VIEWPOINT

Structural Competency and Psychiatry

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The essays in this Viewpoints section emerge from a growing body of literature that posits structural competency as a new conceptual framework for reducing inequalities and promoting social justice in US medicine and psychiatry. Whereas previous models such as cultural competency focus on identifying clinician bias and improving communication at moments of clinical encounter, structural competency encourages clinical practitioners to recognize how social, economic, and political conditions produce health inequalities in the first place. Structural competency calls on health care professionals to recognize ways that institutions, neighborhood conditions, market forces, public policies, and health care delivery systems shape symptoms and diseases, and to mobilize for correction of inequalities as they manifest both in physician-patient interactions and beyond the clinic walls.

Structural competency has been informed by the literature of critical race studies, sociology, economics, urban planning, anthropology, and public health. From this foundation arose a series of benchmark skills that aimed to aid recognition of, and intervention into, structural factors as they arise in clinical and cultural formulations. Fully detailed elsewhere,[1] these skills include the following:

- Recognizing the structures that shape clinical interactions:
  Rather than interpreting patient presentations solely in terms of patients' beliefs and behaviors, clinicians also examine the social conditions and institutional policies that may have contributed to patient presentations.
- Rearticulating "cultural" formulations in structural terms:
  Clinicians develop diagnoses and treatment plans that account for neighborhood and institutional factors.
- Observing and enacting structural interventions:
  Practitioners work on community-, service agency–, or policy advocacy–based projects that address the systemic needs of their patient populations.
- Developing structural humility:
  Practitioners collaborate across disciplines and with community members, bearing in mind that systemic change often progresses slowly and requires long-term investment.

Structural competency thus advocates deeper understandings of how institutional discrimination and its often invisible, systemic oppressions can produce racialized, gendered, and socioeconomic status–related "symptoms" in clinical settings.

Recent interventions have used structural competency frameworks to rethink "social history taking" in emergency medicine settings to identify structural risks to health[2]; restructure care delivery to meet the needs of individuals identifying as lesbian, gay, bisexual, transgender, gender nonconforming, or with differences in sex development[3]; and prepare premed students to reduce health disparities through systemic change.[4]

Essays in this Viewpoints cluster highlight the specific salience of structural awareness for mental health practitioners. Helena Hansen, MD, PhD, Joel Braslow, MD, PhD, and Robert M. Rohrbaugh, MD, detail structural competency approaches in psychiatry training programs in which residents collaborate with community organizations to strengthen patient support networks. Laurence J. Kirmayer, MD, FRCPC, FCAHS, FRSC, Rachel Kronick, MD, MSc, FRCPC, and Cécile Rousseau, MD, MSc, FRCPC, describe how structural competency frameworks enhance physician advocacy.

These essays model how thinking systematically about structure can increase clinicians' recognition of the mental health–related influences of institutions, markets, and health care delivery systems, which in turn can deepen conversations with patients, patients' communities, and the agencies with which patients interact.

Why Now?

Psychiatrists and other physicians increasingly recognize the social determinants of their patients' health outcomes. Yet growing evidence suggests that clinical practitioners remain unsure of how to address these social determinants and structural factors in clinical contexts. Eighty-five percent of primary care clinicians and pediatricians polled in a Robert Wood Johnson Foundation–sponsored survey agreed with the statement that "unmet social needs are leading directly to worse health for all Americans" while at the same time voicing concern that they did not "feel confident in their capacity to meet their patients' social needs," and that their failure to do so "impedes their ability to provide care."[5]

These concerns are particularly salient for mental illness. Stressful social and economic conditions exacerbate mood and anxiety disorders. Substance use disorders such as opioid dependence are shaped by upstream forces such as federal regulations, drug marketing strategies, law enforcement, and racialized societal beliefs about whose pain is worthy of treatment. The diagnosis and treatment of conditions ranging from schizophrenia to eating disorders to postpartum depression have been shown to differ by race, ethnicity, and socioeconomic status based on unspoken institutional practices. Meanwhile, structural factors such as the geographical concentration of incarceration and the lack of housing, transportation, and safe, walkable space in low-income communities of color carry profoundly negative implications for mental health.[6]

Evidence grows suggesting how the pathologic conditions of social and institutional systems affect the biologies of individuals. Epigenetics demonstrates at the level of gene methylation and histone modification how high-stress, resource-poor environments elevate the risk

of schizophrenia, mood disorders, and other psychiatric conditions in ways that may be transmitted intergenerationally if these injurious environments are not transformed. Conversely, owing to lifelong neuroplasticity, social environmental interventions for mental illness, including social rehabilitation and psychotherapy, cause molecular and physiological changes that improve brain function.[7] More broadly, well-functioning social networks promote social cohesion.[8]

To be sure, not every clinical practitioner will aim for extraclinical engagement. At the same time, the evidence suggests that expanding the individual focus that often surrounds expert understandings of mental illness and health, and developing clinically relevant frameworks that address community-, institutional-, and policy-level factors, are necessary to reduce risks for many psychiatric disorders.

Structural competency thus represents one evolving approach that enables clinical practitioners to bridge the microprocesses of their interactions with patients with the macroprocesses of population-level inequalities that often determine their patients' mental health outcomes.[9]

Conclusions

This Viewpoints section presents 2 specific case studies that illustrate how clinician "helplessness" surrounding structural inequity can be met with training and intervention into the mechanisms through which inequities in mental health emerge and are propagated. Of course, such methods will not in themselves rectify complex, multifactorial mental health and societal inequalities. Rather, structural competency aims to develop expertise in recognizing the web of interpersonal networks, environmental factors, and political and socioeconomic forces that surround mental illness.

Such an approach then allows for new modes of alliance and collaboration among those with mental health expertise, community advocates, and professionals in law, economics, urban planning, the social sciences, and humanities, leading to targeted solutions that build community to address psychology and its discontents in an age of ever-growing inquietude. More broadly, structural competency frames mental health as a state we strive for in our daily lives, and as a larger organizing principle for social justice, community betterment, and institutional change.

ARTICLE INFORMATION

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