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Bridging Translational Gaps in Psychological Care – A Care Platform Approach

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ABSTRACT

Psychological care systems face increasing demand while struggling to scale access, quality, and impact. Despite strong clinical evidence for the effectiveness of psychotherapy, many organizations encounter structural frictions that prevent available expertise, human resources, and digital solutions from translating into scalable patient value. This paper examines these challenges through the case of Neue Realitäten AG (NRAG), a Swiss provider of psychological diagnostics, psychotherapy, expert opinions for courts or child protection authorities, and clinical supervision. Adopting a design-oriented and translational research approach, the study applies the Translational Service Research and Design Methodology (TSRDM) to identify four interrelated translational gaps in psychological care: talent-to-value, knowledge-to-role, human-to-scalability, and solutions-to-value. These gaps are understood as organizational and architectural deficiencies rather than clinical shortcomings. To address these frictions, the paper develops a platform-based psychological care architecture grounded in Service Dominant Architecture (SDA). Psychological care is modeled as an end-to-end service system organized around five organizational capabilities: interaction, participation, operant resources, data, and institutions. A structured care pathway integrates clinical care, supervision, billing, office management, and outcome measurement as constitutive services. The findings illustrate how combining SDA with extreme ownership and architectural simplicity enables clearer accountability, scalable supervision capacity, and improved observation of value-in-use in real care situations. The paper offers a transferable design approach for scalable, accountable, and patient-centered psychological care.

Keywords: Psychological care, Service-dominant architecture, Care pathways, Extreme ownership, Simplicity

INTRODUCTION

Psychological care constitutes a critical pillar of modern healthcare systems, particularly in contexts involving trauma, family conflict, and domestic violence. Empirical evidence shows that exposure to domestic violence significantly increases the risk of long-term psychological harm, including depression, anxiety disorders, post-traumatic stress disorder, impaired emotional regulation, and intergenerational transmission of trauma. According to the World Health Organization, approximately one in three women worldwide experiences physical or sexual violence in her lifetime,

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with a substantial proportion developing clinically relevant mental health disorders as a consequence (WHO, 2019). Children exposed to domestic violence, even when not directly targeted, are at heightened risk of emotional, behavioral, and developmental difficulties with long-term consequences.

Effective psychotherapeutic interventions have been shown to reduce psychological distress and improve outcomes across a broad range of conditions (Cuijpers et al., 2014; Wampold and Imel, 2015). However, despite this strong evidence base, access to psychological care remains constrained in many healthcare systems. Rising demand is met by limited supply due to workforce shortages, regulatory requirements, and organizational and systemic inefficiencies across care delivery, supervision, coordination, and reimbursement. These constraints are particularly pronounced in supervision-based models, where junior psychologists require oversight by senior professionals, creating structural bottlenecks that limit scalability.

Neue Realitäten AG (NRAG) is a Swiss-based provider of psychological care, offering diagnostics, psychotherapy, expert opinions for courts and child protection authorities, and clinical supervision. As NRAG grows within a fragmented market, it encounters frictions that limit its ability to scale impact proportionally with demand. These frictions are conceptualized as four translational gaps: talent-to-value, knowledge-to-role, human-to-scalability, and solutions-to-value.

To address these gaps, this paper develops and illustrates a psychological care platform grounded in SDA and engineered through the Translational Service Research and Design Methodology (TSRDM). The objective is to show how a platform-based, service-oriented architecture can enable patient-centric, digitally supported, and human-led psychological care while maintaining quality, accountability, scalability, and organizational agility.

RESEARCH METHODOLOGY

In alignment with the objectives of this research, a design-oriented and translational research approach is adopted. The study follows the Translational Service Research and Design Methodology (TSRDM), which bridges conceptual knowledge and practical implementation in complex service systems through a structured eight-step process integrating empirical observation, theory development, design, and implementation (De Vaus, 2001; Warg et al., 2025).

TSRDM focuses on translation as the systematic transformation of existing knowledge, capabilities, and technologies into effective and scalable services. This integrated logic is particularly suitable for psychological care contexts, where clinically validated knowledge often fails to translate into consistently delivered, scalable care.

Guided by TSRDM, the research proceeds in three steps. First, empirically observable frictions in the NRAG context are conceptualized as translational gaps. Second, relevant theoretical knowledge and mechanisms are analyzed as prerequisites for addressing these gaps. Third, these insights are translated into design principles and architectural patterns that inform the design of a platform-based psychological care system.

A shared service language underpins this methodology and enables consistent reasoning across research and practice. Building on services as the primary structuring paradigm (Gummesson, 1995), service is understood as the application of resources for the benefit of others, while services represent concrete instantiations within care pathways (Spohrer et al., 2022). Service-Dominant Logic and Service Science provide the theoretical foundation for this perspective by emphasizing value co-creation through interaction among multiple actors (Vargo and Lusch, 2004; Spohrer and Maglio, 2008).

Service Dominant Architecture operationalizes this service perspective at the structural level. It is used as a practical design lens to organize psychological care around five organizational capabilities: interaction, participation, scalable expertise, transparency, and accountability (Warg et al., 2016). Building on this perspective, the paper adopts a unifying service language in which psychological care is analyzed and designed in terms of services, service systems, and value co-creation rather than isolated technologies or organizational units.

TRANSLATIONAL GAPS TO PSYCHOLOGICAL CARE

NRAG's growth trajectory is constrained by four interrelated translational gaps that undermine the effective scaling of psychological care.

Talent-to-Value Gap

NRAG can recruit junior psychologists with relative ease but struggles to attract sufficient senior psychotherapists to fulfill supervision requirements. Regulatory and quality standards typically require one senior supervisor for three to four junior therapists, making supervision capacity the primary bottleneck for growth. Many senior psychotherapists prefer private practice due to perceived autonomy and higher income. While flexibility can largely be matched by employment models, income expectations are often anchored on gross tariffs and underestimate administrative costs and non-billable time. The perceived income advantage of private practice is therefore frequently materially overstated.

This misalignment between perceived and realized value limits the translation of senior expertise into scalable organizational supervision capacity and constrains both the productivity and employability of junior psychologists, as supervision availability directly caps junior hiring capacity.

Knowledge-to-Role Gap

New junior joiners, often entering directly after their Master's studies, frequently lack the practical and clinical capabilities required for immediate effectiveness as assistant psychotherapists. Educational institutions provide strong theoretical foundations but insufficient alignment with real-world clinical workflows, supervision structures, and organizational quality standards. As a result, knowledge remains weakly embedded in roles, slowing down productivity and increasing supervision load.

A related challenge arises where required roles do not yet exist in practice because the service system itself is still emerging. Unlike medical settings, where established role models such as medical practice assistants (MPAs) support physicians, psychological care lacks standardized non-clinical and para-clinical roles that translate clinical expertise into operational support. In these cases, organizations must actively design, establish, and educate new roles rather than merely filling predefined ones.

Clinical supervision research highlights the central role of supervision in therapist development and quality assurance, while also emphasizing the need for structured approaches rather than informal transfer (Milne, 2009; Watkins, 2011).

At NRAG, these translation challenges are operationalized, among other mechanisms, through a structured trainee program that embeds supervision, role definition, and learning directly into the care pathway rather than treating training as a separate activity.

Human-to-Scalability Gap

Psychotherapy remains predominantly a one-to-one service, making care delivery highly labor intensive and difficult to scale. Exclusive reliance on individual sessions limits access and prevents the system from leveraging hybrid, group based, or digital formats that could extend reach while preserving quality. The potential of digital and hybrid interventions to expand access and reduce capacity constraints has been emphasized in global health guidance and empirical reviews (WHO, 2019; Lattie et al., 2020).

Solutions-to-Value Gap

Digital tools and innovations such as online interventions, diagnostics, or documentation systems exist, but often remain disconnected from integrated care pathways. Without architectural integration, these solutions fail to translate into sustained value-in-use for patients, therapists, or the organization. While online patient registration and digital appointment allocation are not yet fully implemented, they constitute integral design elements of the proposed platform architecture and are planned for near term deployment.

Architectural Framing of Translational Gaps

From a Service Dominant Architecture perspective, organizational capability is understood as a configuration of five interrelated systems. The System of Interaction structures value-creating encounters between patients, therapists, supervisors, and the organization. The System of Participation governs who can take part in service delivery and under which conditions. The System of Operant Resources institutionalizes knowledge, skills, and expertise as scalable organizational capabilities. The System of Data creates transparency by making service performance and outcomes observable. The System of Institutions defines rules, norms, and accountability structures that coordinate behavior across the system.

From an architectural perspective, the identified translational gaps reflect deficiencies in specific organizational capabilities. The talent-to-value gap primarily relates to the Systems of Operant Resources and Participation, the knowledge-to-role gap to Operant Resources and Institutions, the human-to-scalability gap to Interaction and Data, and the solutions-to-value gap to insufficient integration across all systems.

PSYCHOLOGICAL CARE PATHWAY

Psychological care is conceptualized as an end-to-end care pathway that integrates clinical, supervisory, and administrative services across the full patient journey.

1. Access and intake: referral or self-entry, administrative eligibility checks, clinical triage
2. Assessment and diagnosis: clinical assessment, risk and compliance checks, standardized documentation
3. Treatment planning: therapy planning, supervision requirements, billing logic clarification
4. Therapeutic intervention: psychotherapy sessions, group or digital formats where appropriate, ongoing documentation
5. Supervision and quality assurance: case supervision, outcome review, ethical oversight
6. Care enablement services (continuous): scheduling and case management, billing and reimbursement, office and regulatory management
7. Evaluation and transition: outcome measurement, reporting, follow-up or discharge.

Supervision, billing, office management, professional development, feedback, and data provision operate continuously across the pathway rather than as isolated steps. The care pathway describes the temporal sequence of services, while the Service Dominant Architecture systems described below define the organizational capabilities required to enable value creation at scale.

DESIGN PRINCIPLES FOR BRIDGING THE TRANSLATIONAL GAPS

The following design principles translate the identified translational gaps into actionable guidance for platform design and organizational practice. Two cross-cutting principles guide all design decisions: **simplicity** and **extreme ownership**. Simplicity ensures that new structures reduce rather than increase organizational complexity, while extreme ownership establishes clear end-to-end accountability for each service within the care pathway (Willink and Babin, 2018).

Talent-to-Value Gap

Supervision is designed as a scalable service rather than an informal or individualized activity. Transparent compensation models, administrative

offloading, and flexible participation arrangements increase the attractiveness of supervisory roles for senior psychotherapists. By making effective annual income, supervision premiums, and non-clinical workload explicit, the platform aligns perceived and realized value. Extreme ownership assigns clear accountability for supervision capacity, quality, and developmental outcomes.

Knowledge-to-Role Gap

Learning and capability development are treated as integral services embedded in the care pathway. Structured onboarding, modular learning paths, and early supervised practice accelerate the translation of academic knowledge into effective clinical roles. Where required roles do not yet exist, the platform supports their intentional design and institutionalization. A structured trainee program operationalizes this principle by embedding supervision, documentation standards, and feedback from the outset, with clear ownership for continuous improvement.

Human-to-Scalability Gap

Scalability is enabled through hybrid care models that complement one-to-one therapy with group formats, asynchronous digital content, and standardized educational offerings. These formats reduce dependency on individual therapist availability while preserving clinical quality. Simplicity is achieved by embedding scalable formats directly into the care pathway rather than creating parallel delivery structures, with clear ownership for clinical and operational performance.

Solutions-to-Value Gap

Digital tools are designed as integrated services within end-to-end care pathways rather than standalone solutions. Documentation, outcome measurement, scheduling, and digital interventions are embedded into daily workflows to reduce friction and improve coordination. While online patient registration and digital appointment allocation are planned for near-term deployment, ownership is assigned for value realization rather than tool implementation, ensuring that digital solutions contribute measurably to patient value-in-use.

Simplicity and Architectural Minimalism

Across all gaps, architectural minimalism serves as a guiding principle. By organizing psychological care around a limited number of clearly defined services, assigning end-to-end ownership, and embedding learning and data into core workflows, the platform minimizes unnecessary interfaces and coordination overhead. This preserves organizational agility while enabling scalability, quality assurance, and regulatory compliance.

Table 1: Translational gaps and corresponding design principles.

Translational Gap	Design Principles
Talent to value	Supervision as a service, transparent value proposition, administrative offloading, explicit income comparability, extreme ownership
Knowledge to role	Learning as a service, structured onboarding, modular capability development, trainee program, extreme ownership
Human to scalability	Hybrid formats, group interventions, scalable education, standardized pathways, simplicity by design
Solutions to value	Resource integration, pathway embedding, online registration and scheduling (planned), data driven feedback, ownership for value realization

FINDINGS AND DESIGN PATTERNS OF A PSYCHOLOGICAL CARE PLATFORM

The psychological care platform operationalizes the design principles through Service Dominant Architecture. The platform is not a single IT system but a configuration of service systems that jointly support the care pathway. Extreme ownership is applied at the service level, ensuring that each service within the care pathway has a single, end-to-end accountable owner (Willink and Babin, 2018).

System of Interaction

The System of Interaction structures all value co-creation interactions between patients, therapists, and supervisors. It includes intake interfaces, therapy sessions, supervision interactions, and outcome feedback. Design emphasis is placed on smooth processes, clarity in communication, disciplined handovers, and empowered decisions close to the patient. Digital tools augment human interaction by reducing coordination overhead and enabling continuity across touchpoints.

System of Participation

The System of Participation enables frictionless onboarding and role clarity for all actors. It supports flexible participation models and structured developmental pathways for junior psychologists. Participation design focuses on clear role definitions, fast onboarding, predictable supervision allocation, and low administrative barriers to contribute.

System of Operant Resources

The System of Operant Resources translates individual expertise into organizational capability. In emerging psychological care systems, this also requires the intentional design and institutionalization of new roles where standardized role models do not yet exist, analogous to how medical practice assistants support physicians in medical settings. Supervision protocols,

case review templates, treatment guidelines, and educational content are modularized into reusable service modules. Senior expertise is leveraged across multiple cases through standardized supervision services supported by digital tools.

System of Data

The System of Data integrates clinical documentation, billing information, workload metrics, and outcome measures across the psychological care pathway. Data collection is embedded into everyday workflows rather than treated as a separate reporting activity, ensuring that information is generated as a byproduct of care delivery rather than as additional administrative effort.

In the proposed platform, data is primarily used to observe value-in-use in real care situations, such as patient progress, therapeutic effectiveness, supervision outcomes, and service continuity. Compliance indicators and regulatory documentation function as necessary boundary conditions, but do not substitute for the observation of patient value or service performance.

By making outcomes, capacity utilization, and supervision effects visible at the service level, the System of Data supports continuous learning, quality assurance, and informed decision-making without overburdening clinical staff. This enables transparency and accountability while preserving clinical focus and organizational agility.

System of Institutions

The System of Institutions defines the rules, norms, and accountability structures that coordinate behavior across the psychological care platform. This system is the primary anchor point for extreme ownership. Extreme ownership operationalizes the System of Institutions by assigning end-to-end accountability for each service within the care pathway. Rather than distributing responsibility across departments or roles, each service such as intake, supervision, trainee development, billing, or outcome measurement has one clearly identifiable owner.

These service owners are accountable not only for compliance with ethical, regulatory, and reimbursement requirements, but also for clinical quality, operational performance, and patient value-in-use. Decision rights and escalation paths are explicitly defined, enabling fast resolution of cross functional issues. By embedding extreme ownership into institutional arrangements, responsibility gaps and handover losses are structurally eliminated. Extreme ownership further supports simplicity by eliminating responsibility fragmentation and reducing the need for complex coordination structures.

Table 2: Mapping design principles to SDA systems and friction solving.

Design Principles	SDA System	Friction Solving
Patient engagement and coherent care	Interaction	Improves value-in-use and continuity
Actor onboarding and role clarity	Participation	Accelerates scaling and reduces bottlenecks
Capability reuse through modular supervision and learning	Operant Resources	Leverages expertise and reduces supervision load
Outcome oriented transparency	Data	Enables quality control and learning without bureaucracy
Accountability through extreme ownership	Institutions	Prevents responsibility gaps and handover losses

DISCUSSION AND CONTRIBUTION

This paper contributes to research and practice in several ways. It conceptualizes psychological care as an end-to-end service system and shows how translational gaps can be systematically identified and addressed. It advances Service Dominant Architecture as a practical design framework for psychological care platforms and integrates extreme ownership as a governance principle within service design. The paper further provides a concrete care pathway model that integrates supervision, billing, office management, and data as constitutive services of psychological care. In addition, it positions simplicity and architectural minimalism as key conditions for agility and scalability and offers a transferable platform-based approach for translating clinical expertise, human capital, and digital innovation into scalable patient value.

CONCLUSION

Psychological care systems face rising demand and structural constraints that cannot be resolved through incremental optimization. This study shows that the primary barriers to scalable psychological care lie in the design of service systems and organizational structures rather than in deficits of clinical knowledge or therapeutic efficacy. By combining TSRDM, Service Dominant Architecture, extreme ownership, and simplicity as a design principle within a platform-based care pathway, organizations including NRAG can systematically translate talent, knowledge, and technology into scalable, patient-centered value. The proposed approach provides a robust foundation for future research and practical implementation in digital and human-led psychological care systems.

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REFERENCES

Cuijpers, P., Karyotaki, E., Reijnders, M. and Huibers, M.J.H. (2014). The effects of psychotherapies for major depression in adults on remission, recovery and improvement: A meta-analysis. Journal of Affective Disorders, 159, pp. 118–126.

De Vaus, D. (2001). Research Design in Social Research. London: Sage Publications.

Gummesson, E. (1995). Relationship marketing: Its role in the service economy. In: W.J. Glynn and J.G. Barnes (eds.), Understanding Services Management. New York: Wiley, pp. 244–268.

Lattie, E.G., Adkins, E.C., Winquist, N., Stiles-Shanks, O. and Mohr, D.C. (2020). Digital mental health interventions for depression, anxiety, and enhancement of psychological well-being: A review. Annual Review of Clinical Psychology, 16, pp. 285–314.

Milne, D. (2009). Evidence-Based Clinical Supervision: Principles and Practice. Oxford: Wiley-Blackwell.

Spohrer, J. and Maglio, P.P. (2008). The emergence of service science: Toward systematic service innovations. Service Science, 1(1), pp. 1–15.

Spohrer, J., Maglio, P.P., Vargo, S.L. and Warg, M. (2022). Service as a unifying concept: The application of resources for the benefit of others. Journal of Service Research, 25(1), pp. 3–17.

Vargo, S.L. and Lusch, R.F. (2004). Evolving to a new dominant logic for marketing. Journal of Marketing, 68(1), pp. 1–17.

Watkins, C.E. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. The Clinical Supervisor, 30(2), pp. 235–256.

Willink, J. and Babin, L. (2018). Extreme Ownership: How U.S. Navy SEALs Lead and Win. New York: St. Martin’s Press.

Warg, M., Weiß, P., Engel, C. and Zolnowski, A. (2016). Service-Dominant Architecture: Designing service systems for value co-creation. In: Proceedings of the International Conference on Serviceology. Tokyo, Japan.

Warg, M., Weiß, P., Engel, C. et al. (2025). Translational Service Research and Design Methodology (TSRDM). Working paper.

World Health Organization (WHO) (2019). WHO guideline: Recommendations on digital interventions for health system strengthening. Geneva: World Health Organization.