a short time, or was not remunerated according to their level of education. Approximately 31.6% found a salaried job related to their diploma within a reasonable time of 6 months that was remunerated in accordance with their level of education (i.e. MSc), with an employment of half-time or more and a contract of at least 6 months. For the remaining two-thirds of psychologists it typically takes a longer time to find such a job, and they may take on another job in the meantime. For instance, they reported starting working outside the field of psychology (35.8% of those who took longer to find employment in the field of psychology), they reported starting working as a self-employed psychologist (14.7% of self-employed psychologists started within 6 months after graduation), worked in a job with remuneration at the BA level, or took jobs involving brief contracts. This can reflect issues regarding the labour market, but of course, several findings can also reflect a deliberate choice in

some graduates. For example, some graduates may prefer a job outside the field of psychology or want to gain experience trough training or through a job at BA level, before starting to work as psychologist (see 3.7.1).

The transition from university to work appeared to be slightly more difficult for those with an MSc in clinical psychology; the proportion of participants with a first employment meeting the criteria described above, was slightly but significantly lower in participants with an MSc in clinical psychology (29.1%) compared with those with an MSc in another domain of specialization in psychology (39.5%). Further, there were small age-effects between those with an MSc in psychology; 27.3% of psychologists in the youngest cohort (younger than 30 years old at the time of the survey) reported that their first employment in the field of psychology met these criteria, whereas this was higher than 30% in most other cohorts (see 3.7.1).

Difficulties with entering the field of psychology were also clear in other analyses: 29% of psychologists who work in the field of psychology **did not start their career in this field**, and two-thirds of them attributed this at least partly to perceived difficulties in finding a job in the field (see 3.7.1). This means that for a proportion of graduates in psychology there is a **delay in entering the field of work** of psychology. Although this study seemed to mainly capture psychologists working in the field of psychology, it is not unlikely that a significant number of graduates do not re-enter this field of work after starting their career in another field of work. Furthermore, perceived difficulties can increase competition between applicants in the field, and urge graduates with an MSc in psychology to distinguish themselves, for example, by seeking additional training (see 3.4.3).

Further, among psychologists who **started working as a self-employed psychologist** after less than 6 months of experience, 21.5% indicated that job security was at least part of the motivation for their choice. Psychologists who worked in self-employment usually had at least 2 years of experience in the domain of psychology before they took the step to become self-employed. However, one in three self-employed psychologists started in independent practice after less than 1 year of experience, and one in four started after less than 6 months of experience in the field. These findings may be a cause for concern, as these psychologists may not have the same levels of support and supervision available to them as those in salaried employment. On the other hand, at least a subgroup of psychologists who started to work in independent practice with less than 2 years of experience (close to one in three) indicated that they began to work in independent practice at least partly because of the **opportunity to join a group practice**. This specific motivation was less strong in psychologists with more than 2 years of experience in the field (see 3.7.2). A group practice can potentially have similar characteristics to a setting in salaried employment in terms of the availability of supervision and support in general.

Career

On average, MScs in psychology work in three different sectors in the broad domain of psychology throughout their **career**, with older psychologists working in a greater number of different sectors. This shows the non-static nature of the career of MScs in psychology, even when only the field of work of psychology is considered. Again, there is a predominance of the mental healthcare sector and other

sectors in which mental healthcare is often offered – that is, education and student counselling, social welfare, and healthcare. About two out of three psychologists (68.6%) report at least some experience in the mental healthcare sector, 51.5% have at least 2 years of experience in this sector (see 3.7.3).

Continuing professional development

The Code of Ethics for psychologists and the LHCP require psychologists to invest in **continuing professional development (CPD)**. In general, participants with an MSc in psychology were involved in all four types of CPD that we assessed: (a) short training (conferences and short training courses) (93.7%), (b) participation in intervision or supervision (71.4%), (c) personal therapy (either on a voluntary basis or in a didactic context) (38.6%) and (d) teaching (in short or long training programmes) (30.2%). Psychologists who worked in the clinical field and psychologists who provided psychotherapeutic care, were more involved in all types of CPD (see 3.6.3). Furthermore, 55.3% of those with an MSc in psychology reported **membership of a professional or psychotherapy organization** (see 3.3.4).

The challenges and sources of support of psychologists

Participants with an MSc in psychology perceived their **work pressure** as high, with an average of 7.3 on a 0 to 10 rating scale. This is in line with results on work pressure in healthcare workers in Flanders, which tends to be higher than average (Bourdeaud'hui et al., 2019). Work–life balance was rated less poorly than work pressure, with a fairly neutral score of 4.6 on a 0 to 10 rating scale. Work pressure and work-life balance were related to each other; participants with higher work pressure also reported poorer work-life balance. Peers (friends, family, and colleagues) were an important source of support in dealing with work pressure or poor work-life balance. Work pressure was perceived as being higher and of greater concern in those in salaried employment compared with those in self-employment. However, salaried employment provided an extra source of support, as managers were more frequently turned to for help (see 3.8.1-.3.8.3).

Financial resources and waiting lists are perceived as a structural **challenge** by psychologists (see 3.8.4). Psychologists also indicated relatively high levels of concern about the **high complexity of the problems of people they deal with** (see 3.8.4). This complexity could refer to the socioeconomic or family context of patients, or to high comorbidity of mental health problems, or a combination of both (Auerbach et al., 2019). Two issues are important here, which were also raised by participants in the focus groups. First, it is difficult to focus on mental health problems when patients are faced with socioeconomic deprivation. Second, the high levels of complexity and comorbidity of typical patients in routine care may explain the high levels of specialization in many psychologists. The present study showed that undertaking further training is very common in psychologists. The high number of psychologists undertaking further training may contribute to the perception that an MSc in psychology alone is "not enough" and only a first step in the education of psychologists.

In **dealing with questions and challenges related to their profession**, participants reported that colleagues were the most important **source of support**: 77.2% turned to their colleagues for professional issues or challenges. Close to 40% mentioned professional literature and intervision or supervision, and close to 35% turned to the Code of Ethics and/or the Commission of Psychologists for help. Participants

also indicated seeking further training on the topic, or turning to a professional organization or their manager/employer for support (see 3.8.5).

This stresses the importance of a collaborative and supportive work environment, with access to support from experienced co-workers, intervision, and supervision. **Opportunities to consult colleagues** are partly a feature of the job context. In some work settings, collaboration is a natural **part of the setting**, with team meetings and frequent contact between colleagues. For example, the frequency of interdisciplinary consultation was higher in participants who worked in salaried employment, with a median time of 1 week between interdisciplinary consultations; in self-employment, this was 1 month. Approximately 53% of self-employed psychologists who worked in a private practice worked in a group setting (see 3.6.5).

4.3. The law on the practice of healthcare professions

4.3.1 Clinical psychologist as a healthcare profession

According to the LHCP, "under the exercise of clinical psychology is understood, the common use of independent acts which have for purpose or are proposed to have for purpose, with a human and within the scientific based framework of clinical psychology, the prevention, the evaluation, the screening or the composition of a psycho diagnosis of real or supposed psychic or psychosomatic suffering and the treatment or counselling of that person" (BFP, 2018). In the study sample, 78.4% of psychologists working in the clinical field obtained an MSc in clinical psychology, and 37.3% completed a postgraduate psychotherapy training. In general, sociodemographic characteristics were similar as in the full sample of participants with an MSc in psychology. About half (52.1%) of psychologists working in the clinical field were self-employed, as a primary or secondary occupation (see 3.5.2).

The **tasks relevant to the practice of clinical psychology as defined in the LHCP,** that is, prevention, diagnostic assessment, counselling, and treatment, appeared relevant in the majority of participants with an MSc in psychology working in the clinical field. Prevention, diagnostic assessment, and treatment were part of the tasks of about four out of five psychologists who contributed to people's wellbeing or development and/or provided client care, and more than nine out of 10 reported to engage in counselling. The LHCP tasks were even more relevant for those with an MSc in clinical psychology, for which the LHCP has been designed, compared with those holding an MSc in another domain of psychology. Nonetheless, group differences in educational background were generally small; differences in educational background showed a medium effect size only with regard to treatment as an LHCP task, with a markedly higher number of participants with an MSc in clinical psychology involved in treatment of psychological problems (see 3.6.2).

Furthermore, the LHCP attaches importance to CPD and multidisciplinary collaboration. Psychologists who worked in the clinical field displayed the following **characteristics**:

- 26.5% of self-employed psychologists who provided client care reported to work in a multidisciplinary setting (see 3.6.5)

- 84.5% of psychologists providing client care reported to participate in interdisciplinary consultation at least quarterly, with a median frequency of weekly consultations in salaried jobs and a median frequency of monthly consultations in self-employed jobs (see 3.6.5)
- 76.1% of psychologists working in the clinical field, (i.e., with a job that contributes to wellbeing or development) had participated in intervision or supervision since graduation (see 3.6.4)
- 59.2% of psychologists working in the clinical field reported being member of a general professional association or a psychotherapy organization (see 3.6.3).

Concerning intervision and supervision, 65.2% participated in **intervision** and 49.1% invested to some extent in receiving **supervision**. However, 23.9% had never received intervision or supervision since they graduated, and 36.7% and 55.3% of participants working in the clinical field had not participated in intervision or supervision, respectively, in the past year. Among those who had taken part in intervision or supervision in the past year, the median time between sessions was 2 months, although there was clear variability in the time between sessions, with a considerable group reporting that they attended intervision and supervision sessions at least every month (see 3.6.4).

4.3.2 The provision of psychotherapeutic care

Psychologists who provided treatment were asked whether they also provided **psychotherapeutic care** defined "as a coherent set of psychological treatment techniques, which goes beyond guidance or supportive conversations". This was true for 60% of psychologists who worked in the field of clinical psychology (i.e. they reported to contribute to people's wellbeing in at least one of their jobs) and 64% of participants with an MSc in clinical psychology (see 3.6.6).

The LHCP further stipulates that the provision of psychotherapeutic care requires an educational background in clinical psychology and additional training of at least 70 ECTS and 2 years of full-time supervised practice. In our sample, the vast majority of participants who reported to provide psychotherapeutic care (90%) had an MSc in clinical psychology; 57.6% had a psychotherapy training of 3 or 4 years; and **52.5% obtained both an MSc in clinical psychology and a psychotherapy training** and thus had completed the required training to provide psychotherapeutic care according to the LHCP (see 3.6.6). About half of the providers of psychotherapeutic care reported having been in personal therapy (52.6%) (see 3.6.3).

Psychologists who indicated that they **provided psychotherapeutic care** reported the following **characteristics**:

- 28.9% of self-employed psychologists worked in a multidisciplinary setting (see 3.6.5)
- 90.2% of psychologists participated in interdisciplinary consultation at least quarterly, with a median frequency of weekly consultations in salaried jobs and a median frequency of monthly consultations in self-employed jobs (see 3.6.5)
- 88.2% had participated in intervision or supervision since graduation (see 3.6.4)
- 75.5% have a membership of a general professional association or a psychotherapy organization (see 3.6.3).

Thus, professional and personal development as well as interdisciplinary collaboration are more prevalent in psychologists who provide psychotherapeutic care. However, they are not common in all those who provide psychotherapeutic care: 11.8% reported that they had not participated in intervision or supervision since graduation, 26.9% had not participated in intervision in the past year, and 43.8% had not received supervision in the past year. When they did, the median time between sessions was 2 months, and a considerable proportion participated in intervision (43.6%) or received supervision (37.4%) at least monthly. Furthermore, a multidisciplinary group practice is not the typical setting of self-employed psychologists who provide psychotherapeutic care (see 3.6.5). Although interdisciplinary consultation can be organized in several ways, a multidisciplinary group setting likely facilitates **interdisciplinary collaboration**.

Participants who had obtained psychotherapy **training** were generally more involved in personal and professional development than providers of psychotherapeutic care who had not completed this type of training. Differences in interdisciplinary collaboration were not significant or did not reach the threshold for a small effect (see 3.6.6).

There is also a **subgroup** of providers of psychotherapeutic care who did not obtain a psychotherapy training of 3 or 4 years, but did complete additional **training programmes that were shorter** (1 or 2 years). These include trainings concerning diagnosis or treatment of specific psychological problems, or training in specific treatment techniques. Of the 42.4% that provided psychotherapeutic care without a 3- or 4-year psychotherapy training, one in three (13.5%) had completed such a shorter training. Nonetheless, 28.9% of the participants who reported providing psychotherapeutic care apparently did so **without completing additional training courses** of a minimum of 1 year related to the provision of psychotherapeutic care (see 3.6.6).

4.4. Group differences

4.4.1 Differences according to educational background

Throughout the report, we compared participants with an MSc in clinical or health psychology (including clinical neuropsychology and clinical forensic psychology) with participants with a background in another domain of psychology (personnel management and industrial/organizational psychology; social/cultural psychology; theoretical and experimental psychology; school or educational psychology; special education, disability studies, and behavioural disorders; neuropsychology; other). Our definition of clinical psychology based on the domain of specialization clinical or health psychology may be considered as overly strict, as it is clear that those with a specialization in school or educational psychology and in neuropsychology, may also be active in the clinical domain. This report indeed showed that there is no one-on-one relationship between obtaining an MSc in clinical or health psychology and working in the field of clinical psychology, for example, working in the mental healthcare sector or working in client care (see 3.5).

Taking into account the limitations of this definition, results showed that participants with an MSc in clinical psychology were more likely than those with an MSc in another domain of psychology to **work in the mental healthcare sector** and, to a lesser extent, in sectors where mental healthcare is offered, such

as the healthcare sector and the social welfare sector. Moderate differences in terms of effect size were apparent both in their current employment (see 3.3.2 and 3.5.1) and also throughout their career (see 3.7.3). **Further training** related to the LHCP was also more prevalent in participants with an MSc in clinical psychology, especially psychotherapy training (3 or 4 years), regardless of the orientation of the psychotherapy training(see 3.4.3).

Registration with the Commission of Psychologists was more common among participants with an MSc in clinical psychology than those with an MSc in another domain of psychology (see 3.3.3). This can be partly related to a higher degree of **self-employment** in clinical psychologists and in psychologists who register with the Commission of Psychologists. In Belgium, registration with the National Institute for the Social Security of the Self-Employed requires registration with the Commission. However, **other aspects associated with professional identity** were also more common among participants with an MSc in clinical psychology compared with participants with an MSc in another domain, such as familiarity with the Code of Ethics, using the job title of "psychologist", and membership of a professional or psychotherapy association (see 3.3.3 and 3.3.4).

4.4.2 Differences between language communities

Unfortunately, the number of participants from the German-language community, although reflecting population statistics (0.7%), was too small to permit separate analyses. Because many German speaking psychologists are active in settings where both German and French is spoken, we included them with participants from the French-language community in our comparisons with the Flemish-language community. In general, language communities were more alike than different. When differences emerged, they usually were (very) small.

The French- and German-language community reported somewhat higher scores on **registration** with the Commission of Psychologists and knowledge of the Code of Ethics compared with the Flemish-language community(see 3.3.3). The Commission of Psychologists and the Code of Ethics were also more important sources of support when dealing with professional issues in the French- and German-speaking community (see 3.8.5).

Although the predominance of the mental healthcare sector was clear in both language communities, the **healthcare** sector was more prominent in the French- and German-speaking community, both in the current field of work and during the course of psychologists' careers. In the Flemish-speaking community, the predominance of the mental healthcare sector was more pronounced (see 3.5.2). Except for this difference in the role of the mental healthcare sector, both language communities showed a similar profile in characteristics related to the availability of psychological care (see 3.5.1) and in the provision of prevention, diagnostic assessment, counselling, and treatment (see 3.6.1).

The training in psychology (MSc-level) is organized differently in the French- and Flemish-speaking communities, with more differentiation in domains of specialization in the French community. Nonetheless, the majority of participants in both communities had obtained a specialization in **clinical psychology** (see 3.2). In our sample, participants from the French- and German speaking community on

the one hand and the Flemish-speaking community on the other, reported similar levels of further education, including similar levels of training in psychotherapeutic care (see 3.4.1). There were small differences in the **theoretical orientation** of psychotherapy training: (cognitive-) behavioural psychotherapy was somewhat more common in the Flemish community, whereas psychoanalytic/psychodynamic psychotherapy was more popular in the French- and German-speaking community, but again, differences were small (see 3.4.2).

Both language communities participated in **intervision and supervision**, but participation in intervision since graduation was somewhat higher in the Flemish community, whereas the reverse was true for supervision, which was a bit more common in the French- and German-speaking community (see 3.6.4). Perhaps this is partially related to the difference in the work setting of self-employed psychologists between communties, as self-employed psychologists in the Flemish Community more often reported they worked in a group practice whereas self-employed psychologists in the French community more often worked alone in a private practice (see 3.3.1 and 3.6.5).

4.4.3 Differences between salaried employment and self-employment

Some interesting differences emerged between participants in salaried employment and in self-employment.

Self-employed psychologists showed a **less varied profile** compared with psychologists who worked in salaried employment: self-employed psychologists almost exclusively categorized their work as falling in the mental healthcare sector, whereas psychologists in salaried employment were found in several sectors where mental healthcare was offered (e.g. healthcare, mental healthcare, education, and social welfare). Furthermore, the distinction between primary care and specialized second- or third-tier care was seen as less relevant by self-employed psychologists (see 3.5.2), and there was a stronger focus on client care relative to other job tasks (management, training, research, administrative tasks,…) compared with salaried jobs (see 3.5.3).

As a result, self-employed psychologists tended to identify more strongly with the **clinical field of work** and to be more involved in tasks described by the LHCP, such as offering client care (see 3.5.3), a job focus on psychological wellbeing (see 3.5.1), the provision of prevention, diagnostic assessment, counselling, treatment, and psychotherapeutic care (see 3.6.1), working with patients with DSM-defined problems (see 3.5.7), and involvement in training related to the LHCP (see 3.4.3). They more often identified as a “psychologist”, based on their use of this job title, than psychologists in salaried employment (see 3.3.3). Concerns about the LHCP were also higher among self-employed psychologists (3.8.4). Self-employed psychologists were more engaged in CPD, including intervision and supervision (see 3.6.3 and 3.6.4), and they were more likely to hold membership of a professional or psychotherapy association (see 3.6.3). These forms of peer contact were important sources of support for self-employed psychologists (see 3.8.5). On the other hand, interdisciplinary consultation was less frequent in self-employed psychologists (see 3.6.5). Further, we have to consider that several of the differences between self-employed jobs and salaried jobs became smaller when job content was more similar (e.g., when psychologists in salaried employment and in self-employment both provided psychotherapeutic care).

By contrast, work with minority populations and populations with specific needs, such as persons with an immigration background, a disability, or people with low SES, was more common in psychologists in salaried employment (see 3.5.5). This might indicate that mental healthcare as offered by self-employed psychologists is less targeted towards, or less **accessible** for, members of minority groups or populations with specific needs.

4.4.4 Differences between age groups

We divided participants into five age groups: (1) younger than 30 years, (2) between 30 and 39 years, (3) between 40 and 49 years, (4) between 50 and 59 years, and (5) 60 years and older. Unfortunately, as this study was cross-sectional in nature, we were not able to distinguish age (i.e. differences between older and younger psychologists) and cohort (e.g. the transition from education to field of work or employment situation might be different today from how it was 30 years ago) effects.

Several job characteristics were related to age, although effect sizes were usually small. Some findings might be related to growing experience in the field of work and the possible impact on type of work and work setting. **Self-employment** was more common in older age groups (see 3.3.1) and self-employment typically started several years after graduation (see 3.7.2). Self-employed young psychologists (<30 years) more often reported that they **provided primary care** compared with the older psychologists. They were also more likely to work in a **group setting** than their older colleagues (see 3.5.2) and reported more interdisciplinary consultation (see 3.6.5). Furthermore, having the opportunity to join a group practice was an important motivation for young psychologists to start working in self-employment (see 3.7.2).

The completion of **further training** (e.g. psychotherapy training) was also more common among older participants. When the youngest age group had completed further training, this was more often training of 1 or 2 years (see 3.4.1). Younger participants with an MSc in psychology also appeared to be somewhat **less involved in the provision of psychotherapeutic care** compared with older psychologists (see 3.6.2 and 3.6.6).

4.5. Strengths, limitations and future research

This study is the first to report detailed information on the profile of psychologists in Belgium since the introduction of the LHCP. It has been almost two decades ago since a similar study was conducted in Belgium. In a ground-breaking study, which included almost 1,000 participants, Lietaer et al. (2003) studied the sociodemographic and work profile of psychotherapists in Belgium. The current study had a broader focus, including all those with an MSc in psychology. A separate report focuses on school and educational psychology (Spilt et al., 2021), and a report focusing on orthopedagogy is in preparation (Noens et al., in prep.). Although the study was not designed as a study aiming at representativeness of the population of psychologists in Belgium, the sample was fairly representative in terms of several key sociodemographic characteristics. Nonetheless, caution is needed when generalizing findings from this study, as it is likely that psychologists working in the domain of clinical psychology are overrepresented in the study. Further, although the study included psychologists from all language communities, the Flemish

community was overrepresented compared with the French-language community, and the number of participants from the German-language community, although reflecting population statistics, was too small to permit separate analyses.

The study was cross-sectional in nature. We were thus not able to distinguish age (i.e. differences between older and younger psychologists) and cohort (e.g. differences between the employment situation today versus in previous decades) effects. Furthermore, we relied on participant self-report only, and thus reporting and recall bias may have influenced results.

This report touches on a number of important issues, with potential implications for the education of psychologists, mental health policy and clinical practice. As usual, expanding our knowledge often raises additional questions. As a wealth of data was gathered, several topics can be added or further explored. For example, more detailed analyses on the availability of mental healthcare as offered by psychologists per province, per network of (primary) care, or depending on the level of urbanization are not included in this report. These analyses are also relevant to the second aim of this research project, i.e., the use of mental healthcare in Belgium. More specifically, we will collect up-to-date and detailed information about the prevalence, course and risk factors of mental disorders in Belgium and the use of mental healthcare, including barriers to treatment. This will allow accurate estimates of the extent to which mental healthcare needs are met ("met need") and whether care is appropriately deployed for those who really need it ("unmet need" and "overmet need"). The combination of data on mental healthcare as provided by psychologists and mental healthcare needs in Belgium will allow to make projections regarding the future alignment between care provision and care needs.

4.6 Conclusion

In this report, we focused on the availability of mental healthcare offered by (clinical) psychologists in Belgium, including the settings in which (clinical) psychologists are active, their tasks, expertise, continuing professional development (CPD), and perceived challenges. Results showed that psychologists are a diverse group of professionals, both in terms of training (including the domain of specialization of their MSc, further training and CPD) and job profile. The majority of individuals with an MSc in psychology continue their education in the broad domain of psychology, which is often related to the LHCP. There is a high degree of diversity in further training, in terms of duration and in orientation. Psychologists also participate in multiple forms of CPD, although a subgroup of professionals does not participate in intervision nor in supervision. Psychologists most often work in the mental healthcare sector and in sectors where mental healthcare is offered (such as social welfare, healthcare and education). Self-employment is very common, especially as a secondary occupation. There is currently no a one-on-one relationship between working in the field of psychology and using the job title of “psychologist”, nor between obtaining an MSc in clinical psychology and working in the clinical field[103]. Client care is the most important task in the field of work of clinical psychology, and this is even more pronounced in self-employment. Psychologists report several important challenges for the future, with high work pressure and limited financial resources ranking among the most important challenges. Moreover, knowledge of

[103] This was defined quite broadly, as having a job that contributes to people’s wellbeing or development.

the Code of Ethics can be improved, the transition from university to the labour market appears quite difficult, and training and work setting do not always meet the requirements demanded by the LHCP. These findings are important for the future development of the profession of psychology, education, training and policy.

References

Alonso, J., Angermeyer, M. C., Bernert, S., Bruffaerts, R., Brugha, T. S., Bryson, H., . . . Vollebergh, W. A. (2004). Sampling and methods of the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatrica Scandinavica Suppl(420)*, 8-20. doi: 10.1111/j.1600-0047.2004.00326

Alonso, J., Angermeyer, M. C., Bernert, S., Bruffaerts, R., Brugha, T. S., Bryson, H., . . . Vollebergh, W. A. M. (2004). Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatrica Scandinavica, 109(s420)*, 21-27.

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., . . . Kessler, R. C. (2014). Barriers to mental health treatment: results from the WHO World Mental Health surveys. *Psychological Medicine, 44(6)*, 1303-1317. doi: 10.1017/s0033291713001943

Auerbach, R. P., Mortier, P., Bruffaerts, R., Alonso, J., Benjet, C., Cuijpers, P., Demyttenaere, K., Ebert, D. D., Green, J. G., Hasking, P., Lee, S., Lochner, C., McLafferty, M., Nock, M. K., Petukhova, M. V., Pinder-Amaker, S., Rosellini, A. J., Sampson, N. A., Vilagut, G., Zaslavsky, A. M., … WHO WMH-ICS Collaborators (2019). Mental disorder comorbidity and suicidal thoughts and behaviors in the World Health Organization World Mental Health Surveys International College Student initiative. *International journal of methods in psychiatric research*, *28(2)*, e1752. https://doi.org/10.1002/mpr.1752

Belgian Federation of Psychologists (2018). The new law on mental health professions. BFP.

Bourdeaud'hui, R., Janssens, F., & Vanderhaeghe, S. (2019). Rapport Vlaamse werkbaarheidsmonitor 2019 – werknemers. Stichting Innovatie & Arbeid, Brussel. Verkrijgbaar via https://www.serv.be/stichting/publicatie/werkbaarheidsmonitor-2019-werknemers

Bruffaerts, R., Bonnewyn, A., & Demyttenaere, K. (2007). Delays in seeking treatment for mental disorders in the Belgian general population. *Social Psychiatry and Psychiatric Epidemiology, 42(11),* 937-944. doi: 10.1007/s00127-007-0239-3

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J. P., . . . Chatterji, S. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA, 291(21),* 2581-2590. doi: 10.1001/jama.291.21.2581

Dezetter, A., Briffault, X., Bruffaerts, R., De Graaf, R., Alonso, J., Konig, H. H., . . . Kovess-Masfety, V. (2013). Use of general practitioners versus mental health professionals in six European countries: the decisive role of the organization of mental health-care systems. *Social Psychiatry and Psychiatric Epidemiology, 48(1),* 137-149. doi: 10.1007/s00127-012-0522-9

European Commission (2010). Mental health: Special Eurobarometer 345 / Wave 73.2 – TNS Opinion & Social (https://ec.europa.eu/commfrontoffice/publicopinion/archives/ebs/ebs_345_en.pdf)

European Commission (2016). DG Internal Market, Industry, Entrepreneurship and SMEs (DG GROW): Mutual evaluation of regulated professions – Overview of the regulatory framework in the health services sector – psychologists and related professions. Retrieved from: https://ec.europa.eu/docsroom/documents/16683.

Gisle, L., Drieskens, S., Demarest, S., & Van der Heyden, J. (2020). Geestelijke gezondheid: gezondheidsenquête 2018. Brussel, België: Sciensano; Rapportnummer: D/2020/14.440/4. Beschikbaar op: www.gezondheidsenquete.be

IAPT. (2012). Three-year report. The first million patients. London: Department of Health.

Kohn, L., Obyn, C., Adriaenssens, J., Christiaens, W., Van Cauter, X., & Eyssen, M. (2016). Model for the organization and reimbursement of psychological and orthopedagogical care in Belgium. Brussels: Belgian Healthcare Knowledge Centre (KCE).

Lietaer, G., Van Broeck, N., & Igodt, P. (2003). Beroepsprofiel van de psychotherapeut in België. Onderzoeksrapport ten behoeve van het Federaal Ministerie van Sociale Zaken, Volksgezondheid en Leefmilieu.

Lopez, A. D., Mathers, C. D., Ezzati, M., Jamison, D. T., & Murray, C. J. L. (2006). Global burden of disease and risk factors. New York: Oxford University Press.

Mistiaen, P., Cornelis, J., Detollenaere, J., Devriese, S., Farfan-Portet, M. I., & Ricour, C. (2019). Organisation of mental health care for adults in Belgium. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). KCE Reports 318. D/2019/10.273/50

Murray, C. J. L., & Lopez, A. D. (1996). The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Cambridge, MA: Harvard University Press.

Spilt, J.L., Wouters, S., Frenay, M., & Colpin, H. (2021). Psychologists at work in Belgium: A national study into the field of work of School and Educational Psychology. Leuven: KU Leuven.

Superior Health Council (2015). Definition of and competency profile for clinical psychology in Belgium (SHC 9194). Available from: https://www.health.belgium.be/en/advisory-report-9194-clinical-psychology.

Ten Have, M., Nuyen, J., Beekman, A., & de Graaf, R. (2013). Common mental disorder severity and its association with treatment contact and treatment intensity for mental health problems. *Psychological Medicine, 43(10),* 2203-2213. doi: 10.1017/s0033291713000135

Thornicroft, G., Chatterji, S., Evans-Lacko, S., Gruber, M., Sampson, N., Aguilar-Gaxiola, S., . . . Kessler, R. C. (2017). Undertreatment of people with major depressive disorder in 21 countries. *The British Journal of Psychiatry, 210(2),* 119-124. doi: 10.1192/bjp.bp.116.188078

Vanclooster, S., Vanderhaegen, J., Bruffaerts, R., Hermans, K., & Van Audenhove, C. (2013). Inschatting van de behoefte aan geestelijke gezondheidszorg. Leuven: Steunpunt Welzijn, Volksgezondheid en Gezin.

Vrijens, F., Renard, F., Camberlin, C., Desomer, A., Dubois, C., Jonckheer, P., . . . Meeus, P. (2015). De performantie van het Belgische gezondheidssysteem. Brussel: KCE.

Werkgroep zelfstandigen van de Vlaamse Vereniging van Klinisch Psychologen (2017). Nota “Naar een betere toegang tot de klinisch psycholoog” - Voorstel tot financiering van de klinisch psycholoog als zelfstandig zorgverstrekker. Available from https://www.vvkp.be/dossiers/voorstel-tot-financiering-klinisch-psychologische-zorg.

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., . . . Wells, J. E. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *Lancet, 370(9590),* 841-850. doi: 10.1016/s0140-6736(07)61414-7

Appendix

Appendix A. Flow-chart data-cleaning

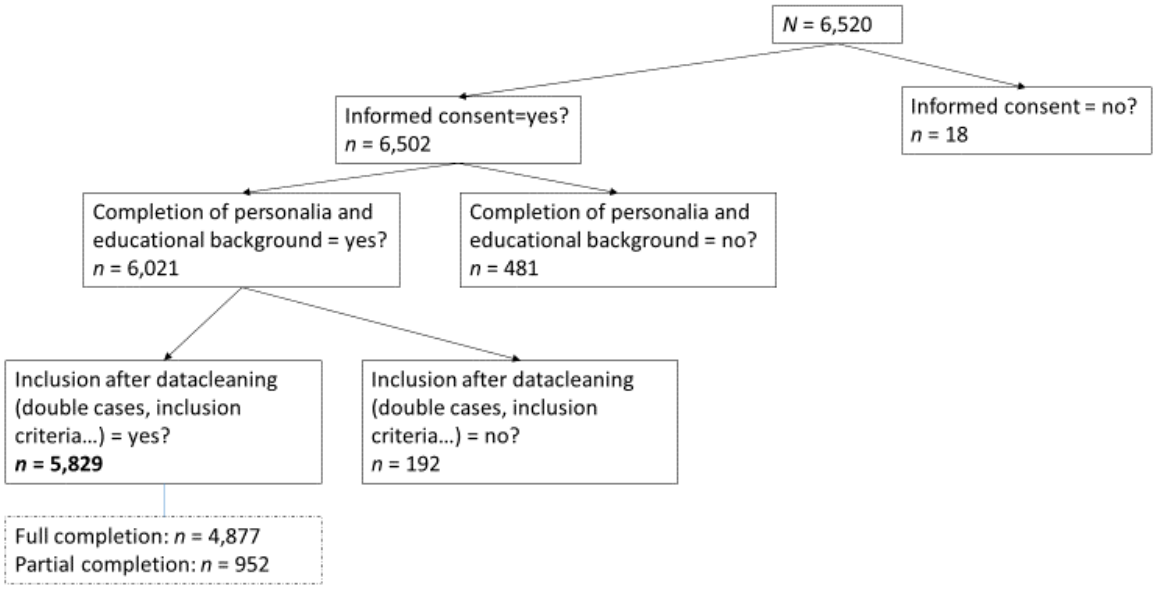

Figure 1. Flow-chart of the data-cleaning process.

Appendix B. Drop-out analysis

Table 1. Differences in demographic and work characteristics between participants who fully completed the questionnaire and those who partially completed the questionnaire

Characteristic (%)	Full completers	χ^2	*df*	φ/Cramer's *V*
Language		37.73***	11	–.09***
Flemish (*n* = 2,847)	87.1			
French or German (*n* = 1,448)	80.0			
Gender		3.17	1	–.03
Male (*n* = 768	86.7			
Female (*n* = 3,536)	84.2			
Age cohort		3.83	4	.03
<30y (*n* = 1,097)	86.1			
30-39y (*n* = 1,529)	84.0			
40-49y (*n* = 913)	84.3			
50-59y (*n* = 521)	83.1			
≥60y (*n* = 244)	86.5			
Type of MSc in psychology		2.91	1	.03
Clinical psychology (*n* = 3,253)	85.2			
Another domain of psychology (*n* = 1,051)	83.0			
Work status		6.59*	1	–.04*
Working (*n* = 4,145)	84.3			
Not working (*n* = 159)	91.8			
Type of (self-) employment		34.29***	2	.09***
Salaried employment (*n* = 2,087)	87.1			
Self-employment as a primary occupation (*n* = 821)	78.4			
Self-employment as a secondary occupation (*n* = 1,237)	83.6			

Note. *p < .05, **p < .01, *** p < .001. Full completers = participants who completed every question that was assigned to them.

Appendix C. Supplementary results

1 Professional situation of clinical psychologists:

On p. 35 (3.3.1), we reported on the type of employment of participants with an MSc in psychology. Here we report this information for participants with an MSc in clinical psychology, including separate information per language community.

Type of employment (%)	Participants with an MSc in clinical psychology – all (*n* = 3,158)	Participants with an MSc in clinical psychology – Flemish language (*n* = 2,226)	Participants with an MSc in clinical psychology – French or German language (*n* = 929)
Salaried employment	**79.5**	**79.9**	**76.3**
Only salaried employment	46.0	47.5	42.2
Self-employment as a secondary occupation	32.8	32.3	34.1
Self-employment	**49.7**	**52.4**	**57.8**
Self-employment as a primary occupation	20.5	19.7	22.6
Self-employment as a secondary occupation	32.	32.3	34.1
Self-employment after retirement	0.6	0.4	1.1

The difference between communities did not reach the threshold for a small effect-size ($\chi^2(3) = 11.49$, $p < .01$, Cramer's $V = .06$, $n = 3{,}155$).

2 Regional differences in field of work and client care:

On p. 110 (3.5.3) we reported regional differences in client care as a primary task. Here, we report information on regional differences in field of work (i.e. does the participants contribute to people's wellbeing or development) and the provision of client care in general (not as a primary task), in the subgroup of participants who contribute to people's wellbeing or development.

Field of work (%)	Region			Test Statistics	
Contribution to people's wellbeing or development	**Flanders (*n* = 2,554)**	**Wallonia (*n* = 972)**	**Brussels (*n* = 782)**	**$\chi^2(2)$**	**Cramer's *V***
Yes	94.6	95.8	86.7	71.51**	.13**
No	5.4	4.2	13.3		
Provision of client care in jobs contributing to people's wellbeing	**Flanders (*n* = 2,395)**	**Wallonia (*n* = 916)**	**Brussels (*n* = 668) (%)**	**$\chi^2(2)$**	**Cramer's *V***
Yes	94.9	97.2	91.8	23.34**	.08**
No	5.1	2.8	8.2		

Note. *p <.01, **p < .001. Participants could be employed in more than one region.

3 Differences in working with families depending on type of employment in those who work in the clinical field:

On p. 114-115 (3.5.4) we reported the proportion of psychologists who worked with families separately for the main job in salaried employment and the main job in self-employment. Here we show the distribution of working with families when information on jobs is combined, and the relationship with type of employment ($\chi^2(2) = 230.07$, Cramer's $V = .25$, $p < .001$, $n = 3{,}684$).

	Type of employment		
	Only salaried employment (*n* = 1,767)	Self-employment as a secondary occupation (*n* = 1,176)	Self-employment as a primary occupation (*n* = 741)
Working with families or couples (%)			
Yes	29.4	56.0	50.2
No	70.6	44.0	49.8

4 Differences in psychotherapy training depending on type of employment in those who provide psychotherapeutic care:

On p 171 (3.6.6) we reported differences in type of employment between psychotherapists with and without psychotherapy training. Here we show the distribution of psychotherapy training per type of employment.

Characteristic	**Without psychotherapy training (*n* = 940) (%)**	**With psychotherapy training (*n* = 1,276) (%)**	**$\chi^2(2)$**	***Cramer's V***	***n***
Type of employment			32.16**	.12**	2,216
Only salaried employment	51.0	49.0			614
Self-employment as a primary occupation	43.3	56.7			601
Self-employment as a secondary occupation	36.7	63.3			1,001

Note. *p <.01, **p < .001.

Appendix D. List of abbreviations

ADHD	Attention Deficit and Hyperactivity Disorder
ASD	Autism Spectrum Disorder
Ba	Bachelor degree
BFP-FBP	Belgian Federation of Psychologists
BTZ	Beratungs- und Therapiezentrum
CGG	Centra Geestelijke Gezondheidszorg
CLB	Centrum voor Leerlingenbegeleiding
ComPsy	Commission of Psychologists
CPMS	Centre Psycho-Medico-Social
CPD	Continuing professional development
DSM	Diagnostic and Statistical Manual for Mental Disorders
FTE	Full-time equivalent
GDPR	General Data Protection Regulation
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies programme
IF-IC	Instituut voor Functieclassificatie/ l'Institut de Classification de Fonctions
INASTI	L'Institut national d'assurances sociales pour travailleurs indépendants
LEPSS	La Loi sur l'Exercice des Professions de Soins de Santé
LFS	Labour Force Survey
LHCP	Law on the Practice of Healthcare Professions
MSc	Master of Sciences
NISSE	National Institute for the Social Security of the Self-Employed
OCD	Obsessive Compulsive Disorder
PhD	Philosopher's degree
RSVZ	Rijksinstituut voor de Sociale Verzekeringen der Zelfstandigen
SES	Socioeconomic status
SSM	Services de Santé Mentale

Statbel	Belgian statistical office
WUG	Wet op de Uitoefening van de Geestelijke Gezondheidszorgberoepen

Appendix E. Project team and research partners

Project team

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Research partners

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- Universiteit Gent
- Vrije Universiteit Brussel
- Université Libre de Bruxelles
- KU Leuven
- Université catholique de Louvain
- Université de Mons
- Université de Liège

The research team was assisted by a steering committee. The steering committee represented researchers and practitioners (including the Commission of Psychologists, professional associations of psychologists such as the Belgian Federation of Psychologists, independent practitioners and practitioners working in subsidized centres/organizations) from different fields and (language) communities in Belgium.

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- Several professional associations
- The Commission of Psychologists
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