Published in final edited form as:

*Clin Psychol Sci*. 2023 May ; 11(3): 476–489. doi:10.1177/21677026221133053.

# System-Centered Care: How Bureaucracy and Racialization Decenter Attempts at Person-Centered Mental Health Care

**Miraj U. Desai, PhD**[1,2], **Nadika Paranamana, MA**[3], **John F. Dovidio, PhD**[4,5], **Larry Davidson, PhD**[1,5], **Victoria Stanhope, MSW, PhD**[6]

[1]Program for Recovery and Community Health, Yale School of Medicine

[2]Yale University South Asian Studies Council

[3]University of Hartford, Department of Psychology

[4]Yale University, Departments of Psychology and Epidemiology

[5]Yale Institution for Social and Policy Studies

[6]NYU Silver School of Social Work

## Abstract

This article presents a study exploring structural biases within mental health organizations, in the context of person-centered care—an emerging framework for health systems globally. Findings revealed how surrounding institutional structures conditioned a powerful influence on clinical operations, in which there is a risk for clients to be systemically seen as a non-person, that is, as a racialized or bureaucratic object. Specifically, the article elucidates how racial profiles could become determinants of care within institutions; and how another, covert form of institutional objectification could emerge, in which clients became reduced to unseen bureaucratic objects. Findings illuminated a basic psychosocial process through which staff could become unwitting carriers of systemic agenda and intentionality—a type of "bureaucra-think"—and also how some providers pushed against this climate. These findings, and emergent novel concepts, add to the severely limited research on institutional bias and racism within psychological science.

### Keywords

institutional bias; mental health services research; health system; clinical psychological science; implementation science; structural racism

Patient- and person-centered care, and related variants, are fast-becoming a staple of health systems in North America and around the world. At stake in the initial formulations of these approaches within medical and healthcare settings was awareness— often born of the

Correspondence concerning this article should be addressed to Miraj Desai, Yale PRCH, 319 Peck St., Building One, New Haven, CT 06513. Contact: miraj.desai@yale.edu.

Contributions: Conceptualization: M. Desai; J. Dovidio; L. Davidson; V. Stanhope; Methodology: M. Desai; L. Davidson; Formal Analysis: M. Desai; N. Paranamana; L. Davidson; Investigation: M. Desai; N. Paranamana; Funding Acquisition: M. Desai; L. Davidson; V. Stanhope; Writing – Original Draft Preparation: M. Desai; Writing – Review & Editing: M. Desai; N. Paranamana; J. Dovidio; L. Davidson; V. Stanhope

sociopolitical movements of “patients” themselves—of how the person was getting lost in the predominant service focus on disease, deficit, and medicalization (De Maeseneer et al., 2012; Groves, 2010; Mead & Bower, 2000). Movement away from paternalistic professional models towards greater focus on shared decision-making, empowerment, and the whole person has gathered momentum (Gask & Coventry, 2012; Groves, 2010; Mead & Bower, 2000), with wider system transformation efforts ensuing. Attempts to implement these strategies, however, still encounter professional and organizational resistance to reorienting care towards the person (Gask & Coventry, 2012; Tondora et al., 2014; Tondora et al., 2014). In addition, much still needs to be learned about whether and how the shift towards person-centered care and shared decision-making addresses the health inequity, disparity, and discrimination that communities of color continue to face (Alegría et al., 2017; Gask & Coventry, 2012; Tondora et al., 2010).

On face value, re-centering care towards person-centered elements of mutual respect, collaboration, and empowerment may in theory be a reprieve for populations who have historically encountered the opposite from societal institutions—trends from which health institutions have not been immune (Alegría et al., 2017; Bailey et al., 2021). Indeed, various reports have called for person- and, increasingly, people-centered care—which places even greater emphasis on addressing the social context of health—as an integral part of the response to the pervasive problem of health inequities (Cloninger et al., 2014; De Maeseneer et al., 2012; World Health Organization, 2022), with the World Health Organization placing people-centeredness as central to achieving the Sustainable Development Goals related to health, and to the allied goal of sustaining genuine universal health coverage within global communities.

However, there is increasing evidence that, despite person-centered aspirations, there remain impediments to quality care for racially, ethnically, and culturally minoritized populations that rest deep within the health system or organization itself (Alegría et al., 2010; American Psychological Association, 2017, 2019; Desai et al., 2021; Gone, 2004, 2008a, 2008b; Hernandez et al., 2009; Jackson, 2015; Katz, 1985; Metzl & Hansen, 2014; Vera & Speight, 2003; Wendt & Gone, 2011). For instance, implicit bias research has suggested that subtle forms of prejudice may negatively influence patient-provider encounters, even for persons with overt commitments to diversity (Blair et al., 2011; Dovidio et al., 2008; Hall et al., 2015). These biases are believed to result in differential and lower quality treatment, care decisions, and attitudes towards minoritized patients (Hagiwara et al., 2020; Hall et al., 2015). While individual-level bias may affect the quality of care that communities of color receive, systemic bias and racism also play an important role (Feagin & Bennefield, 2014). Systemic racism implicates the very structures that undergird society, including the policies, norms, and institutions therein, which shape and are shaped by individuals, but often transcend them. Research has strongly indicated the need to examine these sources of bias and racism beyond the individual, such as within the processes and practices embedded within the health institution itself that lead to compromised care, mistreatment, or worse (Bailey et al., 2017; Desai et al., 2021; Fanon, 1952/1967a; Feagin & Bennefield, 2014; Gone, 2008a; Henry, 2010; Johnson, 2020; Metzl, 2009; Paradies, 2006; Thompson & Neville, 1999; Williams, 2012; Williams et al., 2019).

In one recent article, researchers (Desai et al., 2021) found that regardless of an explicit shift towards person-centeredness, the pre-existing mental health treatment culture remained a major determinant of care. This mental health treatment culture held Eurocentric norms for how clients should behave in order to obtain optimal care (e.g., be verbal, admit an illness/problem, and accept services). These norms received their full exclusionary power by becoming codified as a bureaucratic principle; that is, they were what the system required of clients for the organization to remain financially and operationally efficient (e.g., a clear problem definition, a menu of services, and speech to conduct this service). Implicit *organizational* biases formed against clients who did not readily enact these socio-institutional norms. The overall concept of "implicit organizational bias" therefore refers to the ways in which bias may become inscribed within the hidden norms and functions of organizations, especially how these organizational (institutional) structures help *shape* staff perceptions and behaviors, in biased ways.

As this is a still-growing area of inquiry, more knowledge is urgently needed on how systemic and institutional sources of racial and ethnic bias are sustained within health and other organizations, including the psychosocial processes associated with them. Within psychology, the science of systemic and institutional bias and racism remains grossly underdeveloped. This is despite work in the broader social sciences suggesting that these structures are major contributors to ill health, inequality, and injustice (Bonilla-Silva, 1997; Feagin & Bennefield, 2014; Henry, 2010; Metzl & Hansen, 2014; Paradies, 2006; Ray, 2019). The limited understanding of systemic and institutional bias persists despite being pointed to as such for decades by intellectuals and activists of color (Desai et al., in press; Ture & Hamilton, 1967), including direct challenges to psychology and psychiatry by luminaries like Martin Luther King, Jr. and Frantz Fanon (Fanon, 1952/1967a, b; King, 1968). What is particularly lacking in the psy- fields are descriptions of the psychosocial mechanisms through which systemic problems manifest and proliferate. This lack owes, in part, to limitations in existing research paradigms that have focused primarily on individual bodies, brains, or minds.

The present research, employing a structural qualitative approach (Davidson & Cosgrove, 1991, 2002; Desai, 2014; Fanon, 1952/1967a; Husserl, 1936/1970), extends recent work by more closely describing how systemic demands within the mental health organization and surrounding world co-determined mental health providers' engagement with their clients of color. Understanding how these *hidden*—and therefore elusive—forms of institutional bias affect health and social services is important both scientifically and clinically: Scientifically, it offers greater insight into the multi-level impacts of sociocultural bias; clinically, it informs interventions to improve the quality of mental and physical healthcare provided to clients and patients, particularly those who have traditionally received lower quality of care because of their social group membership (Smedley et al., 2003).

## Method

### Overview

This project was approved by the IRB of Yale University. The study was a supplemental to a larger project focused on evaluating person-centered care implementation at the

organizational level, via a mixed-method RCT design (Stanhope et al., 2015). The study sites were two community mental health centers (CMHCs) located in semiurban and suburban communities in the northeastern United States, with Medicaid and state-based funding. There are over 2,500 CMHCs in the United States, comprising a central feature of the community mental health system (Substance Abuse and Mental Health Services Administration, 2018). Qualitative interviews were conducted with 12 providers at CMHCs who were in the process of receiving training on person-centered care planning. The sample size exceeds established standards for phenomenological research (Giorgi, 2009). Participant demographics are reported in the Results section, and additional detail regarding setting and related information can be found in an earlier paper (Desai et al., 2021).

Study team members included people of Asian, Latinx, and White background, a former CMHC administrator, and experts on mental health inequity, recovery-oriented practice, and phenomenological research. In addition, two of the authors are Licensed Psychologists, one is a doctoral-level Clinical Psychology trainee, and another is a Professor of Social Work. All authors share a strong interest in addressing inequities within mental health and social services.

## Qualitative Interview

Semi-structured interviews focused on obtaining concrete descriptions of providers' most recent work with a client of a racially and ethnically minoritized background. The initial focus of study design was on Latinx and Asian persons, but it also included opportunities for providers to discuss in the interviews persons from other groups (e.g., African American and American Indian clients). The semi-structured interviews included questions about standard person-centered processes such as involvement of support systems, style of decision-making, and any modifications for culture (see Desai et al., 2021). The phenomenological style of interviewing additionally allows participants to guide the interviewer towards aspects of the phenomenon that researchers may not have initially considered (Wertz, 2005). The average interview time was approximately 40 minutes (M = 39m:38s; Mdn = 41m:26s) and occurred in clinic offices. The first author conducted the interviews, which were audio-recorded and subsequently transcribed.

## Qualitative, Phenomenological Analysis

The data were analyzed via qualitative, phenomenological analysis (Davidson, 2003; Malterud, 2012; Sells et al., 2004). Qualitative, phenomenological analysis is a ground-up method that seeks to produce general knowledge of phenomena by rigorously analyzing concrete examples of them (Wertz, 2005). In this study, the concrete examples consisted of providers' work with clients of color *within* institutional contexts. Given that this qualitative method does not proceed deductively from established psychological theory, it is particularly suited for examining phenomena for which there is limited information *and* for examining phenomena that concern minoritized populations that have often been excluded from psychological science (Desai, 2018; Laubscher et al., 2022).

Two forms of analysis were utilized to arrive at general, qualitative knowledge: (a) intentional analysis and (b) eidetic analysis (Wertz, 2005). Intentional analysis is primed

to elucidate the relationship between psychological process and worldly context and was specifically utilized to describe *what* clients come to be perceived *as* in a mental health organization, and *how* they come to be perceived in that way. Eidetic analysis, in turn, involves moving from particular examples towards a more general, structural delineation of a phenomenon, that is, what it is (Wertz, 2010). Eidetic analysis is evidence-driven and lends phenomenological research its scientific character, meeting scientific standards of falsifiability (Wertz, 2010). To arrive at these descriptions of general essences or themes, both empirical variation and what is known as "imaginative variation" are utilized. These procedures involve rigorously varying the central themes and their interrelations to determine what is essential from what is not. Doing so helps to clarify central characteristics or patterns amidst the wider flow of experiences, which in this study were experiences in and of mental health organizations. These analytic procedures have been usefully compared to an analogous procedure in quantitative research of determining the central tendency of phenomena (Giorgi, 1997). One basic way to observe the eidetic analytic process is to trace how, in the Results section that follows, the highest level of heading pertaining to institutional bias (e.g., "Bureaucratic Centering") is supported by variations on this central theme (e.g., [perceiving a] "Person as One Among a Very Many and as Easily Forgotten"; [perceiving a] "Person as Agenda Item, as Paperwork, and as a Unit of Time"; etc.). These sub-variations are, in turn, supported by concrete empirical, experiential data and participant quotes. Each level of heading, or link in the structural chain, helps ground the other. At the bottom of the chain is concrete experience, which serves as the most basic evidentiary root, upon which higher levels of generality are founded. Together, these present an interrelated *and* evidence-dependent general structure.

Additional, extensive scientific justification of these phenomenological methods have been provided elsewhere (Giorgi, 2009; Wertz et al., 2011). Finally, it should be noted that the generation of psychological and cultural knowledge based on in-depth analysis of concrete examples, such as the type found in this study, has long been an essential part of the history and scientific development of the psychological fields (Giorgi, 2009; Wertz et al., 2011). The specific techniques employed in the current study are described next (Davidson, 2003; Malterud, 2012; Sells et al., 2004).

## Analytic Procedure

We have followed established phenomenological analytic procedures articulated by Davidson and others (Davidson, 2003; Malterud, 2012; Sells et al., 2004), and our underlying epistemological approach is informed by phenomenological psychology (Davidson, 2003; Giorgi, 2009; Wertz et al., 2011; Wertz et al., 2018), with extensions for racial and sociocultural considerations (Davidson & Cosgrove, 1991, 2002; Desai, 2014; Laubscher et al., 2022). The first technical step in the analysis of interview data involved two team members conducting close readings of each individual interview, line-by-line, to demarcate specific verbatim lines that speak most directly to the study questions. This is a time-intensive process that entails reading and re-reading the transcript to demarcate relevant "meaning units." Through this process, the analyst produces a roughly 1-page summary that captures essential moments of participants' experiences that speak directly to the study questions (Sells et al., 2004). The general standard for inclusion of a meaning

unit is whether it represents a central dimension of a participant's experience, as narrated by them, without which the summary would lose a key, critical dimension of participants' experience of the phenomenon—thereby crystallizing both intentional and eidetic analysis at this initial, idiographic level (Wertz et al., 2018, p. 115). The 1-page summaries also transform data from a raw, large interview transcript to an analyzable protocol, facilitating subsequent comparisons across individual interviews. In sum, this step "organize[s] and synthesize[s]" raw interview data into a narrative that is concise enough to be "coherent and yet is revelatory of the complexity and richness of the descriptive details" (Sells et al., p. 254).

From these 1-page narrative summaries, the first author began detailing and drafting the emerging general structure of the connection between systemic and psychological process in the context of person-centered care with people of color and met early with the team's senior phenomenologist to discuss it. The first author then iteratively returned to the data to refine the evolving structural description and to further ensure groundedness in the empirical data. Empirical and imaginative variation continued to be utilized to develop general knowledge that coheres across individual instances (Wertz, 2005). The ensuing description was then member-checked by the second protocol analyst (who had robust familiarity with the raw transcripts), and by the two senior methodologists on the team, for fidelity to the phenomenon, which is a key marker of validity in qualitative research (Levitt et al., 2018). That our team included people with lived experience of mental health service use, former CMHC administrators, and people of color provided an additional *experiential* validity check (Wertz et al., 2011). Given that phenomenology involves the analysis of lived experience, it also seriously considers the viewpoints of external stakeholders with direct experience of the phenomenon as yet an additional validity check; specifically, we received confirmatory feedback after presentations given to three respective groups of practicing psychologists, to healthcare practitioners outside of mental health, and to stakeholder advisors with lived experience of mental illness who work with our program. This total process above was utilized to achieve a satisfactory degree of methodological "fidelity to the subject matter" and "utility in achieving research goals"—standards delineated by a recent panel of qualitative experts (Levitt et al., 2018, p. 33).

## Results

### Demographic Details

Providers were mostly White (N = 8), with some providers of African American/Black (N = 3) and more than one race (N = 1) backgrounds. Languages were monolingual English (N = 8); English/Spanish (N = 1); English/Spanish/other (N = 1); and English/other (N = 2). (We have omitted reporting "other" languages and sexual orientation to protect participant anonymity). Reported gender was Female (N = 9) and Male (N = 3). Participants' educational background were representative of a typical US-based community mental health center, including a relatively large proportion of master's or graduate-level education (N = 6); a group with bachelor's degree or fewer years of education (N = 5), often working as case management and support staff; and a smaller group with doctoral-level education (N = 1), typically hailing from a mental health or social service field. Of note for this study is that

the average time working in a respective organization was approximately five years (M = 4.8 years; Mdn = 4.5). We did not provide demographic background alongside specific quotes to protect anonymity.

## Results Overview

Findings reveal that provider efforts to center the person in community mental health services competed with pressures to characterize the person ***in the way the bureaucracy sees them as***—for example, as an object, a number, paperwork, or as a racialized caricature. The goal of person-centering thus competed against ***system-centering.*** System-centering entailed viewing the person as not a person but as they were perceived within the system's meaning contexts of overworked bureaucracy, financial constraints, legal imperatives, and racialization and racism. We term these processes through which staff can be conditioned by systems and institutions to perceive and attribute objectifying meanings as "bureaucra-think" and "bureaucra-seeing," respectively.

The findings and themes we present narrate how providers had to contend with this range of possible ways of seeing their clients. While there was evidence of successful attempts to personalize care, that is, to see the person, providers also worked within a system that presented alternative agenda on them and their work, including bureaucratic ways of framing clients. These pressing demands could lead to a kind of therapeutic attitude that is impersonal (a process which many providers were actually aware of and struggled against). The following presents key empirical examples that illustrate this tension between person-centering aspirations in care and dehumanizing tendencies in the system. We first describe two key variations of structural perception—bureaucratic and racialized—followed by describing providers' efforts to contend with them. Please see Table 1 for a list of major themes and subthemes.

## Bureaucratic Centering

For community mental health providers, the surrounding bureaucracy, large caseloads, budget challenges, tasks and to-dos were a backdrop to their day-to-day experiences. Even if these pressures were to fade into the background, findings show that they could exert considerable psychological influence on the total situation, including how clients could become perceived and *perceived as*, upon entering an institution.

The narrative data below highlight variations of bureaucratic centering, by describing how a client could become viewed as: that is, (a) *as* low-in-priority; (b) *as* bureaucratic objects like agenda items, paperwork, or units of time; or (c) *as* culturally non-distinct—and (d) how the providers themselves could become disillusioned and/or needed to push back against this climate.

**Person as One Among a Very Many and as Easily Forgotten—**Most providers' experience of time was that time was limited, but there was the caseload that you needed to get through, sometimes bordering on triple digits. Along with time, memory of each person could be limited. A culture of overwhelm could emerge, wherein clients were prioritized by

providers along a continuum of severity, with some clients or concerns viewed as lower in priority. For these clients, providers can lose sight of them and their needs.

> You have this large caseload you're seeing people in different modalities … So if it's somebody that's not doing well and you're seeing every week or every other week they're kind of on your radar. But if it's somebody that's pretty stable and maybe you're only seeing once a month or maybe seeing in kind of more of a maintenance stage group you may not remember all those nuances that's going on with them and you may miss following up on something that's important because of that. (D005)

> [A] lot of times you come into the office and you start to listen to your voice mails and you hear, 'Hey, I'm in jeopardy of being put out of my apartment.' 'Hey, I'm in lock-up.' 'Hey, my lights are about to be cut off.' 'I've got bedbugs.' And you, you know, you take all these things and you have to prioritize what the needs are so that you can meet the most. (D009)

In the next quote, a provider similarly describes how detailed memory of each client would, in an ideal sense, be integral to quality work, but that their large caseload prohibited such an expansive awareness.

> [A]t the time when I was first seeing him I probably had 80 to 90 people on my caseload. So sometimes it's hard to remember exactly where you left off with somebody … So I think having that on the treatment plan saying you're supposed to follow up with [this specific issue], that would have been helpful for me then when I saw him again in two weeks. (D005)

**Person as Agenda Item, as Paperwork, and as a Unit of Time—**In the next variation of bureaucratic centering, providers expressed a kind of mechanical way of working that can take hold within an agenda-filled, under-resourced, and paperwork-dependent environment. In these instances, the person before them could be perceived as how the bureaucracy, behind them, sees them—as an agenda item.

> If I'm being mechanical in a session, I slow down, because I, being a supervisor, I have a lot going on and so sometimes, like I said, I can be mechanical like just chop, chop, get it over with. I have my next agenda thing coming. (D003)

Providers described how required agenda like paperwork, despite efforts to incorporate the person's viewpoints in it, often become impersonal due to the time constraints mentioned previously.

> [System] time constraints and paperwork in Community Mental Health is not conducive to personal-centered care planning … sometimes I'm creating it for them. (D007)

**Person as Bureaucratically and Culturally Identical—**These structural limitations could translate into cultural limitations. Specifically, time and personnel limitations could lead providers to view diversity work as yet another strain on resources. This viewpoint could lead to treating clients, implicitly, as bureaucratically and culturally identical, even for

those providers who desired to work better across cultures. The following quote expressed this reality succinctly.

> The realities of time constraints and staff and resources … There's all kinds of stuff that I think would be great for different cultures. But there's a budget. And there's a number of people. (D002)

**Provider as Unrecognized Corporate Employee—**Finally, providers, as person themselves, can also feel this impersonal aura, in which they experience a lack of genuine recognition and of being seen. For instance, one provider perceived the system's new corporate norms and initiatives as an intrusion, and their associated demands as devaluing her own work with and efforts on behalf of her clients. Disillusionment ensued.

> We're implementing some new … corporate thing where we have to have a meeting … And I found myself tearful, it's more work to do for the company … you're never acknowledged for the work that's happening in the group rooms, the clients, or the work that you're doing to help them. (D007)

## Racialized Centering

Within this organizational milieu—in which institutional forms of perception and meaning-making were possible—racialization, racism, and stereotyping could fester, often through hidden means. The data provided below illuminate how racial objectifications could become institutionalized based on how a person is viewed by the bureaucracy (e.g., as a criminal, a safety threat, etc.). At stake in these descriptions is how racial stereotypes and profiles get concretized within and between institutions *as reality*; that is, how racialized descriptors can *become* the person, with negative implications within wider systems such as education and law. We present four variations of this broader theme of racialized centering, or four specific ways in which persons can be seen: (a) as racialized caricature and stereotype; (b) as criminal; (c) as possible suspect; and (d), for providers, as racialized and gendered.

**Person as Racialized Caricature and Stereotype—**This first quote reveals the basic, interpersonal form of stereotyping between providers and clients, as relayed to this provider by a Latinx client.

> [A Latinx client] feels like they're being belittled or talked down to by providers … the stigma, 'twenty-five of us live in a house and we don't work' … [Clients] say that they feel that kind of negativity coming from people when they're dealing with them. And I would imagine that it would come out when … they're presenting as saying, 'Well, I'm, I have housing problems.' And the person goes, 'Well how many of you live together.' You know, that would be something that I would imagine that would spark. Instead of saying, 'Well, what are your housing issues?' there's kind of these stereotypes. (D009)

**Person as Criminal—**Caricatures, however, do not just function within a provider-client context. There is another level, in which they can enter institutional functions, processes, and, indeed, perceptions. One particular instance of this process is when someone is deemed a criminal by the justice system. The person as criminal meaning was not initially reported

here as reflective of the mental health center but instead was relayed as to how the legal system characterized the following African American client. However, it was how the mental health system may now implicitly view him, given the way it first came to know him. As the provider noted, once the marijuana entered this client's *own* system, he could not escape *their* system, and how the system now viewed him.

> It's just the system is kind of set up against, legally … and this kind of goes into a little bit more of my own opinion … but he was a marijuana user, and the marijuana, as much as I would tell him, 'hey, if you stop using marijuana you won't be on probation,' but it was almost like the marijuana was there to keep him in the system. It's like it's targeting a community where marijuana is so prevalent. And so the slightest bit of marijuana in your system and it's like you're in the system that you just can't get out of … (D012)

**Person as Possible Suspect—**Closely aligned with the above racialized centering is the profile—racial, mental health, and otherwise. The third narrative within this section relays a story from a provider about how an Asian client is deemed as a threat due, in part, to his matching a profile with both racial and mental health undertones. The provider does not use the language of profile, and in some ways "understands" the heightened concern but questions the student's expulsion.

> But I think the incident that happened in school was not anything where he assaulted a student or really threatened a student … It was more he was going through his first break and became pretty paranoid and isolative, and I think that the school was more afraid that it was going to escalate into something violent. But to my knowledge, he had never made any specific threats or anything towards the school. But it was right around the time of the other incident that involved an Asian student. So I think that there may have been some concern on the school's part like, 'Oh is he going to be the next one,' which given the climate in the country I mean it's understandable that they would have a high alert anytime that they saw somebody maybe not doing so well … I understand that the school has to protect all the students, but it feels like some of the stuff he did wasn't that terrible that it should have led to an expulsion … And that the school's expectation for us as a mental health provider basically wanting us to guarantee that he would stay on medication and that he would never have another like episode again. Of course, we can't do that, we can't predict the future. But it feels like they were very quick to kind of shut the door. And I don't think that's so much because he was Asian [but] it was more because he [had] mental illness … (D005)

The characterization of suspicion, threat, or criminality appeared to have ongoing consequences for the service user. Specifically, these characterizations reverberated within outside institutions, activating meanings already in place in these organizations, as it had with the criminal profile of the previous African American client.

> One of the goals that he identified for that was wanting to return to school which was a difficult feat. He has a green card but he's not a U.S. citizen so he had that barrier. He also had been expelled from a lot of schools … and apparently,

> schools talk so and when applying to other schools they would find out that he had behavioral issues or safety concerns at previous schools. (D005)

"Schools talk." With this concise phrase, the above provider expressed the ability for multiple institutions to become powerful actors, with capacities for collective perception, judgement, communication, and exclusion: Schools saw, schools judged, schools spoke, and they acted accordingly. This was not just a metaphor. The profile, highly charged with racialized meanings of suspicion, became a kind of conviction. The interinstitutional network still treated the client as if he did something.

**Provider as Racialized and Gendered—**Providers too lived within this world of floating racialized, gendered, or profiled meanings that seep into systems, and had to contend with them as they were activated within social situations, by clients and other providers.

> You know, as a minority, I may walk into a room full of White clinicians and automatically have that thought of 'do they think I'm not supposed to be here?' (D012)

> Just the mere fact that I'm a woman too is, could be, no matter what the culture is, you know, that they don't, you know, wouldn't talk to me. They'll look at a male staff for whatever reason naturally … (D010)

## Recentering the Person

Given the risk of institutions to condition a type of structural perception and meaning-making among staff, that is, of bureaucra-seeing and bureaucra-think, there was a range of possible attitudes that providers could adopt in response, including those that recenter the person. The following empirical variations specifically elucidate the latter, namely of providers offering a more humane approach to their clients. They often characterized this approach as reflective of their own therapeutic attitude or, at times, of what they understood or meant by "person-centered." These were not cures for the systemic issues described above but could be considered to be attempts to care for the person with (re)awakened human eyes, and even, in some cases, like family.

> For me it was more bringing like humanity to what's going on. Because sometimes being in the field for so long, you can become so robotic [like] 'okay what's your goals, what's this, let's go, okay fine, next, have a nice day, you know, take your urine, goodbye' … it can become so mechanical. So, for me, it showed a more humanistic side … because when [the client] came in, he had his head down most of the time … as we talked, and I kind of became more animated, he pulled himself up more and sat up more in the chair … I was getting his attention … 'I'm not just here because probation sent me here. Let me get it over with.' It was more like okay, 'this person cared about me'… it first shifted when I asked about, like his family and I laughed when I mentioned the throwing of the slippers [*chancletas,* in Spanish]. That's when I noticed the shift. And [when] he told me [about his mother who works in the social work field]. He perked up and like his body changed, he had more eye contact and you know, so it showed to me that I became more human

> to him, not just the person doing his assessment to get him in group … He was laughing up a storm because he's like, 'Yeah, you're really a mom.' (D003)

The above provider noted how this "humanistic" attitude became crucial in a context where clients regularly sensed how they may be perceived within and by institutions.

> Because some clients view it like 'I'm only coming here because the state gives you money,' or 'you're making money from my insurance or probation pays you.' So, they see it more of a, 'I'm here to make you money,' more than 'we're here to, like, I'm here to help, get help' … [So, instead of,] 'I'm on probation and the courts want me to do this,' it's more like, okay, so, what would you like for yourself … what they want and where they see their life … He was saying he wants to work. He wants a steady job, go back to college and finish college because he started and didn't finish … And his mother is encouraging him, as well as his grandmother was. (D003)

Regarding issues of race and racialization, the following provider's attempts to recenter the personhood of the client included actively challenging the sense that she, as a White provider, was superior, while also attempting to be non-judgmental towards clients.

> White privilege, power and privilege, right? I work with clients that are low-income, they have a lot of issues that stigmas are around, right? I am their White clinician, educated, right, and well-dressed … And they're telling me … their deepest, darkest secrets and these bad things. By being person-centered they're not judged, and I think I can make that come across by being that way with them. That I'm, you know, that I'm no better than them. (D007)

Returning to the provider who was himself racially minoritized and had learned of racist stereotypes experienced by his Latinx clients regarding housing:

> That was one of the things that they appreciated about my program was that they did not feel that … that's all around the people-centered care planning because to be able to do the open-ended questions… if somebody says, I have housing issues. You don't say how many people live with you. You say, 'Describe those housing issues to me.' (D009)

Another provider, who identified as Hispanic herself, reflected on how renewed voice can emerge for persons who had long been silenced: "Well I think for person-centered planning for them, especially if they're Hispanic or actually anybody, is that they're in a position to have a voice which they may have never had before." (D004)

## Discussion

Drawing on a qualitative, phenomenological method that is well-suited for producing knowledge of psychological process within sociocultural context (Desai, 2018; Wertz, 2011; Wertz et al., 2018), this study examined systemic and institutional sources of compromised care. It particularly explored the process through which these entities could transmit objectified and racialized meanings towards clients. Within such bureaucratic environments, there is a risk for persons to be treated as *non-persons.* Given these risks,

a range of provider stances remained possible, including detaching from such perceptions and recentering towards the person. However, this was by no means a guaranteed or fully completed outcome, as the job at hand—paperwork, agenda, budgets, mandates, orders, and so forth—often reintroduced objectifying meanings to fulfill bureaucratic demands. Thus, if system-centered environments like these are left unchecked, compromised care may become a bureaucratic requirement.

We contend that these processes demand serious consideration within practice settings. They also suggest novel horizons for future inquiry in mental health equity research, which has not fully accounted for these structural-psychological processes, which include but transcend any individual provider, and may ultimately compound the individual biases they may hold. In this discussion, we expound first on how surrounding institutions and systems may condition ways of seeing persons, then develop a taxonomy of the myriad forms of *system-centering* that can emerge in place of a person, including racialized tropes and profiles. System-centering is, in turn, suggested as a concrete mechanism that threatens the quality of care for minoritized groups and as a more general institutional mechanism that is involved within broader forms of societal oppression. To aid future work, we advance critical concepts at the institutional perception and cognition level (e.g., bureaucra-seeing and bureaucra-think), the institution-staff relational level (e.g., becoming carriers of systemic intentionality), and at the practice level (e.g., system-decentered care). We end by discussing alternative possibilities for care and research and by offering concluding statements about the inherent risks of dehumanization within societal institutions.

## Person-Decentered

First, we turn to a central finding that there was a risk inherent in institutions and systems to condition dehumanized ways of perceiving minoritized clients (and, conceivably, many others). The findings revealed a glimpse of what can permeate deeply under the surface of a community mental health encounter beyond the overt work of mental health. This work itself took place within a wider matrix of institutional life, wherein a person could become viewed in the ways that the bureaucracy sees them—as an agenda item, paperwork, a unit of time, or a budget figure. Further, racialized meanings and profiles could also emerge within this matrix and take on a life of their own. The above processes were, in turn, linked to racist and socioeconomic structures beyond these particular institutions. This study thus described how efforts to center the person within community mental health settings can come up against an impersonal fog, which obscures the person and centers the fog. Person-centering regularly competed against person-decentering.

Findings suggest a dynamic interplay between institutions, staff, and clients in the process of delivering care, but with a fourth constituent added to this dynamic: meaning. At stake in these clinical encounters were the ways in which meanings can become ascribed to clients by an institution, which can have little to do with the client's own life and personhood. Based on the available evidence, a range of possible provider stances were suggested in response. On one end of the spectrum lies the possibility of staff creatively navigating these meanings for their clients' care, of pushing back, or even of vying for structural change. On the other end of the spectrum, however, is the possibility of staff drawing on

these floating, institutional meanings to further their own bias or aggression towards people. In the middle, but no less disturbing, is the possibility of staff transmitting these ways of viewing, implicitly and unwittingly—a constant risk within bureaucratic environments filled with procedures and paperwork. It is precisely because objectifying meanings can become so normalized within a bureaucracy (Ray, 2019)—as merely part of the job or the "way things are"—that it conceals how much of an *alive presence* they can be. What the findings suggest here in the latter two cases are the ways in which socio-institutional structures can suppress or "militate" (Gask & Coventry, 2012, p. 139) against something like person-centered care via norms that are antithetical to notions of personhood and well-being —a process that Fanon alluded to as "thingification" (Fanon, 1952/1967b). The implication is that though there are hopes about whether person- or people-centered care—or even culturally-responsive care—can impact inequity, these findings suggest that regardless of what the centering might be on paper, there are ways in which systemic agenda can get centered in their place.

## System-Centered

Moving forward, it may be possible to come up with a typology of the forms of centering that decenter the person within health organizational settings, which would necessarily be locally contingent and yet share similarities with other settings. In other words, what are the ways that a person, a client[1] can become seen by institutions or systems?

Within this typology would include the original centerings of the disease, medicalization, or technological model (Davidson et al., 1997; Greenhalgh, Snow et al., 2015; Groves, 2010; Kleinman & Benson, 2006; Mead & Bower, 2000; Rogers, 2007; Scheper-Hughes & Lock, 1987; Stewart, 2001), which prompted many of the initial shifts towards person-centeredness. Then there are the innumerable ways that the categories of the economic, financial, and bureaucratic enter the picture, for instance, in the many ways that people can become reduced to a number (e.g., dollars and cents, caseloads, charts, reimbursable units, time and resource burdens, efficient/inefficient processes). These can proliferate in a financialized health system (Cohen, 2017; De Maeseneer et al., 2012, p. 604, 612; Flanagan et al., 2009; Gibson & Beneduce, 2017). In addition, there are the host of oppressive stereotypes and caricatures, including those related to race, ethnicity, gender, sexual orientation, religion, ability, and so forth. Future research would need to develop this typology of system-centeredness further. Included in this research would be investigations of which institutions and systems are prone to which gazes, the frequency of each within a given organization, and how higher-order processes like systemic racism, financialization, and market-driven health care relate to them. In addition, research is especially warranted on how clients and other stakeholders experience and respond to being seen in this manner.

A main point here is that when care becomes system-centered, it means that persons are likely being viewed in the non-human ways that systems are capable of, such as bureaucratic or racialized objects. If so, this moves us towards the disturbing possibility that systems have the capacity to *see* and often in ways that remain hidden to human eyes.

[1]We are also aware that the terms one uses for persons in a health system, such as client, patient, and service-user are also bound up within these possible systems of meaning.

The staff member, in turn, may become an unwitting carrier of the system's intentionality and meaning-making. The staff, as a whole, can become *collective* carriers, systematically enforcing a particular reality onto the person. The reality that gets produced may then be considered as objective, rather than as skewed or biased (Foucault, 1975/1995). On a local scale, this reveals the importance of coming up with creative approaches to guard against the risks inherent in such bureaucra-think or bureaucra-seeing, such as humanizing the care system, diversifying the workforce (given evidence that minoritized providers could see racial dynamics others could not), and providing opportunities for stakeholders to remain vigilant about their occurrence. However, even if clear-eyed souls on the staff see beyond these, the system may still see them that way.

On a broader scale, we wonder: How can a human be seen as other than human? It helps when not only everyone, but every*thing,* is doing it. This is just the health care system, which in theory is focused on well-being, and one can surmise how these phenomena might play out in other institutions not solely focused on well-being, such as within the law enforcement or justice systems (Henricks, 2019). When taken beyond institutions to an even further mass societal scale, processes like "being a carrier of the system's intentionality" may reveal some of the psychosocial conditions that support widespread dehumanization. The last several years have witnessed repeated instances of global socioeconomic and political instability, where dehumanization is not just hidden institutional agenda but explicit governmental policy. Marginalized persons from Black, Indigenous, and People of Color (BIPOC) communities continue to be harmed by this environment. Critical attention to the entire spectrum of these issues is urgently needed, focusing our own eyes on the system's eyes.

## Imagining Other Possibilities for Care

Returning back to mental health settings, the findings suggest ways providers may counter these trends or occupy different attitudes towards the person in front of them. There was evidence that person-centeredness or, more specifically, attuned and aware clinicians could present a different vista wherein clients could breathe, move, and dream in a less stifling, stigmatizing environment. Yet, while the findings suggest that these stances are possible, they also allude to the texture of what this work is up against to make that a reality. Therefore, in addition to person- or people-centered care, a next step within this overall movement may need to be a more active ***system-decentered care****,* which fosters critical awareness of the non-human attributions that can become sedimented within systems —and, in turn, delivers more attuned and effective care. To be sure, the most direct route to achieving system-decentered care would not be through the individual staff level but through the system transformation level. That is, multilevel problems would benefit from a multilevel, system-wide approach, including through the collective involvement and empowerment of a wide range of community and organizational stakeholders.

## Limitations

There were numerous limitations to this study. The data collection did not initially seek to study bureaucratic processes but was pointed to them by the participants' narratives and the phenomena themselves. This study should thus be considered as a starting point,

and one that is limited with respect to factors like geographical location, setting type, and the backgrounds of both researchers and participants. More research focused on these areas, with explicit data collection on bureaucratic processes and shared, institutional subjectivities is warranted. This research could involve multiple stakeholders (e.g., clients, staff, administrators, and community members) and multiple forms of inquiry (e.g., direct observation, focus groups, policy and document analysis), particularly given that the present study relied heavily on provider narratives. Such research might more directly consider the positionality of each stakeholder group as it relates to their views on the system or institution. A related avenue of research would be to examine whether the institutional factors outlined in this study vary by discipline, years in the field, and type of mental health facility, as well as comparative analyses of institutional processes beyond mental health. Lastly, a novel science of institutional life that investigates the psychosocial meanings and processes therein—like objectification, racism, and financialization—is warranted. Neither the sole domain of psychology, sociology, or economics, this approach to research is necessarily transdisciplinary.

## Conclusion

This study fills a critical gap within psychological science by showing how institutional and systemic mechanisms influence everyday clinical encounters, specifically how, within a bureaucratic healthcare environment, there emerges a risk for persons attending a clinic to be treated as non-persons (e.g., as agenda items, numbers, or racial profiles). Multi-level interventions within such system-centered environments are therefore needed to disrupt the multi-level risks of dehumanization and compromised care.

A focus of this article was to describe the tension between humanistic innovations in care and dehumanizing trends in the social world. However, if person-centered care translates most simply as dignified and respectful care, then we may just be scratching the surface of how the latter gets undermined by the deeply inter-institutional forces of objectification and racialization.

## Acknowledgments

We thank our organizational partners, study participants, and research team (e.g., Kimberly Blackman, Merarilisse Crespo, Maria O'Connell, Luz Ocasio, and Maria Restrepo-Toro) for their time and contributions. Brief portions of this study were presented at the 2020 Fall Symposium, Honors and Scholars Village, NC State University; the Connecticut Psychological Association; the Asian American Psychological Association Convention; and APA (Division 1). The project was funded by a NIMH/NIH Administrative Supplement for Minority Health and Mental Health Disparities Research (Desai, awardee; Stanhope, PI of R01, MH099012). The first author's research is also made possible by a past CTSA Grant Number KL2 TR001862 from the National Center for Advancing Translational Science (NCATS), and a current K01MD016166 from the National Institute on Minority Health and Health Disparities (NCATS), both components of the NIH. The manuscript's contents are solely the responsibility of the authors and do not necessarily represent the official view of NIH. The authors declare no conflict of interest.

## References

Alegría M, Alvarez K, & Falgas-Bague I (2017). Clinical care across cultures: What helps, what hinders, what to do. JAMA Psychiatry, 74(9), 865–866. doi:10.1001/jamapsychiatry.2017.1994 [PubMed: 28746720]

Alegría M, Atkins M, Farmer E, Slaton E, & Stelk W (2010). One size does not fit all: taking diversity, culture and context seriously. Administration and Policy in Mental Health and Mental Health Services Research, 37(1-2), 48–60. doi:10.1007/s10488-010-0283-2 [PubMed: 20165910]

American Psychological Association. (2017). Multicultural guidelines: An ecological approach to context, identity, and intersectionality. Retrieved from, http://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association. (2019). Race and ethnicity guidelines in psychology: Promoting responsiveness and equity. Retrieved from, http://apacustomout.apa.org/commentPracGuidelines/Practice/Race%20and%20Ethnicity%20Guidelines%20For%20Open%20Comment%20V2.pdf

Bailey ZD, Feldman JM, & Bassett MT (2021). How structural racism works—racist policies as a root cause of US racial health inequities. New England Journal of Medicine, 384(8), 768–773. doi:10.1056/NEJMms2025396 [PubMed: 33326717]

Bailey ZD, Krieger N, Agenor M, Graves J, Linos N, & Bassett MT (2017). Structural racism and health inequities in the USA: evidence and interventions. The Lancet, 389(10077), 1453–1463. doi:10.1016/S0140-6736(17)30569-X

Blair IV, Steiner JF, & Havranek EP (2011). Unconscious (implicit) bias and health disparities: Where do we go from here? The Permanente Journal, 15(2), 71–78. doi: 10.7812/tpp/11.979

Bonilla-Silva E (1997). Rethinking racism: Toward a structural interpretation. American Sociological Review, 62(3), 465–480. doi:10.2307/2657316

Cloninger CR, Salvador-Carulla L, Kirmayer LJ, Schwartz MA, Appleyard J, Goodwin N, … Rawaf S (2014). A time for action on health inequities: Foundations of the 2014 Geneva Declaration on Person- and People-centered Integrated Health Care for All. International Journal of Person Centered Medicine, 4(2), 69–89. [PubMed: 26140190]

Cohen M (2017). A systemic approach to understanding mental health and services. Social Science & Medicine, 191, 1–8. doi:10.1016/j.socscimed.2017.08.037 [PubMed: 28881215]

Davidson L (2003). Living outside mental illness: Qualitative studies of recovery in schizophrenia. NYU Press.

Davidson L, & Cosgrove L (2002). Psychologism and phenomenological psychology revisited, Part II: The return to positivity. Journal of Phenomenological Psychology, 33(2), 141–177.doi:10.1163/15691620260622877

Davidson L, & Cosgrove LA (1991). Psychologism and phenomenological psychology revisited, Part I: The liberation from naturalism. Journal of Phenomenological Psychology, 22(2), 87–108. doi:10.1163/156916291X00082

Davidson L, Stayner DA, Lambert S, Smith P, & Sledge WH (1997). Phenomenological and participatory research on schizophrenia: Recovering the person in theory and practice. Journal of Social Issues, 53(4), 767–784. 10.1111/j.1540-4560.1997.tb02460.x

De Maeseneer J, van Weel C, Daeren L, Leyns C, Decat P, Boeckxstaens P, … Willems S (2012). From “patient” to “person” to “people”: the need for integrated, people centered health care. The international Journal of Person Centered Medicine, 2(3), 601–614. doi:10.5750/ijpcm.v2i3.148

Desai MU (2014). Psychology, the psychological, and critical praxis: A phenomenologist reads Frantz Fanon. Theory & Psychology, 24(1), 58–75. doi:10.1177/0959354313511869

Desai MU (2018). Travel and movement in clinical psychology: The world outside the clinic. Palgrave Macmillan.

Desai MU, Laubscher L, & Johnson S (in press). Perspectives (of people of color) on psychological science: Does psychological science listen? Review of General Psychology.

Desai MU, Paranamana N, Restrepo-Toro M, O’Connell M, Davidson L, & Stanhope V (2021). Implicit organizational bias: Mental health treatment culture and norms as barriers to engaging with diversity. American Psychologist, 76(1), 78–90. doi:10.1037/amp0000621 [PubMed: 32134280]

Dovidio JF, Penner LA, Albrecht TL, Norton WE, Gaertner SL, & Shelton JN (2008). Disparities and distrust: The implications of psychological processes for understanding racial disparities in health and health care. Social Science & Medicine, 67(3), 478–486. doi:10.1016/j.socscimed.2008.03.019 [PubMed: 18508171]

Fanon F (1967a). Black skin, white masks (Markmann CL, Trans.). Grove. Original work published 1952 as Peau noire, masques blanc)

Fanon F (1967b). The “North African Syndrome.” In Fanon F (Ed.), Toward the African revolution: Political essays (Trans. Chevalier H) (pp. 3–16). Grove. (Original work published 1952 as Le « syndrome nord-africain »)

Feagin J, & Bennefield Z (2014). Systemic racism and U.S. health care. Social Science & Medicine, 103, 7–14. doi:10.1016/j.socscimed.2013.09.006 [PubMed: 24507906]

Flanagan EH, Miller R, & Davidson L (2009). “Unfortunately, we treat the chart:” Sources of stigma in mental health settings. Psychiatric Quarterly, 80(1), 55–64. doi:10.1007/s11126-009-9093-7 [PubMed: 19191027]

Foucault M (1995). Discipline and punish: The birth of the prison (Sheridan A, Trans.). Random House. (Original work published 1975 as Surveiller etpunir: Naissance de la prison)

Gask L, & Coventry P (2012). Person-centred mental health care: The challenge of implementation. Epidemiology and Psychiatric Sciences, 21(2), 139–144. doi:10.1017/S2045796012000078 [PubMed: 22789160]

Gibson N, & Beneduce R (2017). Frantz Fanon, psychiatry, and politics. Rowman & Littlefield.

Giorgi A (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research. Journal of Phenomenological Psychology, 28(2), 235–260. 10.1163/156916297X00103

Giorgi A (2009). The descriptive phenomenological method in psychology: A modified Husserlian approach. Duquesne University Press.

Gone JP (2004). Mental health services for Native Americans in the 21st Century United States. Professional Psychology: Research and Practice, 35(1), 10–18. doi:10.1037/0735-7028.35.1.10

Gone JP (2008a). Dialogue 2008: Introduction: Mental health discourse as western cultural proselytization. Ethos, 36(3), 310–315. doi:10.1111/j.1548-1352.2008.00016.x

Gone JP (2008b). ‘So I can be like a Whiteman’: The cultural psychology of space and place in American Indian mental health. Culture & Psychology, 14(3), 369–399. doi:10.1177/1354067X08092639

Greenhalgh T, Snow R, Ryan S, Rees S, & Salisbury H (2015). Six ‘biases’ against patients and carers in evidence-based medicine. BMC Medicine, 13(1), 200. doi:10.1186/s12916-015-0437-x [PubMed: 26324223]

Groves J (2010). International Alliance of Patients’ Organizations perspectives on person-centered medicine. International Journal of Integrated Care, 10(5), 27–29. doi: 10.5334/ijic.481

Hagiwara N, Dovidio JF, Stone J, & Penner LA (2020). Applied racial/ethnic healthcare disparities research using implicit measures. Social Cognition, 38(Supplement), s68–s97. doi:10.1521/soco.2020.38.supp.s68 [PubMed: 34103783]

Hall WJ, Chapman MV, Lee KM, Merino YM, Thomas TW, Payne BK, … Coyne-Beasley T (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. American Journal of Public Health, 105(12), e60–e76. doi:10.2105/ajph.2015.302903

Henry PJ (2010). Institutional bias. In Dovidio JF, Hewstone M, Glick P, & Esses VM (Eds.), Handbook of prejudice, stereotyping, and discrimination (pp. 426–440). Sage.

Henricks K (2019). Power to the paperwork? Mandatory financial sanctions and the bureaucratic means to racially unequal ends. American Behavioral Scientist, 65(8), 1104–1126. 10.1177/0002764219859620

Hernandez M, Nesman T, Mowery D, Acevedo-Polakovich ID, & Callejas LM (2009). Cultural competence: A literature review and conceptual model for mental health services. Psychiatric Services, 60(8), 1046–1050. doi:10.1176/ps.2009.60.8.1046 [PubMed: 19648191]

Husserl E (1970). The crisis of European sciences and transcendental phenomenology (Carr D, Trans.). Northwestern University Press. (Original work published 1936 as *Die Krisis der europaischen Wissenschaften und die transzendentale Phänomenologie: Eine Einleitung in die phänomenologische Philosophie*)

Jackson VH (2015). Practitioner characteristics and organizational contexts as essential elements in the evidence-based practice versus cultural competence debate. Transcultural Psychiatry, 52(2), 150–173. doi:10.1177/1363461515571625 [PubMed: 25710948]

Johnson TJ (2020). Intersection of bias, structural racism, and social determinants with health care inequities. Pediatrics, 146(2), e2020003657. doi:10.1542/peds.2020-003657 [PubMed: 32690807]

Laubscher L, Hook D, & Desai MU (Eds.). (2022). Fanon, phenomenology, and psychology. Routledge.

Katz JH (1985). The sociopolitical nature of counseling. The Counseling Psychologist, 13(4), 615–624. doi:10.1177/0011000085134005

King ML (1968). The role of the behavioral scientist in the civil rights movement. American Psychologist, 23(3), 180–186. doi:10.1037/h0025715 [PubMed: 5643229]

Kleinman A, & Benson P (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. PLOS Medicine, 3(10), 1673–1676. doi:10.1371/journal.pmed.0030294

Malterud K (2012). Systematic text condensation: A strategy for qualitative analysis. Scandinavian Journal of Social Medicine, 40(8), 795–805. doi:10.1177/1403494812465030

Mead N, & Bower P (2000). Patient-centredness: a conceptual framework and review of the empirical literature. Social Science & Medicine, 51(7), 1087–1110. doi:10.1016/S0277-9536(00)00098-8 [PubMed: 11005395]

Metzl JM (2009). Protest psychosis: How schizophrenia became a black disease. Beacon Press.

Metzl JM, & Hansen H (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. Social Science & Medicine, 103, 126–133. doi:10.1016/j.socscimed.2013.06.032 [PubMed: 24507917]

Paradies YC (2006). Defining, conceptualizing and characterizing racism in health research. Critical Public Health, 16(2), 143–157. doi:10.1080/09581590600828881

Ray V (2019). A theory of racialized organizations. American Sociological Review, 84(1), 26–53. doi:10.1177/0003122418822335

Rogers CR (2007). The basic conditions of the facilitative therapeutic relationship. In O'Hara M, Cooper M, Schmid PF, & Wyatt G (Eds.), The handbook of person-centred psychotherapy and counseling (pp. 1–5). Palgrave Macmillan.

Scheper-Hughes N, & Lock MM (1987). The mindful body: A prolegomenon to future work in medical anthropology. Medical Anthropology Quarterly, 1(1), 6–41. doi:10.1525/maq.1987.1.1.02a00020

Sells D, Topor A, & Davidson L (2004). Generating coherence out of chaos: Examples of the utility of empathic bridges in phenomenological research. Journal of Phenomenological Psychology, 35(2), 253–271. doi:doi:10.1163/1569162042652164

Smedley BD, Stith AY, & Nelson AR (Eds.). (2003). Unequal treatment: Confronting racial and ethnic disparities in health care (Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Institute of Medicine). National Academies Press.

Stanhope V, Tondora J, Davidson L, Choy-Brown M, & Marcus SC (2015). Person-centered care planning and service engagement: A study protocol for a randomized controlled trial. Trials, 16, 180. 10.1186/s13063-015-0715-0 [PubMed: 25897762]

Stewart M (2001). Towards a global definition of patient centred care. BMJ, 322(7284), 444. doi:10.1136/bmj.322.7284.444 [PubMed: 11222407]

Substance Abuse and Mental Health Services Administration. (2018). National Mental Health Services Survey (N-MHSS): 2017. Data on mental health treatment facilities. Substance Abuse and Mental Health Services Administration.

Thompson CE, & Neville HA (1999). Racism, mental health, and mental health practice. The Counseling Psychologist, 27(2), 155–223. 10.n77/0011000099272001

Tondora J, Miller R, & Davidson L (2014). The top ten concerns about person-centered care planning in mental health systems. International Journal of Person Centered Medicine, 2(3), 410–420.

Tondora J, Miller R, Slade M, *&* Davidson L (2014). Partnering for recovery in mental health: A practical guide to person-centered planning: John Wiley & Sons.

Tondora J, O'Connell M, Miller R, Dinzeo T, Bellamy C, & Andres-Hyman R (2010). A clinical trial of peer-based culturally responsive person-centered care for psychosis for African Americans and Latinos. Clinical Trials, 7(4), 368–379. doi:10.1177/1740774510369847 [PubMed: 20571133]

Ture K, & Hamilton C (1967). Black Power: Politics of liberation in America. Random House.

Vera EM, & Speight SL (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. The Counseling Psychologist, 31(3), 253–272. doi:10.1177/0011000003031003001

Wendt DC, & Gone JP (2011). Rethinking cultural competence: Insights from indigenous community treatment settings. Transcultural Psychiatry, 49(2), 206–222. doi:10.1177/1363461511425622 [PubMed: 22194346]

Wertz FJ (2005). Phenomenological research methods for counseling psychology. Journal of Counseling Psychology, 52(2), 167–177. doi:10.1037/0022-0167.52.2.167

Wertz FJ (2010). The method of eidetic analysis for psychology. In Cloonan TF & Thiboutot C (Eds.), The redirection of psychology: Essays in honor of Amedeo P. Giorgi (pp. 261–278). Le Cercle Interdisciplinaire de Recherches Phénoménologiques (CIRP), l'Université du Québec.

Wertz FJ (2011). The qualitative revolution and psychology: Science, politics, and ethics. The Humanistic Psychologist, 39(2), 77–104. 10.1080/08873267.2011.564531

Wertz FJ, Charmaz K, McMullen LM, Josselson R, Anderson R, & McSpadden E (2011). Five ways of doing qualitative analysis. Guilford.

Wertz FJ, Desai MU, Maynard E, Misurell J, Morrissey MB, Rotter B, & Skoufalos NC (2018). Research methods for person-centered health science: Fordham studies of suffering and transcendence. In Englander M (Ed.), Phenomenology and the social context of psychiatry (pp 95–120). Bloomsbury.

Williams DR (2012). Miles to go before we sleep: Racial inequities in health. Journal of Health and Social Behavior, 53(3), 279–295. doi:10.1177/0022146512455804 [PubMed: 22940811]

Williams DR, Lawrence JA, & Davis BA (2019). Racism and health: Evidence and needed research. Annual Review of Public Health, 40(1), 105–125. doi:10.1146/annurev-publhealth-040218-043750

World Health Organization. (2022). Service organizations and integration. Retrieved from https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/service-organizations-and-integration

**Table 1.**

Main Themes and Subthemes

- **Bureaucratic Centering:** Impact of bureaucratic structures on how providers and the institution perceive clients
  - ***Person as One Among a Very Many and as Easily Forgotten:*** Because of large caseloads, prioritization of clients by perceived need, leading to limited attention for certain clients
  - ***Person as Agenda Item, as Paperwork, and as Sand-in-an-Hourglass:*** Perception of clients as a bureaucratic, impersonal object
  - ***Person as Bureaucratically and Culturally Identical:*** Because diversity is viewed as straining resources, perceptions of clients in terms of a singular cultural identity
  - ***Provider as Unrecognized Corporate Employee:*** Provider experience of being treated impersonally and being devalued by the institution
- **Racialized Centering:** Impact of structural racialization and stereotyping on how clients are viewed by providers and the institution
  - ***Person as Racialized Caricature and Stereotype:*** Perception of a client in racially and culturally stereotypic ways
  - ***Person as Criminal:*** Perception of a client as a criminal, as deemed initially by the criminal justice system
  - ***Person as Possible Suspect:*** Perception and treatment of a client as suspicious or as a threat, due to their matching a racial or mental health profile
  - ***Provider as Racialized and Gendered:*** Provider experience of being treated by colleagues and clients in terms of harmful racialized and gendered notions.
- **Recentering the Person:** Provider adoption, or readoption, of a humane, personalized perspective to care for the client