

Implicit Organizational Bias: Mental Health Treatment Culture and Norms as Barriers to Engaging With Diversity

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There are increased efforts to improve patient–provider relations and engagement within North American mental health systems. However, it is unclear how these innovations impact care for ethnic minorities, a group that continues to face social and health disparities. This study examined one such engagement innovation—person-centered care planning—to gain a better understanding of this overall process. We specifically explored how mental health providers trained in person-centered care planning work with their patients of Latinx and Asian backgrounds. In-depth interviews were conducted with mental health providers in community clinics, and narratives were analyzed via phenomenological methods. Findings revealed that regardless of specific practice innovations, it was providers’ own embeddedness in their mental health organizational culture that became conspicuous as a determinant of care. This culture contained implicit preferences for clients considered to be ideal (e.g., are verbal, admit a problem or illness, accept services, and are individually oriented). These clients were experienced as ideal largely because they helped the system operate efficiently. Findings suggest that these organizational norms, preferences, and expectations—and bureaucratic demands for efficiency—may engender an implicit organizational bias that creates barriers for culturally different groups. These biases may also hinder practice innovations, whether patient-centered, disparities-focused, or otherwise.

Public Significance Statement

Mental health organizations hold norms and expectations regarding what an ideal client should act like and typically prefer clients who help them operate efficiently. This presents serious barriers for cultural minority clients, whose own norms and preferences often conflict with the preferential biases of mental health treatment culture.

Keywords: race and ethnicity, mental health, organizational culture, implicit bias

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To serve an increasingly diverse clientele more effectively, mental health providers are often trained to be culturally competent. Despite this training, the task of responsively working with multicultural populations can remain a challenge for many (Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009). Improving this process is important for many reasons, not the least of which is the possibility of reducing the pervasive health disparities found among various ethnic minority groups (Hernandez et al., 2009; Jackson, 2015). For these groups, the system has often not worked for them or, in many other cases, is rarely considered as a viable or relevant option (Atdjian & Vega, 2005; Desai et al., 2019; Gone, 2004). There thus remains a pressing need for improving mental health practices for and with culturally diverse populations.

Better attending to client culture and values are a major part of the overall move toward person-centeredness among systems of care (Berwick, 2002; Coulter et al., 2015; Davidson et al., 2012; Mezzich, Snaedal, van Weel, & Heath, 2010; Stanhope, Ingoglia, Schmelter, & Marcus, 2013). Person-centeredness in health care shifts the focus away from a narrow deficit or disease model toward an articulation and addressing of a person's values, preferences, and goals; emphasizes coproduced rather than expert-driven care; and has increasingly been accepted as a guiding vision for health care (Berwick, 2002; Davidson, Tondora, Miller, & O'Connell, 2015; Gask & Coventry, 2012). By reorienting service provision toward greater alignment with clients' own goals, values, and support systems, person-centered care may show promise in enhancing therapeutic alliances, incorporating stakeholder perspectives, addressing disparities, and improving engagement and outcomes (Hamovitch,

Choy-Brown, & Stanhope, 2018; Stanhope et al., 2013; Tondora et al., 2010). However, there remain questions about whether aspects of the person-centered model may not correspond to the values and norms of people who are from cultural backgrounds that are not always "person-centered" but instead perhaps family, spiritually, or collectively centered (Tondora et al., 2010).

Cultural critiques of this kind have been common within the area of cultural competence. Cultural competency initiatives have had a long and influential history in attempting to improve the cultural responsiveness of psychological practice and research (Katz, 1985; Sue et al., 1982). Recently, scholars in various mental health fields have suggested revising, expanding, or returning cultural competency toward more critical scrutiny of health provider culture itself and greater attention to structural and sociopolitical issues (Kleinman & Benson, 2006; Metzl & Hansen, 2014; Vera & Speight, 2003; Wendt & Gone, 2012)—issues that the most recent American Psychological Association (APA) guidelines on multiculturalism, race, and ethnicity (e.g., APA 2017, 2019) also address.

The problems of cultural difference and disconnection in mental health care clearly remain a challenge, even in an era of culturally competent and person-centered health care. The present study attempted to learn more about the complexities and shortcomings of cultural engagement in contemporary mental health care, particularly in the context of burgeoning person-centered health care initiatives, like person-centered care planning and shared decision-making. We were interested in examining this process as it pertains to the two fastest growing subgroups in the United States, according to the 2010 Census: the Latinx and Asian diasporas, for whom new information is urgently needed (U.S. Census Bureau, 2011). These two groups have been the subject of recent paired studies including the large-scale, epidemiological National Latino Asian American Study (Alegria et al., 2004; Sanchez, Adams, Arango, & Flannigan, 2018; Takeuchi, Gong, & Gee, 2012), due in part to commonalities in migration history (Alegria et al., 2004). Yet, relative to need, research on these groups, which continue to face xenophobia, harassment, and invisibility in the current climate, is vastly limited (Takeuchi, Alegria, Jackson, & Williams, 2007; Takeuchi et al., 2012).

To discover what may be continued sources of barriers and cultural conflict, we attempted to examine what happens when a provider actually meets and works with a person from the above communities, and vice versa, as revealed through both providers' and clients' descriptions of that encounter. In this article, providers' narratives of the encounter are analyzed and described. It was important to choose a research approach that could reliably access professional viewpoints and yet also get "below" the technical concepts that may be used by professionals to explain their work (i.e., to reveal the concrete experiences underlying



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them; Spiegelberg, 1972). Technical and abstract definitions, although perhaps useful for communication as shorthand between professionals, may impede scientific analysis and clear description of the original events. A phenomenological method was chosen in light of its capacity to critically examine presuppositions and return to and freshly describe the lived experiences in question (Davidson, 2003; Giorgi, 2009). Among the family of qualitative methods, phenomenology is one that was originally designed with the goal of having investigators remain grounded in the lived world and living or lived experience and allowing meanings and themes to emerge from this concrete basis of life-as-lived, rather than by proceeding from or resulting in theoretical constructions (Husserl, 1936/1970; Wertz, 2005; Wertz & Desai, 2013). This approach, which can be used in tandem or in dialog with other culturally responsive methods like ethnography (Good & Good, 2005; Katz & Csordas, 2003), is attuned to accessing and describing professional and community perspectives, the differences or similarities between them, and the sociocultural structures in which both are embedded.

Method

Institutional Review Board approval was obtained from Yale University. The study's main focus was on the Latinx and Asian communities, though other U.S. minority groups were also discussed and addressed in the context of interviews. This study was embedded within a larger randomized control trial evaluating person-centered care planning initiatives at community mental health centers (Stanhope, Tondora, Davidson, Choy-Brown, & Marcus, 2015). The re-

search team included licensed psychologists and allied mental health professionals; a past clinical director of a community mental health center; and persons of Asian, Latinx, and White or Caucasian background.

Settings

Participants for the present investigation were recruited from two of the trial sites in which staff were receiving training and technical assistance regarding person-centered care planning; therefore all providers had at least basic knowledge regarding these efforts at the time of interview. These sites were community mental health centers (CMHCs) in the northeastern United States. In the United States, there are 2,538 CMHCs, which employ a substantial number of psychologists and other allied health professionals (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). State mental health agencies collectively spend nearly \$30 billion, or three quarters of annual national expenditures, on community mental health programs in general, which account for almost 7 million persons served (SAMHSA, 2017). These particular CMHCs are located in semiurban and suburban areas and funded by both Medicaid and state sources.

Participants

The current project featured 37 participants—25 clients and 12 providers—and was focused on understanding culture, supports, and disparities in participants' lives and in the context of care engagement, person-centered care planning, and shared decision-making. This article focuses on the subset of analyses pertaining to the 12 providers, all of whom participated in an in-depth qualitative interview (details below). Recruitment efforts included information sheet handouts and organization-wide announcements. Demographic information for the final participants is presented below in a way to protect anonymity. Ethnicity and age varied (seven reported *Caucasian American/White*, three reported *African American/Black*, and one *more than one race*). Languages were mostly monolingual English ($N = 8$), but *English/Spanish* ($N = 1$), *English/Spanish/other* ($N = 1$), and *English/other* ($N = 2$) were also reported ("other" languages not presented to preserve anonymity). Reported genders were mostly female ($N = 9$; male $N = 3$). Average age was ~ 40 years ($Mdn = 39$). Sexual orientation was assessed but not reported, for confidentiality reasons. Educational levels were consistent with community mental health settings in the United States, including: staff with a bachelor's degree or fewer years of education typically serving as case managers ($N = 6$); staff with master's or graduate level training ($N = 6$); and fewer doctoral-educated personnel ($N = 1$), with a reasonable assumption being that the latter two groups had degrees from a mental



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health or social service field. Finally, average time working in their particular organization was 4.8 years (*Mdn* = 4.5).

Interview Guide and Procedure

The interview guide was developed by research team members in accordance with established phenomenological interviewing principles that focus on obtaining concrete descriptions of experience, rather than judgments or opinions (Wertz, 2005). The guide was developed through a series of team meetings, with the goal of providing questions that would elicit descriptions of everyday situations and scenarios in the context of person-centered care, shared decision-making, and cultural engagement (see the [Appendix](#) for the interview guide). In the interview, providers were asked to describe their recent work with both a Hispanic or Latinx client and an Asian client, if possible. All participants gave their informed consent and, upon completion of the interview, were paid \$40. Interviews were conducted at the mental health organization in provider offices (average and median time length were 39 min 38 s and 41 min 26 s, respectively). Interviews were audiorecorded and transcribed.

Analytic Procedure

The raw interview data were then subjected to phenomenological analyses, which have been used extensively by members of the research team. Specific procedures for the present study consisted of having two research team members transform each of the 12 interviews into a one-page summary of essential moments pertaining to the research foci on culture, person-centered care, and social supports

(Malterud, 2012; Sells, Topor, & Davidson, 2004). This time-intensive process entailed carefully reading the entire interview first to gain a sense of the overall experience and then rereading each line, highlighting passages that spoke directly to the research foci above. This process was repeated until all relevant passages were annotated, followed by a higher order process of determining what was essential to the phenomenon (i.e., eidetic analysis, described below). These essential moments were then compiled into a roughly one-page summary. The 12 one-page summaries were then read and reread to first discover significant thematic domains within each, thereafter producing a new, reordered individual structure outlining key themes and illustrative quotations. From these individual structures, an overall general structure of provider–client engagement vis-à-vis culture was produced, via the use of both comparison and contrast across data and the method of imaginative variation. Imaginative variation, a major component of eidetic analysis, involves analytic steps to clarify what a phenomenon is, while distinguishing its vital, composite features. It is an integral step that moves qualitative and experiential findings into the realm of general knowledge (Wertz, 2010), where conflicting data must be continually integrated into a revised and infinitely revisable structure (Natanson, 1973). Final delineation of the general findings required returning back and forth between the emergent general structure and the individual summaries. The general findings were also read by and discussed among members of the larger research team for verification, elaboration, and refinement.

Findings

Findings reveal that regardless of specific practices, it was providers' own embeddedness in their mental health organizational culture that became conspicuous as a determinant of care, a culture containing implicit preferences for clients that help the system operate efficiently (e.g., clients who are verbal, admit a problem or illness, accept services, are proactive and individually oriented). This culture was made apparent to our research team through providers' descriptions of their interactions with culturally diverse clients and especially through what providers observed as noteworthy, challenging, or incongruent during these encounters. In sum, when providers narrated their work with Asian and Latinx clients, it was paradoxically the treatment, service, or bureaucratic "culture" in which this work took place that became most conspicuous.

The mental health culture and bureaucracy served as an already present starting point for engaging with culturally diverse others, framing providers' perceptions and reality. Within this culture, there were norms for speaking, relating, and understanding (e.g., being verbal, opening up, focusing on feelings, and accepting a problem). Providers, to varying degrees, brought these standards or expectations with them



Maria O'Connell

into their work with clients. To be sure, these norms were often intended to benefit the client, and, as norms, they were not exact or universal. They also shifted depending on the unit (e.g., clinical or case management) or in the context of center initiatives, circumstances, and changes (including person-centered care, corporatization, and budget issues). Nonetheless, there remained a corresponding ideal client for whom the system appears designed to run without tension. The less clients adhere to standard norms, the less ideal they become in the eyes of the system or organization. Below illustrates such a model of an “easy” client:

Q: “[What did] you mean by easy on this one?” *A:* “‘Easy’ in terms of there are clients of low maintenance. They come in, communicate, are open, are willing to change. They’re at a stage of change where they’re really working on their recovery, mental and substance-wise. You just have no issues with them. And they’re very motivated.” (D001)

The above quote succinctly begins to reveal the underlying organizational culture at play for providers, along with the kinds of organizational forces that shape and inform client engagement. The following presentation of findings presents key features of such engagement from providers’ experience. Our intent is not that of provider-blaming but instead of empathic immersion in the situations they face, the structures they must navigate, and the norms they must regularly overcome to meet culturally different clients where they are. Part of our challenge was to remain rooted within providers’ experience while also describing this sedimented culture in which they are almost inevitably submerged and to which their personal experience connects. The focus is on identifying norms

of engagement, with the added understanding that many providers skillfully and effectively negotiate or break these norms in their work to meet clients where they are—even in some of the cases outlined below and sometimes with a person-centered ethos in mind (which are the focus of a separate set of analyses, to be featured in future presentations).

When a Client Walks Into a Clinic

In general, providers were trying to understand what the problems, limitations, goals, and/or supports of their clients were and to get them on the pathway toward improving their situation. Providers could draw from a host of services in this effort, as well as rely on a stock of knowledge, concepts, and other ways of interpreting the client’s situation. Some providers mentioned how this underlying approach was consistent across client background.

[Between English- and Spanish-speaking populations] I cannot really think of anything that makes them necessarily stand out or to be different, or that we have needed to do anything separate for them, you know. [Decisions about care for the Asian population are] not any different than any other clients when clients come in and they participate in the intake. The clinicians’ job is to say, “Well, this is what you’ve presented to me; these are the options that I think would best fit you for these reasons. Is that—what do you want to do out of these options?” And they choose, and then we match them up from there. (D12)

Both the above quote and the next reveal how a certain *acultural* perspective of mental health providers is tied closely to the *menu* perspective on mental health services. A host of problems connect to a menu of services, and various providers see their work as connecting the two, regardless of client background. The menu culture is the truly operative one.

I think it’s just been more generalized . . . how to . . . provide, like, individualized care based on . . . their activities that they are living and whatnot and how to link them to proper services. I really do not think that their ethnicity or anything like that has anything to do with it . . . and then if there becomes a barrier, like, with, like, the culture in regards to like their language or something like that, obviously, we have those programs set in place where additional assistance could be applied. (D005)

Even for providers who express more explicit engagement with cultural difference and ethnicity, there were still imprints of an organizational culture within their descriptions of their work. In the following quote, a provider discussed how the typical process is to help the client pursue “goals,” along with facilitating client “independence” and “empowerment.” The point here is that



Larry Davidson

providers bring with them habits of mind and practice to their work—it is a type of lens through which they view others’ lives.

[In the first meeting] I explain that . . . our program is skill building by nature. We are a guide with them; we work *with* them not *for* them . . . It’s all about the client gaining their independence and working on the goals that they feel that is important, not what I feel . . . should be important. [Person-centered care planning] empowers them that they’re making a decision on their life. (D009)

Ideal and Nonideal Clients

During the engagement process, providers can encounter rough waters, particularly when clients behave in ways that providers experience as conflicting or incongruent with norms and expectations. These clients would not be described by the participant at the outset as easy, nor by the system as efficient. To be sure, there were examples of providers skillfully responding to norm conflicts to their clients’ benefit, but in general, it may be safe to say that an ideal client a day keeps the systemic conflicts or tensions away. The following quote, although referring to American Indian clients, is revelatory:

I feel like for me with Hispanic folks we’re . . . very similar. With the Native American population, we had a lot of, definitely a lot of, differences. How they view mental health treatment, like, actually medicine and stuff like that. You know, that traditional therapies are not the first course of action; there’s a lot of push-back in that. There’s just real cultural divide for me there . . . In terms of person-centered with those folks, I do not know that I did as good of a job.

I’m just thinking of two particular people, but not really wanting to talk about their feelings all that much. So, it’s difficult to dig in . . . which can then be frustrating, and then you’re not really acting in a person-centered way; it’s more methodical. . . . (D006)

In the above, there are several instances of incongruence among this participant’s work with the American Indian population, including clients who question treatment and medicine itself and who prefer not to discuss their feelings or “dig in.” These present considerable problems for a system that is built on treatment, medicine, and discussing feelings (i.e., digging in). When the preferred engagement style was not met, the providers identified themselves as becoming “methodical,” which strongly suggests that, in their eyes, the quality of interaction or rapport suffered when there was strong deviation from the norms of interaction required of the treatment or service menu model.

Not Speaking Much or Speaking “Simply”

Providers encountered incongruence of many types. One of the more conspicuous and central ones involved providers working with a client who did not speak much, remained relatively silent, or was nonexpressive, which, in the following data, were sometimes characterized as irritating, “simple minded,” or failing to “open up.” These presentation styles were challenging for providers working within a system that cannot move forward without speech or language.

I think she’s doing the work inside, but she’s not talking about it . . . She’s very adverse to anything I ask her to, but then you . . . look over and she’ll be doing something. (D006)

Like, I’ll ask her questions and she . . . will not answer them, so, we’ll just wait until you answer. [Other providers] would be like . . . “Can you please just answer the question?” Like, get irritable at her. (D006)

He really was a simple guy. Work [and] family [were] really important to him . . . really didn’t want to work on more than that . . . [In group, he] got something out of listening to others . . . But you also want them to be able to share some of their own experiences and insight, so people can learn from them . . . He was limited in that way. I’m not sure that a whole lot of people learned much from him, because he just was pretty concrete. And I just think that’s who he is. And he’s a decent person, contributing to society. His ideas are just simple . . . he’s pretty simple-minded. (D011)

But some, some ethnic minorities do not. Yeah, they do not want to open up. Especially if they’re male, too. I think a lot of that definitely is cultural. It would be like an embarrassment, absolutely, to have help. (D003)



Victoria Stanhope

Not Accepting, Admitting, or Understanding the Problem or Illness

Another pervasive form of incongruence from the providers' perspective was when an ethnic minority client would not accept or admit to having a problem, illness, or mental health issue or one that requires treatment, medication, therapy, or professional help. Recall, too, that this appears within the context of a service or menu culture, which features clear and distinct services that link to (relatively) clear and distinct problems. Without a problem, what's the service?

I see a lot of ethnic minority people not want to not just relate but admit to the fact that mental health is a reality. Not just admitting that it is a reality but also realizing that just you have a mental health problem it means you need help. You need medication, you need therapy, whatever the case is. (D002)

Providers could interpret clients' family members as diverging from this preferred norm as well.

But the first time I actually met the family was I had gone out on a crisis visit for him, and his parents had called with concerns, and we went out to the home, and actually he had taken a hammer . . . and put holes in the door or something. He was off his medication; he was not doing well. But basically, the feedback from the parents was, well, why does he need to take medication? Can you fix him? When is he going to be fixed? So there was not even an understanding of the mental illness piece. And we tried to explain to the family; this is like diabetes, this is like cancer. (D008)

Divergences were, at times, interpreted as a form of denial or resistance to the underlying problem and/or as having a cultural basis, as indicated below.

What I have found in the Hispanic population is that there is a lot of ignoring of the issue, a lot of just . . . especially with alcohol . . . ignoring the fact that the problem exists. But once it is accepted, then it is almost like, "Alright, I'm just going to stop." There is a bit of a resistance to treatment and all. (D001)

He really didn't identify with alcohol being a problem . . . On the one hand, he was doing really well with [his goal of] staying off of opiates. On the other hand, he really struggled with the alcohol . . . He was, "Fine. I know I shouldn't. I'm going to do what I want to do" . . . I think for him it was about you were not a man if you didn't drink . . . People understood that he couldn't do drugs and that was going to kill him, and he didn't want to do it . . . That seemed to be easier for people to accept. But it didn't seem okay to not drink . . . And especially if you're a man, you should be able to drink [and] not make a fool out of yourself or put other people in danger . . . I could feel for him that this really was not that easy for him . . . He was not going to not be around his family . . . because that was a really important part of his culture. (D011)

Not Doing Anything, Not Holding Goals, or Not Following Recommendations

Both of the above forms of incongruence—being verbal and accepting a problem or illness—were related to the providers' general need for clients to *do something*. It is indeed hard to imagine a system that featured clients not doing anything. Providers worked in a system whose task was to do something, often about problems, and to use speech to conduct this work. In the following quotes, we see how providers experienced significant difficulty when encountering clients who did not appear to do much.

I think that the first meetings were pretty difficult because he did not want to be there, didn't understand why he was there, he was not that compliant and was not stabilized on his medication. So it was really difficult to do anything with him. It was just, I want to go back to school. I do not understand why I cannot . . . So I think that in the beginning again it was a lot of just working with him on the safety issue and, Are you taking your medication? What are the barriers to taking your medication? Are there concerns about side effects? (D008)

The only thing with person-centered care planning that, that I think that is always going to be a losing battle is you have to meet the client where they are at. And, some clients do not want to engage and other clients do want to engage . . . You shouldn't personalize it, but you are going to have some clients that just do not, do not want to do anything. They get into the program and you know they do the bare minimum, or they are very self-sufficient and go both ways, and then they just do not feel a need to have to do any services. I do not really think it's really necessarily all based on, like, their background. I think a lot of times, I mean, you have clients of all different backgrounds that just do not want to do anything, sometimes, and whether it be trust issues, or whether it be they

are very self-sufficient, because I have had, I have had clients who are Hispanic and are very self-sufficient. (D005)

Not wanting to do anything is closely aligned with not having goals, another form of incongruence.

They tell me their goals, and I put it in their own words. We could, you know, we could encourage them, give suggestions and pros and cons and do some brainstorming naturally. Because some, they say, you know, “I don’t know. I don’t have a goal.” (D003)

Some clients did want to do something, but in their own way, not in the way the providers recommended, which clashed with what was normally expected of clients.

He tended to want to create his own program. Do it the way that he wanted to do it versus how we are recommending . . . attendance and really not complying . . . was not necessarily that he didn’t like groups . . . There was a sense that he was above it, that this was not treatment that was going to meet his needs, that he was different from some of the people in the group, which is in of itself a characteristic of those addictions. It’s one of the symptoms of addiction. So, it’s interesting if you have cultural difference which is real. Yet you also have this characteristic that’s part of addiction. [This provider came to creatively work with the incongruence by adapting her style of engagement to something that she saw as a better fit with the client’s style and age range.] (D011)

Nonindividual: Family Involvement, Systemic Oppression, and Beyond

Deep within the mental health culture lied a focus on the individual and an expectation of individualism. The individual—the person’s problems and responses—largely remained the focal point. Further, support systems were, for the most part, viewed in relation to how they may facilitate the individual’s progress. Systemic problems like racism were viewed in terms of what the individual could do in the face of them.

Within providers’ discussion of nonindividual issues, some pertinent trends emerged. Several providers found that intensive involvement of family members was noteworthy, particularly when providers were not of the same ethnic background as their client. The first quote reveals how providers found intensive family involvement as outside the norm but quite helpful. The second quote references a cross-cultural therapeutic dyad featuring an Asian client whose involvement of and respectfulness toward his uncle was seen as unusual but “really cool.”

[The client’s family was] very involved, very family-orientated . . . They would attend the sessions. They would make phone calls to talk about their daughter, what their concerns were . . . [and] the proper level of care that they thought she should be under. They were also *very* supportive (The word “very” indicates that family involvement was non-

normative). It was a blessing for the consumer . . . When all of their components are, all of their treatment providers, all of their supports, are together, it makes for a very successful recovery. (D004)

The thing that was a little different for him is his family was very involved and supportive . . . [The uncle] actually even requested to meet me. That was the only time that that’s happened since I’ve been here. It didn’t seem like an uncle; it felt like I was dealing with his dad . . . I saw the way they interacted together, and there was a lot of respect between the two . . . Another thing that I thought was really cool was how the nephew was accepting of it. (D001)

The system’s individualist expectations, and the propensity to bracket the individual in the midst of wider structures, could extend to structural problems like racism. Here, providers experienced limited options and returned to a focus on the individual and their role, even when deeply attuned to these issues.

I always kind of ask them what their role is in [institutional racism or discrimination]. Because the reality is, no matter how I would feel about it, I cannot change it. That client cannot change the judge or the way that the system works, at least not in their kind of situation. (D001)

Provider’s Embeddedness and Own Incongruence

Most providers are, for the most part, not aware that they are embedded within such a clinic culture in which they hold or apply such norms toward their work. Further, some mental health culture norms are taken for granted more than others are; that is, they are taken up by providers as legitimate, real, and valid without much reflection or awareness. It is reality. However, in some cases, providers may become aware of various norms operating as norms. One key route is when providers themselves experience incongruence with the same system, engendering glimpses into the mental health culture, values, or preferences. This may be particularly possible for those who are from a minority community themselves (though certainly not necessarily). The following ethnic minority provider lamented the lack of focus on spirituality when she began in the field: “When I first started out in this field, you’re told that, like, it’s more biopsychosocial, that spiritual is not really a big focus . . . It’s kind of difficult when you start [and] you come from a [cultural] background where spirituality is a big focus” (D010).

Providers may also have found ways to incorporate personal norms, cultural values, experiences (e.g., of a medical condition, of systemic racism), or nonnormative understandings of their professional role (e.g., entering into a client’s world is “walking on sacred ground”), which may or may not align with the system standard. The following provider discussed her personal motivations for this work

and the familial ways she has found to humanize the above process.

This case, he's a father. He was a husband at one time before he got ill. I think that the person-centered care, for me, is to remember that they are somebody's son, somebody's father, somebody's brother, somebody's sister . . . That's my feeling of it. I kind of always kind of thought that way, if you want the truth. I didn't get in this field to get rich, and I do not mean that in a sarcastic way, but I care. And I'm not going to fix anybody . . . But I'm here to support, offer resources, but I always felt like that to [a] point. I was very happy when, a few years back, they wanted to try to drive our goals toward more person, personable . . . It's about time somebody, just to plant the seed even. [B]ack to humanistic and, you know, all of that. And it's their treatment plan, it's not mine. (D003)

Even in these cases, however, providers still found themselves within a system founded on standard or ideal practices. To bring in these alternative perspectives, creativity or resistance may be required.

Discussion

This phenomenological study examined cultural engagement among providers in community mental health and observed that the surrounding organizational culture, and its hidden architecture, was a main determinant of care—and a potential source of institutional bias—toward Latinx, Asian, and other ethnic minority communities.

The Invisible Architecture of Mental Health Organizations

Clinics are built with bricks and mortar and concrete. This is the visible architecture of the building. But there is also an invisible architecture to the building, hidden walls that are difficult to perceive at first glance, but they are no less real and no less crucial to the clinic's operations than the raw physical materials are. The clinic's building blocks found in this study included speaking; doing something; understanding or accepting a problem; focusing on goals and results (and, at times, empowerment); accepting recommendations; and being receptive to treatments, medicine, and services. What is a modern clinic without the vast majority of these? Our main finding of this study of providers' work with Asian and Latinx or Hispanic populations was that there was this invisible culture of the clinic and that, within it, there were ideal ways and styles that helped the system function normally and efficiently. Clients who fell outside of these norms presented challenges for providers, who, at times, experienced their capacity to be of service as reaching limits, suffering, or requiring modification. (Participant D006 also mentioned more dismissive behavior of other providers vis-à-vis incongruent clients.) This implicit organization became an implicit organizational bias. That is, the

mental health culture could be a kind of a wall. This was a wall of norms, of what was considered to be (or needed to be) normal, for the system to move forward efficiently.

It is indeed difficult to imagine a clinic in the United States that does not heavily feature services, treatments, and a focus on results or recovery, let alone doing, talking, or tacit communication norms, like “opening up” or “digging in” (Gone, 2011, p. 295; Katz, 1985). Providers' care for their client often needed to be contained within these boundaries of engagement. A major problem suggested here, however, is that the system may, at times, be structurally unable to think outside of itself, encouraging a particular way of practicing while preventing more expansive engagement with what's beyond, such as social-, spiritual-, cultural-, and societal-level struggles, like racism. A quote from a past study on how sociocultural issues get left out of clinical encounters is revelatory in this regard: “I think the services are OK, right, but do they get to the core of the matter about how things truly affect the community we live in? Not even a drop. Not even a drop in the bucket. (African-American participant)” (Delphin-Rittmon et al., 2013, p. 148; cf. Cohen, 2017).

Further, these findings suggest that incongruence could lead to the entire process stalling or falling apart for the client and that providers themselves could become alienated or experience incongruence. Adaptation was of course possible, but the point is that for a potentially vast population, the frame does not fit. In addition, what is considered to be “care” usually must adhere to select boundaries, leaving out other potentially effective, culturally responsive, or supportive practices that may not fit within this structure (the incorporation of which is, in theory, supposed to be a part of person-centered care). Just to take one counterexample, there are many healing practices not avoidant of but founded on silence. Silent meditation, influenced in great part by Asian practices, is increasingly becoming a part of health systems, but in these traditions, one would certainly not find remaining silent a barrier to well-being. It is a key driver of it. One could similarly find counterexamples of transformative psychosocial practices for the other norms identified above, from nearly every corner of the globe—from the silent, body-based practices of Asian Indian tradition to the indigenous practices of American Indian communities (Gone, 2013; Wendt & Gone, 2012) and most nonindividual-centric interventions or social actions.

Whose Culture?

It is increasingly apparent that there is a culture of the clinic. Scholars have cautioned about the failure to acknowledge and address this implicit culture of mental health or “psy” fields, including the potential for erasure of cultural difference, and have shown how these are often modeled on Euro-American ideals and archetypes (Alegria, Atkins,

Farmer, Slaton, & Stelk, 2010; Bess, Prilleltensky, Perkins, & Collins, 2009; Desai, 2018; Fernando, 2014; Gone, 2004, 2008a, 2008b; Gone, 2016; Katz, 1985; Kirmayer, 2007; Kleinman & Benson, 2006; Wendt & Gone, 2012). Writing in the context of the American Indian community, Gone (2007, 2008b) has argued that the culture of the clinic regularly conflicts with the culture of the community, often in problematic ways. His work has revealed fundamental differences, or “incommensurabilities,” between mental health culture and American Indian cultural notions of cause, assessment, care, communication, and norms of distress and well-being, the latter prominently featuring explicit incorporation of historical trauma, indigenous healing, ecological connection, cautious expressivity, and alternative ways of knowing (e.g., Gone, 2004, 2008b, 2016). One important lesson of this research that speaks to issues raised in the current study is that mental health providers are themselves enculturated and that this enculturation needs to be better recognized and critically examined as such (Gone, 2004).

Our article adds to this literature by focusing our phenomenological inquiry on providers’ work with Asian and Latinx populations. We empirically dove into sources of incongruence at the organizational level, further revealing the specificities of mental health culture, including its norms, rules of engagement, and, of importance, demands for efficiency that often transcend this or that provider. Providers certainly do bring their own cultural backgrounds with them, but there is a wider system culture in which they too find themselves. Even the most culturally savvy providers are left to navigate these rules, norms, and bureaucracies, which the system makes it difficult to think beyond because there would then be no system at all. Difficult—but not impossible. Nonetheless, the crux of the dilemma outlined here is that key sources of barriers are, at the same time, the essential components of the system itself. Implicit organizational biases may then ensue.

Why Culture? Beyond the Clinic

Our qualitative study revealed some of the local stories of the care system once clients are already in the door, but there is perhaps a broader issue at stake. The mental health system and culture in North America and arguably elsewhere may not work for many of its intended beneficiaries. Most mental health or evidence-based practices presuppose some form of being verbal, accepting a problem (or illness), doing something, being open to treatment, and so forth. These are widespread, taken-for-granted assumptions that implicate nearly the entire gamut of the mental health fields. They are reality, that is, taken-for-granted as reality (and, as a result, impact clients of any cultural background—even the word *client* reflects these assumptions). Awareness of these norms and their implications is an important place to

start. However, the concern is that unless these systems begin to let in more of the world and its diverse ways of being, so that the community sees themselves and their lives as reflected in it (Desai et al., 2019; Kirmayer, 2012; Sundararajan, 2018), there will continue to be incongruence. Maybe a health system in and of itself is a cultural presupposition, but there may be room to change its meaning and structure to be more responsive to (e.g., diversity) or critical of (e.g., injustice and oppression) what is around it (Bess et al., 2009; Metzl & Hansen, 2014; Vera & Speight, 2003).

There is an allied need for vigilance regarding how an institution’s or discipline’s own norms can reflect such institutional biases and how these biases are tied to deeply entrenched historical, political, and racial entanglements and enactments (Adams, Dobles, Gómez, Kurtiş, & Molina, 2015; Bhatia, 2017; Bulhan, 1985; Fanon, 1952/1967; Fernando, 2017; Gergen, Gulerce, Lock, & Misra, 1996; Martín-Baró, 1994). This has direct implications for psychologists and mental health providers to better address institutional bias in which their own disciplines may play an unwitting role (Prilleltensky, 1997; Vera & Speight, 2003). In the specific context of mental health organizations with singular or interdisciplinary teams, there is a need to examine for whom and for what ends current standard operating procedures (of treatment settings and professional disciplines) are currently designed and to challenge and change the biases therein, preferably in partnership with key stakeholders and marginalized communities (Bess et al., 2009). Developing organizational bias assessment tools and infusing community input into all levels of health service administration—from clinical policy to waiting room procedures and aesthetics—are two concrete recommendations to facilitate this process.

Where Is Culture? The Need for Expansive Structural Competency

Cultural competence, in this light, may thus entail greater understanding of the culture of the clinic or organization itself and how it relates, welcomes, or rejects the communities around it (Alegría et al., 2010; Gone, 2004; Katz, 1985; Kleinman & Benson, 2006). This is in line with how structural competence has been recently discussed (Ali & Sichel, 2014; Hansen, Braslow, & Rohrbaugh, 2018; Metzl & Hansen, 2014). Structural competency addresses the social structural determinants of health and mental health, and the structure found in this article is that of the mental health system itself. But that is not the only system. Indeed, in a conjoined set of analyses, it was found that frontline clinical and case management providers are constantly being inundated by systems external to the classical notion of mental health work, such as corporatization, bureaucracy, major budget constraints, institutional racism, state demands, gatekeeper demands, and beyond. The system itself needs a

structural competence intervention, becoming more cognizant of its own organizational culture, a kind of critical awareness of the fishbowl that it is in, but also about how that fishbowl is being overwhelmed by waters coming from a veritable endless ocean of competing and often conflicting demands, which move against what most would consider the work of mental health (Cohen, 2017; Gask & Coventry, 2012). This latter piece is, of course, an increasing concern for many clinicians (as was also revealed, for instance, by Ware and colleagues 20 years ago in their study of clinicians' concerns about managed mental health care and its economic and bureaucratic demands; Ware, Lachicotte, Kirschner, Cortes, & Good, 2000). Our suggestion is that these above dimensions of real-world practice need to be taught and critically analyzed alongside what is considered to be clinical theory and technique, which, in their pure forms, are essentially found nowhere.

Limitations

There were several limitations of this study. The data collection relied on individual interviews, which are limited in their capacity to elicit the full range of collective-level processes. Future research may want to utilize ethnographic or in vivo methods of data collection as well. In addition, future research may also want to more closely examine within-group and between-groups differences and to study culturally informed programs to determine whether these norms are at play when a clinic adopts an explicit alternative paradigm (Wendt & Gone, 2012; Zane, Bernal, & Leong, 2016). More longitudinal research on providers long after receiving person-centered or other forms of training is warranted, given that this study was probably reflective of the early stages of the transformation. Similarly, there have been recent guidelines produced by professional bodies like the APA (2017, 2019) on the topics of race, power, privilege, difference, oppression, and disciplinary bias, and it will be important moving forward to observe the effect of these kinds of initiatives on the structural biases in mental health organizations described here (see especially Guidelines 2 and 5 in APA, 2017 and Guideline 4 in APA, 2019), especially given that individual implicit biases may vary based on type of training or discipline (Hall et al., 2015). Nevertheless, one implication of the present study is that hidden organizational norms, structures, and demands may still push against the work of even the most culturally and structurally attuned providers and therapies. Finally, a note on delimitation: The general structure described above regarding provider–client relations is not suggested to be the only possible one—but it is suggested to be possible, and pervasive, nonetheless: In sum, that which the mental health system requires from people may be, simultaneously, that which pushes some of them away.

Conclusion

The findings revealed that, in this study of provider engagement with multicultural populations in the context of person-centered care, it is the culture of the mental health system itself that may pose substantial barriers to a more robust engagement with client diversity. These structural barriers and organizational biases persist despite, and may even coopt and work against, emerging practices focused on empowering the client (which themselves may unintentionally recapitulate certain system norms). In this article, we have described general themes regarding these system norms, ideal clients, and incongruence, which we argue can be found far beyond these particular halls and walls. All of these are in play before a client ever walks in the door. The central message suggested by this study is to consider removing, rather than building, yet another new wall.

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Appendix

Interview Guide

Reflect on your recent work with a client of [Hispanic/Asian] background

(or a client from an ethnic minority background, if they cannot recall a specific case from the above)

1. How did it go, working with this person?
2. What were their main concerns that you worked with them on?
3. What happened in the first meetings?
4. How were decisions made with regard to their care?
5. What was helpful about the person-centered care planning process?

6. What could the person-centered care planning not address in the client's life?

7. Was their family involved or discussed? How so? Other supports?

8. Were there aspects of your intervention that you had to modify due to the culture or language of the person?

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