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Dutch Therapists' Professional Autonomy and Moral Agency After the Marketization and Bureaucratization of Mental Healthcare: Between Impracticalities and Impossibilities

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Abstract

Over the last decades, western mental healthcare has increasingly been governed by market and bureaucratic principles. As a consequence, therapists are faced with conflicting demands and decreased autonomy. This study examines how they cope and whether their strategies suffice. Drawing on the direct experience of therapists through interviews, we demonstrate that psychologists have become quite skilled at balancing and navigating bureaucratic and market demands that were at odds with professionalism. However, when they were structurally faced with bureaucratic and market demands that were already irreconcilable with each other, these skills fell short. Trying to meet all requirements took up so much of their resources that sometimes, professional reasoning and agency disappeared altogether. In some cases, this led to detachment, burnout, and patient neglect. Our findings suggest that the public interest in having a well-functioning mental healthcare system requires more room for professional autonomy.

Keywords

Mental healthcare, therapists, professionalism, commodification, bureaucracy, professional logic, moral agency

Introduction

From the nineteen eighties onward, healthcare systems in western welfare states have been subject to changes brought about by the turn to neoliberalism. Although proponents of neoliberalism failed to abolish welfare states where they existed, they did manage to introduce elements of entrepreneurialism, such as surveillance, financial accountability, and productivity in the public sector, that were ill-suited to them (Harvey, 2005). The mismatch lies in excessive government, focused too much on performance (Dean, 1999), to the erosion of professional values such as calling, loyalty, and authority (Freidson, 2001; Tonkens, 2016). Sandel (2012, 2013) argues for a critical debate about where markets serve the public good and where they do not belong.

Public administration scholars have studied extensively whether this neoliberal turn – they tend to speak about New Public Management, or NPM, but this refers more neutrally to the same phenomenon – at least delivered on its promise to improve public services by enhancing their quality and making them more efficient. For instance, Hood and Dixon (2016, p. 31) studied the effects of three decades of NPM in the UK and observed that it resulted in a proliferation of rules, standards, and benchmarks enforced by independent or semi-independent regulators, without reducing costs. Diefenbach (2009) conducted an extensive meta-analysis and concluded that the negative sides of NPM far outweigh positive outcomes in the public sector. A more value-based public governance model has been proposed as an alternative to NPM, which is already emerging in some parts of the public sector (Bryson et al., 2014).

In the healthcare sector specifically, the negative effects of NPM are well documented. A system of external controls has replaced the traditional regime of self-regulation, to the detriment of professional autonomy (Adams, 2016; Blank et al., 2017; Dwarswaard, 2011; Exworthy, 2015; Trappenburg, 2006). We will zoom in on what that entails by elaborating on the work of Freidson (2001) and Zacka (2017).

Freidson (2001), in his seminal work on professionalism, argues that the decline of professional autonomy is problematic because autonomy is crucial to professional work. This work is specialized and moral in nature, cannot fully be captured in protocols and policies, and requires discretionary space to keep its "soul" and be applied in socially useful ways. According to Freidson, it should be governed by the professions themselves, supported by the academic disciplines linked to them, and rooted in what he calls "the logic of professionalism" (2001, p. 2). This logic is difficult to reconcile with the two other (neoliberal) logics that exercise control over the sector: the logic of the market, which focuses on productivity, patient satisfaction, and measurable outcomes (see also Kapucu, 2006; Leicht, 2016; Pollitt &

Bouckaert, 2017), and the logic of bureaucracy, which organizes care according to rational rules, predefined procedures and impersonal hierarchies to promote equality, minimize risk and maximize accountability (for a discussion, see Exworthy, 2015; Kalberg, 2017). Although Freidson (2001) recognizes that these other two logics have value in and of themselves, he argues that they should not drown out professionalism: "The issue should be whether the virtues of each are suppressed by emphasis on the other and their vices excessively stimulated" (p. 181).

A more recent scholar who investigated the effect of working under the pressure and duress of conflicting logics is Zacka (2017). Although his work is usually seen as a sequel to Lipsky's (1980) influential book on street-level bureaucracy, or the liaisons between government policy-makers and citizens, he also builds on Freidson by understanding public sector work as moral and the bureaucratic encounter it involves as a moment of citizenship. Through his ethnographic studies, he found that frontline public sector workers have become quite skilled at navigating conflicting demands while maintaining their moral agency. He calls this a "gymnastics of the self" (Zacka, 2017, p. 114). At the same time, he admits that these gymnastics will only take a professional so far. When working under constant pressure, he observes that workers will resort to reductive stances: moral positions that exclude other perspectives. Zacka identifies three such reductive stances: caregiving (giving precedence to the needs of the patient), enforcement (giving precedence to the rules), and indifference (detachment). He argues that professionals will be most prone to adopt one of these strategies when faced with what he calls "impossible situations" (Zacka, 2017, p. 200). He uses this term to indicate the double bind created by tension between the concrete requirement for action (an external imperative) and the abstract appeal from one's professional identity and morality (internal). "Impossible situations arise when these two levels are at odds with each other: when the actions that are required and the sense of self that is fostered cannot be reconciled" (Zacka, 2017, p. 229). Zacka later adds, "They can also arise when we ask public agencies to do or be too many things at once without giving them adequate resources to do so" (Zacka, 2017, p. 237).

One can only experience a situation as impossible if one is personally committed to a certain understanding of the role that one is then brought to undermine. Zacka emphasizes that this creates a double bind and concludes:

> There is no good way for individual agents to confront impossible situations on their own. […] It is the managerial practices and public policies that give rise to such situations that have to change. (Zacka, 2017, p. 232)

In our study, we use the concept of the *impossible situation* to investigate the current state of professional autonomy and moral agency in mental healthcare in the Netherlands, to assess and differentiate the dynamics within that sector. We will describe this context and then outline our research questions.

The Netherlands has a social insurance system (of old comparable to Germany, more recently resembling Switzerland) instead of a tax-based national health service like many European countries (e.g., Britain, Sweden) (Blank et al., 2017). Social insurance is compulsory and has helped to establish a culture of care prioritizing formal care. The provision of healthcare is predominantly in the hands of private non-profit organizations.

Mental healthcare (practices, institutions, ambulatory services, and inpatient facilities) used to be financed through the Exceptional Medical Expenses Act (AWBZ) but is currently governed by the more market-based Health Insurance Act (Zorgverzekeringswet) since 2006. This change shifted the sector from the domain of "care" to that of "cure," changing the focus from process to result and opening the door to a more outcome-oriented approach (Boot, 2005; Bouman, 2010). Subsequently, an avalanche of NPM measures was introduced to direct and monitor these outcomes. This relatively recent shift to NPM makes the sector a valuable case for analyzing its effects on professionals. Research on mental healthcare in the US and Australia has shown that similar policy changes led to difficulty in defending established treatment practices (based on professional standards) against organizational demands for cost-containment and performance-based outcomes (Scheid, 2000, 2004, 2009). Clinicians felt their professionalism was threatened (Kirschner & Lachicotte, 2001). The feeling that organizations were not meeting professional-based criteria for care was an important cause of a rise in burnout (Scheid, 2009), as was a lack of autonomy, notably among psychologists (McCormack et al., 2018). Psychologists argue that their workplaces and training settings need to reorient from a focus on performance and technique to also include the recognition and support of the personhood and professionalism of the therapist (Turnbull & Rhodes, 2021).

In the Netherlands, several individual clinicians have written about their experiences since the transition to the Health Insurance Act, drawing attention to the inherent complexities of working with people with mental vulnerabilities and the incompatibility of this reality with what, from an analytical point of view, are NPM and bureaucratic demands (e.g. Bosch, 2019; Schakenbos, 2015; Van Oenen, 2019; Van Os, 2014). However, no structured analysis of professionals' experiences and views has been carried out yet.

We discuss the following questions: 1) When, why, and how are professionals in Dutch mental healthcare able to handle difficult situations originating from conflicting logics? 2) When and why do they experience situations as truly impossible? 3) What are the consequences of these impossible situations for mental healthcare as a professional discipline?

Methods

Twenty-five professionals were interviewed to identify the type of situations they experience as impossible, according to Zacka's (2017) definition. Through interviews, it becomes possible to understand the lived experience of people and the meaning they attribute to that experience as a basis on which to build social abstractions (Seidman, 2013). To promote uniformity

in the sample, only professionals who conduct therapy (i.e., psychologists) were included, as opposed to professionals who provide other interactions with patients (e.g., prescribing medication or providing practical support).

Participants

To select participants, a convenience sample was assembled starting with eight psychologists in the first author's network (not direct colleagues). Inclusion criteria were that all of them were practicing licensed psychologists with extended clinical training, resulting in a registration in the Register for Professions in Individualized Healthcare (in Dutch: BIG-register) that allows them to provide care independently. All participants worked in mental healthcare and provided care under the health insurance law, to the exclusion of other settings that are governed by different policies, such as prisons or hospitals. These criteria ensured that all participants had sufficient experience and a general lived understanding of problems in the field: the range of years of experience was 9 to 40, with an average of 20 years.

Two people declined because of a full schedule, and one did not respond. Participants were interviewed and asked to identify other people who met the criteria. Another 25 people were approached, of which five declined, mainly due to busy schedules. The process was repeated until data saturation was reached (Onwuegbuzie & Leech, 2007). After 15 interviews, the researchers had a good initial impression of recurring themes and concerns, but the interviews still provided rich new experiences, perspectives, and nuances. After 22 interviews, a first general analysis of the data indicated that we were reaching the point of saturation. We conducted three more interviews to assess this with more certainty and found that the interviews provided more examples and details of what we already heard. No new themes came up. The final sample consisted of 25 interviews.

Interview method

The study was introduced to respondents as concerning work pressure among psychologists in mental healthcare. The consent form states: "This concerns the relationship with factors such as policy and client behavior on the one hand and the possible moral dilemmas that arise as a result on the other. [...] Your input is important in order to understand which situations psychologists encounter in their work and what consequences arise from this."

The interviews were semi-structured. Although we started from an interview guide and each interview followed the same outline, follow-up questions were formulated depending on the topics the respondents brought up.

The interviews first explored different aspects that may put pressure on professionals, with follow-up questions about respondents' emotions, their ideas about how and why such situations had come to exist in their organizations, their perceptions of differences between organizations, and their responses and (career) decisions. The second part of the interviews focused on case descriptions where professionals felt they were under more pressure than

usual, with follow-up questions focusing mainly on coping strategies and moral decision-making.

Consent and confidentiality

Participants received information about the aim of the interview and signed a consent form adapted to interviewing (Seidman, 2013, p. 64). The research proposal and data management plan were reviewed and approved by the ethical committee of the University of Humanistic Studies. Data are treated confidentially and stored in a secure location. The names of participants were removed.

Analysis

The interviews were recorded, transcribed verbatim, and analyzed using NVivo. The analysis took place over three rounds of coding (Boeije, 2010; Charmaz, 2006). The first round of open coding gave an initial idea of perceptions of pressure and moral conflict in the field. We focused on sources of pressure, attributions, coping strategies, emotions, and (moral) decision-making. During the second round, we used axial coding to refine the coding scheme around several single categories or axes, where Freidson's and Zacka's frameworks were used as core concepts. We differentiated between the type of demands (abstract vs. concrete, internal vs. external, corresponding logic) and the classification of the truly *impossible situation*, of which we found three good examples – or cases – that consistently showed up in most interviews and caused much distress. A fourth situation was quite prevalent and had the potential to become an *impossible situation*, but it did not, so we used it as a counterexample or a situation that is "merely" difficult. Lastly, selective coding was used to further describe and flesh out these core concepts and the relations between them. Most notably, we related participants' emotions, attributions, and decisions back to the nature of the conflicting demands and the perceived "double bind" they created.

Situations that only showed up in the data sporadically or intermittently, for instance because they were person- or context-specific, are not included in the description below.

Results

The results indicate that conflicting demands from professional, market, and bureaucratic logic do consistently put pressure on professionals, but not always to the same extent.

On the one hand, professionals deal with what can be described as *difficult situations*. In these situations, their professional logic is threatened by conflicting demands, but they can still carve out enough room to make moral decisions that align with their professional logic. On the other hand, sometimes conflicting demands lead to *impossible situations*; room for professionalism disappears almost altogether. We will provide one example of a *difficult situation* and, subsequently, three *impossible situations*. We will analyze the difference between them according to the different kinds of logic and their accompanying demands.

Difficult situations: The case of medicalization

Medicalization of mental healthcare refers to thinking about psychological problems in terms of a DSM classification, often to be treated by a protocol-based treatment of which the effectiveness has been proven in randomized controlled trials. In the Netherlands, this way of thinking has been heavily endorsed by policymakers, as it is results-oriented and cost-effective (logic of the market), as well as standardized (logic of bureaucracy). In the Netherlands, health insurance companies decide which DSM classifications and which treatments are covered and, therefore, accessible to patients.

Although the value of scientific evidence for the effectiveness of treatment was mentioned explicitly by some respondents, many described a mismatch between protocols and reality, as well as difficulties with the notion stimulated by the medical model that psychological problems are individual (a disorder of the person) rather than contextual (related to a person's life events or other social problems such as diminished social cohesion, the individualization of society, poverty, job insecurity or performance pressure). They feel that the assumption that these problems can be meaningfully named and fixed on an individual, decontextualized level is tricky, as in this example:

> The kid was referred to us for [individual] trauma treatment. And the mother, but the family guardian too, ask us to treat him accordingly. But we feel that such a treatment will only make the dynamic more difficult for this boy. What he needs, what would reduce his stress, is that the uncertainty about where he is going to live is eliminated, as well as the battle and loyalty conflicts around him. [011]

Individual DSM classifications can induce overidentification with and hyperfocus on the terms used, even after recurring discussions about their meaning. As one respondent explains:

> People want a label, well not a label per se of course, but they want to know exactly what you think and that must be it. While psychological assessment is an ongoing process. [014]

Other respondents described how the results-oriented, standardized nature of the medical model led to high or unrealistic expectations, "As if treatment is predictable" [014]. These expectations can hinder the development of professional competence and confidence.

> It bothers me that patients have these expectations of therapy. And that the institutions themselves have of therapy. And the expectations of the whole world, of the therapist, make me uncomfortable in my work. I always feel tense, during sessions too. And beforehand. And afterward, sometimes, a sense of relief. Like, "Oh, that went quite well". But never really satisfied. No. [022]

The medical model and its associated problems have existed for quite some time and most respondents found ways to work with it, or sometimes around it. Inside their consultation

rooms, they have quite some space to work with contextualized, descriptive diagnoses instead of the DSM categories and to adapt treatment methods to their individual patients and the context of their lives. The odd manager who "doesn't have a background in healthcare and thinks throwing a protocol at someone will fix their problems" [009] is found annoying but not that influential. Senior therapists, in particular, proved to be skilled at integrating scientific evidence with clinical experience and understanding the development of new treatments as an ongoing process without an ultimate truth.

To sum up, different assignments originating with different logics are given at the same time. Also, in accordance with Zacka's definition, bureaucratic and market-based demands tended to be more concrete and rule-based, whereas the professional imperative was experienced as abstract and value-based (see Table 1).

Table 1

Differing Logics in the "Difficult Situation" of Medicalization

Bureaucratic logic: label symptoms according to the DSM and give everyone the same treatment, regardless of contextual factors.	Professional logic: give good care, attuned to the person as well as their life circumstances. Help people live with their problems. Recognize that problems are subject to change and diagnoses are often only temporary.
Market logic: provide effective treatment with measurable, verifiable results. Fix the problem.	

Though the excerpts above clearly describe pressure and tension, the therapists still engage in moral reasoning, figuring out how to relate to the conflicting demands and expectations, and succeed in avoiding a reductionist moral stance. Two important factors allow for this: 1) the bureaucratic and market logic conflict with professional logic, but not with each other; and 2) the organization has some control over DSM classifications and protocols, but very little over how professionals discuss them in consultations and sessions. Both factors will be different in the three impossible situations described below.

Impossible situations

Production norms

Production norms, the term itself a quintessential example of market language, were mentioned by almost all respondents. They can refer either to the percentage of working time that should be billable, often around 85%, or to the number of patients to be seen or intakes to be scheduled.

> The terminology we're using is the most idiotic thing ever. I remember a manager I had a couple of years ago, who remarked: "Oh, now I'm saying production as well! I'm saying

> product now." Nowadays it's not even a thing anymore, we just talk about production and product. It's crazy, but we do it. [014]

Several respondents expressed an understanding that patients generate income that is necessary for the continuation of the organization. However, the terms felt alien to them and the strict norms had adverse effects. One respondent mentioned the pressure of "mechanically having to see seven people every day, like a machine" [002]; another was bothered by e-mails her team received from their manager about production numbers: "The corporate tone of it. It has me thinking: Hey, I don't work for a commercial enterprise! But it feels like I do" [004].

Feelings of invalidation, underappreciation, and distrust were prevalent and experienced as difficult. However, four other things really push the matter into *impossible situation* territory (see Table 2).

The first is the irreconcilability of these market demands with how professionals understand the nature of their work. Their professional logic requires them to be present and available, exercise reflection, and practice proper self-care to be able to do all those things.

> It didn't feel right to me. Those seven people that I see, I want to be completely attuned to. And give proper care to. If you just retrieve one after the other from the waiting room… With seven in a row your recovery time is minimal. Very little time to write a more elaborate report sometimes, to prepare a session more thoroughly, or consult a GP or occupational health doctor. Or to just think: Geez, I really need to clear my mind or vent to a colleague. And then I will be fine, and present, again. But I didn't feel that I had that space. It cost me tremendously. [003]

The second factor creating impossibility was the relentless pressure some organizations applied, making it impossible to counter the measure with either covert strategies such as civil disobedience, or collaborative problem solving such as openly discussing the problem. Respondents described group e-mail distribution of everyone's production numbers, monthly meetings with managers to evaluate brightly colored production graphs, visits from the owner, having an external planning department filling out any blank spaces in their schedules immediately, and having their production numbers used against them as leverage when contract extension had to be negotiated.

> They really increased the pressure. 100% billable time was the demand at one point. We said: we can't even have a bathroom break then. They replied: Can't you think about a patient while you're on the toilet, so it will still be billable? [013]

The production norm became part of the organizational culture, so professionals stopped exercising both self-care and care for coworkers.

> High work pressure was more likely to be seen as: "Look at their production, great!" Instead of: "They are on the verge of burnout, let's see what we can do to help them." [013]

The two factors (irreconcilability with professional norms and managerial pressure) frequently piled up, for instance, by having to keep meeting intake norms because it makes money to accept more patients, while having no time to keep seeing them for treatment. The same piling-on effect can be seen in this example, where a manager was worried about the effect of "no-shows" on production.

> If people didn't show up for their appointment twice, you had to end their treatment. And this was at a trauma department. With people who were very vulnerable. And, well, sometimes would miss their appointment. […] At one point there was this manager, who had thought up the solution of scheduling two people at the same time. If one of them didn't show up, at least you had seen someone. If they both showed up, you saw both briefly. […] It stopped making sense altogether. [019]

The third factor was that the concrete market and bureaucratic demand were already conflicting, abstract notions of good care and professionalism aside. Many respondents brought up that 85 to 100% production norms meant they could not meet other requirements made by the organization itself. This production norm leaves no room for bureaucratic demands to keep files up to date, report back to the (referring) GP, train younger colleagues, and attend multidisciplinary consultations. Let alone for professional performance.

Last, these demands are much easier to implement and control externally than in the *difficult situation* of medicalization, where professionals still have relatively free space in their consultation rooms to reclaim some autonomy.

Table 2

Differing Logics in the "Impossible Situation" of Production Norms

Market logic: Be billable for 85% of your working time. See x people per day, or conduct x intakes per week/month/year.	Professional logic: Be present and available to the patient; give good care and take time to reflect, practice self-care, and develop yourself professionally.
Bureaucratic logic: treat everyone equally, attend all required meetings, and fulfill all administrative and protocol requirements.	

This situation causes a much more obvious moral breakdown. "It's crazy, but we do it" hardly qualifies as a moral decision. Participants used stronger language when describing their inability or unwillingness to do something, and expressed more doubt, despair, and disbelief.

Almost all participants who had worked in organizations with high production norms had left, and many stated explicitly that the norms were the main reason – the ultimate solution to resolve an *impossible situation*.

Waiting lists and partitions

Another circumstance that created *impossible situations* for therapists was the system of waiting lists and partitioned care. Waiting lists for mental healthcare are notoriously long in the Netherlands. Three to four months is common, even for small practices, and waiting lists for more specialized departments can easily exceed six months to over a year (Nederlandse Zorgautoriteit, 2023). Professionals feel the pressure of these waiting lists continuously. Combined with the aforementioned imperative to keep inviting people for intakes, perfect conditions are created for *impossible situations* to develop.

The person who did the intake is legally responsible for providing treatment (bureaucratic logic) but cannot actually offer any. Organizations think up elaborate constructions that feel counter-intuitive to professionals.

> So you have to call [these people on the waiting list] every three months, a phone call to ask how they're doing, not really a session, and often people will have gotten worse. […] I think we have some legal liability. So if anything happens to them, we can say we've been in touch. So it's more or less a charade, because you're not actually giving care. It's embarrassing, I try to detach myself entirely when I have to do it. Turn it into a task. [022]

Professionals feel troubled and powerless when witnessing people getting worse without being able to do anything about it. Procedures like the one described above feel unethical to them and push them towards an indifferent moral stance.

Another conflicting demand presents itself when the intake indicates that the organization cannot offer the required care, for instance, because it lacks specific expertise. This frequently happens because, in the Netherlands, mental healthcare is partitioned into specialized departments. In such a scenario, professionals are required to arrange follow-up care and transfer their patient to another organization. However, they cannot do that because these all have waiting lists too, and because their production norms limit their time to make calls and arrangements.

> So you will be bickering about patients and it sort of turns into an argument, and someone else has to come and mediate, well, that's really unpleasant. You're colleagues, but competitors too. It's unhealthy. [009]

In the meantime, professionals remain responsible, and also *feel* responsible: they experience a moral appeal to care and not dismiss the patient. Many professionals want to organize a "pre-therapy" arrangement so the patient has someone to talk to and receives support, even if they are not yet treated. These arrangements are not without risk and can take a long time.

> She was a woman, 63 years old, who [when asked about her treatment history] said: "I mainly have waiting list experience […]." I can't abandon her. […] I can't reject her here as well, I can't do that to her. Symptoms are severe, autism, depression, suicidal ideation. Yeah, that of course doesn't fit into any box. Formally I could say she's better off somewhere else, but everyone else is doing that already. So I feel: "Sure, but this woman is really stuck. Let's see what we can do." It's an endless bureaucracy that makes me think: this cost her three years of her life and so much money. To the insurance company too. Well, at least we're not ping-ponging her around in Amsterdam anymore. [009]

Because of the risk (bureaucratic concern), poor prognosis (low effectiveness, no measurable results; market concern), and uncertainty about how long these arrangements will last, some organizations forbid them altogether, forcing the professional to refer the patient back to the GP. The demands of the organization clash with the professional imperative to give good care and be there for patients.

Table 3

Differing Logics in the "Impossible Situation" of Waiting Lists and Partitioned Care

Market logic: schedule x amount of intakes. Don't spend time on activities that can't be billed or don't have a measurable outcome.	Professional logic: Given the reality of partitions and waiting lists, try to be there for the patient as best as you can, and advocate for them to arrange follow-up care if necessary.
Bureaucratic logic: follow protocol regarding liability for people on the waiting list and regarding the referral and transfer of care.	

Again, the logic of the market and bureaucracy impose conflicting demands (see Table 3): One cannot endlessly keep accepting new patients (market logic) and fulfill one's legal and procedural obligations towards all of them (bureaucratic logic)—not even mentioning the professional reasons for not wanting to do so. If any leeway is to be found, it is with the bureaucratic demands, not the market ones, because these can (and are) imposed more forcefully. This is disconcerting because it makes the professional more vulnerable.

The excerpts above reveal moral reduction or breakdown, such as having to shut oneself down, bickering with colleagues, desensitizing oneself in the face of patients getting worse, and taking reductionist stances ("I cannot abandon her" is another reductionist position towards caregiving).

Structure of the profession

A third impossible situation was embedded in the structure of the profession and professional registration. In the Netherlands, psychologists need post-academic training and extra registration (BIG-registration) to work with patients independently. These training positions are limited and difficult to obtain. Psychologists with only a master's degree (MSc) need supervision from a main practitioner, have no registration that holds professional and legal significance, and their employment position remains vulnerable. Economically speaking, it is attractive to employ many MSc psychologists supervised by a limited number of BIG-registered main practitioners. The structure is similar to the medical field, where residents perform care under the supervision of specialists, but a resident will already have more work experience and possess their own BIG-registration.

This structure, when subjected to market and bureaucratic logic, creates major problems for psychologists. One set of concerns revolved around the position of the MSc psychologists, the other around the main practitioners who supervise them.

MSc psychologists

Many young psychologists who just finished their degree have difficulty finding a job. They sometimes have to settle for unpaid "work experience positions" in the hope of improving their resume. Even when they do eventually find a job, they still have to deal with high competition, temporary contracts and limited chances to be admitted to the postgraduate training program. To them, the demands of high production norms and medicalization are even more untenable than to their BIG-registered counterparts, described by many respondents as an unhealthy rat race.

> They fear, and lie awake at night, if they don't meet their production norms. In meetings it was sometimes made explicit: "Guys, if we as a team don't meet production norms, we don't know if we can keep everyone on." I think that's morally questionable for people in a vulnerable position. [009]

Respondents felt that apart from the individual risk of burn-out (sometimes people will collapse within months of starting the much-desired post-academic training program because they have been working too hard to get into it), there was also the collective problem that diversity and authenticity in the therapist population decreased. Only the type of people who could hold their own in the rat race, or who could be socialized that way, would remain.

Another way to build a resume is to participate in additional courses. Several participants felt this was undesirable, primarily because the first course people take is usually cognitive behavioral therapy, an often highly protocolized treatment method.

> For them to develop a sense of what they want, professionally, is very important to me. That they don't turn into protocolized, fearful robots. They don't really, of course, they are also quite ambitious and able to think for themselves. But the pressure and dependent position could cause this. [014]

Other professional courses were described by respondents as more in-depth or advanced; these courses build on the knowledge and clinical experience gained during the postgraduate program. Respondents felt that taking these courses prematurely to build a resume is not optimal.

> The power of these courses is […] EMDR and schema therapy only make sense when you have experience with [the population]. I think if I had done it before my [postgraduate] training I would have understood far less of it, like what is this idea exactly and how can I apply it. Also because you don't really see patients yet with an indication for EMDR or schema therapy [as a MSc psychologist]. [003]

Many respondents described the importance of a slow start at the beginning of a career as a therapist, with a patient population that matches their professional capabilities and plenty of opportunities to observe, reflect, and ask questions.

Main practitioners

After obtaining the coveted BIG-registration, working as a main practitioner disappointed many. They now had a much higher responsibility, for caseloads sometimes exceeding 400 patients.

> That practitioner is no longer doing the work he would like to do. Not what he's good at, and what he was trained to do. The word "main practitioner" is mentioned exactly zero times in the postgraduate program; it trains you to be a diagnostician and therapist. And that's precisely what you are no longer doing. The whole rich profession of making a good assessment, doing good research, doing psychotherapeutic research, and providing psychotherapy, that is no longer part of your work. So that means quite a lot for the psychologist, and then for the patients, it also means that you hardly see that person, who is ultimately responsible for your treatment. You only see them once a year, or twice a year. [024]

The job was described as a busybody [015], a case manager [011] or a coordinator [013].

> And I felt completely out of place, I thought it was a terrible job. I just wanted [my child patients] to confide in me. That they would tell me what was troubling them. Starting

> from there and reflecting and thinking about: how do you deal with that? But as a treatment coordinator, you just have to make sure that the child goes from one group to the next and that everything proceeds without too much trouble. Yes, that's what I felt it came down to. That just didn't make me happy. [013]

Not seeing the patients themselves, while being legally responsible for their treatment, was seen as complicated. Main practitioners also felt they were (too) dependent on the expertise of the (BA or MSc) therapist conducting the actual treatment, and their relationship with them. This was exacerbated because many organizations decide when and how the main practitioner and MSc psychologist interact.

> Sit in with a session for five minutes, talk about this topic for ten minutes, then another evaluation because it's time for that again. I like to provide supervision to young colleagues, I'm passionate about it and I have always done so. But it used to happen much more organically. Treatment consultations in a small team on a weekly basis also had a mutually inspiring effect. You talked to each other if the treatment was difficult and when someone had a question about it; you scheduled time to discuss it properly. Fifteen minutes or twenty minutes. I also believe that young psychologists benefit from high-quality work supervision. And you evaluated at the point in treatment when there was really something to evaluate: a natural moment. In my current workplace, anyone without a BIG-registration must discuss every treatment with the coordinating practitioner every six weeks. Even if all goes smoothly. [016]

When asked further questions, many respondents expressed unclarity about the responsibility and liability of their main practitionership. Most of them knew that a BIG-registration entailed disciplinary liability, but were unable to clarify what this meant. Some respondents made statements that were vague or even incorrect.

> Everyone is also responsible for their own actions. The concept of responsibility is of course sometimes confusing, I guess. The colleagues of whom I am a main practitioner or the patients, that… the [MSc] psychologist is also responsible for her own actions and also for discussing issues if she thinks things are not going well or something. [008]

There was no consensus among the respondents about what would happen if the MSc psychologist and main practitioner disagreed.

It was striking that respondents were so aware of their own legally vulnerable position in other situations, but with regard to coordinating treatment, this was hardly elaborated upon, and the urgency was not felt.

Table 4

Differing Logics in the "Impossible Situation" of the Structure of the Profession

Market logic: For MSc psychologists: see x number of patients and meet production norms. For main practitioners: supervise the treatment of x amount of patients and MSc psychologists.	Professional logic: For MSc Psychologists: give good care; come into your own as an authentic professional who can make complex moral decisions. For main practitioners: give high quality attentive (time-consuming) care and support younger colleagues in their professional development towards providing such care.
Bureaucratic logic: make sure to follow protocols regarding the execution of the main practitionership (e.g., when and how to evaluate). Bear legal responsibility for all treatments.	

As before, the market and bureaucratic logic already pose conflicting demands (see Table 4). A professional cannot be responsible for hundreds of patients and fulfill all obligations towards them in a meaningful way. And again, the market measure is more easily enforced than the other two.

Conclusion

As described in the introduction, many clinicians and researchers in mental healthcare have experienced or feared that the forces of market and bureaucracy harm their field. Freidson (2001) and Scheid (2004) provided them with the framework and language of differing logics to understand their predicament and to predict the consequences for professionalism if the other two logics were allowed to take center stage. Zacka (2017) added that the "gymnastics of the self" to cope with conflicting demands would only take a professional so far, and workers would eventually have to resort to reductionist moral stances.

Our results show that (research question 1) professionals have adapted to working under the constant duress of conflicting demands and are, to some extent, able to protect both the patient and their professional values. However, when managerial and bureaucratic demands are also at odds with each other, juggling them takes up so much time and resources that professionalism is under too much pressure, and the conflict cannot be resolved without giving up one's professional values (research question 2). These situations are truly impossible. We found that in these situations, professionals either cease to act at all or act in a way they cannot defend from a moral or professional point of view. They are forced to turn to detachment while resenting it (*indifference*), let themselves be pushed into a legally vulnerable position, just to meet everyone's demands (*enforcing*), or resort to focusing just on the patient

while neglecting the moral obligation to work with (not against) their organization (*caregiving*) (research question 3).

In short, our study shows that excessive bureaucratic and market control destroy precisely what society wants from its healthcare professionals. Governing bodies, healthcare authorities, insurance companies, professional organizations, patient organizations, and other parties involved need to align with professionals to resolve these impossible situations because professionals cannot do it alone. Our interviews indicate that if these impossible situations remain unresolved, two concerns will persist that hurt everyone's interests.

The first concern is that having professionals work under extreme moral stress is not sustainable. It will hinder their professional development, as it does not give them the time and space to grow into nuanced moral decision-makers with a strong professional identity, and will eventually lead to burnout, high staff turnover, or both. Many professionals suffer and have to distance themselves in order to survive.

The second concern is that the quality of care deteriorates. The patient who is put on a waiting list and is contacted every three months, not to be offered help but to "check-in" to prevent legal liability in case "something happens," is deprived. So is the patient who is booked simultaneously with another patient to prevent non-billable time in the therapist's schedule in case one of them does not show up, and is only offered a brief session instead of a full one. That is not care; that is neglect. Patients need therapists who, in the words of Zacka (2017), can act as full-fledged moral agents and are engaged, not distanced.

In sum, our study suggests that the critics of the commodification and bureaucratization of healthcare were right. Despite everyone's efforts, we have found obvious and disconcerting examples where the professional logic disappears altogether. Our analysis justifies the recommendation for a substantial reappraisal of professional logic. That means diminishing bureaucratic and market demands, paying attention to at least aligning them so that fewer impossible situations arise, and leaving more decisions to professionals. As far as these decisions concern epistemological stances about which there is no consensus in the field, as we found in the example regarding the use of DSM categories, the discussion should be solved within the academic disciplines linked to the professions without the intrusion of preferences originating from different kinds of logics.

For example, it seems sensible to recommend having practitioners decide on the size of their caseload rather than having the organization decide for them. They will be more aware than anyone of the balance between their own capabilities, the needs of their patient population, and possible room to see new patients. Professionals in our study were acutely aware of the undesirability of waiting lists and the necessity of maintaining a full caseload if the organization wanted to survive financially.

Similarly, practitioners appear well-equipped to assess the professional development of the MSc psychologists they are supervising, in relation to the patient population. There is no rational argument to be made for forced evaluation moments. Leaving this up to professionals will free up time and resources.

To sum up, we argue for restoring trust in the professional. Fear that professionals will close their consultation room doors, avoid accountability, and resort to ineffective treatment methods of their liking, seems outdated and was not supported by descriptions in our sample. The sector has already been through the process of professionalization: professional guidelines, supervision, peer consultation, and learning networks are firmly in place. Psychologists are motivated to contribute to their further development. So, there is a strong infrastructure for a relatively self-regulatory sector, with no reason to assume this will harm the public interest.

All mechanisms of control have pros and cons, but the disadvantages of far-reaching market and bureaucratic control seem to outweigh its benefits by far.

Limitations and recommendations

Our study has a few limitations. Although we paid attention to assembling a representative sample with diversity in age, location, and work setting, the sample size is small, and caution should be exercised when generalizing our findings to the population.

Furthermore, it is important to note that the interview mainly focused on work pressure, and most of the interview was devoted to exploring its nature, causes, and consequences. This might have led respondents to (over)emphasize the difficult aspects of their work. We noticed that participants often spontaneously included aspects they liked about their work, took a humorous approach, or gave counter-examples. For one respondent, this was even the reason for participating in the study: to explain that the state of her field is not as bad as is often pertained in media. Additional interviews on work pleasure, calling, and job satisfaction, or a more comprehensive approach such as ethnographic research, would possibly give a more balanced picture of the field as a whole. After all, it's a complex world, and working in it entails more than the sum of its problems.

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