When Psychology Became a Production Line

An Army Psychologist Reflects on the Bureaucratization of Care

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Entering the Profession: A Different Era of Psychology

When I entered the Army as a young clinical psychologist, the profession still believed in thinking.

My years in uniform unfolded during a distinctive period in military history, the post-Vietnam Army, the Cold War years, and the era surrounding Desert Storm. The military was still absorbing the psychological lessons of Vietnam while preparing soldiers for the geopolitical tensions of the Cold War. By the time Desert Storm arrived, the realities of combat stress and trauma had become impossible to ignore. Those were serious years for military psychology. The human challenges were complex, the stakes were high, and the work demanded thoughtful clinicians capable of exercising real judgment.

A clinical psychology PhD meant something very specific in those days. We were trained as scientist–practitioners. That meant learning how to read research critically, understand its limitations, integrate theory, and apply it wisely to the human being sitting across from us. We were not trained to become technicians who simply applied treatment algorithms. We were trained to think.

That training mattered because the problems we faced were never simple. Soldiers struggling with trauma, family breakdown, moral injury, and the psychological weight of military life did not fit neatly into standardized protocols. Effective care required flexibility, wisdom, and the willingness to adapt treatment to the individual. Psychologists were trusted with that responsibility because the profession believed in the importance of clinical judgment.

Of course there were standards, and there should be. When human lives are involved, clinical excellence is not optional. But what I watched unfold over the decades was not the strengthening of clinical excellence. It was the gradual replacement of professional judgment with bureaucratic systems designed primarily to manage numbers.

Seeing Two Different Eras of Psychology

I spent roughly a decade in active-duty Army service. Years later, after working outside the military system, I returned to the Department of Defense as a civilian clinician and spent nearly another decade there. That gap gave me a perspective few people have. I was able to see the same system from two very different eras.

When I returned, the profession I had once known had changed dramatically.

The language sounded reassuring. Everything was now framed in terms of "evidence-based care," "efficiency," "accountability," and "access." On paper, these goals sounded admirable. In practice, they increasingly translated into centralized appointment systems, rigid treatment protocols, productivity metrics, and session limits that treated psychotherapy as if it were an industrial process.

Psychology had begun to resemble a production line.

Patients were moved through standardized treatment tracks designed to satisfy administrative expectations. Therapists were evaluated by productivity numbers rather than the depth or durability of the healing they helped produce. Administrators spoke confidently about metrics and outcomes while clinicians in the therapy room often saw something very different unfolding.

It looked good on paper. It did not always look good in reality.

Anyone who has worked seriously with trauma knows that healing does not operate on a bureaucratic timetable. Complex trauma cannot be resolved simply because an administrative system has decided treatment should end after a predetermined number of sessions. Real healing requires time, trust, and the freedom for clinicians to think and adapt their work to the complexity of the person before them.

Yet increasingly the system seemed less interested in those realities than in the numbers.

Refusing to Play the Numbers Game

This created a moral tension for many clinicians. Some learned to navigate the system successfully, aligning themselves with productivity expectations and administrative metrics. In large institutions, that behavior is often rewarded. But many clinicians quietly struggled with the same uncomfortable feeling: the sense that the work they were being asked to do no longer resembled the profession they had originally entered.

I never adapted easily to that shift.

Throughout my later years in the system, I frequently found myself in conflict with administrators because I refused to treat psychotherapy like a production line. When policies imposed rigid session limits on patients whose trauma clearly required deeper work, I pushed back. When productivity expectations began to override clinical judgment, I refused to simply move patients through the system.

That stance did not always make me popular, but it reflected something fundamental that had been drilled into us during our training: the clinician's primary responsibility is to the patient, not to the spreadsheet.

I saw mediocrity rewarded. I saw clinicians pressured to prioritize numbers over depth of care. And I refused to bend the knee to it.

The Larger System Behind the Change

What I witnessed in psychology was not unique. Similar pressures have reshaped much of modern medicine. Insurance systems reward volume. Pharmaceutical interventions are easier to scale than long-term therapeutic work. Administrative structures increasingly prioritize measurable outputs that can be reported upward through bureaucratic chains of command.

Many physicians now see far more patients per hour than their predecessors did. Pediatricians and family physicians often have only minutes to address complex medical and emotional concerns before moving to the next appointment.

I know many frontline doctors, excellent, thoughtful clinicians, who quietly acknowledge how difficult it has become to practice medicine in a system that measures success primarily through numbers.

The emotional toll on clinicians is real. Across the country therapists and physicians alike speak openly about burnout, moral distress, and the quiet sadness of feeling that the system has slowly transformed their work into something mechanical.

The Ponerology of Systems

In many ways this reflects a deeper problem in large institutions. The field of ponerology, the study of how systems themselves can become pathological, helps explain how good people working within complex bureaucracies can gradually find themselves participating in structures that distort the original purpose of the profession.

Medicine and psychology exist to heal human beings. But when systems begin prioritizing administrative metrics, financial incentives, and bureaucratic compliance above thoughtful clinical care, the structure itself begins to shape behavior in unhealthy ways.

The result is a system that can appear highly efficient on paper while leaving both patients and clinicians feeling something essential has been lost.

What a PhD Was Supposed to Mean

The scientist–practitioner model that shaped clinical psychology PhD programs was built on a simple idea: clinicians should think scientifically.

Research was meant to inform judgment, not replace it. A psychologist trained in that tradition was expected to evaluate evidence critically, understand its limitations, and integrate scientific knowledge with clinical wisdom.

Over time, however, many healthcare systems began to interpret evidence-based practice as protocol compliance. Nuanced scientific reasoning was replaced by treatment manuals that could be easily measured and audited. But science was never meant to eliminate thinking. It was meant to sharpen it.

When systems reduce evidence to checklists and therapy to protocols, something essential disappears, not science itself, but the thoughtful application of science to the complexity of human lives.

A Word to Fellow Clinicians

If you are a clinician reading this—whether you are a psychologist, psychiatrist, pediatrician, family physician, or therapist—and you feel the quiet weight of this system pressing down on your work, you are not alone.

Many thoughtful providers carry the same tension. They entered their professions to heal human beings, not to serve production quotas or satisfy administrative dashboards. The quiet misery many clinicians feel today is not a sign that they have failed the profession. It is often a sign that the profession has drifted away from the very values that once made it noble.

Reclaiming the Profession

Psychology was never meant to be an assembly line.

It was meant to be a discipline that combines science, wisdom, and human understanding. It requires clinicians capable of thinking independently, adapting thoughtfully, and responding to the uniqueness of each person seeking help.

If the profession is to recover its deeper purpose, we must remember what we were originally trained to do.

We were trained to think.
We were trained to integrate science with wisdom.
We were trained to care for human beings, not simply to manage numbers.

The profession we entered is still worth defending.

And reclaiming it begins with the courage to think independently again.