Dear Subscribers,

I am writing to inform you that the Editorial Board recently voted to make a change to our journal operations in an effort to keep up with current trends in academia and in an effort to contain the costs associated with producing our journal.

Starting in March 2020, our journal will be published online only. Once a year, however, we will publish a hard copy of the journal, that will be mailed to all of you, containing the most widely read articles published during the previous 12 months. Like other journals, ours depends heavily on library subscriptions, and libraries are no longer purchasing paper copies of journals. They prefer to have electronic subscriptions.

We trust that you will continue to enjoy the Journal of Sociology and Social Welfare and support it through your publications and subscriptions!

Sincerely,

Héctor Luis Díaz, Ph.D., Professor and Senior Editor
Journal of Sociology and Social Welfare
A Special Issue on Structural Competency

Leah A. Jacobs and Tina Sacks
Special Issue Editors

Introduction to the Special Issue on Structural Competency
Tina Sacks and Leah A. Jacobs

The Culture-Structure Framework: Beyond the Cultural Competence Paradigm
Mimi E. Kim

Structurally Competent Social Work Research: Considering Research Methods and Approaches that Account for a Recursive Relationship between Individuals and Structures
Jaime M. Booth

Structural Competency in Child Welfare: Opportunities and Applications for Addressing Disparities and Stigma
Jaclyn E. Chambers and G. Allen Ratliff

Don’t ”Just Call the Social Worker“: Training in Structural Competency to Enhance Collaboration between Healthcare Social Work and Medicine
Margaret Mary Downey and Joshua Neff, Kate Dubé

The Trans Person is not the Problem: Brave Spaces and Structural Competence as Educative Tools for Trans Justice in Social Work
Jama Shelton, Kel Kroehle, María Monica Andía
Constructing the Structurally Competent Classroom

Leah A. Jacobs and Hanna Mark

BOOK REVIEWS

Dayna Bowen Matthew
Reviewed by Karen Flint Stipp and Trista Smith

The Future of Capitalism:
Facing the New Anxieties
Paul Collier
Reviewed by Edward U. Murphy

Social Work and Social Justice:
Concepts, Challenges, and Strategies
Michael Reisch and Charles D. Garvin
Reviewed by Jennifer K. Allen

Social Work Practice and Social Welfare
Policy in the United States: A History
Philip R. Popple
Reviewed by Ethan J. Evans

Pressure Cooker: Why Home Cooking Won’t Solve Our Problems and What to do About It
Sarah Bowen, Joslyn Brenton and Sinikka Elliott
Reviewed by John E. Tropman

The Politics of Compassion:
The Challenge to Care for the Stranger
Edward U. Murphy
Reviewed by Daniel Liechty

Addictions Counseling:
A Competency-Based Approach
Cynthia A. Faulkner & Samuel S. Faulkner
Reviewed by Shena Leverett Brown

Corresponding Authors
Introduction to the Special Issue on Structural Competency

Tina Sacks and Leah A. Jacobs
Special Issue Editors

Social work emerged as a practice, profession, and area of study preoccupied with how social problems affected the human condition. Jane Addams, for example, established settlement houses to provide housing, community, and job and language skills to newly arrived immigrants. She understood the challenges they faced maneuvering in burgeoning American cities to be about a lack of resources, not simply individual failings. Interventions had to address the fundamental causes of their problems (e.g., lack of shelter, food, or access to education), in addition to the psychological impact said deprivations might have created. In short, the interplay between structural and individual determinants of ease and (dis)ease were fundamental concerns of social work, and the social “work” needed to encompass activism, advocacy, therapy, counseling, case work or a combination thereof. Yet, as the profession coalesced around an identity that foregrounded mental health treatment, social workers’ emphasis on social structure as a determinant of social problems was, even if never fully eclipsed, decidedly overshadowed.

Meanwhile, other professions, like medicine and public health, have come to terms with the implications of structural forces that shape inequality, particularly discrimination and exploitation. These professions are grappling with the ways in which such forces impact their practice and their role in alleviating social problems. In our view, social work—with its long history of attending to the structural causes of individual problems—has lessons to offer other professions interested in identifying and intervening upon structural forces and related consequences.

In spite of our profession’s legacy, the recent turn toward structural competence has, to our surprise, come not from social
work scholars, but from physician scholars. Through their structural competence framework, Jonathan Metzl and Helena Hansen promote a training model for medical students that emphasizes the structural determinants of health and healthcare. The framework seeks to shift medicine away from a training model that emphasizes individual-level determinants of well-being and practice. It also expands beyond the cultural competency framework to incorporate other socio-structural factors that, alone or in interaction with culture, affect patients, providers, and healthcare delivery. Over the past five years, as structural competence gained momentum in medicine, we noted an emerging interest among social work scholars and practitioners. We wondered, has structural competence reinvigorated interest in structural models of social work training and practice—is this a reversal in the partial eclipse of structural social work?

This special issue of the *Journal of Sociology & Social Welfare* is dedicated to exploring the philosophical, theoretical, and practical connections between structure and social work. Further, the issue provides an opportunity for social work scholars and practitioners and those from other fields to apply structural competence to social work intervention and education; draw from theoretical and applied work on structural competence in other disciplines; and debate the similarities and differences of cultural and structural competence.

To that end, Mimi Kim’s paper analyzes how social work scholars and human service organizations employ the terms “culture” and “structure,” particularly in the context of intimate partner violence. In so doing, she suggests that human service organizations must more explicitly attend to the ways in which racialized hierarchies of power are often muted by the emphasis on culture over race. Kim articulates a culture-structure framework that grapples with the differences between culture and structure while also centering notions of power and hierarchy. In so doing, she provides a roadmap for social work practitioners and scholars to engage theoretically and practically with categories of identity and experience such as race/ethnicity, gender, class, sexuality, immigration status, ability, age, and religion.

Applying the work of social theorist Anthony Giddens to structural competence, Jaime Booth argues that structuration theory may facilitate a fully theorized approach to evidence-based
social work intervention. She notes that structural competency should promote a reconsideration of our unidirectional understanding of the relationship between structures and people, and go beyond simply illuminating the relationship between structures and problems. Booth further urges us to draw on “evidence-based strategies to address those structures identified as important for client outcomes.” She presents several methodological recommendations to arrive at such strategies for changing the structures that inhibit clients’ well-being.

Chambers and Ratliff apply structural competency to a central social work practice arena—the child welfare system. They note that while Black and Indigenous children are much more likely to be system-involved compared to their white counterparts, scholarship in this area has focused on individual-level behavior, such as biased decision-making, apart from other structural factors that undoubtedly contribute to this disparity. Chambers and Ratliff explore structural competency as a strategy to reduce these racial differences.

Turning toward another central practice arena, medicine, Downey, Neff, and Dube discuss the relationship between medicine and social work and argue that both professions would benefit from deeper engagement with the structural forces that influence health and healthcare. Doing so would forge a shared lexicon and could soften the long-standing hierarchy between these deeply intertwined professions. The authors also argue that structural competency training may force a re-imagining of the work healthcare providers and social workers can do to change the fundamental causes of disease. Only through working together and alongside patients and communities may we redress these structural harms.

Applying structural competence to social work with a specific population, Shelton, Kroehle, and Andia focus our attention on social work education as it relates to trans people and communities. They argue that the dominant pedagogical approach to social work education needs to move from an emphasis on “safe” classrooms to “brave” spaces, and from cultural competence to structural competence. Shelton and colleagues argue that this shift would better prepare social workers to disrupt cisgenderism, dismantle the gender binary, and stem anti-trans violence.

Jacobs and Mark make structural competence tangible by presenting an evaluation of a course guided by Metzl and Hansen’s
framework. They find that structural competence provided a useful pedagogical guide and that it helped students conceptualize the interaction between macro and micro forces. However, they also found students lacked a clear vision of how to implement structurally competent practice. Jacobs and Mark argue that, much like cultural competence, the true test of structural competence must come from its operationalization and assessment in social work practice settings.

Taken together, these papers explore the theoretical underpinnings of structural competence and the potential for structural competency across social work practice settings, populations, and pedagogy. They also provide a critical assessment of the benefits and limitations of structural competency as an intellectual and practical tool, though in our view the promise of structural competency requires further investigation. Specifically, future scholars should (1) thoroughly assess the historical evolution of structural social work, in order to understand its uneven uptake; (2) critically assess the reflexive need to turn to medicine as a model for training a structurally competent social work workforce; and (3) empirically test the effect of structural competence training on social work practice. We hope for and look forward to ongoing and lively debate on structural competence from social work scholars, practitioners, and activists.
The Culture-Structure Framework: Beyond the Cultural Competence Paradigm

Mimi E. Kim
School of Social Work
California State University, Long Beach

This article provides a framework for understanding the distinctions between culture and structure in its application to the human services. Using intimate partner violence (IPV) as a case study, this article builds upon the contributions of intersectionality, which was first introduced as a critique of white-dominated IPV interventions. It also follows the development of the concept of cultural competence to demonstrate the ways in which it both opened opportunities to discuss cultural differences but also suppressed the analysis of racialized hierarchies of power, which are often muted by the elevation of culture over race. Finally, this article proposes a general culture-structure framework that more clearly distinguishes the differences between culture and structure and provides analytical categories for looking at how culture and structure organize along lines of categories of identity and experience such as race/ethnicity, gender, class, sexuality, immigration status, ability, age, and religion. The framework also centers hierarchies of power, demonstrating how dominant individuals and groups often have both cultural dominance and greater control over and access to structural resources.

Keywords: cultural competence, structural analysis, race, intersectionality, intimate partner violence
The language of culture in the human services is polyglot. Those of us who regularly weave between the worlds of theory and the less pristine categorical boundaries of on-the-ground human intervention constantly seek new frameworks to bring clarity not only to how we think about our work but how we do our work. With those frameworks comes the obligatory manufacturing of words and phrases used to name new concepts and their operationalized set of practices. For those of us specifically addressing marginalized populations, such tasks as naming problems and proposing solutions are imperative and also daunting in the face of today’s growing inequities and human-caused catastrophes.

The term *cultural competence* has been used to address racial/ethnic disparities and to improve interventions in public health, social work, education and other arenas of human services. While the influence of culture is ubiquitous across human life, the term is generally reserved in the context of the United States for individuals and communities that are non-dominant and non-white (Sakamoto, 2007; Sue, 1998). The concepts of culture and, hence, cultural competence, have also become umbrella categories used to demarcate a multitude of distinctions or characteristics associated with a non-dominant race or ethnicity (Gallegos, Tindall, & Gallegos, 2008). These may include factors such as beliefs, values, customs, traditions and language, which are usually considered distinctly cultural (Bennett, 2015). But culture and cultural competence often address conditions that are not within the purview of culture, but may be better described as structural, referring to the material conditions that shape the life opportunities and barriers faced by individuals and communities.

Using the field of intimate partner violence (IPV) as a case study, this paper examines the conflation between cultural and structural factors, the distinctions between the two sets of explanations, and a proposal for a culture-structure framework with implications for analysis of social problems and for interventions to address them. The paper builds upon the applications and critiques of the conventional use of culture and cultural competence in reference to IPV. It also references the contributions of Metzl and Hansen (2014) and their proposal for the notion of structural competency as applied to medical education. Based upon my experience in a culturally specific
IPV organization and research in the field of IPV intervention and prevention, I argue for a rigorous distinction between cultural and structural factors, offering a general culture-structure framework to guide practice, policy and research across the human services and which also may be relevant to broader social movements. Clarifying and refining these conceptual domains will promote better understanding of the complex conditions underlying social problems, improve policy and practice (especially for marginalized communities), and contribute to social change strategies that can more effectively address the root causes of social problems.

This conceptual paper employs the case study of IPV, relying primarily upon secondary literature addressing culture, cultural competence, and culturally specific programming as related to human services, generally, and more specifically to interventions to IPV. I also use my own experience as a long-time advocate in immigrant-specific domestic violence programs and as a proponent of alternative community organizing intervention models to inform the paper’s organization and analysis.

Culture and Cultural Competence

Emergence of Cultural Competence in the Human Services

The history of social work is rooted in the racial/ethnic and class differences between the “provider” and the “client.” This is evident in the settlement house movement that established the foundations of social work and the distinctions between settlement workers, primarily white, middle-class, educated women, and immigrant settlers (Lissak, 1989). During this period, settlement workers mostly neglected African Americans. Instead, they primarily served European immigrants during a time when “new immigrants,” such as Irish, Italian and Russian populations who settled in urban centers in the late-1800s, were considered to be “racially” different than Northern European white populations (Hounmenou, 2012).

It was not until the 1980s that the concept of cultural competence emerged as a way to deliver sensitive and effective social services to ethnically and racially diverse communities (Gallegos et al., 2008). The concerns arose from the broader civil rights and racial justice movements of the 1950s and 1960s, as
well as in response to the increasing numbers of non-white immigrants entering the United States. As the U.S. population became more diverse, cultural competence also represented a way to manage anxieties about these changes. Cross, Bazron, Dennis, and Isaacs (1989), whose early handbook on cultural competence set new standards across human services, were cognizant of changing demographics as well as the new and differentiated organizational contexts, including: “1) mainstream agencies providing outreach services to minorities; 2) mainstream agencies supporting services by minorities within minority communities; 3) agencies providing bilingual/bicultural services; and 4) minority agencies providing services to minority people” (Cross et al., 1989, p. vii). They recognized that many human service organizations were not only serving non-white populations, but were also run by them.

By 1996, the National Association of Social Workers (NASW) adopted a policy statement on cultural competence, raising this as an ethical responsibility of social workers (NASW, 2001). NASW codified the features of “knowledge,” “competence” and “sensitivity” that had already served as the foundations for policies, protocols, and curricula underlying cultural competence. The 1990s similarly witnessed an expansion of diversity trainings and multicultural programming within the broader arena of human services spurred by these same concerns (Gallegos et al., 2008; Kohli, Huber, & Faul, 2010; Warrier, 2008).

Despite the rise in culturally specific organizations, which were often established by and staffed by representatives of the target communities (Hung, 2007), human service organizations still grapple with many of the same assumptions that characterized the formation of social work as a profession. Specifically, human service organizations are typically run by administrators and providers from more privileged and culturally dominant positions than service users. As Stanley Sue (1998), a prominent psychological researcher on Asian American communities, chronicles, “[o]ne of the most frequently cited problems in delivering mental health services to ethnic minority groups [in the 1990s] is the cultural and linguistic mismatches that occur between clients and providers” (p. 441). Since that time, mandates for cultural competence have raised the promise of relevance and recognition for those deemed to be the cultural “other” (Sakamoto, 2007), while simultaneously imposing
the oppressive practices that so often accompany these demands (Abrams & Moio, 2009; Kumagai & Lypson, 2009). One of the primary critiques of applications of cultural competency is that it provides a manageable compendium of *how-to’s*, sets of instructions cuing providers on fixed characteristics of “cultural” groups, and “sensitive” service delivery to African Americans, Latinos, Asian Americans, Native Americans and, more recently, Muslim Americans (Kumagai & Lypson, 2009; Warrier, 2008). Practices of inclusion are also accomplished through the selection of tokenized representatives in the name of cultural diversity (Beckwith, Friedman, & Conroy, 2016).

Despite the sensitivity to contextual variation grounding the application of cultural competence in some of the earliest formulations of the concept (Cross et al., 1989), it has become more common in the cultural competence literature to assume cultural “mismatch” (Sue, 1998), thus normalizing differences in provider and client that may replicate relations of power from a century earlier. This assumption further disregards or minimizes the option for human services designed and delivered by providers who may actually share common racial/ethnic (and other), hence, cultural attributes with their service users or constituents. This narrow cultural competence lens suggests that sufficient knowledge and corrected provider attitudes and behaviors can remedy what might be more accurately understood as deeper structural conditions such as lack of resources for services provided by and for people from specific marginalized communities. At the same time, the suppression of such categories as race and class yield to the more neutral term “culture” and a more digestible reference to differences in values, customs and language, rather than differences in power and access to resources (Abrams & Moio, 2009; Sakamoto, 2007).

*Defining Structural Competency*

Through the lens of cultural competence, barriers to access or health disparities too often elide cultural explanations with structural causes. Metzl and Hansen (2014) sought to disentangle the notions of culture from those of structure, maintaining the significance of the cultural while delineating characteristics or behaviors more accurately tied to structural factors. Metzl and Hansen begin with a more concrete material definition of
structure, which they describe as “the buildings, energy networks, water, sewage, food and waste distribution systems, highways, airline, train and road complexes, and electronic communications systems that are concomitantly local and global” (p. 128). This definition provides welcome specificity synthesized from the contributions of classic social scholars and applied to the contemporary field of medical education. More familiar perhaps to those arguing for structural analysis is the emphasis on ways in which access or lack of access, control over or lack of control shape inequities in society—inequities that often follow the contours of race/ethnicity, gender, class, sexuality, immigration status, ability, age, religion and other categories. Using this definition of structure, Metzl and Hanson (2014) advocate for an alternative concept, to both disentangle from and connect cultural considerations to the practice they name structural competency. Building upon the language of cultural competence, structural competency reflects a set of skills used to “discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication ‘non-compliance,’ trauma, psychosis) also represent the downstream implications of a number of upstream decisions” (p. 128). While they focus on the medical industry, this definition and the five skill sets they advance to operationalize structural competency are relevant across human services.

Using case studies, they deconstruct clinical interactions that may benefit from a structural analysis of individual behavior. For example, they describe the situation of “Mrs. Jones...an African American woman in her mid-60s who comes late to her office visit and refuses to take her blood pressure medications as prescribed” (p. 128). These behaviors can be interpreted as typical of older African-American women or, alternatively, can be viewed through an understanding of structural factors such as lack of access to insurance, exposure to toxins, or a lifetime of exposure to racism. The example of Mrs. Jones illustrates how a facile turn to cultural attributes to explain individual or group behavior may obscure a more accurate appraisal based upon structural barriers tied to poverty, sexism and racism.
Intersections of Culture and Structure in IPV

IPV, Cultural Competence and Intersectionality

Following a historical chronology embedded in the broader evolution of social work, the history of IPV interventions in the United States first addressed domestic violence as witnessed among immigrant families by late nineteenth century social workers who were at the time almost completely made up of white, educated women and men, primarily of northern European ancestry (Gordon, 1988). However, the field of IPV has also been driven by feminist social movements, not only advocating for the safety and integrity of others, but also self-organizing for the self-determination of girls and women. Emerging from civil rights, labor rights, welfare rights and anti-war movements, the contemporary feminist movement was primarily made up of white women who espoused a continuum of political positions (Schechter, 1982).

Race-specific organizing and culturally specific programs have been present, if poorly documented, since the beginning of the contemporary anti-violence movement. The names of the earliest shelters, such as La Casa de Las Madres in San Francisco in 1974 or Harriet Tubman Women’s Shelter in Minneapolis in 1976, belie the prominence of women of color in the earliest moments of the battered women’s movement. Their contested origins also reflect racial struggles that underlay these histories (Schechter, 1982). An increase in government funding for IPV services followed the passage of the federal Family Violence Prevention and Services Act in 1984 and continued with the Violence Against Women Act (VAWA) in 1994. This rise in funding coincided with increased demands for culturally relevant programming. Cultural relevance referred not only to race or ethnic specific services but also increased immigrant, lesbian-gay-bisexual-transgender-questioning-intersex-2-spirit (LGBTQI2S) and disability access. As a result, the 1990s, in particular, opened up a new era of “culturally specific” IPV programs, many of which were initiated and run by members of marginalized communities (Kim, Masaki, & Mehrotra, 2010). These shifts were made at a time when the language of cultural competence informed policy mandates and local governmental and private funding initiatives. As a service delivery
field, practitioners and policymakers, even among programs established by those from marginalized populations, often acquiesced to a less critical adoption of the discourse of culture (Munshi, 2011; Sakamoto, 2007). However, the social movement’s origins and continued influence also fueled critiques that illuminated multiple and intersectional categories of identity, while also pointing to the problematic use of culture and cultural competence. Those leading culturally specific programs within the IPV field struggled with the limitations of the category of culture, the pragmatics of new culturally specific funding, and the urgency to provide some sort of basic cultural education to uninformed mainstream providers and policymakers (Kim, 2018; Kim et al., 2010).

Tendencies towards acquiescence matched political decisions made early in feminist social movement development. Struggles over racial equity within the anti-violence movement were contained by the gender essentialist position adopted early in movement history in the 1970s and 1980s (Goodmark, 2013). In the United States, feminist anti-violence movements had made formative decisions to suppress race and class differences in favor of an every woman analysis of domestic and sexual violence that emphasized the vulnerability of all women to gender-based violence, regardless of race, ethnicity and class (Kim, 2019; Richie, 2012). During the time of the formation of this enduring trope, same gender IPV within LGBTQI2S communities remained invisible (Kanuha, 1990). In the 1990s, people of color began to emphasize that vulnerability to IPV was related to the intersection of race/ethnicity with gender, gender identity, class, language, sexuality, immigration status, religion, ability, age, size and other categories (INCITE!, 2016; Kim, 2018).

The term intersectionality, first coined by legal theorist Kimberlé Crenshaw (1991), emerged from her critique of the negligent or negative effects of gender-based violence remedies on women of color, particularly African American and immigrant women. These remedies made explicit the inadequacies of undifferentiated notions of gender. Crenshaw’s nuanced critique of the symbolic and material consequences—not only of gender-based violence, but also of white-dominant responses to these forms of violence—did not reproduce rigidly compartmentalized categories of race within the construct of gender. Rather, the introduction of intersectionality made conceptual space for indeterminacy
and contradictory tensions stemming from the multiple identities that constitute each person and community.

It also demonstrated the ways in which structural conditions such as chronic poverty, language barriers, and vulnerability to immigration control are tied to gender, race, and class, categories that would later expand across other identities as the concept of intersectionality rapidly diffused across movements and disciplines. Abuses of cultural competence frameworks prevail and persist despite the insights of intersectionality; however, Crenshaw’s powerful analysis also opened the way towards a more robust framing of the relationships and distinctions between categories of identity and structural conditions.

Conceptual Reframing:
A Culture-Structure Framework

Introduction to a Generalist Culture-Structure Framework

The proposed culture-structure framework articulates more clearly the distinctions between culture and structure raised in these critical debates on culture and cultural competence with a focus on the contributions raised in response to IPV. It also acknowledges the limits of these critiques and the lack of attention that IPV-related practice, policy and scholarship have paid to the breadth of structural factors that influence vulnerability to IPV. The culture-structure framework turns to Metzl and Hanson’s (2014) synthesis of structural concepts derived from social theory as a foundation for a comprehensive definition and conceptualization of the various components that constitute structural factors.

I begin the framework with general definitions of culture and structure (see Table 1) drawn from the literature on culture and structure, respectively. The framework follows with three intervening categories, or domains, through which I argue that both culture and structure must be further analyzed. Figure 1 illustrates these domains as categories of: (1) identity and experience (e.g., race/ethnicity, gender and class); (2) location (e.g., domestic, local and national spheres); and (3) hierarchies of power (e.g., dominant versus subordinate).
The following section describes the primary categories, that is, culture and structure, further divided by three intervening domains: identity/experience, location, and hierarchies of power. Within each category, examples will be used to illustrate how the complex lives of individuals and groups require this more intersectional frame for understanding the relationship between cultural identities and structural conditions.

**Defining Culture and Structure**

*Culture.* To define culture, I turn back to a rather conventional, ethnographic definition dating back to the late 19th century that defines culture as a set of knowledge, beliefs, morals, and customs held by a defined group of people (Bennett, 2015). There is the sense that culture is shared, often unconsciously held, and tends to organize relationships among a set of people who identify as a common group.

Table 1. Defining Culture and Structure

<table>
<thead>
<tr>
<th>Definition</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CULTURE</strong></td>
<td>Included in definition. This list can be expanded to include language and other factors.</td>
</tr>
<tr>
<td>A set of knowledge, beliefs, morals, and customs held by a defined group of people.</td>
<td></td>
</tr>
<tr>
<td><strong>STRUCTURE</strong></td>
<td>(a) Basic necessities such as income/employment, housing, food, education, health/mental health services, communication, transportation;</td>
</tr>
<tr>
<td>Economic, political, social and ecological conditions and systems that shape control over and access to material goods and resources necessary for individual and collective life.</td>
<td>(b) Political rights such as personal and political decision-making power, rights to assemble, rights to freedom of expression (including gender identity, sexuality and religion), reproductive rights, rights to citizenship, rights to homeland; and</td>
</tr>
<tr>
<td></td>
<td>(c) Safety from harm such as interpersonal violence, community violence, state violence, surveillance, incarceration, war, displacement, forced migration, forced separation from family and community, and natural and human-made disasters.</td>
</tr>
</tbody>
</table>
Structure. In this framework, structure is defined as the economic, political, social and ecological conditions and systems that shape control over and access to material goods and resources necessary for individual and collective life. Because the breadth of these material conditions is so great in contemporary society, I expand the framework to discern categories to consider. I identify these categories as: (a) basic necessities such as income/employment, housing, food, education, health/mental health services, communication, transportation; (b) political rights such as personal and political decision-making power, rights to assemble, rights to freedom of expression (including gender identity, sexuality and religion), reproductive rights, rights to citizenship, rights to homeland; and (c) safety from harm such as gender-based violence, interpersonal violence, community violence, state violence, war, displacement, forced migration, and natural and human-made disasters. While this is not a comprehensive list, it includes categories that impact one’s ability to live and thrive as individuals and as a collective group.

Three Intervening Domains: Identity/Experience, Location, and Hierarchies of Power

Viewed through an intersectional lens, a simple distinction between culture and structure is insufficient. Rather, culture and structure are made meaningful by the categories that shape individual and collective perceptions, experiences, and access to resources. I name these categories as: (1) identity and experience; (2) location; and (3) hierarchies of power.

Identity and experience. First, categories of identity or experience are those that have always been critical to the life opportunities and trajectories of individuals and groups. Although this list is not conclusive (nor does it reflect significant categories outside of a U.S. context or within all geographic areas of the United States), I highlight the categories of race/ethnicity, gender, class, sexuality, immigration status, ability, age, and religion. Because the term identity tends to be associated with some sort of fixed qualities that are thought to attach to the bodies of individuals, I also include the term experience to emphasize that some of these categories may also be the result of experiences
that can then take on meaning as identities in specific contexts. For example, immigrants may have been born into geographic communities where their families had lived for generations; however, it is their experience of migration from home countries that creates a new identity as immigrant.

Furthermore, the word *culture* tends to be associated with one’s race/ethnicity alone. It is important to highlight these various categories of identity/experience, as culture can vary among what we might call subcultures, constituted among people who may share a particular race or ethnicity, but who may also be organized by another category of identity or experience. For example, those who identify as LGBTQI2S within a specific ethnic community may also organize as a subpopulation sharing certain cultural norms and practices distinct from the broader ethnic community. Hence, it is necessary to distinguish intersectional identities in order to challenge the inaccurately simplified assumption of uniform cultural traits within a specific race or ethnicity.

**Location.** This framework further distinguishes locations in which culture and structure operate. I categorize these as (1) domestic/home; (2) local community; (3) local institutions; (4) national; and (5) global. The domestic or home sphere (also often referred to as the private sphere) is that of intimate or family relationships that may be centered in the home; these can include biological family members, family members through marriage or domestic partnership, or chosen family. The local community may extend outside of the home, but be inclusive of communal

---

**Table:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Race/Ethnicity</th>
<th>Gender</th>
<th>Class</th>
<th>Sexuality</th>
<th>Immigration Status</th>
<th>Ability</th>
<th>Age</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic/Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Institutions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Diagram:**

Figure 1. Culture and Structure: Categories of Identity/Experience, Location, and Hierarchies of Power

---

*Note:* The diagram illustrates the interactive relationship between culture and structure, highlighting the varying locations (domestic/home, local community, local institutions, national, global) and the hierarchies of power (subordinate, contested/shifting, dominant).
relationships that may be important in one’s daily life, such as extended family, neighbors, workplace, one’s faith institution, or other close-knit community members that are influential in defining and shaping culture and access to material goods and resources. I distinguish this from local institutions, as the latter may be less intimate or familiar, but may be influential in the ways in which they govern opportunities or challenges/barriers in cultural life and structural systems. These might include local commercial systems, educational institutions, medical institutions, or local systems of governance. The national level describes the system of national laws and governing institutions that regulate broad levels of material goods and resources and that further influence local and domestic spheres. They also include national level commercial systems. Finally, the global level may include global systems of regulation, commercial flows, security and conflict, and systems of migration.

Hierarchies of power. Central to the culture-structure framework are hierarchies of power. The exercise of power is not only overt; it can operate through the heightened visibility of some individuals and groups over others. That visibility can be positive or negative in terms of their associated levels of status and power. I further use the categories of (1) dominant; and (2) subordinate to distinguish in more stark terms the ways in which power is distributed and the relationships between those who are dominant and, conversely, those who are subordinate. I also add another more liminal category, that is, contested/shifting, to emphasize that the definition of dominant and subordinate is always shifting and subject to struggle.

Interaction Between the Three Domains

While these domains are presented as conceptually distinct, in the real world, they interact. In the following sections, the framework will expand to illustrate how culture and structure, respectively, can be seen through the individual categories of identity/experience, location, and hierarchies of power.

As with any conceptual framework, categories are meant to provide greater analytical clarity in order to disentangle the complexities and ambiguities of the real world. They provide conceptual elements that can be scaffolded in order to build a more comprehensive understanding of individual and
collective situations. They are to be understood as intersecting elements, not to entrap and encase into more distinct, but still static stereotypes. Rather, the framework is constructed to illuminate and guide towards a richer and more comprehensive understanding of our social world.

Culture and the Three Domains

**Culture and identity/experience.** In the United States, culture has been strongly identified with the categories of race, ethnicity, and religion. Stereotypical views of culture still hold these as immutable over time and as uniformly held within a geographic boundary or among a specific race/ethnicity. However, contemporary interpretations of culture are no longer so rigid and stable. Early definitions of culture were established in relationship to Western anthropological notions of culture attributed to pre-modern societies (Bennett, 2015). While these views still persist, culture is now understood to be flexible, indeterminant, and shifting due to unstable territorial boundaries, diasporic migrations of people, and changing economic, political, social, and ecological conditions over time.

Furthermore, one can see that cultures, even within a specific geographic location, are often complex. Intersectional identities within any group of people, that is, by race/ethnicity, gender, class, sexuality, immigration status, ability, age and other categories, may yield distinct forms of knowledge, beliefs, morals, and customs that can also be understood to represent a subculture. Subcultures may be recognized, such as youth culture or hip-hop culture. They may also be unrecognized, especially if they are held within a subordinate group with little visibility, status, or power.

**Culture and location.** While culture is considered to include multiple aspects of life, we can also think of specific locations or spheres in which culture operates. How does culture operate in domestic life or the private sphere? How might this be different than cultural expressions at the level of the community? How is culture performed within organizations and workplaces? How are local cultures defined as compared to national cultures? At the global level, what is the influence of culture associated with globalization, such as cosmopolitan bourgeois culture or a global culture of proletarian solidarity?
Culture and hierarchies of power. Simplified categories of hierarchies of power in this framework are divided into those that are dominant, subordinate/marginalized or shifting/contested. However, these different cultural forms are subject to complex and often contradictory relations of power. For example, a working class young adult Latinx woman who is an undocumented migrant from Guatemala may carry a set of knowledge, beliefs, morals, laws and customs from her village in Guatemala. She may feel a sense of pride and connection to the religious customs with which she was raised in her home country. She may also suffer from IPV in a patriarchal relationship with her husband who comes from the same locale. In her home country, she may also have been culturally different if she were from an indigenous community marginalized within a Spanish-language-dominated country with a history of violent discrimination against indigenous people.

As an immigrant to the United States, she may be subject to a dominant white, patriarchal, xenophobic, elite U.S. culture that considers her to be uneducated, intellectually inferior, and even criminal. From a human services standpoint, an anti-violence provider may view her through a dominant cultural lens that casts her as someone ignorant about her rights or oppressed by her female passivity due to cultural norms. Conversely, she may also be “appreciated” within this same dominant culture, but for aspects defined by and valued by the dominant culture. For example, she may be viewed as exotic, a good cook, or desirable as a lover. While perhaps perceived as positive cultural traits, the definitions of these traits and the presumed consumption of these traits by the dominant culture render these subordinating to the woman and the presumed “culture” to which they are ascribed.

Structure and the Three Domains

Structure and identity/experience. Structures are also often organized along the contours of categories of identity/experience such as race/ethnicity, gender, class, sexuality, immigration status, ability, age, and religion. Individuals and communities falling under a certain category or intersection of categories are organized in such a way that they have access to these materials and resources or, alternatively, do not have access. In this way, structural conditions are also often defined by broader terms such as racism, sexism,
classism, and ableism because control of and access to material goods and resources are often significantly organized according to these broad categories and their intersections.

Structure and location. Structural conditions can also be categorized by location. It may be useful to think of the ways in which the domestic sphere or families/households distribute resources according to categories of identity/experience such as gender and age. Each geographic level organizes material goods and resources in distinct ways, with lower and more local levels often subject to the greater authority and control over resources wielded at higher regional or national levels. Finally, global systems also determine access to material goods and resources. The control of international monetary institutions, trade agreements, and military alliances are all examples of the influence of global systems over national and local structural conditions. Each location shapes and is shaped by the control and distribution of material goods and resources through regional, racial/ethnic, class, religious, and other hierarchically organized categories.

Structure and hierarchies of power. Structural relationships clearly determine control over and distribution of material goods and resources via hierarchies of power that operate at the levels of the domestic or private sphere, local communities, local institutions, national, and global levels. These sources of power are also controlled by those within dominant categories of identity/experience; accordingly, those in subordinate or marginalized positions often suffer from lack of control and access to material resources. As relations of power reflected in culture are subject to constant shifts and contestations, so too are structural systems in flux and subject to struggles over control and distribution.

Interaction between Culture, Structure, and the Three Domains

While this framework distinguishes culture and structure, delineating differences so often erased or misunderstood, culture and structure also interact. The dotted line between culture and structure in Figure 1 denotes the permeability and interaction between these two conceptual categories. Similarly, there is interaction between the category of identity/experience and the column representing location, and the bottom row of the figure represents hierarchies of power and indicates interaction between these domains.
To return to the example of the Latinx woman who may have migrated to the United States from rural Guatemala, cultural distinctions that may become apparent in her migration to the context of the United States are also influenced by structural conditions tied to her migration. For example, conditions of chronic poverty, economic neglect and extraction from rural areas, and international trade agreements that further exacerbate economic and political inequities may have contributed to her migration. The resulting isolation from family and cultural institutions that may have provided support could also worsen her situation of IPV as she becomes more geographically separated from these assets. While it is important to separate culture and structure, it is also important to recognize that culture and structure interact in the complex lives of individuals and communities.

**Using the Framework to Understand Struggle and Change**

The framework further includes the dynamic of ambivalence, contention, contradiction, struggle, and change. The hierarchies of power under culture and structure all assume dominance and subordination; however, they also assume that these relationships of power are always subject to fluidity and struggle.

Using another example, a 22-year-old college-educated Hmong American woman may have status and power within her small Hmong community but have little status among white, elite faculty on campus. Her status may be questioned among male Hmong leaders at a clan meeting but may be elevated when the community leaders are attempting to negotiate with officials at a city council meeting, as they find it beneficial to take advantage of her greater knowledge of English and U.S. systems of governance. She may move between these locations or spheres several times in a given day, at times subject to the greater authority of males in her clan or family, and at other times, subject to dominant forces on campus. Her identity and position may appear flexible compared to elder males who may appear to hold static views of culture. However, every individual and group is subject to shifting levels of visibility, status, and access to resources. For older Hmong males, in this example, their position of power may depend upon whether they look internally within their family or clan where they may exercise dominance or outward to white-elite dominant systems of civil society, market, and governance, where they may have little power.
As the category of hierarchies of power indicates (Figure 1), relationships of power are not static; they are subject to negotiation and struggle. The struggles for a 22-year old educated Hmong woman may be different than those for a Hmong male elder. At times, these parties may come together to suppress differences in order to join in strategies that have a greater chance of success; they may take advantage of specific forms of power and resources each subculture may have in certain contexts in order to achieve greater collective goals. These struggles may attempt to shift relationships of power between the broader Hmong community and the greater dominant neighborhood, city, or state structures. At the same time, young Hmong women may also demand greater respect and decision-making within their local Hmong families and clan structures; these struggles may aim to change cultural notions of gender, age, and their relationships to status and power.

Discussion and Conclusion

Culture, Structure, and Lessons from IPV

The contemporary history of the feminist anti-violence movement demonstrates how the dominance of a gender essentialist position suppressed differentiation based upon race/ethnicity, class, sexuality, immigration status, ability, and other categories of identity and experience. While the movement included strong leadership from women of color from its beginning, the rise of race and ethnic specific programs throughout the late 1980s and 1990s increased the presence of women of color, immigrant and LGBTQI2S-led programs. Their growing numbers, constituencies, and cumulative experiences created more visibility and power to diversify the movement/field and to demand changes.

At the same time, the IPV field was constrained by an often conservatizing language of culture and cultural competence. While attention to culture opened opportunities for greater inclusion of formerly invisible communities of color that expanded to LGBTQI2S communities and individuals with disabilities, narrow focus on identity without attention to structural conditions constrained the types of interventions to those defined by dominant white feminist leaders (Richie, 2012). Crenshaw (1991)
directly critiqued the consequences of the gender essentialist framework, pointing to the material effects the suppression of race, class, and immigration status had on the lives of women of color. The introduction of the concept of intersectionality further strengthened the distinction between categories of identity and the structural conditions that are shaped by and through these categories.

**Implications for Policy and Practice**

The culture-structure framework attempts to clarify a rich, manifold, and often muddied field in order to provide a more systematic guide to inform practice, policy, and future research across the human services with implications for broader social movements. In a human services field that tends towards flattened and simplified cultural tropes as a way to diagnose social problems that marginalized communities face, the culture-structure framework reminds us that that which might present itself as “culture” may more accurately be understood as a result of the very real opportunities and constraints of structure. It turns our attention from the often “othering” frame of cultural competence towards a more action-oriented mandate to change the structural conditions that deprive entire communities of the material goods and resources necessary for a robust individual and collective life. It reminds us that human life is, indeed, complex and that the role of engaged scholarship is to honor the lived experience of those most marginalized and to shine a light on those in struggle to illuminate a way forward.

Acknowledgements: I thank my sisters at Asian Women’s Shelter, Creative Interventions, Freedom, Inc., KAN-WIN, Korean American Coalition to End Domestic Abuse, Asian Pacific Islander Institute on Gender Based Violence, National Organization of Asian Pacific Islander Ending Sexual Violence, and Incite! for the collective work that informed and inspired this article.
References


Structurally Competent Social Work Research: Considering Research Methods and Approaches that Account for a Recursive Relationship between Individuals and Structures

Jaime M. Booth
School of Social Work
University of Pittsburgh

Structural competence, recently introduced in the medical literature, has always been present in social work’s approach to addressing social problems. To achieve structural competence, in medicine and in social work, an evidence base for the structural determinants of social problems and interventions is needed. Social work researchers have made some strides in developing an evidence base to inform a structurally competent practice by employing structurally competent research methods in the investigation of social problems. This paper argues that Anthony Giddens’ structuration theory adds to the medical literature’s understanding of structural competence and discusses several research methods and/or approaches that have been and should continue to be employed by social work researchers in developing a structurally competent evidence base to inform practice.

Keywords: structural competence, structuration theory, research methods, multilevel modeling
Introduction

Metzl and Hansen (2014) introduced the concept of structural competence in the medical literature as a clinical practice in which doctors not only identify a patient’s presenting problem, but also the upstream factors that may be impacting his or her health. A structurally competent approach to clinical practice requires extensive knowledge regarding the ways in which structural factors—such as neighborhoods, zoning laws, school systems, and/or language barriers—impact client outcomes directly and indirectly. Even though Metzl and Hansen (2014) argue that scientists now have a greater recognition that structures impact health outcomes, they also acknowledge there is less evidence to guide practitioners in imagining structural interventions, and in the face of not knowing, practitioners rarely act to do so (Metzl & Hansen, 2014, p. 130).

To be structurally competent, practitioners in medicine and social work need more than evidence of existing structural relationships; they need evidence-based strategies to address those structures identified as important for client outcomes. Developing this evidence base may require the use of theories and/or research methods/approaches outside of those typically used in medical intervention research. Although social work is not the only discipline to make strides in this area, social work’s long history of attempting to intervene on the structures that are impacting vulnerable populations makes it well positioned to contribute to conversations regarding the theories and research methods needed to create such an evidence base. This paper discusses what might be gained by considering: (1) the relationship between structures and individuals as bi-directional; and (2) the research approaches used by social work researchers to investigate bidirectional relationships, such as a multilevel modeling framework, social network analysis, participatory-action research approaches (based on critical dialogue), and in-depth ethnography. The purpose of this paper is to highlight the research methods and approaches that social work researchers presently use in conducting the structurally competent research needed to imagine structural interventions and inform a structurally competent social work practice.
Laying a Theoretical Foundation for Structural Competence

In classic theories of human behavior, there has been a tendency for theorists to favor a structural explanation or an individual explanation, with few theorists integrating both (Kondrat, 2002). Macro theories of human behavior (which tend to favor a structural explanation) have classically defined social structures and institutions as “social regularities and objective patterns external to individual actions, intentions, and meaning” (Kondrat, 2002, p. 436). Sewell (1992) suggests that theories which focus strictly on structures as determinants of human behavior are limited, as they do not explain how structures are created and maintained, and/or changed. According to Baber (1991), theories that focus on human interactions to explain human behavior overlook the influence of structures in shaping behavior. This dualism is not helpful when developing structural interventions designed to change those structures impacting a client’s well-being.

Although some social work frameworks (i.e., ecological systems theory) describe the relationship between individuals and structures, they typically describe the relationship as uni-directional and therefore remain limited in their utility. Other frameworks, such as Giddens’ structuration theory and Lerner’s developmental systems theory, conceptualize the relationships between structures and individuals as bidirectional. Theorizing a bi-directional relationship may be particularly important to consider when assessing structural interventions and the research methods required to develop and test them, as these processes describe pathways through which individuals can change structures. Although Lerner’s developmental systems theory argues the bi-directional relationship between individuals and their contexts are central to human development, individual development remains the primary focus of the theory; consequently, less attention is paid to how individuals change structures (Lerner, 2018). Conversely, in Giddens’ structuration theory, the relationship between individuals and structures is central and dynamic and provides an explanation for how structures are created and maintained (Giddens, 1979, 1984, 1991). These theories do not necessary contradict each other; however, due to the explicit focus on the dynamic creation and re-creation of structures within Giddens’ structuration
theory, it is used in this paper to organize the discussion of structurally competent social work research methods.

Metzl and Hansen (2014) define structures as “the buildings, energy networks, water, sewage, food and waste distribution systems, and highways...diagnostic and bureaucratic frameworks...and assumptions imbedded in language” that impact health (p. 128). In this definition, although not explicitly stated, an individual’s behaviors are determined or constricted by existing structures that simply exist with little explanation of how they came to be. In contrast, Giddens (1984) defines structures as “rules and resources, recursively implicated in the reproduction of social systems” (p. 377). Giddens integrates the theories of structural influences and individual agency by conceptually connecting the everyday life of an individual to larger social structures. Within this theory, social structures are not separate from the individual; rather, they are comprised of individuals that are continuously co-constructing the social regularities that characterize that structure. For example, the structure of a workplace is maintained when the workers agree to come to work and perform the prescribed tasks, and management agrees to impose sanctions when the rules are not followed. If any of the involved parties do not perform according to the rules (i.e., the workers do not show up for work), the structure will no longer exist. Therefore, Giddens argues, social structures are, foundationally, constructed realities with a set of rules that govern behavior—rules that individuals have consciously or unconsciously agreed to abide by. The concept that social reality and social institutions are recursively constructed is central to Giddens’ understanding of the relationship between structures and individuals; it is a particularly useful concept when attempting to imagine structural interventions.

Several concepts in Giddens’s theory are important to understand if they are to be applied to structurally competent research. For example, for individuals to consciously work to change structures, they must become aware of the governing rules and their role in maintaining them. Although this may seem simple, the majority of the rules that create and maintain structures are taught to us as children and become habitual, outside of our conscious awareness (Wheeler-Brooks, 2009). For example, the rule that dictates we should say “please” when making a request is not a rule we necessarily identify as
a structure we actively worked to co-create. It is so ingrained in our behavior that we do it with little awareness of a tacit agreement with the rule. Giddens calls this type of knowledge “practical knowledge” (Kondrat, 2002, p. 440). Consequently, for individuals to realize their role in the construction and maintenance of structures, they must be able to observe their behavior and identify the rules—a process that requires reflexivity. If individuals are able to reflexively observe their behavior within a structure, they can build their awareness of the social constructions that govern social structures and then actively work to reshape them.

Giddens does not ignore the unequal distribution of power within the social structure that gives some individuals more power than others in constructing structures. Power, functioning according to the amount of knowledge a person has of the rules that govern social interaction, gives those who have it the ability to actively shape social structures (Wheeler-Brooks, 2009). Within the conception of structures, all that is needed to create change is for individuals with agency to become aware of the rules that govern them. They may then collectively refuse to abide by them, effectively co-creating a new structure with new agreed-upon rules. In structuration theory, Giddens is conceptualizing how social action can take place (Baber, 1991).

Despite its strengths, structuration theory has been critiqued for being a-priory and a-historical, effectuating its failure to adequately account for power differentials and existing structural properties (Archer, 1982; Baber, 1991; Mouzelis, 1989). Although Giddens recognizes the role of knowledge and resources in an individual’s ability to impact structures, his theory has been critiqued for failing to consider other aspects of power that exist based on an individual’s position within the structure, and any pre-existing aspects of the structure (Archer, 1982; Bourdieu, 1979; Mouzelis, 1989). Archer (1982) argues, for example, that some structures may be easily changed, while others may be highly resistant to change, and still others may be unchangeable (i.e., classroom rules, tax law, the constitution, exhausted natural resources). Despite these critiques, Baber (1991) suggests that the connection structuration theory draws between human agency and structures provides an explanation of action largely absent from other theories of human behavior that strive to account for the role of structures. Accordingly, structuration
theory provides some insight into the types of research questions that structurally competent social work research should be addressing, and it suggests that research methods must account for the bi-directional relationship between individuals and structures.

Although the ability of individuals to change structures may vary based on the individual’s position/power and the malleability of the structure, the idea that rules can be changed when an individual gains knowledge of them provides a framework for imagining structural interventions (Metzl & Hansen, 2014). By theorizing a bi-directional relationship between structures and individuals, Giddens not only explains the relationship between the two, he also identifies the ways by which individuals can exert their agency to change existing social structures. If social workers were to become aware of the ways they and their clients contribute to the co-construction of structures, they could actively work to change them.

Methods Used in Structurally Competent Social Work Research

To apply these theoretical concepts to structurally competent research, methods are needed to empirically assess the bi-directional relationship between individuals and structures, as opposed to simply relying upon methods that describe one (the individual) or the other (the structure). Although traditional research methods/approaches (i.e., cross-sectional surveys, randomized control trials, OLS regression) may be used to generate evidence that will inform structurally competent social work practice, some research methods/approaches employed in social work research may be more applicable for investigating the bi-directional relationships between individuals and structures as theorized by Giddens.

The remainder of this paper will examine four research methods/approaches that have been used in social work research to account for the bidirectional relationship between individuals and structures outlined in structuration theory (see Table 1). The methods/approaches discussed and the studies that are used to illustrate their application in social work research are not meant to serve as a comprehensive review of the work that is being done to understand the bi-directional relationship between structures and individuals in social work.
<table>
<thead>
<tr>
<th>Features of Ecosystems Perspective (Kondrat, 2002)</th>
<th>Research Methods /Approaches</th>
<th>Features of Structuration Theory (Kondrat, 2002)</th>
<th>Research Methods/Approaches</th>
<th>Examples in social work research</th>
<th>Recommended methodological guides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uni-directional transaction between micro and macro systems</td>
<td>OLS regression with robust standard errors</td>
<td>Recursive relationship between individuals and structures</td>
<td>Multi-level models with cross level interactions</td>
<td>Little &amp; Tajima, 2000</td>
<td>Raudenbush &amp; Bryk, 2002</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ethnography</td>
<td></td>
<td>Hammersley &amp; Atkinson, 1995</td>
</tr>
<tr>
<td>Unit of analysis: transactions between persons and macros systems</td>
<td>OLS regression with robust standard errors</td>
<td>Unit of analysis: the human agent acting in concert with other human agents to create and maintain structures</td>
<td>Social network analysis including the examination of how norms spread in networks</td>
<td>Barman-Adhikari et al., 2016</td>
<td>Borgatti et al., 2009</td>
</tr>
<tr>
<td></td>
<td>Decomposition of effect in multi-level models</td>
<td></td>
<td></td>
<td>Rice et al., 2018</td>
<td>Knoke &amp; Yang, 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Scott, 1988</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ethnography</td>
<td></td>
<td>See above</td>
</tr>
<tr>
<td>Individuals knowledge of structures are not considered</td>
<td>N/A</td>
<td>Reflexivity of human actor in role of creating and maintaining structures</td>
<td>Participatory Action Research</td>
<td>Wagaman, 2015</td>
<td>Kemmis, McTaggart &amp; Nixon, 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Schormans, 2010</td>
<td>McIntyre, 2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ethnography</td>
<td></td>
<td>See above</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>See above</td>
</tr>
</tbody>
</table>
research; they simply provide a discussion of four methods and approaches, with examples of how they have been applied.

Multilevel Modeling: Testing the Relationship between Individuals and Structures

Structurally competent social work research that builds an evidence base for structurally competent practice (based on Giddens’ conception of structures) explicitly investigates: (1) the relationship between structural factors that may be impacting outcomes; and (2) how individuals collectively contribute to the recreation of structures. Some of these structural factors may include agency policies, neighborhood crime rates, school climates, and work-place training opportunities. If, for example, a social worker found evidence that the school climate is impacting their client’s attendance, a structurally competent social worker may begin to investigate how the school climate might be changed or what individual characteristics (students, teachers, or administrators) work together to co-construct a school climate that supports or hinders student attendance. In order to establish an evidence base for the relationships between climate and attendance, the social work researcher would need to investigate the relationship across multiple schools, requiring the use of statistical methods that account for clustering. Once the social work researcher concludes that the school climate is related to attendance, he or she may want to investigate if teacher norms are contributing to the school climate and if the difference in teacher norms changes the relationship between school climate and attendance. In order to address these types of structurally competent research questions, social work researchers may use multi-level modeling and test cross-level interactions.

The simplest statistical models used in social work research, such as OLS regression equations, may easily test the relationship between individual-level factors (i.e., school attendance and grades) and structural-level factors (i.e., school suspension rates and the number of teachers in a school across schools). To establish an evidence base for the relationships between climate and attendance, the social work researcher may need to investigate the teachers’ and/or students’ means across multiple schools. This will require the use of statistical methods that: (1) account for the dependence of observations that occur when
there is clustering; and (2) allow the research to decompose the individual- and structural-level variation.

Multilevel modeling provides researchers the tools to model the relationships between individuals and structures within a regression framework. When examining structural factors using surveys or other forms of measurement, researchers often have multiple participants within one organization, school, or neighborhood, consequently rendering these observations dependent. In order to correct for this violation of assumptions of regression, statistical methods must be used to account for the dependence; researchers can adjust for the clustered standard errors or estimate multi-level models. In these situations, however, it may also be important to understand what amount of variation in individual-level variables can be attributed to structural characteristics and what amount of variation can be attributed to individuals (Duncan, Jones, & Moon, 1998). For instance, we may measure a school’s climate by asking students a series of questions about their school. In order to understand how much of this report is a reflection of the school’s climate and how much of the response is due to differences in individual experiences, and/or characteristic multilevel models are needed.

Multilevel models position researchers to acknowledge that structures are simply a collection of individuals, allowing the research to model the part of individual experiences are consistent across structures and therefore become characteristics of that structure (Raudenbush & Bryk, 2002). Multilevel models also allow researchers to test cross-level interactions to determine if the impact of structures varies by individual experiences or actions (Duncan et al., 1998). For example, once the social work researcher concludes that the school climate is related to attendance, they may want to investigate if a student’s willingness to intervene in fights (individual agency) is contributing to the school climate (characteristics of the structure) and if the differences in a student’s willingness to intervene changes the relationship between school climate and attendance.

Although multilevel modeling gives researchers the tools to test the relationship between structures and individual outcomes, research designs and the types of applicable measures dictate whether researchers can test the unidirectional relationship between structures and individual outcomes alluded to by Metzl and Hansen (2014) or the bidirectional relationships
theorized in structuration theory. Research designs employing multilevel models to test the relationship between structural aspects of society and individual outcomes frequently include observations at one point-in-time. This is a restriction which constrains the researcher’s ability to hypothesize or test the directionality of the relationships. In such cases, researchers typically rely on theories to support the argument that associations flow down from structures to individuals. Consequently, researchers rarely test the impact of individuals on structures. Although the use of multi-level models does not inherently indicate that the researcher is testing the relationships between structures and individuals, as theorized by Giddens, it does give researchers a tool for modeling these relationships.

Little & Tajima’s (2000) study provides an example that uses cross-sectional data to understand the bidirectional relationship between individuals and structures by explicitly measuring individuals’ attributes that may be working to influence structures and by testing their relationship within a multilevel framework. More specifically, Little & Tajima (2000) use multi-level modeling to understand how attributes of social workers (i.e., having Master degrees) might work together to co-create program structures that impact client outcomes. In this study, individual client characteristics, such as substance abuse and stable housing; worker-level attributes, such as job clarity, autonomy, and deficit orientation; and program-level characteristics, such as case load, positive climate, and service intensity, were considered. Although much of the variation in collaboration was observed at the individual level, 13% of the variance in collaboration was attributed to between-worker variation and 4% of the variance in collaboration was attributed to program characteristics. After the variance of cooperation at each level was determined, the authors tested which features of each of these levels accounted for the variation. At the individual level, they found that workers were less likely to collaborate with African-American mothers, and African-American workers were more likely to collaborate with all of their clients. They also found that those workers with a Master’s degree were more likely to collaborate with substance-using mothers and those workers who had worked in the child-welfare system for more than a year were less likely to collaborate with families who had severe deficits in child-care skills.
Little & Tajima (2000) also used cross-level interactions to examine the relationship between clients, individual workers, program-level characteristics, and parental engagement in child-welfare programs. Their study provides an example of how concepts in structuration theory can be modeled in a multi-level framework to provide insight that can inform structurally competent social-work practice. Based on these findings, an organization, for example, may decide that hiring masters-level social workers is essential for creating an organizational structure that facilitates client collaboration. This is exactly the type of evidence that is needed for social workers to practice in a structurally competent manner.

In order to explicitly test the bidirectional relationships between structures and individuals, examining longitudinal data within a multilevel framework is needed. Longitudinal data allows the researcher to test the potentially recursive relationship between structures and individuals as theorized in structuration theory. Although it is typically assumed that structures are static over time, structuration theory would argue that is not necessarily the case, and this could be tested over time. In a recent article, Lee and colleagues (Lee, Shapiro, Kim, & Yoo, 2018) outlined how social work researchers can use multilevel structural equation models to understand the direct and indirect effects of teachers and classroom characteristics in youth’s healthy development. In their example, they found that variance in the students’ social/emotional competence occurring at the classroom level could be explained by the teacher’s social/emotional competence and could be mediated by the number of lessons a teacher taught on the subject. Although this use of longitudinal data does not directly model the recursive nature of individuals and structures, it does model how teacher characteristics impact the structure of a classroom—in this case, the lessons being taught that impact youth outcomes. Modeling longitudinal data in a multi-level SEM framework gives social work researchers the tools to test the possible influences of structural change, moving the field toward developing evidence-based structural interventions.
Social network analysis is another method that social workers have employed to investigate aspects of structuration theory that may inform structurally competent practice. Giddens’ assertions that structures are created and recreated through interactions which are governed by agreed-upon rules, leads researchers to question how rules and norms are spread among individuals. If social work practitioners are able to understand how rules are being shared within networks, structurally competent interventions may be designed to disseminate alternative rules, which, in turn, may change the structures themselves. Suppose a social work practitioner endeavored to address the rates of violence within a neighborhood, and he or she knew that the pervasive neighborhood rule of not reporting crimes was contributing to high rates of violence. To intervene in this problem, a structurally competent social worker may aim to change the structure of the neighborhood by changing the rules of the neighborhood to “if you know of a crime taking place, say something.” In order to effectively change the old rules (and as a consequence, have the structure impact client outcomes), the social worker would need to understand how the rules are disseminated within the neighborhood’s networks. Social network analysis allows social work researchers to investigate how rules and/or norms are shared within structures—information which may lead to social work interventions that are able to change the structures by changing the rules.

Consistent with structuration theory, social network analysis allows researchers to examine how human agents work in concert to create and maintain structures. Social network analysis involves graphing social connections as a series of nodes (actors) and edges (relationships) (Wasserman & Faust, 1994). The shape and patterns found in these connections are called the structure of the network (Wasserman & Faust, 1994, p. 3). Methods have been developed to describe these structures and understand how an actor’s position within the structure impacts his or her knowledge, behavior, and norms (Scott, 1988). More specifically, network graphs have been used to map the spread of norms through the networks, the relational structures of organizations, neighborhoods, and classrooms, in addition to understanding...
the behavior of the networks based on the characteristics of the actors (Borgatti, Mehra, Brass, & Labianca, 2009). Social network analysis also describes how individuals choose to associate with one another—data that potentially has significant implications for how structures are created and maintained.

Lastly, social network analysis provides a precise definition of the members and non-members of a group—knowledge that can be used to understand the social structures in schools, social service agencies, and/or governing bodies (Neal & Neal, 2013). Due to the importance of networks to the spreading of norms, Rice and Yoshioka-Maxwell (2015) explicitly argue that social work researchers and practitioners should be using this method to develop more effective interventions.

Much of the social work research that has employed social networks simply characterize an individual’s egocentric network or the relationship that one individual has with another member of the focal person’s social network. In an article that examined the role of a participant’s egocentric networks within mental health self-help agencies, social work researchers Hardiman and Segal (2003) found that participants with social networks which consisted of other self-help agency members reported a higher level of organizational empowerment, while valuing less concrete services.

In another example, social work researchers Zakour & Harrell (2004) investigated the cooperative links between social service organizations and the intensity of those links during a disaster condition. The study found there were fewer organizations in high-risk neighborhoods (defined as a high percentage of African-American female-headed households, children under the age of 5, and adults over the age of 75) and fewer cooperative links between these organizations and organizations outside the area. Although these studies did not include the relationships between all members of the network, in both studies the ego-centric networks were used to understand other aspects of the larger structures—organizations in the first example and neighborhoods in the second.

Both of these studies are examples of the use of network analysis to describe the attributes of structures, as defined by Giddens, that impact individuals, and in these cases, the lives of vulnerable individuals. The egocentric networks described, to some degree, imply a recursive relationship, although the roles
of additional actors in the creation and co-creation of these organizations and their collaborative relationships are not examined. The findings of both of these studies are very useful to social workers striving for structural competence. Based on the findings of the first study, a structurally competent social worker may attempt to increase a client’s perceptions of organizational features by working to grow the social networks among the members of the self-help agency. Based on the findings of the second study, a structurally competent social worker may actively work to bring more organizations into underserved areas and actively work to build relationships between the organizations.

Socio-metric studies attempt to collect complete social networks to create a social network map that will contain all of the relationships (or lack thereof) between the actors within a closed system. In socio-metric studies, researchers strive to describe the structure of a whole network, including features such as network density and centrality. These measures can be used to: (1) understand how information spreads within a closed system; (2) understand who in the network has the most power; and (3) understand who in the network serves as a bridge between two groups or clusters within the network (see Rice & Yoshioka-Maxwell, 2015, for a more detailed description of these measures).

Barman-Adhikari and colleagues (2016) collected data on two socio-metric networks of homeless youths in California. In this study, researchers used interaction with the drop-in centers to delineate the closed system needed to conduct these types of studies. Using defined boundaries, they were able to describe complete networks and test the relationship between network characteristics and the perceived methamphetamine-use and the methamphetamine-use norms. This study revealed that an individual’s location within dense networks (or cohesion) was significantly related to the participant’s beliefs regarding a network partner’s drug-use norms. From this analysis, they concluded that leaders, or those with the most connections in the community, might not be the most effective at spreading prevention messages and that any intervention attempting to spread prevention messages through social networks should target members of the densely cohesive social groups for maximum coverage. Rice and colleagues (2018) then used this information to create an algorithm to identify individuals within
a network that could spread a prevention message the most efficiently and tested the effectiveness. The researchers found there was significantly more HIV testing and condom use in the group that used the algorithm to identify the people who were trained to spread prevention messages.

Studies such as these provide an efficacious and compelling example of how social networks can be used to better understand structures and how an understanding of those structures can be used to influence individual behaviors. These constructs could be applied to the spread of any idea or norm within a social network, providing a greater understanding as to how individuals create and co-create structures. In addition, any shift in the norms that can change the character of the structures may also become apparent. Findings from these types of studies could be employed in structurally competent social work practice to substantially affect structural change.

**Participatory Action Research Facilitating Discursive Knowledge**

Another important aspect of structuration theory is the idea that humans are reflexive human actors, which is to say that they are able to monitor their own social performances and change them to fit existing norms (Kondrat, 2002). The reflexive nature of humans means that individuals have the capacity to become aware of structures that are oppressive and then actively work to change them. Within structuration theory, structures are not something to be overcome; rather, they are a social construction that simply needs to be reconstructed to affect change (Wheeler-Brooks, 2009). Becoming aware of the rules and norms that govern social structures may be challenging, particularly when these rules and norms are implicit, or exist as what Giddens calls practical knowledge (Wheeler-Brooks, 2009, p. 130). Within structuration theory, an individual cannot begin to create new structures until the practical knowledge regarding the rules and norms that heretofore have maintained the old structures are made explicit or become discursive knowledge (Wheeler-Brooks, 2009, p. 130). Participatory research methodologies, such as participatory action research, represent a research approach that facilitates this process and therefore may be useful for social work researchers when building an evidence base of structural interventions (Metzl & Hansen, 2014, p. 130).
In the 1970s, Paulo Freire proposed a method for facilitating the development of critical consciousness and discursive knowledge (popular education) among peasant farmers living in Brazil (Freire, 1970). Participatory action research, based on Freire’s approach to popular education, is a research approach that utilizes dialogue as a means for creating consciousness among individuals being negatively impacted by a social structure and working with individuals to co-create a new set of norms, thereby changing the structure. Participatory action research (PAR) engages participants in the co-creation of research which may give them insight into the impact that structures have on them, thereby encouraging them to use that knowledge to advocate for change. Consistent with structuration theory, it assumes that participants have the power (i.e., agency) to change the structures that are impacting their lived experience, and it actively works with participants to develop a reflexive understanding of the structures that are impacting their lives (Akom, Cammarota, & Ginwright, 2008). In PAR, participants can use a variety of data collection methods, providing they serve the goal of collecting information that will yield insight into a problem the group has collectively decided is an issue facing them all. In this approach to research, it is the researcher’s job, in the tradition of Freire, to guide the group through a critical dialogue that begins with their own individual experience and results in a collective understanding of social structures that impact their well-being.

In one example illustrating the use of PAR to understand and address structures, social work researcher Wagaman (2015) engaged 15 LGBTQ young people in a research study that examined intracommunity bigotry among the LGBTQ community. In a study detailing the process of conducting PAR, Wagaman (2015) found that participants developed self-awareness, a critical consciousness, and an increased sense of control over systems and structures. The participants developed a willingness to challenge the systems of oppression and to change the commonly held beliefs. They also identified strategies for changing the LGBTQ social service agency with which they were involved.

In another example of PAR, Schormans (2010) engaged a group of individuals with an intellectual disability in a research
project that examined and challenged media portrayals of them. The project began with participants selecting images of intellectually disabled individuals from a large public database and then critically assessing the images based on a series of questions. The group was generally very displeased with how the media portrayed individuals with intellectual disabilities and discussed how the images could be changed to challenge these representations and project a more accurate and positive message. The group then used Photoshop to alter the images, and in some cases, created their own images to portray messages that were compatible with how they preferred to be portrayed by the public. The group then decided that they wanted to display these images in an exhibition and used the exhibition to engage participants in a dialogue regarding the work they had just viewed. After the exhibition, the research participants believed their voices had been heard and they felt empowered.

Both of these studies illustrate how PAR can be used to develop discursive knowledge through reflexivity and how participants can use that acquired knowledge to actively work to change structures. Not only is this a research approach that generates knowledge, it is also a method for creating structural change. Structurally competent social work practitioners may employ this approach to investigate structural factors that are impacting their clients’ well-being and help their clients develop the knowledge they need to begin to make structural changes.

*Ethnography: Identifying Rules and How They Work to Create Structures*

In-depth ethnographies are yet another research method/approach that has been used by social work researchers to investigate the bi-directional relationship between individuals and structures as described in structuration theory. Unlike the previous methods discussed, ethnography allows social work researchers to describe the relationships between participants, the rules they subscribe to, and how these rules function to co-construct structures over a long period of time in a holistic way. In-depth ethnography has its roots in anthropology and is primarily concerned with the “social interactions, behaviors, and perceptions that occur within groups, teams, organizations, and communities” (Reeves, Kuper, & Hodges, 2008,
p. 512). Within this definition, the method’s ability to connect human agency (social interactions), rules (behaviors and perceptions) and structures (organizations and communities) is apparent. Ethnographies are conducted by having sustained contact with individuals within the context of their daily lives and aims to respect the complexity of the social world (O’Reilly, 2012). Ethnographies use detailed observations and interviews to gain insight into individual actions and beliefs and the characteristics of the structures in which they live.

In this approach, social work researchers are not testing hypotheses; rather, they are exploring phenomena. In the application of structurally competent social work research, researchers are particularly interested in how participants understand their role in structures, their perception of the rules, and the way in which changes in rules impact the function of the larger structure. In fact, O’Reilly (2012) argues that all ethnographies should be explicitly interested in understanding social life as an outcome of interaction between structure and agency. Ethnography’s ability to produce rich case studies of human interactions across context and time makes it a useful research tool for translating theory into insights that can be used in structurally competent social work practice (Floersch, Longhofer, & Suskewicz, 2014).

In an example of ethnography in social work research, Stanhope (2012) followed ten clients and 14 case managers for a year to investigate social interactions that facilitated engagement in a housing-first program. The goal of the project was to understand how structures and context shape interactions. Using ethnographic methods, the researchers aimed to understand the process of the implementation of the evidence-based practice, a process they argued that could be aided or hindered by the agency structure. In this study, two researchers spent 280 hours in the field observing interactions and conducting interviews in a variety of settings, including in the home, in the community, in the office, and during a wide variety of activities. One of the research findings revealed that service engagement was enhanced when caseworkers and clients co-created a shared narrative and the narratives were reciprocal. The creation of a shared narrative revolved around key processes in service delivery—in this case, moving into an independent apartment. Through the shared experience of a client moving
in and setting up a home, the client and the social workers were co-creating the structure of the home, a new structure that could be contrasted with the client’s previous structure of street life. The researchers also described the social work offices, and how the structure of the offices, with an open door policy, facilitated interactions between case managers and clients. Based on this structure, the phenomenon of clients popping in became part of the daily routine and therefore worked to create and recreate the structure of the office.

In another example of structuration theory, when the manager suggested that the case managers rotate on-call duties, as all of them did not need to be on-call all the time, the case managers objected, stating that other case managers would not know their clients. This is yet another example of how individuals worked to co-create the structure of the agency though the creation of rules and how the rules worked to support their interactions on a daily basis.

Ethnography easily allows researchers to observe the bidirectional relationship between individuals and structures over time. These in-depth accounts provide structurally competent social work researchers with important insights into how structures impact clients’ lives, and also how social workers and clients create and co-create rules that change the very nature of the structures. Although the generalizability of ethnographies may be limited, based on their scope, they may be extremely useful for collecting data essential for designing a structural intervention within a given context. In-depth ethnography may also be used to develop more detailed theories regarding the actions by which individuals can change structures, which can then be tested across contexts using some of the methods that have been described in this paper.

Conclusion

The concepts of structural competence in medical literature has motivated social work to re-assert its continued role in the generation of structurally competent research required to lay the foundation for imagining structural interventions. The social work profession has always considered the role of social structures in social problems a reality that is reflected in the theories that social workers draw upon and in the methods and/or
approaches that social workers use to investigate these relationships. Giddens’ theory of structuration, employed in social work research, encourages research beyond the unidirectional understanding of the relationship between individuals and structures to a more nuanced understanding of how social workers and their clients recursively interact with structures to create and maintain them.

An understanding of this recursive relationship may help social work researchers in their continuing efforts to build an evidence base for interventions aimed at modifying those structures inhibiting our clients’ well-being. Multilevel modeling, social network analysis, participatory-action research and ethnographies are several research methods and/or approaches that are being employed to generate the evidence base needed to inform structurally competent social work practice. This social work practice will continue to evolve as technology allows researchers to leverage big data, collect data in real time, and model more complex and dynamic relationships. Social work, given its focus on micro and macro approaches to practice, should be an integral aspect of structurally competent research in building an evidence base for structural interventions needed to address social problems.
References


Structural Competency in Child Welfare: Opportunities and Applications for Addressing Disparities and Stigma

Jaclyn E. Chambers
G. Allen Ratliff
School of Social Welfare
University of California, Berkeley

Race and class disparities in the child welfare system, as well as stigma associated with child welfare involvement, have received much attention in the child welfare field. Black families living in poverty are over-represented within the child welfare system and have disparate outcomes. Additionally, scholars have highlighted how parents often experience the child welfare system as stigmatizing, particularly due to threats to their identity and loss of autonomy stemming from child welfare’s focus on an individual intervention model. Child welfare agencies and researchers have employed a range of interventions to address these issues of disparities and stigma, with an emphasis on reducing bias in child welfare decision-making through practices such as cultural competency training; however, the field is beginning to shift its focus to the broader structural issues that lead to child welfare involvement and contribute to disparities. The emerging concept of structural competency could be a new framework for enacting structural responses in child welfare work. This paper examines applications of structural competency to child welfare practice and explores how it may be a promising framework to reduce disparities and stigma.

Keywords: child welfare, structural competency, racial disparities, stigma, poverty
Families from marginalized groups—including Black and Indigenous families, families experiencing poverty, and parents with disabilities—are disproportionately represented in the child welfare system and have disparate outcomes (e.g., rates of out-of-home placement, length of time in the system) (Barth, 1997; Barth, Wildfire, & Green, 2006; Berger & Waldfogel, 2004; Hill, 2006; Lee, 2016; Park, Solomon, & Mandell, 2006; Wildeman & Emanuel, 2014). These disparities reflect wider social and cultural trends of marginalization (Asad & Clair, 2018; Collins, 2017; Harnois & Ifatunji, 2011; Subramanian, Chen, Rehkopf, Waterman, & Krieger, 2005). Parents who have been the subject of child maltreatment allegations report feelings of stigma related to being labeled “bad parents” and the reduction in autonomy that results from child welfare interventions that typically prescribe services targeting parents’ individual behavior (Colton et al., 1997; Dumbrill, 2006; Scholte et al., 1999; Sykes, 2011; Thrana & Fauske, 2014). While there is a large body of child welfare literature that highlights these issues of disparities and stigma, the problem remains.

Researchers and child welfare practitioners have posited various reasons for disparities and stigma within the child welfare system, with a primary discourse focused on bias in decision-making (Dettlaff et al., 2011; Rivaux et al., 2008). However, recent scholars have called for a focus on structural factors in the way we define and respond to child maltreatment (Dunkerley, 2017; Reich, 2005; Roberts, 2002). Structural forces include the policies, institutions, infrastructure, and cultural/normative beliefs within our economic, social, and political systems that interact with individuals and families in their daily lives (Bourgois, Holmes, Sue, & Quesada, 2017; Metzl & Hansen, 2014). Structural approaches to clinical practice are the center of an emerging model of structural competency in medicine and public health that promotes an understanding of how social structures impact health and behavior in order to address micro and macro disparities. Because medical practices and child welfare practices perform similar functions (e.g., assessment, treatment planning, provider/client interactions), it is logical to extend the application of structural competency to child welfare. This model could be a new framework for enacting structural responses in child welfare.
In order to motivate future practice and research in structurally competent approaches to child welfare, this paper will: (1) describe systemic disparities in the child welfare system and experiences of stigma related to existing child welfare interventions; (2) articulate structural forces impacting child welfare involvement and interventions; (3) introduce structural competency as a strategy to decrease disparities and reduce experiences of stigma; and (4) provide conceptual guidance for applying structural competency principles in child welfare.

Background

The issues of disparities and stigma within the child welfare system have been covered substantially in the literature and there are existing interventions that aim to reduce these problems, yet these initiatives have not focused on structural forces that impact both parents and child welfare workers. An examination of these structural forces reveals an opportunity to apply the framework of structural competency as a potential avenue to address disparities and stigma.

Disparities and Stigma in Child Welfare

Disparities. There are numerous differences in rates of involvement, intervention strategies, and case resolutions for families in the child welfare system depending on the family's social position. Racial and class disparities in child welfare have been studied the most widely, although there are intersecting disparities that deserve equal attention. A review of the child welfare literature found that Black families are more likely than White families to: (1) be screened in for investigation; (2) have substantiated allegations; and (3) have a child removed from the home (Hill, 2006). In their nationally representative analysis of risks for foster care placement, Wildeman and Emanuel (2014) found that Black children had 2.26 times greater relative risk of foster care placement between birth and age 18 compared to White children ($p < .001$), and Indigenous children had 3.18 times greater relative risk ($p < .001$). Studies consistently find disparities in the length of foster care placements, with White children exiting to permanency much more quickly than Black children (Barth, 1997; Wulczyn, 2003). Noonan and Burke (2005) found that Black children
in foster care have a significantly lower risk of termination of parental rights compared to non-Black children (hazard ratio = 0.87), but they are also less likely to be reunified with their parents (hazard ratio = 0.93), suggesting Black children are less likely than their peers to achieve speedy permanency.

Socioeconomic status (SES) is also strongly associated with child welfare involvement. A recent national study found that children from families with lower SES had 5.8 times greater relative risk of maltreatment compared with children from higher SES families (Sedlak et al., 2010). Children from low-income families are more likely to be removed from home compared to families with higher incomes, with the likelihood of placement decreasing as family income increases (Berger & Waldfogel, 2004). Further exploring the relationship between poverty, race, and child welfare involvement, a recent study examined national maltreatment data and census data and found that the differences in official maltreatment reports between Black and White children are largely a result of racial differences in poverty rates (Kim & Drake, 2018).

While race and class have appropriately been a primary focus in the child welfare literature on disparities in system involvement, there are known disparities among other marginalized groups. For example, the prevalence of child welfare cases that involve parents with a disability are five to ten times higher than the prevalence rates of parents with disabilities in the population generally (Callow & Jacob, 2014). Parents with a serious mental illness or with developmental disabilities are more likely to have their children removed from their care than parents without these diagnoses (Booth & Booth, 2005; Llewellyn, McConnell, & Ferronato, 2003; Park et al., 2006). Intersectional disparities between marginalized identities and child welfare involvement remains an area for further exploration in the literature.

Stigma. Experiences of stigma arise when parents feel disempowerment, shame, or disgrace related to their child welfare involvement. Child welfare research, practice, and policy have overwhelmingly conceptualized child welfare involvement as a parental behavior issue. In this paradigm, children are brought to the attention of child protective services because their parents are engaging in harmful, dangerous, or otherwise unacceptable parenting practices, and they remain in the system because their parents are unable or unwilling to change. This
narrow focus on individual behavior can cause parents to experience child welfare intervention as stigmatizing, particularly due to perceptions of being labeled as a “bad parent” and the loss of power over their own decision-making about their families (Dumbrill, 2006; Sykes, 2011; Thrana & Fauske, 2014).

Intervention paradigms within the child welfare system suggest “the first line of intervention within the child welfare context is to modify parenting behavior” (Landers et al., 2018, p. 546). When the problem is viewed as a parental behavior issue, the remedy has been to require parents to comply with individual services to change their behaviors (Daro & Dodge, 2009; Daro & Donnelly, 2002), and there is an extensive literature devoted to service planning and engagement for parents (e.g., Gladstone et al., 2012; Kemp, Marcenko, Hoagwood, & Vesneski, 2009; Lalayants, 2012; Yatchmenoff, 2005).

Qualitative studies have explored how the child welfare system can stigmatize and disempower families. A qualitative study of child welfare workers and mothers with open, substantiated neglect cases found the child welfare workers indicated a preference for working with mothers who were deferential and compliant with services; thus many mothers felt forced to “play nice” with caseworkers in order to keep their families together, even if they questioned the legitimacy of child welfare’s findings of neglect against them (Sykes, 2011). Dumbrill (2006) found that how child welfare workers wield their power is a key determinant of parents’ perceptions of the child welfare system: parents who experienced a child welfare worker’s power as supportive rather than punitive tended to feel less stigmatized and be more engaged with services. As families move deeper into the child welfare system, their perceptions of stigma grow: foster care and out-of-home services are seen as most negative, while in-home, preventive services are the least negative (Colton et al., 1997; Scholte et al., 1999). Furthermore, the experience of child welfare stigma is likely to be more pronounced for families from marginalized groups that are disproportionately represented at every step in the system.

Child welfare initiatives to reduce disparities and stigma. Understanding and addressing the causes of racial and class disparities and associated stigma in the child welfare system requires an understanding of the causal forces at play and the paradigms of intervention. Chibnall and colleagues (2003) describe three
main theories in the child welfare literature about the causes of racial disparities: (1) racial disparities arise from bias in reporting and addressing child abuse; (2) racial disparities reflect real differences in level of need and child maltreatment rates; and (3) racial disparities are a result of the compounding interaction of real risk and implicit bias. Expanding on these theories, a more recent framework conceptualized by Boyd (2014) broadens the possible causes of child welfare disproportionality and disparities into five explanatory pathways: (1) disproportionate need; (2) human decision-making; (3) agency-system factors; (4) placement dynamics; and (5) policy impact. Boyd’s framework expands upon previous theories by capturing structural-level contributors to disparities, such as agency-system factors (e.g., agency infrastructure, institutional racism) and policy impact (e.g., federal legislation, funding).

Interventions that aim to address disparities and stigma have mainly focused on individual biases in decision-making, with cultural competency training as one of the more prevalent practice initiatives (Osterling, D’Andrade, & Austin, 2008). Cultural competency was originally an attempt to address the interpersonal dissonance between White healthcare providers and their patients of color and included a variety of approaches to train providers on how to engage with diverse patients (Metzl & Hansen, 2014; Metzl & Roberts, 2014). Cultural competency training in child welfare aims to address potential worker bias and has been a focal point in the field for at least two decades (Pierce & Pierce, 1996). Although cultural competency promotes an important need for providers to engage respectfully and authentically with diverse clients, the model fails to incorporate an understanding of how the structural forces at play affect the lives of clients beyond simple interpersonal dynamics. Cultural competency training has been shown to improve workers’ awareness and skills related to working with culturally diverse families (De Jesús, Hogan, Martinez, Adams, & Hawkins Lacy, 2016; Lawrence, Zuckerman, Smith, & Liu, 2012) but there is little evidence of its impact on overall disparities and stigma.

Scholars have noted that strategies to reduce disparities are in urgent need of further exploration (Hill, 2006), and a review of major child welfare policy and practice shifts in the past few decades identifies disparities related to race and SES as major areas that need to be addressed by researchers (Petersen et
al., 2014). Child welfare workers have also expressed a desire to address disparities, but they do not have sufficient evidence to guide their practice toward this end (Chibnall et al., 2003). Drake and Jonson-Reid (2011) call for addressing root causes of poverty; Roberts (2002) implores the field to examine how child welfare policies and practices are impacting communities of color at large; and Reich (2005) examines the child welfare system itself as a structure of social control and challenges the unequal power dynamics in state/parent interactions. These scholars have decidedly taken a structural lens, yet these ideas have not been translated into practice strategies and evaluated for their impact on disparities and stigma. A few recent child welfare initiatives have emphasized structural racism and structural barriers to accessing support and have begun training workers to better understand these issues (James, Green, Rodriguez, & Fong, 2008; Johnson, Antle, & Barbee, 2009), but these approaches appear to be relatively rare.

Structural considerations in child welfare. Before examining the structural factors impacting child welfare involvement, it is important to further clarify what is meant by the term “structural.” Drawing on previous scholars’ definitions of structure, structural forces are hierarchical economic, social, and political systems that interact with people in their daily lives, including the policies, institutions, infrastructure, and cultural beliefs that comprise these systems (Bourgois et al., 2017; Metzl & Hansen, 2014). That these structural forces impact people on an individual level is not a new concept to child welfare, or to social work more broadly, as the profession has long utilized a biopsychosocial model focused on how environmental factors impact clients (Cornell, 2006; Norton, 2012; Pardeck, 1988).

The interaction of structural forces and child welfare disparities implicates the need to highlight structural vulnerability as it relates to child welfare. Structural vulnerability describes the particular risk of adverse outcomes for certain groups due to the systemic factors working against them and illustrates how some groups are especially vulnerable to poor outcomes given their social position in a hierarchical society (Quesada, Hart, & Bourgois, 2011).

There are known structural factors that make certain groups more vulnerable to child welfare intervention. Poverty has been
consistently associated with child welfare removals, and there is a significant association between low SES and higher rates of child removals (Berger & Waldfogel, 2004; McGowan, 2005; Myers, 2008). Children living in poverty are more likely to experience maltreatment, with national estimates showing an incidence rate 26.5 times higher in families making less than $15,000 per year, compared to families making above $30,000 per year (Chibnall et al., 2003). The economic position of families experiencing poverty makes them particularly susceptible to child welfare intervention, because the majority of child welfare cases (78%) stem from allegations of neglect (U.S. Department of Health & Human Services, 2013), and poverty can be difficult to distinguish from neglect, as inadequate shelter, malnutrition, inadequate clothing, and similar resource deprivation are all considered criteria for child neglect (Tang, 2008). Finally, researchers have also noted a strong correlation between poverty and mechanisms that may contribute to child maltreatment (e.g., parental stress), making families living in poverty more vulnerable to these risk factors (Chaudry & Wimer, 2016).

The intersection of race and SES situates families of color in a particularly structurally vulnerable position. Families of color in poverty are disproportionately represented in the child welfare system and experience higher rates of related negative outcomes. Racial disparities and SES disparities are enmeshed, as families of color are much more likely to be living in poverty than White families (Chibnall et al., 2003; Drake et al., 2011). Recent U.S. census data show the racial disproportionality in poverty rates: about 77% of the population identifies as White and the poverty rate for this group is 8.8%, while 13.4% of the population identifies as Black and the poverty rate for this group is 22% (Semega, Fontenot, & Kollar, 2017; U.S. Census Bureau, 2017). Kim and Drake (2018) examined national maltreatment and census data to better understand the relationship between race, poverty, and maltreatment and found that maltreatment risks did not differ between Black and White children after controlling for county-level poverty rates. Their analysis suggests the disproportional poverty rate between Black families and White families is a primary driver of racial disparities in maltreatment reports, implicating economic structural factors as determinants of child welfare involvement for families of color experiencing poverty.
In addition to economic systems, scholars have noted the importance of place-based social systems, such as neighborhoods, in understanding child welfare involvement. Coulton, Korbin, Su, and Chow (1995) found neighborhood conditions were significantly related to rates of child maltreatment reports. Child maltreatment rates have been linked housing insecurity (Warren & Font, 2015), unemployment (Freisthler, Merritt, & LaScala, 2006), social disorder and lack of social integration (Freisthler & Maguire-Jack, 2015; Garbarino & Sherman, 1980) and community violence (Lynch & Cicchetti, 1998).

It is also crucial to recognize how the structure of the child welfare system constrains and impacts workers. Smith and Donovan (2003) found that “best practices in child welfare are compromised not only by organizational pressures, such as time limitations, but also by pressures to conform practices to the expectations of powerful institutions in the organizational environment” (p. 541). A key structural force that has been highlighted in the literature is the immense workload placed on child welfare workers. Child welfare workers are often assigned extremely high caseloads, so the amount of time they have to understand a family’s needs and strengths may be limited (Kim, 2011; Yamatani, Engel, & Spjeldnes, 2009). The public cultural discourse around child welfare work can constrain workers’ options for intervention. For example, child welfare workers are often blamed or subject to lawsuits when egregious child outcomes occur, such as sexual abuse or a child fatality. This socio-political atmosphere can encourage workers to increase monitoring of families and avoid any actions (or inaction) that could lead to possible negative press or litigation (see Cook, 2018; Lawlor, 2018; Winton, 2018).

Child welfare policy can produce its own structural constraints. Ayón and Aisenberg (2010) found that workers’ actions are limited by organizational structural factors, such as the power structures (e.g., supervisors as decision-makers) and policies that determine decision-making within the child welfare system. One example of child welfare policy that directly impacts workers is the permanency time limits mandated by the 1997 Adoption and Safe Families Act (ASFA). Even if a worker recognizes that a longer-term intervention plan may be beneficial for a family dealing with structural barriers to housing, employment, healthcare, or other needs, ASFA constrains the
timeframe that child welfare workers and families have to implement achievable goals. There are also signals that a state’s overall policy regime type affects how punitive its child welfare system is, suggesting that the political systems within a state could impact trends in child welfare practice (Edwards, 2016). Recognizing the resources, politics, and policies surrounding the child welfare system allows for a better understanding of how the structure of the child welfare system is itself constraining in worker/family interactions.

Structural Competency: An Opportunity

Recent literature in social sciences details the extensive impacts of structural factors on the health and wellbeing of individuals. Widely referred to as social determinants, social environmental factors, and social-ecological factors, these structural or non-individualistic factors are outside of an individual’s control, yet play an outsized role in how they affect an individual. In response to this growing body of research and the need for healthcare professionals to address structural factors in their service provision, a new framework for pedagogy and clinical practice has emerged, known as structural competency (Metzl, 2012). Initially developed within medicine by physician-scholars who advocated for medical providers to be more aware of the structural factors that impact patients, Metzl and Hansen (2014) define structural competency as the “trained ability to discern how a host of issues” (i.e., symptoms, attitudes, behavior) represents “downstream implications” of “upstream decisions” (p. 5). This recognition of how “upstream” (i.e., policy) decisions lead to “downstream” (i.e., practical, actual effects on individuals) implications is the heart of structural competency. Structural competency has primarily focused on the development of pedagogical approaches to train healthcare providers to intentionally recognize the structural factors at play in the lives of patients (Bourgois et al., 2017; Metzl & Roberts, 2014). As a nascent practice paradigm, structural competency has yet to be supported with empirical data, but growing calls for structural awareness across social sciences highlight the need for increased attention on this framework.
Structural competency is not only a response to the wider acknowledgement of structural factors at work in the lives of individuals, but also a response to an outdated cultural competency paradigm (Metzl & Hansen, 2014). The structural competency literature has articulated the differences between structural competency and cultural competency as clinical approaches, arguing that a structural approach to patient care “must consider structural determinants of stigma and inequalities” (Conley & Malaspina, 2016, p. 194). In order to translate this focus into practice, a set of five core competencies were described by Metzl and Hansen (2014). These are: (1) recognizing the structures that shape clinical interactions; (2) developing an extra-clinical language of structure; (3) rearticulating “cultural” presentations in structural terms; (4) observing and imagining structural intervention; and (5) developing structural humility. These core competencies are intended to provide healthcare providers and educators with the tools to interrogate their own approaches to clinical practice and education.

Early qualitative evaluations of medical educational programs grounded in structural competency have found that structural competency training improves medical student awareness of structural factors that affect health outcomes, resulting in stronger clinical relationships with clients (Metzl & Petty, 2017; Metzl, Petty, & Olowojoba, 2018; Neff et al., 2017). An instrument called the Structural Foundations of Health Survey was created to assess understanding of structural factors of certain health conditions (e.g., diabetes). When used to evaluate the ability of medical students to identify causal factors linked to health conditions, the students who had been trained in structural competency were significantly more able to describe complex structural factors leading to disease than were students who had not been trained (Metzl & Petty, 2017).

Structural competency has emerged in medicine, yet adjacent helping professions that interact with clients facing disparities have also taken up structural competency. Structural competency emphasizes an understanding of the process by which policy decisions lead to on-the-ground implications for clients and practitioners. The opportunities for structural competency to be incorporated within helping professions are rapidly growing as new fields conceptualize these opportunities
Within research, practice, and pedagogy. Although the five core tenets of structural competency have been built into medical training programs that have evolved from the structural competency movement, there are few examples of applications of the core tenets to other specific fields. An excellent example of applying the core structural competency tenets to another field is the Downey and Gómez (2018) elaboration of structural competency within reproductive healthcare, in which the authors describe each tenet of structural competency in relationship with the practices, needs, clients, and values of reproductive health practice.

Applying Structural Competency to Child Welfare

A structural competency approach in child welfare emphasizes a practical examination of how structural forces lead to child welfare involvement and contribute to a greater likelihood of entering the system (and deeper system involvement) for families of color, those living in poverty, and other marginalized groups. Each of the five core structural competencies outlined by Metzl and Hansen (2014) are described below in more detail and conceptually applied to child welfare. This conceptual application is intended to motivate a broader discourse on effective child welfare practices addressing structural forces. To incorporate these competencies into child welfare policies, practices, training, and evaluation, structural competency training could be required in addition to, or instead of, the cultural competency training that is required by many jurisdictions.

1. Recognizing the structures that shape clinical interactions. The first structural competency focuses on the cornerstone: understanding and recognizing how structures impact clinical interactions. A structural vulnerability checklist developed by Bourgois, Holmes, Sue, and Quesada (2017) for use in medical settings may be a helpful tool to consider the breadth of structural factors at play. This checklist organizes its structural assessment into the following domains: financial security (e.g., employment, income); residence/shelter (e.g., safety, stability, access); risk environments (e.g., violence, environmental risks like pollution); food access (e.g., adequate, good quality, accessible); social network/support (e.g., friends/family members); legal status (e.g., unresolved legal cases, documentation); education
(e.g., literacy, access to education); and discrimination (e.g., complications in resource access due to inequitable treatment). These domains can be easily connected with child welfare contexts—many of them are areas that are already considered in child welfare in individualized applications. Further, structural competency training can help trainees to recognize structures in these domains that impact clinical interactions. A qualitative study evaluating a structural competency training course for physicians found that physicians who had taken the course increased their attention to structural factors in assessment, diagnosis, and treatment, and also reported improved clinical relationships with patients (Neff et al., 2017). These results highlight the importance of implementing structurally-competent frameworks within child welfare, as increased attention to structural factors can address disparities, while improved relationships can reduce stigma.

2. Developing an extra-clinical language of structure. This competency describes the importance of speaking to structures in our society at large, naming how they impact families and communities, and incorporating a language of structure into the lexicon of child welfare. Metzl and Hansen (2014) suggest physicians should become familiar with interdisciplinary literature on structures from economics, sociology, history, and other fields. While a review of these literatures may not be feasible within the context of child welfare training, key structural competency topics (e.g., recognizing structural barriers, understanding structural vulnerability) could replace or augment child welfare’s current training efforts focused on cultural competency. The Structural Foundations of Health Survey (Metzl & Petty, 2017) that has been previously used to evaluate structurally competent medical training programs could be adapted to fit a child welfare context and utilized as an evaluation tool for structural competency trainings for child welfare workers.

By providing child welfare workers training on the terms and central tenets of key literature bases, the child welfare field will be better able to recognize and describe structural barriers that differentially impact certain families. When equipped with an extra-clinical language of structure, child welfare workers working with families experiencing poverty can better understand and describe socioeconomic status as a structural construct due to policies and practices that have historically limited
wealth accumulation, employment opportunities, and intergenerational mobility for people of color living in poverty. This extra-clinical language of structure can create opportunities for parents to feel understood in their experiences and increase engagement in interventions. The use of structural language in child welfare interactions can decrease feelings of stigma by recognizing that often problems are not the sole responsibility of the parent and that devoted parents in bad structural conditions can struggle with parenting. Additionally, this language can support positive identity in parents without losing sight of the need for child safety.

3. Rearticulating “cultural” presentations in structural terms. The third tenet of structural competency calls for an expanded understanding of why families come to the attention of the child welfare system and how to intervene. The practical application of this tenet can be illustrated by a hypothetical but familiar case example: a mother who is reported to the child welfare system after leaving her 2-year old son at home in the care of her 10-year old daughter for several hours one evening while she was at work. A structurally competent response would ask what local, state, or national policies might be restricting the family’s access to childcare? What economic factors have led the mother to work an evening job?

Another common example is a family whose housing poses some threat to their children’s safety, perhaps due to overcrowding, exposure to hazardous materials, or problems with the physical structure of the building. A structurally competent assessment might ask what policies or physical structures are contributing to the lack of safe, affordable housing? Is there a transportation infrastructure that restricts where the parents can reasonably live and work? Is there something about the interaction of this particular family’s characteristics (e.g., race, gender, income, family structure, mental and physical health, criminal history) and these policies that may lead them to have fewer housing options available? Rather than essentializing or stereotyping, structural competency calls for understanding how structures impact different families in varying ways. While child welfare cases are often much more complex than these brief hypothetical scenarios, these examples allow for an
initial exploration of how this tenet of structural competency might be applied.

4. Observing and imagining structural intervention. It is likely that in many instances child welfare workers are not overlooking these structural factors, but rather feel limited in terms of what they can do to address them. It may be difficult to talk about structural issues, and even harder to imagine how to help families, given these barriers. Dedicated child welfare workers may find the resources at their disposal miss the mark in addressing the actual underlying issues that led to a family’s involvement with child welfare services. Observing and imagining structural intervention may seem like the most difficult aspect of structural competency, as structures may feel unalterable.

Structural barriers may be an area where all parties in a child welfare case—parents, workers, judges, and others—feel as though their hands are tied. It is important to recognize, as noted by Downey and Gómez (2018), that “by definition, structural issues cannot be addressed by an individual” (p. 217). Micro interventions alone will not address structural-level problems, and macro changes may indeed seem infeasible, given the current political and economic environment in which child welfare systems function. Structural competency gives workers a language to recognize these structural barriers, and it calls for interventions that fit a family given the relevant structural constraints.

Returning to the case examples above, each person involved may determine that they cannot impact the availability of evening childcare options or safe, affordable housing. While a child welfare worker likely cannot change structural barriers in any given case, they may instead highlight such issues and suggest exploring feasible alternatives given a family’s structural barriers. Using the first example from above, a structurally competent response might encourage the child welfare worker to collaborate with the mother’s neighbors to explore options related to communal child care, or the worker might collaborate with other providers to advocate for subsidized child care services in the area (especially if multiple families are confronting the same struggle), rather than requiring the mother to secure paid childcare or alter her work hours.

A moderate but feasible practice change might be for case-workers to communicate structural vulnerability information
to supervisors, judges, and other decision-makers, emphasizing the structural factors that affect families, with the goal of creating a practical plan for a family facing structural barriers. Child welfare can thus recognize a risk to child safety posed by structural determinants, and help reduce stigma by helping parents feel understood and supported. In recognizing problems that lie within structures and not within the family, the system may be better positioned to make changes on a macro level.

A practical approach could be to incorporate a structural vulnerability checklist into the child welfare safety and risk assessments that are utilized by child welfare agencies and typically focus on family-level risk and protective factors (Southern Area Consortium of Human Services [SACHS], 2012). Incorporating a structural vulnerability checklist—akin to the Bourgois and colleagues (2017) structural vulnerability checklist mentioned previously—within safety and risk assessments could help child welfare workers better name the structural factors impacting families, understand their prevalence, and begin the process for brainstorming structural intervention. While some practice changes that the child welfare field could consider have been discussed here, organized advocacy for an integrated structural competency paradigm within child welfare is necessary to effect wider shifts on disparities and stigma. The goal is for child welfare practice to incorporate changes that will better assist families in addressing their needs given structural constraints, beginning a pivot from oversight to advocacy, while ultimately striving toward larger structural changes.

5. Developing structural humility. Structural humility calls for individuals to accept that the full impact of structural barriers for any given family may never be fully understood, no matter how much training one receives. Metzl and Hansen (2014) call for structural competency practitioners to recognize that the skills they develop are “the beginning points of conversations rather than endpoints” (p. 12). This tenet makes explicit that structural competency is a process rather than an accomplishment, and addressing structural factors is an ongoing practice that has no threshold for completion.

In child welfare, this competency suggests a training and practice paradigm that emphasizes the unique and particular structural interactions for each family, decentering the notion of workers as the sole arbitrators of correct or appropriate
parenting practices. Child welfare workers adopting a structural humility perspective may be less inclined to feel frustration toward parents who do not readily and quickly respond to individual-focused interventions, possibly reducing disparities and stigma felt by parents in their interactions with workers. Structural humility is a foundational mindset for constructing effective and achievable interventions for parents and families living in hierarchical systems that marginalize them.

Conclusion

Existing paradigms in child welfare continue to frame parent behavior as the cause of child maltreatment and the target for intervention, but these approaches fail to address wider structural factors operating in the lives of vulnerable families. Structural competency challenges the traditional assumption that child welfare involvement results from parents’ personal agency alone and reframes child maltreatment to include societal-structural issues, expanding the site for intervention. It can give child welfare workers language and knowledge to address structural issues they have already begun to identify in their work. While structural competency is not a silver bullet that will address all of the complexity related to disparities and stigma, it could motivate a needed shift in child welfare practice. Updating policies with a structurally competent lens may decrease disparities on a macro level, and training workers to see and speak to structural forces may reduce experiences of stigma on a micro level. Conceptual and concrete suggestions presented here for how structural competency might be implemented in child welfare are by no means exhaustive, nor are they intended to be prescriptive. Practitioners, policy makers, researchers, and families are best positioned to implement structural competency more broadly, collaborating to develop creative methods for integrating structural competency.

The literature on structural competency in the medical arena is still nascent, and further research is needed to assess methods for implementing structural competency. Additionally, while the fields of child welfare and medicine do have many parallels, they also have crucial differences. One major difference between medicine and child welfare is that families do not often voluntarily seek out child welfare intervention,
whereas people often actively seek out healthcare intervention. Another difference is that the primary clients in medicine are the patients themselves, whereas in child welfare “the primary client of services is the child, and yet the focus of much concern about cooperation and engagement is the parent” (Platt, 2012, p. 140). Therefore, what works for implementing structural competency in medicine may or may not work in child welfare, and strategies for implementing structural competency within child welfare should be subject to rigorous empirical testing in order to determine their impact.

Structural competency provides a unified language for discussing the structural issues that many in the child welfare field already recognize to some degree. Ideally, if structural factors are widely accepted as important and examined within child welfare services, there will be increased motivation and opportunity for engaging with structural issues at macro levels in policy development and advocacy. Just as Metzl and Hansen (2014) suggest medicine needs to incorporate social and political action to address structural factors that lead to disparities, so too can child welfare recognize the need for wider advocacy. Structural factors that implicate disparities and stigma in child welfare can only be shifted at structural levels, requiring an evolution in research, practice, and dialogue at local, regional, and national levels.
References


Don’t “Just Call the Social Worker”: Training in Structural Competency to Enhance Collaboration between Healthcare Social Work and Medicine

Margaret Mary Downey
University of California, Berkeley
School of Social Welfare

Joshua Neff
University of California, Los Angeles
Semel Institute for Neuroscience and Human Behavior

Kate Dubé
University of California, San Francisco
Department of Psychiatry

In this short paper, we argue that providing in-depth structural competency training to both social workers and physicians has the potential to promote a deeper collaboration between these two fields—to the benefit of patients as well as providers. We describe structural competency’s evolution as a pedagogical and practical framework in medicine and social work, then discuss three overlapping ways in which structural competency can enhance collaboration between physician and social work practitioners and educators. First, training in structural competency can fill gaps in both medical and social work education and training—namely a lack of curricula that consistently attend to the sociopolitical forces that influence health and healthcare—thereby offering these fields shared vocabulary and concepts that can improve inter-professional understanding. Second, structural competency frameworks can denaturalize the hierarchies between these professions, a necessary step for working together in genuine collaboration. Third, by
preparing medical providers and social workers to imagine and work toward changing the sociopolitical forces that harm their patients and constrain the practice of healthcare, structural competency training provides a basis for these two professions to join together and work alongside patients, communities, and other providers to demand and help build social structures that promote health and well-being.

Keywords: structural competency, medicine, social work, health

Healthcare social workers are an essential part of effective healthcare delivery. From hospital floors and emergency departments to primary care clinics, physicians turn to social workers when the social influences on patients’ lives (e.g., housing, immigration status, unemployment) arise in the course of medical care. In turn, social workers understand healthcare to be a necessary and impactful site of social work intervention (Social Work Policy Institute, 2011, 2012). Various observers have suggested that successful collaboration between social workers and physicians can improve a range of clinical outcomes, including reducing incidence of health complications, length of hospital stay, hospital readmission rates, functional decline, and mortality rates (Marmo & Berkman, 2018; McPherson, Headrick, & Moss, 2001; Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011; Zwarenstein, Rice, Gotlib-Conn, Kenaschuk, & Reeves, 2013). It may also improve overall job satisfaction for physicians and social workers, as well as nurses and other health professionals (Marmo & Berkman, 2018).

The interactions between healthcare social work and medicine, however, often fall short of true collaboration (Goldman et al., 2016; Mizrahi & Abramson, 2000; J. Park, Hawkins, Hamlin, Hawkins, & Bamdas, 2014). Previously documented challenges to collaboration include lack of physician understanding of social work scope of practice; social workers’ experience of physicians lacking respect for them and their profession; status differences reflected in disparate compensation and working conditions; and the physical and professional isolation of social workers from other healthcare professionals (Abramson & Mizrahi, 1996; Ambrose-Miller & Ashcroft, 2016; Garth et al., 2018; Goldman et al., 2016; Mizrahi & Abramson, 2000; Nugus,
Collaboration between Healthcare Social Work and Medicine

Greenfield, Travaglia, Westbrook, & Braithwaite, 2010). And yet, as healthcare systems increasingly strive to address social determinants of health (Centers for Disease Control and Prevention, 2017) and the need for interprofessional clinical care models increases (Ambrose-Miller & Ashcroft, 2016; Hoff, Weller, & DePuccio, 2012; Meyers et al., 2010; McCleary, Porterfield, Stanhope, & Wiford, n.d; Nyweide et al., 2015), physicians and social workers must collaborate more often and more deeply. In this short paper, we argue that providing in-depth structural competency training to physicians and social workers has the potential to address such difficulties by promoting more meaningful collaboration between these two fields—to the benefit of patients as well as both types of providers.

Structural competency is an emerging paradigm in healthcare and healthcare education that centers the influence of social, political, and economic structures on the degree and distribution of health disparities. Initially proposed by physician-scholars, structural competency articulates the need for healthcare providers to recognize and respond to the structural factors—from labor markets and zoning laws to criminal justice policies and trade agreements—that impact health outcomes and the practice of healthcare (Metzl & Hansen, 2014). Though originally framed as a paradigm for medical education, structural competency is equally relevant to other health-related professions. Accordingly, a range of such disciplines (e.g., community psychology, public health, bioethics) have commented on structural competency’s capacity to address gaps in healthcare knowledge and improve research, training, and practice in their own fields (Ali & Sichel, 2014; Metzl & Petty, 2017; Tsevat, Sinha, Gutierrez, & DasGupta, 2015).

As a practice and pedagogy, structural competency has clear relevance for social work. Its core component of recognizing the upstream factors that impact individual and community well-being while working collectively to address them resonates with social work’s principles of empowerment, social justice, and advancing human dignity (National Association of Social Work, 2017). Furthermore, medical care requiring a structurally-competent approach will often involve patients eligible for social work services. Prior to this special issue, however, the implications of structural competency for the training and practice of social work have not been adequately considered in
the literature, nor has the existing literature examined the ways that structural competency can influence the intersection of and interactions between medicine and social work specifically.

In this article, we specifically attempt to address the latter gap by discussing three overlapping ways in which structural competency can enhance collaboration between physician and social work practitioners and educators. First, by filling gaps in both medical and social work education and training—namely a lack of common curricula consistently attending to the sociopolitical forces that influence health outcomes—structural competency offers these fields a shared vocabulary and concepts that can improve inter-professional understanding among social workers and physicians. Second, structural competency may help these providers to denaturalize the hierarchies between their professions, a necessary step for working together in genuine collaboration. Third and finally, in preparing physicians and social workers to imagine and work toward changing the sociopolitical forces that harm their patients and constrain the practice of healthcare, structural competency training provides a basis for these two professions to join together and work alongside patients, communities, and other providers to demand and help build social structures that promote health and well-being.

Medicine and social work are just two of many professions within healthcare. While other inter-professional dynamics (including those involving nurses, physician assistants, patient care technicians, pharmacists, and physical and occupational therapists, among others) may be similarly influenced by the incorporation of structural competency into training and practice, it is beyond the scope of this article—and beyond our collective experience as an author team—to consider these. We hope that practitioners from other professions will expand this discussion to include their work and interprofessional experience.

Background: Structural Competency in Medicine and Social Work

Currently, neither medicine nor social work consistently applies frameworks that adequately account for or attend to the myriad structural forces that influence their professional practice
and exacerbate persistent health disparities. Physician-scholar Paul Farmer and colleagues observe that medicine continually struggles to develop “biosocially” informed answers to the persistently disproportionate burden of illness and disease in certain groups, instead focusing primarily or exclusively on biological approaches (Farmer, Nizeye, Stulac, & Keshavjee, 2006). Contrary to the vision for medicine articulated by medical luminaries from Rudolf Virchow and Salvador Allende to Melanie Tervalon and Atul Gawande, this orientation conceives of physicians’ role as narrowly attending to patients’ physiology and pathophysiology. Structural competency represents a substantive departure from standard medical education in that it situates health problems not only in the bodies of patients, but in the society that gives rise to ill health in the first place.

Structural competency is gaining traction in medical education at sites around the country, for trainees of various stages (Hansen et al., 2013; Metzl & Petty, 2017; Neff et al., 2017; Neff et al. 2019; Paul, Curran, & Tobin Tyler, 2017; Tsevat et al., 2015). Various observers have commented on the potential benefit of incorporating such perspectives into medical practice, ranging from improved relationship-building with patients to helping physicians to engage in addressing structural issues (Messac, Ciccarone, Draine, & Bourgois, 2013; Neff et al., 2017). Medical students and physicians note they feel ill-equipped to understand and address such issues (Harris Interactive, 2011); structural competency proposes to fill this gap in physician education and workforce development.

However, not all physicians share the perspective that structural competency is relevant for their practice. In his experience regularly conducting structural competency trainings for medical audiences (Neff et al., 2019; Structural Competency Working Group, 2018) and in his clinical training, author Neff has observed that some physicians and physicians-in-training believe it is beyond the scope of their role to consider the structural factors affecting patients’ lives. In some instances, participants have suggested that the appropriate response is rather to “just call the social worker”—suggesting a belief that it is principally the social workers’ role to consider structural factors influencing patient health, and an assumption that it is within the training and scope of practice of social work practitioners to attend to such matters. In these instances, a social work referral is
misunderstood as a structural intervention and physicians miss
an opportunity for meaningfully engaging with their social
work colleagues around the structural issues facing patients.

Given social work’s role in helping patients navigate social
systems as well the profession’s association with vulnerable
populations, it is not surprising that some physicians conclude
that healthcare social workers are universally trained to ap-
proach social issues surrounding health in a fundamentally
structural way. (Similarly, some may also view public health as
a discipline that is inherently structural in its framing/orienta-
tion. However, Harvey and McGladrey [2018] argue that this
is far from the case.) Contrary to this view, however, various
observers of social work practice and education have argued
that curricula which prepare social workers to think and inter-
vene structurally are the exception rather than the rule (Fisher
& Corciullo, 2011; Reisch, 2016; Reisch & Andrews, 2002). Some
highly influential approaches within social work are parallel
to and in fact overlap significantly with the perspectives high-
lighted within structural competency, including but not limited
to feminist, anti-oppressive, and ecological frameworks. In this
sense, structural competency’s potentially novel contribution is
not analytic or theoretical. Rather, it is in its effort to establish
understanding and applying such frameworks as an essential,
core competency for all healthcare practitioners and trainees—
healthcare social workers included.

Indeed, the inclusion of the above frameworks and struc-
tural perspectives generally in social work training is far from
ubiquitous. Nor, for that matter, is there agreement that such
content should be emphasized; the debate around how social
work should relate to structures affecting patients’ and provid-
ers’ lives is unresolved within the profession.

Yoosun Park and colleagues have observed that since its in-
ception (Park & Kemp, 2006), social work has struggled inter-
ally as to whether its leading frameworks sufficiently account
for structural forces such as poverty, inequality, racism, nativ-
ism, or classism (Park, 2008a, 2008b; Park, Bhuyan, Richards, &
Rundle, 2011; Park, Crath, & Jeffery, 2018; Park & Kemp, 2006).
Through extensive reviews of social work practice both past
and present, these scholars argue that “structures are relegated
to the margins” of social work education and practice “in favor
of individualized analysis and intervention” (Park et al., 2018,
As a result, social workers can ultimately promote their clients’ “capacity to accommodate—not actively change—their social/political environments, including their interactions with social work and social workers” (Park et al., 2018, p. 15).

Others have argued similarly that social work training and practice lack a consistent, interprofessional tradition of accounting for the influence of structures on patients and providers (Murdach, 2010; Pine, 2016). In other words, while social work research, education, and practice consistently relate to structurally-shaped realities such as poverty and inequity, the structural analysis and subsequent intervention vis-à-vis these forces is not ubiquitous. The field sometimes misses or even re-inscribes problematic trends that individualize social problems and demand that an individual, family, or group be responsible for changing their own circumstances, as authors Downey and Dubé have observed in their training and practice. In sum, contrary to an assumption sometimes made outside as well as within social work, although they attend to social factors as a matter of course, social workers today are often not prepared to engage structurally.

As above, this is not to overlook or diminish the many inspiring historical and contemporary examples of social work practice and curricula that do seek to address harmful societal structures. For instance, in the 1930s and 1940s, social work’s Rank-and-File movement collectively organized for labor rights of social workers at a national scale as well as organized against the ongoing lynching of Black people in the United States and widespread racial discrimination at welfare agencies (Abramovitz, 1998; Reisch & Andrews, 2002). In the 1960s and 1970s, as Joyce M. Bell observes, Black social workers drew on the lessons of the Black Panther Party to challenge the White supremacist agenda of social and medical research and to organize a Black Social Workers caucus within the National Association of Social Workers to address the White-dominant nature of their professional organization (Bell, 2014). More recent efforts include Smith College’s School of Social Work implementation of a school-wide anti-racism commitment (Smith College School for Social Work, n.d.), Columbia University School of Social Work’s “Foundations of Social Work Practice: Decolonizing social work” curricula (Columbia University School of Social Work, 2017), and the policy & services section of the integrated behavioral health (IBH) curricula that exists
across more than 30 schools of social work (Council on Social Work Education, as cited in Horevitz & Manoleas, 2013). These and other examples point the way toward and have helped lay a foundation for a structurally-oriented social work, including medical social work.

Structural competency presents an opportunity for social work and other health professions to build on these efforts by developing the analytic and practical skills necessary to help address structural issues. Furthermore, as we argue in the remainder of this paper, offering structural competency training across professions has the added benefit of promoting interprofessional collaboration.

Shared Understanding: Promoting Collaboration via Building Structural Vocabulary and Concepts

Previous research suggests that one barrier to physician-social worker collaboration is a lack of common language around what is happening to patients and why (Min, Spear-Ellinwood, Berman, Nisson, & Rhodes, 2016; Reilly, Patten, & Moffett, 1977; Sheppard, 1985). Physicians and social workers from the same care team may utilize different terms and explanations to describe the same patient context, characteristics, or needs. They may in turn come to different and sometimes divergent conclusions about patient need, which can interfere with a team approach to care and create or exacerbate inter-professional tensions (Reilly et al., 1977). For example, an ethnographic study of physicians and other allied health professionals (including social workers) on an internal medicine hospital ward found that difficulties in communication “may arise from lack of a common cross-team understanding of the care priorities for a specific patient at a specific time” and that “(t)his… may cause patient, family, professional and team confusion and dissatisfaction, with delays and readmission rather than directly attributable specific adverse events” (Zwarenstein et al., 2013, p. 2).

Training physicians and social workers in structural competency can promote collaboration between medicine and social work by creating a common framework for analyzing and discussing the structural issues that impact health and healthcare. As discussed in Neff et al.’s evaluation of a structural competency curriculum for medical residents, structural competency
training may lower the barriers to discussions among providers about the structural influences on health and healthcare—perhaps in part due to the shared vocabulary and conceptual frameworks offered by such training (Neff et al., 2017). It may also reduce stigmatizing language that blames individual patients for outcomes shaped by structural factors beyond their control (Neff et al., 2017). We expect the same effect would be observed across professional lines—including but not limited to social work and medicine. Interprofessional training may further improve the benefits of structural competency training (McPherson et al., 2001); however, we expect interprofessional collaboration will improve through structural competency training so long as the training offered is similar across professional lines. For a description of structural competency training offered in a range of professional contexts, see Neff et al., 2019.

In sum, giving social workers and physicians a common vocabulary of structure has the potential to improve understanding, communication, and ultimately collaboration between these professions. Further study is needed to explore this possibility.

Denaturalizing Hierarchies: Promoting Collaboration via Understanding Structurally-Shaped Work Hierarchies

One of the stated goals of structural competency is to help providers understand, analyze, and improve the practice of healthcare (Metzl & Hansen, 2014; Neff et al., 2017). Structural competency may help accomplish this by giving providers a fresh perspective on the hierarchies entrenched within healthcare itself.

Physicians and healthcare social workers are differentially positioned within their workplaces and within society. Traditionally, if implicitly, physicians hold a higher social status. This hierarchy often goes unquestioned in medicine and social work alike. Whitehead (2007) provides a contemporary example of interdisciplinary education on diverse healthcare teams in which communication regarding patients takes place around the doctor’s schedule, reinforcing the doctor’s “centrality.” Other professional asymmetries that go unquestioned include
physicians’ higher salaries, greater professional autonomy, and greater decision-making authority vis-à-vis their social work counterparts (Ambrose-Miller & Ashcroft, 2016).

These under-acknowledged hierarchies between physicians and social workers impede meaningful interprofessional collaboration by hampering effective communication, increasing interpersonal tension, and increasing stress or burnout (Abramson & Mizrahi, 1996; Goldman et al., 2016; Mizrahi & Abramson, 2000). As one social worker in a 2015 focus group on collaborative care models shared:

I’d love to see our body talk more with the medical body. As social workers we need to have this conversation (about role clarification) so often. Medical doctors don’t need to do that so I think we need to show how we, as social workers, need to communicate this. If we did this in the education then things would change drastically. (Ambrose-Miller & Ashcroft, 2016, p. 105)

Given the rapid expansion of the social determinants of health framework and IBH in primary care settings (Horevitz & Manoleas, 2013), increased attention to workforce preparedness for collaboration is necessary. Without a shared understanding of entrenched professional hierarchies, true collaboration between social work and medicine may prove difficult or impossible.

As articulated by Pierre Bourdieu in his discussion of “symbolic violence,” hierarchies and other forms of inequality become “naturalized” when they are made to appear inevitable or deserved (Bourdieu, 2001; Bourdieu & Wacquant, 1992). Structural competency, through introducing and discussing the concept of “naturalizing inequality” (Neff et al., 2019), can help healthcare providers develop a critical understanding of the professional hierarchies in which they are embedded. Understanding how hierarchy is naturalized may also help social workers and physicians alike to imagine new forms of interprofessional collaboration, which could in turn help improve interactions between the professions.

To be sure, such understanding is not sufficient to eliminate the harmful effects of workplace hierarchy, but it may be a necessary component. Teaching physicians and social workers about the structural forces—both historical and contemporary—
that shape these workplace inequalities creates a basis for these professions to begin conversing and working together to address these inequalities. Moreover, without this shared language, providers may reflexively focus on interpersonal factors (thinking of an individual or group as mean-spirited, lazy, difficult, incompetent, etc.), rather than recognizing and working together to address root causes. Again, research is needed to investigate if and to what extent structural competency improves interprofessional collaboration by denaturalizing common and taken-for-granted hierarchies.

Common Cause: Social Workers and Physicians Working Together for Social Change

Finally, structural competency training can promote collaboration among social workers and physicians as well as other healthcare professionals by orienting providers toward working collectively for structural change. In the absence of a structural approach, when confronted with structural inequity, healthcare providers in the U.S. today may think primarily of what they can accomplish as individuals or at other relatively individual scales. While recognition of structural-level issues can inform action at any scale (Neff et al., 2019), addressing structural issues at their roots requires collective-level action. Structural frameworks can help providers to expand their horizons accordingly.

Increasingly, healthcare scholars use the language of political solidarity and political will as important frames for addressing health inequities, outlining the integral role these approaches can play in transforming healthcare systems (Braveman, Egerter, & Williams, 2011; Braveman, Egerter, Woolf, & Marks, 2011; Gould, 2018; Pine, 2016). The California Nurses Association (CNA) offers a powerful example of this potential. Among other accomplishments, through more than a decade of sustained effort—including grassroots political organizing, direct action, and building relationships of political solidarity with allied organizations and communities—CNA was able to establish California legislation capping patient-to-nurse ratios in various clinical settings (e.g., 5:1 in medical-surgical units and 2:1 in intensive care units). These ratios improve not only nurses’ working conditions, job satisfaction, and risk for burnout—they
also are good for patient care (Aiken et al., 2010). For example, a study from the University of Pennsylvania School of Nursing found that implementing California’s nursing ratios would result in 14% and 11% fewer deaths in surgical units in New Jersey and Pennsylvania, respectively (Aiken et al., 2010). This is just one example of people wielding collective power to influence structural change.

Unfortunately, there are countless examples of healthcare providers continuing to individually go above and beyond to fill in the gaps caused by systemic issues—leaving the larger issues in place and increasing their own risk of burnout. Primary care physicians, for example, regularly work extra hours to provide essential care for their patients and complete charting requirements while being compensated a fraction of what their specialist colleagues earn. Thus far, there is no broad, collective movement among primary care providers to address these issues at their roots. Social workers, meanwhile, typically make far less than primary care doctors, for work that has potential to address health issues further “upstream” and is no less taxing. And yet social workers also lack a cohesive, grassroots movement that can address structural inequities through and within their profession (Reisch & Andrews, 2002). We suspect that the structural awareness developed through training in structural competency may be necessary, if certainly not sufficient, for social workers, physicians, and various other professionals to begin organizing collectively for structural-level change.

This holds true for organizing across as well as within professions. The ongoing hierarchy and accompanying pay differential among these professions notwithstanding, the fact remains that healthcare providers more and more face similar challenges and constraints in a system that prioritizes profit and a myopically-defined “efficiency” over long-term patient and provider well-being. The manifestations of this include the increasing bureaucratic demands placed on providers in order to meet arbitrary insurance billing requirements; the continual pressure to see patients in less time than allows for quality care; the defunding of social programs that leaves healthcare settings as the front-line social safety net (accessed by people with illnesses that could have been prevented through services such as affordable housing, job training, etc.); and the need across healthcare professions for most providers to take on exorbitant
educational debt (Morra, Regehr, & Ginsburg, 2008). All of this hinders job satisfaction and contributes to high rates of burnout, stress, and fatigue across the healthcare professions (Gabassi, Cervai, Rozbowsky, Semeraro, & Gregori, 2002).

The ideological landscape in the United States in recent decades is such that many healthcare workers do not consistently recognize the influence of social structures that afflict their patients and hamper their workplace efficacy and satisfaction. Nor do providers consistently recognize the potential for structural change to be leveraged through sustained collective action (Wear & Kuczewski, 2008). We believe that structural competency holds potential to help providers develop that awareness — awareness that may be necessary, if not sufficient, for healthcare professionals to organize for structural change within as well as across professions.

We do not know exactly what forms interprofessional organizing inclusive of physicians, social workers, and other providers might take. Nevertheless, we are hopeful that interprofessional collaboration among healthcare providers to address structural issues can be fostered in part through a shared understanding of the structurally-mediated harms to patients and to providers. Such a movement would have tremendous power. Physicians and social workers alike wield a great deal of symbolic capital and are well positioned to recognize and challenge the impacts of various structural issues on health and healthcare. Here as well, further study can shed light on the merit or lack thereof of these hypotheses.

**Conclusion**

Physicians and social workers struggle to effectively collaborate across disciplines at a time when increasingly complex health systems and persistent health disparities demand the opposite. We have discussed three reasons that rigorously training physicians and social workers alike in structural competency may improve collaboration and address longstanding challenges within and between these professions. First, co-education in structural competency gives physicians and social workers a shared framework to recognize and discuss the structural factors impacting the health of their patients. Second, structural competency can improve collaboration by offering a lens to
denaturalize the hierarchy that has long-defined the relationship between physicians and social workers. Finally, structural competency can promote social worker and physician collaboration by enhancing both professions’ awareness of their potential to contribute to a wider movement for structural change.

Structural competency highlights realities, from police brutality to wealth inequality to labor exploitation, that may at first seem daunting and insurmountable to healthcare providers. It also, however, emphasizes that healthcare providers can and should play a role in addressing such injustices. In a moment when other social services are minimal and shrinking, healthcare providers are uniquely positioned to recognize the harms—to body, psyche, and spirit—of unjust social structures. Moreover, healthcare providers have both social standing and widespread trust among the public, positioning them to be effective advocates for change.

Our hope is that structural competency training for both social workers and physicians will give both of these professions the analytic and practical skills to move beyond a shallow collaboration in which physicians “just call the social worker” when they observe structural factors impeding patient health outcomes—and toward collaboration built on a shared understanding of structure, equitable work partnerships, and common cause in working for social change.

References


Collaboration between Healthcare Social Work and Medicine


Chapter Title

Collaboration between Healthcare Social Work and Medicine


The Trans Person is not the Problem: Brave Spaces and Structural Competence as Educative Tools for Trans Justice in Social Work

Jama Shelton
Silberman School of Social Work, Hunter College

Kel Kroehle
School of Policy & Practice, University of Pennsylvania

Maria Monica Andia
Silberman School of Social Work, Hunter College

Social work students must be equipped to confront injustice and oppression. Effectively challenging oppression necessitates attention to the ideological origins and subsequent systematic marginalization of oppressed populations. This article critically examines social work education as it relates to trans people and communities. We propose two interconnected pedagogical shifts for consideration: moving from the social work classroom as “safe space” to the social work classroom as “brave space,” and broadening the commonly used educative method of cultural competence to structural competence. We argue that these pedagogical shifts will better prepare social work students to disrupt cisgenderism and dismantle the gender binary, and to be responsive across multiple axes of power, privilege, and oppression—necessary measures for advancing equity and justice for trans people and communities.

Keywords: social work education, transgender, brave space, cultural competence
Introduction

By featuring Laverne Cox’s infamous cover photo, *Time Magazine* declared in 2014 that the progress engendered by trans visibility had at last brought the United States to a “transgender tipping point” (Steinmetz, 2014). From here, it was suggested, trans equity was not only within reach, but inevitable. Yet five years later, rampant discrimination and violence continue to be enacted upon trans people, and the White House is seeking to fully legislate the trans community not just out of protections, but out of existence entirely (Green, Benner, & Pear, 2018). What happened? Evidently, not enough, as such a rapid shift in transphobic tenor indicates that despite the empathy visibility generates, visibility itself does not ensure structural transformation. Rather, sustainable forward movement requires not only noting and valuing the lives of trans people, but, more importantly, shifting our gaze to the pervasive cisgenderism underpinning our social, cultural, and political norms and institutions.

Such an approach is embedded within the core values of social work, evidenced by the National Association of Social Workers (NASW) and the Council on Social Work Education’s (CSWE) emphases on social justice and endorsements of trans-affirming social work education and practice (CSWE, 2015; NASW, 2015). Yet in order to effectively meet these education and practice standards, social work students, faculty, researchers, and practitioners must be attuned to the ideological origins and subsequent systematic marginalization of trans populations. Without this focus, social workers may not only be ineffective in combating social injustice, they may also be unintentionally perpetuating the marginalization they are charged with addressing. For example, consider social work’s historical connection to the oppression and marginalization of trans people and communities. Though a marginalized group in society, the oppression of trans people and communities has been perpetuated by the social work profession through the use of language of individual pathology, gatekeeping, and complicity with systems and institutions that reinforce the gender binary and presume cisgender identity. Trans people experience barriers to care in social service settings, ranging from a lack of trans-affirming care to hostile and discriminatory treatment (James et al., 2016). In fact, social work education itself reinforces
the gender binary throughout the curriculum. Developmental models widely taught in human behavior classes reinforce the gender binary, as does the pervasive research instruction of gender as example of a dichotomous variable.

Today, the limited attention given trans communities within social work tends to be framed within cultural competence, the profession’s primary mechanism for “engaging with difference” (CSWE, 2015). Just as visibility does not engender institutional change, an approach such as cultural competency does little to address the structural causes of trans oppression. The aims of this article are to: (1) situate trans oppression and marginalization within the prejudicial ideology of cisgenderism; (2) offer a critique of cultural competence and the subsequent effort to create “safe spaces” as the primary educational method for preparing social workers to effectively engage with trans people and communities; and (3) demonstrate the utility of “brave spaces” and a structural competence framework in educating social work students to work with trans people and communities.

Social Work and Trans Oppression

Locating trans oppression within social work calls first for a broader survey of the function of a binary gender classification system within society at large. The gender binary refers to the pervasive idea that there are two, rigidly bounded genders, with classification under the binary as a foundational element of contemporary United States’ social structures. While he never explicitly named the trans individual or body, Michel Foucault’s (1982) analysis of categorization-as-power proves pertinent to the success of the gender binary as a mechanism of population management and societal regulation. Describing the discipline of deviance, Foucault suggests that a powerful truth regime “categorizes the individual...attaches him to his own identity, [and] imposes a law of truth on him which he must recognize and which others have to recognize in him” (Foucault, 1982, p. 781). As a central organizing principle for society, then, a binary system of gender categorization creates the conditions for the trans person to be marked as a deviant subject in need of correction. Foucault suggests that as society internalizes such truth regimes, power becomes pervasive and dispersed, and the state
becomes able to rely on science and social customs to enforce its classificatory systems.

Across such arenas as law, education, and government, trans people are rendered invisible, illegible, or disallowed through cisnormative systems that disregard identities that do not adhere to the gender binary or that presume a cisgender history (Grossman & D’Augelli, 2006; Shelley, 2009). Foucault (1984) locates science, with its privileged empirical status, as the site at which such norms become specified, sanctified, and thus embedded within these structures. In particular, medical discourses have heavily influenced the theoretical conceptualizations of trans identities and subsequently the frameworks made available to the world at large (Sanger, 2008), including the social work profession. Medical models focus on a binary construction of sex, a binary construction of gender, and a binary construction of trans identity. Describing the pervasiveness of such constructs, legal theorist Dean Spade states:

These norms and codes of behavior reach into the most minute details of our bodies, thoughts, and behaviors. The labels and categories generated through our disciplined behavior keep us in our places and help us to know how to be ourselves properly. (Spade, 2011, p. 54)

Thus, as indicated by a historical overemphasis on “‘correcting’ gender deviance through reassignment to the ‘appropriate’ gender,” both the physician and the social worker stand to enact disciplinary power over the trans subject (Shelley, 2009). This inherently oppressive and assimilationist framework reflects society’s frequent rejection and denial of trans identities and experiences (Shelley, 2009).

As indicated by a breadth of scholarly work, histories of gender deviance and trans oppression are deeply interwoven with other axes of power and oppression (Bey, 2017; Brubaker, 2016; Holland, 2012; Rifkin, 2011; Snorton, 2017; Stoler, 1995). Notably, those trans bodies deemed legible (albeit pathologized) reflect that gender is not neutral, but instead that the very coherence of a trans identity is contingent upon racial, national, classed, and abled borders (Krell, 2017). Testifying to the “collective amnesia” regarding Black trans life in the United States, Riley Snorton (2017) highlights how even the most pathological
trans body is racialized, as the very binary of femininity and masculinity is conceptualized as White. Detailing the logic of Christine Jorgenson’s fame, the first known trans woman to undergo hormone therapy, Snorton states she was “a peculiar emblem of national freedom, not beloved but somehow incor-
porable” (2017, p. 142). In her essay “Don’t Exist,” Eva S. Hay-
ward (2017) takes the implications of this collective amnesia a step further, suggesting that the very possibility of White trans visibility and empowerment is built on the bodies of Black trans women and trans women of color and the imperative that they “don’t exist.” This consolidation of gender with other axes of difference deserves ongoing attention within any consideration of trans liberation, as it invisibilizes a majority of trans lives and, further, amplifies the corrective violence faced by those who deviate not only from gender norms but from expectations of whiteness, ability, or class.

Situated within this sociocultural context, the profession of social work writ large is no different. Despite its commitment to social justice, the social work profession has historically con-
tributed to the oppression of trans people. At times, this op-
pression has been direct, such as through the classification of trans people and experiences as mental illness. Though the social work profession has moved away from conceptualizations of trans identities as inherently pathological, as evident in re-
cent practice guidelines by the National Association of Social Workers and the Council on Social Work Education (Austin et al., 2016; Social Work Speaks, 2009), the oppressive historical context must be acknowledged because current practices of di-
agnosing and treating are rooted in this foundational history (Markman, 2011). A brief summary of this oppressive historical context follows.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) represents a central point of historical contention be-
tween social work and many marginalized communities. Trans communities hold a particularly fraught history with the DSM, given its historical deployment as a tool that circumscribed the trans body within a science of normals and deviants. Gen-
der Identity Disorder (GID) made its debut in the DSM III in 1980 in the form of two diagnoses, gender identity disorder of childhood (GIDC) and transsexualism. Concurrently, the diag-
nostic category sexual orientation disturbance (which replaced
homosexuality in 1973) was replaced with ego dystonic homosexuality (Drescher, 2009). The latter category was removed with the publication of the DSM III-R in 1987, signifying the end of official psychiatric pathologization of sexual orientation. An additional category was added to the GID repertoire at this time—gender identity disorder of adolescence and adulthood, non-transsexual type, specifying criteria for children and adolescents/adults (Drescher, 2009). Some argue that the timing of the introduction of GID as a diagnostic category was not coincidental, but was intended to provide a means for diagnosing “homosexuality” following its removal from the DSM (Burgess, 2009; Langer & Martin, 2004). While the DSM-IV eliminated the added diagnosis of GID of adolescence and adulthood, non-transsexual type, it replaced it with “gender identity disorder”—a diagnosis that created one diagnosis covering both GIDC and transsexualism.

The recent revision in terminology from GID in the DSM-IV to gender dysphoria in the DSM-V has been recognized as an attempt to better reflect the incongruence between an individual’s gender identity and the societal expectations regarding how an individual “should” understand and live out their gender based on their sex assigned at birth. This shift in terminology does more accurately explain the problem, which is that societal definitions of gender do not reflect people’s lived experience of gender. However, the new diagnosis continues to identify the source of dissonance within the individual and through a lens of pathology (Markman, 2011). Its inclusion in the DSM perpetuates the notion that trans identities are non-normative, furthering the production and maintenance of prejudice and discrimination against trans people and communities. Additionally, the idea of incongruence still suggests that congruence is the norm, and that incongruence is inherently problematic (DeCuypere, Knudson, & Bockting, 2010).

The implications of these diagnoses have been far-reaching. Per the World Professional Association for Transgender Health’s Standards of Care (WPATH), a trans person seeking gender-affirming care, such as hormones, chest surgery, or genital surgery, must first obtain an expert “letter of recommendation” detailing their diagnosis of “gender identity disorder” and “readiness” for transition. As cisgender individuals seeking hormone therapies or cosmetic surgeries such as face lifts or
breast augmentations require no such letter, this represents an emphasis on trans-as-pathology “which reifies the idea that the dissonance between the gender performance of an individual and the expectations of society are the result of a psychological problem within the individual rather than a societal problem with defining gender” (Markman, 2011, p. 320). Highlighting the nature of this diagnostic power, transgender activist Pauline Parks proclaimed “every psychiatrist who diagnoses GID in a patient merely by virtue of the individual’s transgender identity is complicit in the manipulation and control of transgender people and their bodies” (Bilodeau & Renn, 2005, p. 31). The same could be said for social workers—every social worker who is complicit in the psychiatric diagnosis of a person based solely on their gender identity or expression reinforces the oppressive and systematic management of trans people and their bodies, as this diagnostic power is not solely symbolic, but rather, arbitrates a trans person’s access to gender-affirming care. Even if not engaged in the direct act of diagnosing, social workers frequently act as gatekeepers, requiring individuals to prove and defend their gender identities and limiting an individual’s ability to make their own choices regarding their body and access to gender affirming medical care.

Inherent in this gatekeeping process is the notion that an individual person does not possess the requisite knowledge to self-designate their gender; rather, it assumes that social workers are the experts who are able to discern, to *know*, the trans Other. A historical prerequisite for becoming “known” has been an adherence to the gender binary (Markman, 2011). Thus, individuals had to agree to the assimilative frame of the gender binary and adopt a “born in the wrong body” narrative in order to obtain necessary medical care. As discussed earlier, the system of binary gender underpinning “knowability” is deeply embedded with raced, classed, and abled norms. This interplay means that for many trans people of color, trans people with disabilities, or poor trans people, their gender may not be legible to a social worker who is operating under “neutrality,” disregarding intersectionality, or unaware of the impact of their own lens. As such, access to gender-affirming medical treatment “became entangled with a socially conservative attempt to maintain traditional gender, in which changing sex was grudgingly permitted for the few of those seeking to do so,
to the extent that the practice did not trouble the gender binary for the many” (Stryker, 2008, p. 94).

Despite perpetuating the notion of trans-as-pathology, it is important to note that the WPATH Standards of Care offer a framework to health professionals who might otherwise further pathologize, mistreat, or fully refuse trans people seeking gender-affirming medical care. Thus, for some trans people, engaging in the process of gathering expert proof of their identity is a lifesaving means to an end.

While the “born in the wrong body” narrative may be an accurate depiction for some, it does not reflect the heterogeneity of gender experiences. This dominant narrative limits individual and societal conceptualizations of gender identities while reinforcing the gender binary. Yet the problematic nature of the gender binary does not preclude trans people from an identification with the gender binary. In fact, some people of trans experience identify with the gender binary. It is when a binary classification is imposed and does not align with one’s understanding of their own gender that it becomes problematic (Ansara & Hegarty, 2012) or when identification within the gender binary is a prerequisite for access to social systems. Rather than stringently adhering to the DSM’s clinical metric for gender identity, then, social work could better respond to the disempowering treatment of trans individuals by relocating the truths of gender identity within the individual’s word.

*Structural Oppression: Cisgenderism*

Recent literature demonstrates the pervasive discrimination and marginalization of trans people in the United States (Grant, Mottet, & Tanis, 2010; James et al., 2016). As a group, trans people, or people whose self-designated gender differs from the expectations associated with their designated sex at birth, experience disparities in housing, employment, and health, are subject to police profiling, and experience violence in their schools, workplace, and communities (James et al., 2016; Stotzer, 2009). Given the cumulative power of intersecting forms of oppression, multiply marginalized trans people are disproportionately represented among those facing such individual and structural mistreatment. This includes significantly higher rates of discrimination, violence, and economic hardship among
trans people of color, undocumented trans people, and trans people with disabilities, among others (James et al., 2016). Adding to this marginalization, only twenty states and the District of Columbia ban discrimination based on gender identity and expression (Human Rights Commission [HRC], n.d.). This lack of protection and inclusion in public policy results in a greater need for services, advocacy and specialized care. These legislative practices demonstrate the ways in which the repudiation and unjust treatment of trans people extend beyond the clinical discourse (Shelley, 2009).

To understand and effectively address this pervasive discrimination and marginalization, it is imperative that social workers broaden their lenses of analysis from the individual and interpersonal levels of discriminatory acts to the structure of social systems and institutions that permit and often encourage the discriminatory behavior of those within said systems and institutions. In other words, social workers must recognize the role of structural discrimination in the marginalization and oppression of trans people. Structural discrimination refers to “the policies of dominant race/ethnic/gender institutions and the behavior of the individuals who implement these policies and control these institutions, which are race/ethnic/gender neutral in intent but which have a differential and/or harmful effect on minority race/ethnic/gender groups” (Pincus, 2000, p. 31). The practice of broadening the analysis to the structural level is not new. For instance, social workers, researchers and advocates have traded the concept of homophobia for heterosexism. Heterosexism enables an understanding and analysis of the systemic marginalization of lesbian, gay, and bisexual (LGB) people and the structural favoring of heterosexual people over LGB people (Ansara & Hegarty, 2012).

Likewise, cisgenderism is a prejudicial ideology that “others” people who self-identify as or who are otherwise labeled as transgender (Ansara & Hegarty, 2012). Lennon and Mistler (2014) define cisgenderism as “the cultural and systemic ideology that denies, denigrates, or pathologizes self-identified gender identities that do not align with assigned gender at birth as well as resulting behavior, expression, and community” (p. 63). The concept has been outlined in depth in the psychological literature by Ansara and colleagues; it offers a structural framework for understanding the systemic delegitimization of
an individual’s self-identified gender as a form of societal oppression (Ansara & Hegarty, 2014; Riggs, Ansara, & Treharne, 2015). Cisgenderism constructs cisgender people as the presumed way of being, or as the neutral standard, and those who are trans as Other. Therefore, understanding the marginalizing and discriminatory experiences of trans people through the lens of cisgenderism locates the problem outside of individual and interpersonal actions, focusing instead on the oppressive ideologies and institutional structures, rooted in the existence of a neutral standard, that produce and maintain their marginalization (Shelton, 2015).

Utilizing cisgenderism as a framework for understanding the health, housing, education, and employment disparities of trans people is in alignment with the social work profession’s commitment to social justice. Rather than situating the causes for these disparities within the individual, and subsequently targeting interventions solely at the individual level, applying a lens of cisgenderism illuminates the ways in which an individual’s self-understanding is structurally and systematically denied, challenged, and overlooked.

Likewise, such a reconceptualization de-centers a normative trans identity that might marginalize people who do not fit expectations of whiteness, ability, or income, instead shifting focus to the structures conditioning limited possibilities for trans people to begin with. Though this thinking is in alignment with the profession’s commitment to social justice, such conceptualizations are lacking in social work education, practice, and scholarship examining the needs, experiences, and challenges of trans people and the social service response to those needs, experiences, and challenges. It is imperative that social workers grasp this concept if they are to make lasting change for trans people and communities. One method for ensuring social workers are able to grasp this concept is to shift the profession’s long-standing educative focus from cultural competence to structural competence.

Cultural Competence

Cultural competence is arguably social work education’s most well-established method for addressing cultural differences and inequities. With ten standards and dozens of practice
indicators, the National Association of Social Work operationalizes cultural competence as “the integration of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings” (NASW, 2015). While the Council for Social Work Education’s Educational Policy Accreditation Standards no longer explicitly name cultural competence, “Engage diversity and difference in practice” is the second social work competency listed. Yet despite its continued centrality within social work’s core curricula, cultural competence has demonstrable limitations as a pedagogical response to cultural difference and social injustice. A growing body of research points to the framework’s inadequacies, highlighting: (1) a positivist portrayal of culture as knowable, true, and capable of being mastered; (2) the positioning of the social worker as culturally neutral (i.e., white, middle-class, cisgender); (3) the equating of the social worker’s comfort with their self-awareness; and (4) an overemphasis on access to discriminatory structures over structural change (Fisher-Borne, Cain, & Martin, 2015; Jani, Pierce, Ortiz, & Sowbel, 2011; Nylund, 2006; Ortega & Faller, 2011; Ortiz & Jani, 2010; Pon, 2009; Sakamoto, 2007; Tervalon & Murray-García, 1998).

Under this educative framework, the social work student comes to understand the social worker to be the knowing subject and the client as the culturally-distinct, knowable Other. Such an approach does not mandate the social work student to critically engage with power, privilege, and oppression, but rather demonstrate competency in the knowledge, acceptance, and management of difference. The neglect permitted by cultural competence may manifest at micro, mezzo, and macro levels as social work curricula teaches about difference while simultaneously upholding the conditions of inequity. For example, a social work student may learn about disability yet continue to use ableist language, learn about racialized economic disparities yet not be made to reflect on racial inequities in the staffing of their institutions, or learn of health challenges facing Native American and Indigenous communities yet remain unaware of social work’s long history in the forced removal of children from these communities. In such a focus on managing the Other’s difference, cultural competence curricula inadvertently perpetuate the very injustices they seek to address. Absent an analysis of accountability and with a lens turned outward, this
approach is inadequate for readying social work students to engage in anti-oppressive structural change.

As a subset of the cultural competence umbrella, transgender cultural competence is similarly insufficient for preparing students to challenge cisgenderism and act as advocates for trans people and communities. First, the notion of transgender cultural competence presumes the existence of a transgender culture that can be known, accepted, and managed. While socially and culturally constructed, gender does not constitute a culture in and of itself. Rather, gender, and thus trans-ness, is historically, locally, and culturally contingent. Some may assert that trans is indeed a culture. If we entertain this notion, transgender cultural competence remains inadequate for “it is not just transgender phenomena per se that are of interest, but rather the manner in which these phenomena reveal the operations of systems and institutions that simultaneously produce various possibilities of viable personhood, and eliminate others” (Stryker, 2006, p. 3). Focusing our gaze only on trans individuals and not also on the conditions that “allow gender normativity to disappear into the unanalyzed, ambient background” (Stryker, 2006, p. 3) limits the ability of social work students to critically engage with the systems and institutions that perpetuate trans marginalization.

Additionally, transgender cultural competence reduces the experiences of trans people to their gender identity only, without attention to other dimensions of identity and the interlocking systems of oppression that exist at the intersections of gender identity, race, ethnicity, immigration status, ability, and socioeconomic status. A cursory glance at the cultural competence literature further demonstrates the inadequacy of this mechanism for preparing social work students to challenge cisgenderism and engage in socially just practice with trans people and communities. Many cultural competence texts offer only passing mention of transgender topics, often collapsing trans into the LGBT acronym in content exclusively about sexuality (Austin, 2018; Austin, Craig, & McInroy, 2016; Erich, Boutté-Queen, Donnelly, & Tittsworth, 2007). Additionally, few social work programs have core curricula that require education on practice with trans people and communities (Fredriksen-Goldsen, Woodford, Luke, & Guitierrez, 2011; Logie, Bridge, & Bridge, 2007).
A desire for established parameters to the trans community—such that the social work student might *know* the Other—is additionally evident in prolific research on the cause, development, and achievement of a trans identity. For example, the language of *persisters and desisters* standardized within research on trans children continues despite growing recognition of the fluidity and mutability of gender (Durwood, McLaughlin, & Olson, 2017; Olson, Schrager, Belzer, Simons, & Clark, 2015). The approach to risk and victimization found in transgender cultural competence literature similarly invokes a metanarrative that encourages the social work student to become empathic toward a subjugated trans community. In depicting trans communities as uniformly at-risk and victimized by education, health care, workplace, and community violence, the social work student is provided an externalized cause for concern that dismisses the role that the cisgender social worker and agency may play in creating environments of and perpetuating the conditions of risk and victimization (Austin, Craig, & McInroy, 2016; Burdge, 2007; Shelton, 2016). Finally, the disparate number of texts grounded in the medical model of trans identity indicate the emphasis of transgender cultural competence on managing difference over interrupting the structures that punish it. With such textual emphasis on the cause, victimization, and treatment of the trans individual, the social work student’s capacity for addressing inequity is limited by the know/accept/manage approach to difference.

Through educating the social work student to know, accept, and manage the difference of trans communities, transgender cultural competence reifies a belief in the neutral subjectivity of the social worker and renders the trans community the knowable, culturally diverse Other. And, in so doing, acts as an educative tool focused not on equipping social work students with tools for enacting structural transformation, but rather on generating competencies that register across cisgender communities and institutions. Insofar as it does not demand individual and institutional cisgender accountability, then, transgender cultural competence is not the means for preparing students for social change.
Safe Spaces

Though arguably less common than cultural competence frameworks, safe spaces are another frequent response by social work to questions of cultural difference and inequity. Safe spaces have their origins in the 1960s gay bars that offered LGBTQ individuals community during persecution under anti-sodomy laws and a place for “practical resistance to political and social repression” (Harris, 2015, para. 4). The era saw similar safe spaces for women in which, according to the 1970s feminist organization New York Radical Women, “The idea was not to change women...It was and is the conditions women face, it’s male supremacy, we want to change” (Kenney, 2001, p. 24). Far from being institutionally-sponsored, these original safe spaces were both underground and resistant, seeking to provide a haven for the marginalized in which they might imagine change.

Yet over the past 50 years, safe spaces have evolved into a relatively mainstream phenomenon. Typically associated with high school classrooms and college campuses, Merriam-Webster defines safe space as a place “intended to be free of bias, conflict, criticism, or potentially threatening actions, ideas, or conversations” (safe space, n.d.). Many sectors of social work have adopted the safe space effort, posting stickers and signage around agencies and schools to communicate inclusivity and safety for LGBTQ communities, and hosting safe space programming and support groups for LGBTQ clients and students. While a safe(r) space is a necessary resource in an unsafe environment, this approach unfortunately does very little to interrupt patterns of marginalization and violence within the profession of social work.

Within social work education, the notion of a safe space forecloses critical opportunities for real learning, which require some level of discomfort, risk, and vulnerability (Cook-Sather, 2016). Because removing risk from the examination of controversial issues is impossible, social work classrooms built on the premise of a safe space often avoid the kind of critical analysis of power, privilege, and oppression necessary for socially just practice (Arao & Clemens, 2013). Further, as a safe space is intended to be a space free of conflict, it is often limited to a symbolic gesture in which an environment remains entrenched in the status quo. The focus on safety prioritizes those who are
used to being granted safety in society—commonly those who are class privileged, white, cisgender, male, heterosexual, and able-bodied (Love, Gaynor, & Blessett, 2016). In this way, cisgender social work students are not made to address their participation in the creation of an unsafe setting, and the structure retains its rootedness in cisnormativity. In avoidance of conflict or criticism, the safe space ensures its continuance.

Steeped in a rich history of pathologizing trans communities, social work must remain accountable to undoing the structural conditions of cisgenderism and gender binarism that undergird practice, research, and education today. While cultural competence is often invoked as one of social work’s primary social justice mechanisms, its know/manage/accept approach to trans communities renders it complicit in the normalization of the cisgender social worker and the production of trans Others. Cultural humility, an emergent alternative to cultural competence, suggests a self-reflexive approach that demands a social worker be accountable to their positionality in inter- and intra-personal cross-cultural settings. Unfortunately, due to its overemphasis on micro-processes, cultural humility fails to attend to social work’s role in confronting the broader systems contextualizing difference and oppression (Danso, 2018). Similarly, safe spaces may provide an important physical resource but fall short in generating the difficult dialogues necessary to engender accountability and enact structural change. In the interest of redirecting the social work profession’s efforts toward social justice, the next section will call upon two emergent strategies—structural competence and brave spaces—to suggest a more viable, sustainable, and genuine approach to change.

**Structural Competence in Social Work Education**

As evidenced by the previous discussion of cultural competence, the current trend in social work practice and education is toward the individualization of problems. As such, education and practice often focus on alleviating an individual’s symptoms rather than identifying and addressing the underlying causes of social problems (George & Marlowe, 2005). Thus, social workers may see their primary responsibility as helping to ensure access to supports and services rather than working to alleviate the need for such supports and services. The individualization of
social problems contributes to a perceived divide between casework/clinical practice and community/macro practice (Mullaly, 1997). Agencies that provide direct services typically do not engage in macro level change efforts, and agencies that engage in social change efforts do not often provide direct services (Kivel, 2009; Mullaly, 1997). This macro/micro divide, in education and practice, fuels a separation of the personal and the political. Social work practice resulting from this separation fails to address the reality of people’s lived experiences (Mullaly, 1997).

Conversely, structural social work, aligned with a feminist tradition, connects the personal and political through the identification, examination of, and action toward the causes of oppression (George & Marlowe, 2005). An emphasis on structural competence thus indicates that an engagement with the systemic causes of oppression is not only a macro practice, but a necessary intervention in order to effectively provide support at the individual level. This approach proves particularly apt when considering supporting trans communities facing intersecting oppressions. For example, structural competence would suggest that a social worker’s capacity to truly affirm a trans individual rests upon not only micro practices such as correct pronoun usage but simultaneous engagement with the macro structures conditioning that trans individual’s survival, such as a school-to-prison pipeline specifically hostile to trans students of color, or immigration policy that refuses undocumented trans people their basic human rights. In this way, a structural social work lens enables social workers and social work students to assume accountability for the multiple axes of power impacting the trans communities they seek to serve.

Despite an existing tradition of emancipatory social work theory and practice, the social work profession has not widely accepted structural social work practice, in part due to the concern that focusing on societal transformation will result in an inadequate focus on individual needs (George & Marlowe, 2005). The reality is that structural social work practice may pose challenges, particularly in the current neoliberal context of state-mediated service delivery in which the corporate interests of the insurance and pharmaceutical industries directly influence social work practice and social service delivery. As such industries frequently place emphasis on funding efficiency and measurable outcomes, treating trans individuals’ symptoms of
cisgenderism is perceived as a more attractive investment than engaging in a nebulous, long-term intervention with the structure of cisgenderism itself. Nevertheless, the task is to: return to the profession’s core values; reimagine our organizational and educational goals and divorce them from the “reductionistic, decontextualized, medicalistic approaches to treatment” (Ali & Sichel, 2014, p. 907); and adopt a both/and approach to social work education and practice. As societal structures are the source of disparate individual needs, societal change is an immediate need.

**Brave Spaces**

A relatively new concept in higher education, “brave space” is an emergent framework for deepening the dialogue around power, privilege, equity, and justice (Arao & Clemens, 2013). Whereas safe spaces establish rules meant to minimize conflict and moderate emotional responses, brave spaces invite authentic engagement and risk-taking (Stanlick, 2015). Inherent in the concept is a “combination of active risk and built-in affirmation” (Cook-Sather, 2016, p. 1). Brave spaces remove the passivity inherent in remaining comfortable and set the expectation that conflict and discomfort are likely to arise. When conflict and discomfort arise in brave spaces, they are addressed and moved through. Thus, brave spaces invite social work students to be courageous and active participants in their learning. Those who enter the space have the courage to take risks and to face discomfort, because they know that conflict or painful experiences will not be avoided, dismissed, or quickly shut down (Stanlick, 2015).

In brave space classrooms, all students are held accountable for their words. In moving discussions past polite, surface level conversations, brave spaces confront both the implicit and explicit ways in which inclusion and exclusion, dominance and subordination, and belonging and alienation manifest for people with different identities (Cook-Sather, 2016). It is only through confrontation with these dynamics that transformational learning can occur and critical consciousness can develop. Often situated within systems and institutions that perpetuate the marginalization and regulation of trans people and their bodies, social workers need to be equipped to recognize, address, and frame their work around the historical, sociopolitical,
and cisgenderist context of trans marginalization. Brave spaces are more likely than safe spaces to enable the kind of analytic skills and critical consciousness required of social workers to address the multiple sources of inequities faced by trans people and communities. Brave spaces can easily be situated within a structural competence framework (discussed below) due to their facilitation of dialogue regarding how various identities are impacted by societal systems.

From Cultural Competence to Structural Competence

How would a structural social work approach look in relation to preparing students for practice with trans communities? Prior to applying a structural framework to educating social work students about practice with trans communities, social work educators must first identify the ways in which their curricular content is rooted in the know/accept/manage approach of cultural competence, cisgenderism, and the gender binary. Recent scholarship details the ways in which cisgenderism, and thus reinforcement of the gender binary, may show up in the social work classroom (Shelton & Dodd, 2019; Wagaman, Shelton, & Carter, 2018). Following the previous critique of the know/accept/manage approach inherent in cultural competence frameworks, we offer the following strategies for adapting social work education to a structural competence framework. The proposed shift from the know, accept, and manage approach of cultural competence to a process of recognizing, reflecting, and confronting is in alignment with the five tenets of structural competence for use in medical education outlined by Metzl and Hansen (2014). It is our recommendation that social work educators and administrators first use the strategies outlined below to inventory existing pedagogy, curricula, and classroom materials for cultural competence frameworks. Following this, educators and administrators might consider the adaptations required to shift their praxes to better reflect the values of recognition, reflection, and confrontation characteristic of structural competence, and pursue the resources needed for implementing such shifts.
## Table 1. Moving from cultural competence to structural competence

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowing:</strong></td>
<td><strong>Recognizing:</strong></td>
</tr>
<tr>
<td>• Claiming binary gender is natural and universal</td>
<td>• Learning about the history of a racialized gender binary and trans medicalization</td>
</tr>
<tr>
<td>• Citing familiarity with trans communities using oversimplified or dominant narratives</td>
<td>• Diversifying information sources to include marginalized voices unrepresented within mainstream narratives</td>
</tr>
<tr>
<td>• Establishing parameters to encapsulate trans people (bodies, medical histories, transition plans)</td>
<td>• Understanding the binary conditions of trans health supports (focused on transitioning from one gender to &quot;the other&quot;)</td>
</tr>
<tr>
<td>• Seeking to understand the &quot;how&quot; and &quot;why&quot; of trans identity</td>
<td>• Acknowledging the policing of gender delegitimization, and the requirement that trans people prove who they are</td>
</tr>
<tr>
<td>• Locating source of conflict/distress within the individual</td>
<td>• Locating conflict/distress as a result of societal intolerance</td>
</tr>
<tr>
<td><strong>Accepting:</strong></td>
<td><strong>Reflecting:</strong></td>
</tr>
<tr>
<td>• Reinforcing dominant narratives of trans identity</td>
<td>• Acknowledging one’s own position of power and privilege</td>
</tr>
<tr>
<td>• Fitting trans people into the gender binary</td>
<td>• Identifying the systemic conditions that make trans people need to fit into the gender binary</td>
</tr>
<tr>
<td>• Empathically viewing trans people one-dimensionally as victims</td>
<td>• Considering and validating the right of trans people to feel powerful, in control, and enraged</td>
</tr>
<tr>
<td><strong>Managing:</strong></td>
<td><strong>Confronting:</strong></td>
</tr>
<tr>
<td>• Focusing solely on coping within oppressive contexts</td>
<td>• Eliminating the pervasive assumption of cisgender identity in systems and institutions</td>
</tr>
<tr>
<td>• Insisting on obtaining access to services via individual pathology and encouraging trans people to avoid conflict and confrontation within service systems</td>
<td>• Reversing the erasure of trans people’s existence and experience in systems and institutions</td>
</tr>
<tr>
<td>• Emphasizing the good intentions of others</td>
<td>• Addressing the impact of individual and institutional oppressive behaviors rather than intentions</td>
</tr>
<tr>
<td>• Answering hardship solely with coping (“It gets better”)</td>
<td>• Working to dismantle the socially constructed gender binary</td>
</tr>
</tbody>
</table>
Addressing the Gender Binary in Social Work Education

Cisgenderism cannot be disrupted and equity cannot be achieved for trans people and communities without dismantling the gender binary. Yet, social work education continues to reinforce the gender binary in explicit and implicit ways (Austin, Craig, & McInroy, 2016; Shelton & Dodd, 2019). Social work educators can engage in curricular expansion to ensure they are adequately addressing the gender binary. For instance, rather than reinforcing false parameters of an imagined trans community, furthering the notion that social work students can come to know a trans Other, teach students that it is an ethical obligation for social workers to dismantle the gender binary (Burdge, 2007). Social work educators can provide students with the critical thinking skills to do this work by including the following in their lessons: theoretical approaches that view gender as a fluid social construct; the historical and sociopolitical context of gender based pathologization; and examples of social problems for which macro level and policy interventions have been implemented. For instance,

...in other areas where children are routinely bullied, for example racial or ethnic discrimination and physical or mental disabilities, the focus of intervention has been policy directed toward changing the social conditions that maintain abuse, not changing children to better fit in to oppressive circumstances. (Lev, 2005, p. 49)

Burdge (2007) offers another example, drawing a parallel between the role of the individual vs. the role of society in relation to gender identity and poverty. She states:

Ending gender oppression to help transgender people is analogous to finding structural solutions to eliminate poverty, rather than trying to help poor people cope with their unfortunate plight in a hostile environment. We cannot end gender oppression by ignoring the inherent oppressiveness of the hierarchical gender binary. (p. 247)

Exposing social work students to contemporary innovative strategies for addressing the root causes of social problems can expand their ideas of practice from symptom management to
include structural change (George & Marlowe, 2005). For instance, Ali and Sichel (2014) call for training in counseling psychology to forge alliances with activists who seek to radically expose the dramatic influence of the pharmaceutical industry in the proliferation of biologically based treatment models, and partnering with groups that have successfully found alternatives to mainstream psychiatric care for conditions across the spectrum of psychological suffering. (p. 907)

Similarly, social work education can partner with trans community members and grassroots organizations that are finding innovative ways to resist the state interference in and governance of their lived experiences of gender. Learning directly from those who are engaged in the work of dismantling the gender binary, whether they were educated as social workers or not, would move structural competency from an abstract classroom discussion topic to a concrete strategy for addressing social inequity.

Social work education and training needs to remind itself of the core professional values of social justice, equity and commitment to marginalized groups in society that guide our professional practice. These values lend legitimacy and context for structural social work practice. “Such exposures to radical experiences would also help dispute the notion of structural social work as an idealistic theory” (George & Marlowe, 2005, p. 21).

Conclusion

Guided by the Code of Ethics, social workers have a professional responsibility to “pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups” (NASW, 2008, p. 3). Effectively addressing the pervasive oppression and marginalization of trans people and communities requires social workers to broaden their lenses of analysis beyond the individual to include the societal structures that create and maintain their marginalization. It is incumbent upon social work educators, then, to equip their students with the tools to recognize and disrupt oppressive systems. Intentionally establishing social work classrooms as brave spaces can
facilitate an exploration of cisgender privilege and the development of analytic skills and critical consciousness required of social workers to address the inequities faced by trans people and communities.

As the primary educative tool for teaching students to understand diversity and difference (CSWE, 2015), cultural competence alone does not adequately prepare students to engage in social change efforts with trans communities. Rather, the know, accept, and manage approach of cultural competence perpetuates the false neutrality of the social worker and renders trans people as Other. Similarly, the pedagogical approach of establishing social work classrooms as “safe spaces” undermines the ability for students to acknowledge, reflect on, and be held accountable for their own role in upholding oppressive systems.

Structural competence offers a framework for moving past the know, accept, and manage approach to a strategy of recognize, reflect, and confront. This approach enables students to locate an additional site of intervention—one that resides not within the trans individual but within the rigid boundaries of the binary gender system that is embedded within societal institutions. Moving beyond competencies that were developed by and thus maintain the privileged position of cisgender individuals and institutions, social work students are better equipped to challenge the status quo by connecting individual struggle to structural causes.
References


Constructing the Structurally Competent Classroom

Leah A. Jacobs  
School of Social Work, University of Pittsburgh  

Hanna Mark  
School of Social Welfare, University of California, Los Angeles

Social work seeks to address social problems through interventions that span micro and macro systems. As such, all social workers are obligated to understand the interplay between individual realities and structural forces. Yet prior models of structural social work play a marginal role in social work education, leaving social work educators without the means to meet these obligations. This structural gap in social work classrooms risks deemphasizing macro practice and failing to prepare micro practitioners to account for structural forces that impact client wellbeing and client-social worker interactions. This paper examines the framework of structural competence as a potential solution to this challenge. It focuses on the use of structural competence as a pedagogical tool, describing its integration into a social welfare policy course and an evaluation of this effort. We find that structural competence can provide a unifying framework through which structural social work may be articulated and anchored. Though it helped students conceptualize the interaction between micro realities and macro forces, it requires further operationalization to provide a clear vision as to what structurally competent social work practice looks like in action.

Keywords: Structural competence, cultural competence, social work education, structural social work, social policy
Introduction

On a sunny Wednesday morning we stood as instructors before a class of 48 undergraduate social work students and asked, “Who has learned about ‘empowerment’? ‘Resilience’? How about ‘psychiatric diagnoses’ or ‘cultural competence’?” A majority of students raised their hands. We continued. “Okay, and who has learned about ‘institutional racism’? ‘Neoliberalism’? ‘Coded language’? The ‘structural forces’ that influence health and wellbeing?” Few hands went up. The majority, instead, perplexedly stared forward.

Social work espouses a central person-in-environment framework, yet the students before us were much more familiar with the person than the environment. Their lack of knowledge was not an anomaly. Surveys indicate social work students have little exposure to macro concepts, interventions, and field experiences (Miller, Tice, & Hall, 2008). Lack of exposure to macro concepts and practice opportunities across curriculum is a crude but clear indicator of a structural gap in social work education.

In our view, this structural gap limits the success of a profession charged with enhancing the welfare of individuals and groups by insufficiently attending to the socio-structural forces that shape client outcomes and practice. Social workers profess a commitment to addressing poverty and social exclusion across micro- and macro-levels of practice (British Association of Social Workers, 2012; National Association of Social Workers, 2008). They also profess a desire to produce knowledge that deepens understanding of and provides solutions to marginalization (Brekke, 2012). Yet social workers struggle to turn these intentions into reality. For example, many social workers fail to integrate political action and social work practice (Rome & Hoechstetter, 2010). Filling social work’s structural gap and addressing related sequelae requires, at a minimum, a unified framework and vision for teaching students about the socio-structural forces that impact the individuals and communities with whom they will work, the role of structural forces in shaping their interactions with clients, and the interventions they deliver. Structural competence is one such framework.

Initially conceptualized by medical anthropologists Jonathan Metzl and Helena Hansen (2014), structural competence is a
framework for understanding the ways in which social, cultural, and economic forces influence health behaviors and outcomes, provider-patient interactions, and healthcare delivery. Though a structural approach to social work is hardly new, a point to which we return below, it has remained marginal and has been hindered by an impractical reputation. Further, its application to the social work classroom, to our knowledge, has gone unexamined. Emphasizing competence and lending itself directly to professional training, structural competence holds promise for social work.

In this paper, we aim to reinvigorate conversation about structural social work, while also making structural social work tangible. In doing so, we describe our adaptation and application of the structural competence framework to an undergraduate social welfare policy course. Based on our evaluation of this course, we highlight the strengths and challenges to integrating this framework into the social work classroom. Before further discussing the framework and our adaptation, we first situate structural competence within literature on structural social work and competency-based frameworks.

**Structural Social Work: Legacy and Limitations**

Structural social work is not new. Assessing structural influences on wellbeing has a legacy spanning social work’s earliest days (see, e.g., Addams, 1910; Lee, 1937). Later, the term “structure” was popularized by 1970’s radical and Marxist social work scholars (see, e.g., Brake & Bailey, 1980; Galper, 1975; Moreau, 1979). In writing about structure, scholars such as Bailey, Blake, and Galper highlighted income inequality, social control-oriented social services, and the individualism inherent within the capitalist social order. Subsequent scholars have expanded the meaning and scope of structural social work.

Since Marxism’s decline in scholarly popularity, several contemporary authors have provided updated conceptualizations of structure and structural social work. In *The New Structural Social Work* (2007), Mullaly drew on feminist, anti-racist, and postmodern approaches to define structure as “the means by which oppression is institutionalized in society [and]...the ways that social institutions, laws, policies, and social processes and practices all work together primarily in favor of the dominant group at the expense of the subordinate group” (2007, p. 262).
In *Structural Approach to Direct Practice in Social Work: A Social Constructionist Perspective* (2006), Wood and Tully used a social constructionist lens and defined structure as “a set of narratives and their related sociocultural and local interactions” that persist over time, becoming institutionalized and normalized (2006, p. 25). In contrast to their predecessors, these 21st century definitions of structure suggest that structure is not limited to the terrain of political economy, nor that the target of structural social work is dismantling the capitalist order. Instead, contemporary structural social work involves intervening across material and symbolic dimensions of economic and social inequality—from increasing access to benefits to race-making.

What does this notion of structure mean for social work practice? Both Wood and Tully (2006) and Mullaly (2007) suggest that structural social work offers goals and techniques applicable to a variety of micro- and macro-level practice settings. Wood and Tully identified four primary tasks in structural social work: structural social work should help people connect with resources, change social structures that limit capacity or cause suffering, help people navigate problematic situations, and help people deconstruct sociopolitical discourse to reveal connections to daily struggles. Mullaly identified two goals for structural social work—immediate relief from oppressive social structures and longer-term structural change.

Though these scholars have developed foundational strategies for structural social work (i.e., “tasks”) and overarching aims (i.e., “goals”), their work remains marginal and infrequently used by social work educators. One potential challenge to the integration of contemporary structural approaches is the perception that they are impractical, an impressions that has lingered since structural social work’s Marxist days. Another potential reason for their marginal role may be the lack of demonstrated application to social work pedagogy and curriculum. Despite pleas for educational reform in this area (e.g., Miller et al., 2008), we know of no models for how structural social work can be integrated into curriculum or taught. As we discuss further below, structural competence may be a useful model for overcoming these challenges to structural social work, with its integration of theory and practice, and its focus on educating “competent” practitioners.
Teaching Competency: Concepts and Controversies

The integration of competence into structural social work, at least in name, could be key to increasing the perceived (and, with any luck, actual) practicality of structural social work. The essence of competence is “observed performance in role” (Clark, 1995, p. 565). To ensure social work students are adequately capacitated to implement social work interventions in the real world, the field has increasingly turned to competency-based models for guiding social work education. Though competence-based education in social work can be traced from the profession’s early formation, competence is now inextricably tied to social work’s scope. Competence is highly emphasized by the Council on Social Work Education (CSWE), which has refocused its accreditation standards under a “competency-based education framework” (CSWE, 2008).

Few would argue with the value of ensuring social work students are adequately trained to practice in accordance with the field’s principles and standards. However, scholars have debated the degree to which competency-based frameworks achieve this aim. Concerns regarding competency suggest it promotes a narrow conception of social work which fails to prepare social workers for the moral and ethical specificities of practice (Higgins, 2015). Some have accused competency-based models of being formulaic, representing an inflexible “toolkit mentality” of social work training (Abrams & Moio, 2009; Higgins, 2015). Others suggest that competence is conceptually muddled, lacking empirical bases, and in need of valid and reliable measures of attainment (Clark, 1995).

Despite these critiques, the need to maintain standards in social work practice propels competence forward as an organizing principle for the profession (e.g., CSWE, 2015). CSWE has attempted to circumvent some of the aforementioned concerns by enveloping knowledge and values into its definition of competency (CSWE, 2008). Other critiques have been assuaged in the United Kingdom by adapting a capabilities framework (Higgins, 2015), wherein skill acquisition is treated as an ongoing developmental process instead of a goal with a concrete end.
In relation to structural social work, competence may have utility despite its limitations. The practicality of competence gives it the potential to add an important dose of pragmatism to structural social work. With the abovementioned critiques in mind and careful attention to avoiding recognized pitfalls, a competence-based approach might bring together the tasks and goals articulated by previous structural social work scholars into a set of tangible, teachable practices. We apply structural competence, as delineated below, to structural social work in this effort.

Structural Competence

Structural competence, according to Jonathan Metzl and Helena Hansen, is the:

trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases...also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health. (2014, p. 4)

Here, “structure” is an inclusive term, applicable to physical structures (e.g., transportation, infrastructure, buildings, the organization of neighborhoods, sanitation), frameworks (e.g., diagnostic classifications, bureaucracies), and the associations and assumptions embedded within language and attitudes (e.g., stigma, racism). The approach is intended to help medical providers answer complex questions, like: What are the factors that shape stigma and health outcomes? How do these factors influence the health problems of patients seeking care? And, how do these factors influence patient provider interactions? Metzl and Hansen purport that structural competence is enacted via five competencies. The first is to “recognize the structures that shape clinical interactions” (2014, p. 6). When doctors draw on research that identifies structural influences on healthcare delivery and health behaviors, Metzl and Hansen argue, they can better identify the factors that constrain their work. The second competency seeks to develop “an extraclinical language of structure” (2014, p. 7). This competency
urges doctors to develop the ability to discuss the structural forces that impact health outside of clinical interactions and in communities. The third competency is “rearticulating ‘cultural’ presentations in structural terms” (2014, p. 9). Here doctors are encouraged to understand that what is classified as “cultural” is often actually the manifestation of ethno-racial disparities rooted in structural inequality. Shifting aims from understanding toward action, the fourth competency is “observing and imagining structural interventions” (2014, p. 10). The fifth competency is “developing structural humility,” or the ability of doctors to recognize the limitations of their training and ability to truly understand the experiences of patients who may face structural barriers to health.

Structural competence has three essential characteristics. First, structural competence is fundamentally transdisciplinary in its theoretical and empirical foundations. In order to understand the ways in which a multitude of structures shape client outcomes and practitioner-client interactions, practitioners must draw from varied bodies of literature.

Secondly, structural competence forefronts inequality. In its effort to do so, structural competence aims to expand, not replace, cultural competence by examining how “race, class, gender, and ethnicity are shaped both by the interaction of two persons in a room, and by the larger structural contexts in which their interactions take place” (Metzl & Hansen, 2014, p. 3). Structural competence does not devalue attempts to understand differential health outcomes or healthcare utilization. It instead encourages practitioners to consider how disparities or health behaviors conceptualized as cultural in nature may be rooted in the interaction between culture and structured inequality that privileges the health of some groups over others.

Finally, structural competence takes a broad view of training. Structural competence is not intended to be a checklist of skills. It is meant to be a framework that better equips healthcare professionals to identify and organize structures and how they relate to social problems, oppression, and injustice.

Structural competence aligns well with social work in its approach and aims. Social work is interdisciplinary, inequality-focused, and oriented toward a broad conceptualization of competence. Structural competence also aligns with social work in their mutual recognition of cultural competence, though with
structural competence the focus is expanded to address how even the very definitions of culture and cultural groups are shaped by structures. By drawing attention to the structural factors that perpetuate social injustice and that generate social problems, structural competence could help social workers link knowledge to action, assuaging concerns regarding the impracticality of structural models of social work. In sum, structural competence is an approach with the potential to refocus social worker education on the material and symbolic forces that impact clients and practice, maintaining a practical focus while avoiding the pitfalls of mechanistic competency-based models. The remainder of this paper focuses on our adaptation of this approach, illustrating it through our operationalization of structural competence in a policy course.

Methods

We adapted the structural competence model proposed by Metzl and Hansen to social work and utilized it as a guiding framework for an undergraduate social welfare policy course. The course was taught at a large, public university situated in a large, West Coast city. Each class period within the eight-week course, which met twice a week, consisted of two hours of an all-class lecture, and a third hour for smaller discussion sections. To understand the process of adapting structural competence and the influence of the framework on instruction and learning, we evaluated our adaptation. Specifically, our evaluation sought to answer two questions: (1) How can structural competence be adapted for use in a social welfare policy course? And, (2) how does the structural competence framework shape student learning and instruction?

In order to answer these questions, we employed Taylor’s (1993) strategy for evaluating social work education. Taylor’s strategy promotes illuminative, qualitative, and utilization-focused evaluations. Illuminative evaluations seek to monitor and describe the process of course implementation and contribute to its ongoing development, qualitative evaluations center student and instructor perspectives, and utilization-focused evaluations prioritize the practical utility of the evaluation for research consumers. Our two evaluation questions are illuminative in that we document and link the process of adapting
and implementing the structural competence framework to teaching and learning. The evaluation is also fundamentally qualitative in that, while some quantitative indicators are used, findings and conclusions center around participant and instructor perspectives and are generated through a qualitative review of several outcomes. Finally, by providing sufficient detail on the adaptation of the model, as well as the strengths and weaknesses of the approach taken, the evaluation is focused on informing educational practices among social work educators, and thus is utilization-focused in nature.

Table 1. Evaluation Questions, Data Sources, and Analytic Approach

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Data Source</th>
<th>Analytic Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How can structural competence be adapted to a social welfare policy course?</td>
<td>Adaptation table</td>
<td>Document review</td>
</tr>
<tr>
<td></td>
<td>Syllabus</td>
<td>Document review</td>
</tr>
<tr>
<td></td>
<td>Lesson plans</td>
<td>Document review</td>
</tr>
<tr>
<td>2. How does the structural competence framework shape student learning and instruction?</td>
<td>Student course satisfaction</td>
<td>Quantitative description and comparison (two-sample t-test)</td>
</tr>
<tr>
<td></td>
<td>(pre-SC and SC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student grades</td>
<td>Quantitative description and comparison</td>
</tr>
<tr>
<td></td>
<td>(pre-SC and SC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Structural competence portfolios</td>
<td>Deductive thematic analysis</td>
</tr>
<tr>
<td></td>
<td>Instructor reflections</td>
<td>Inductive thematic analysis</td>
</tr>
</tbody>
</table>

Several data sources and analytic approaches were employed (see Table 1). To answer question one, we conducted a review of instructor preparation materials and course materials. These materials included an Adaptation Table used to document our reconceptualization of structural competencies for social work, and to align readings, activities, and assignments with each competency. Materials also included the course syllabus and lesson plans, which were used to anchor our description of the adaptation in the intended and actualized course content.

For question two, we used three data sources to assess student learning. First, we assessed differences in satisfaction captured in formal course evaluation scores on Likert scale questions from a first iteration of the course when a structural competency framework was not implemented (to be called the “pre-SC course”) and the second iteration of the course when a structural competency framework was implemented (to be called the “SC course”). Secondly, we assessed impact on student
learning by comparing median class grades from the first and second iterations of the course. Thirdly, to assess impact on student learning, we qualitatively analyzed content from students’ Structural Competency Portfolios, the final course project. To analyze these portfolios, we deductively coded for knowledge or skill acquisition articulated within any of the five structural competencies. Finally, to assess influence on teaching, we inductively analyzed instructor reflections for themes related to strengths and weaknesses of the approach.

Findings

Adapting Structural Competence

Before describing the ways the structural competence framework shaped instruction and student learning, we operationalize our adaptation. Adapting structural competence for a social welfare policy course involved two primary processes. First, we conceptualized concepts such as “structural forces” and “structural competence” for the purpose of social work practice. Secondly, we translated this reconceptualization into a policy curriculum.

Defining Structural Forces and Structural Competency. In order to implement structural competence in a social welfare policy course we began by defining structural forces for social work practice. We defined structural forces as the broad social, economic, cultural, health, and environmental conditions and policies that exist at the global, national, state, and local levels. We classified structural forces into four clusters: the physical aspects of a society (e.g., transportation infrastructure, waste management, and buildings); the systems and institutions used to organize a society (e.g., political, economic, and school systems and institutions); the frameworks employed by a society (e.g., dominant analytic approaches and guidelines); and the language and beliefs that give meaning to a society (e.g., labels, coded language, and political values). It was emphasized that all structures can simultaneously intersect and influence one another to produce social outcomes. Given the focus of the course, we specified that policies themselves, in addition to the values, frameworks, languages and analytic approaches used to interpret and evaluate them, are examples of structural forces.
We defined *structural competency* as knowing how structural forces influence the behaviors, attitudes, and wellbeing of clients, understanding how these forces and their impacts come to be defined, and obtaining the skills necessary to influence structural forces. While structural competency within medicine primarily focuses on improving micro interactions between doctors and patients, we expanded our focus to include the macro-, in addition to micro-level work. In other words, we underscored how social workers can apply structural competency to macro-level interventions by intervening directly on social structures in addition to underscoring how structural forces impact social worker-client interactions.

Further, we adapted Metzl and Hansen’s (2014) five main competencies as major aims of the course. The adapted competencies sought to capacitate students to: (1) identify major policies and related structural forces that impact client wellbeing; (2) recognize the practice implications of those policies and related structural forces; (3) develop ability for structural assessment, including knowing how to assess the ways in which policies and other structures produce/reduce inequalities, and/or how policies create/eliminate barriers for inclusion; (4) identify or conceptualize policy interventions that enhance wellbeing while cultivating awareness of policy interventions that address structural barriers to equity and wellbeing; and (5) develop structural humility. *Structural humility* was established as the capacity to recognize an individual practitioner’s limitations when it comes to understanding the entirety of how structural forces influence each client’s life. It also involved repudiating the notion that full mastery of complex and evolving structural forces as they interact with complex and evolving individuals and groups is ever fully plausible.

*Structure of Course.* In order to use the structural competence framework to guide study of social welfare policy, the first third of the course delineated space for orienting students to structural competence in addition to the standard orientation to social welfare policy (i.e., the processes of policy creation and evaluation, political perspectives, and elements of policy). We provided definitions for and examples of structural forces and competencies and strove to illustrate the way in which factors across levels influence wellbeing outcomes. To help students learn how policies interact with other structural forces to
produce social outcomes, we spent two classes on inequality, including the interactions between poverty, racism and other identity-related inequalities.

After establishing these bases (to which we continuously returned), the remainder of the course was devoted to policy fundamentals. Lectures covered major social insurance and social assistance programs and lectures specific to healthcare, mental health, child welfare, education, housing and homelessness, immigration, and criminal justice policies. Within each of these domains, we highlighted how policies interact with other forces to produce social outcomes. We also highlighted how these forces shape social worker-client relationships. We drew on an interdisciplinary body of empirical and theoretical literature and cultivated space for identifying the structural forces that influence the problems social welfare policies set out to address.

Assignments were designed to promote both the acquisition of policy basics and the enhancement of structural competence. In addition to a midterm and final exam, two written reading responses and a policy analysis paper were required. To help facilitate structural humility, the policy analysis paper included an autobiographical component in which students were asked to reflect on the way in which a policy had influenced their own developmental trajectory.

The final assignment was a Structural Competency Portfolio. The portfolio was submitted on the last day of the course, wherein each student was asked to present and reflect upon their structural competency gains. Though this portfolio represented ten percent of the final grade, it was a low-stakes writing assignment that emphasized processing more than the writing itself (Elbow, 1997). The assignment offered space for both instructors and students to solidify the use of structural competency as the course’s primary cohesive agent.

Structural Competence’s Influence on Student Learning and Instructor Approach

We examined the influence of the structural competence framework by assessing student learning, as measured by student performance, course evaluations, and instructor reflections on the teaching process.
Student learning. Overall, student performance reflected attainment of learning objectives. The median student final grade for the course was 92.2, a 4.5 percent increase from 87.7 percent in the pre-SC iteration. Furthermore, deductive content analysis of the final Structural Competency Portfolios for the SC-students (N = 41) found that the vast majority of students (n = 35, 86%) were successfully able to articulate an understanding of structural competence and their perceptions as to how their structural competence had increased during the course. Among the five established competencies, four were widely discussed in portfolios. Competencies one and five, specifically, were the most prominently featured. For competency one (identify major policies and related structural forces that impact client well-being), 14 students (34%) noted an increased capacity. Students reflected that learning about how policies and other structural forces intersect and impact one another improved their grasp on their notions of “interconnectedness” and “person-in-environment”; they saw these things as integral to their learning in the course. One student articulated:

I was able to consider how the conflation and confluence between factors [across] levels ultimately influence the ways in which policies are framed, designed, and implemented... Considering the interplay of structural forces in policy design can provide a more holistic approach towards understanding what the policy’s intentions, goals, objectives and consequences are. I feel as though without any consideration of structural forces we lack the substantial information necessary to fully understand policies.

Increased capacity for the fifth competency, the development of structural humility, was also endorsed by 14 students (34%). These students discussed coming to understand that “you don’t know what you don’t know,” learning to look at issues in a different way, and practicing personal evaluations of their own belief systems. One student elaborated: “This class taught me that I may have some knowledge of how I want things to go but there’s much more to be learned and it is often more complicated than what I make it out to be. Instead of approaching problems with a set solution in mind, this class has taught me to listen, to pause, and to learn how to learn from others.”
Twelve students (29%) discussed their improved ability to understand how to analyze policy and therefore how to analyze a major structural force (competency three). One focus here was on assessing the values and ideologies that drive policies. Students wrote that through their increased comprehension of the values that drive the welfare state, they were better able to analyze policies. For example, one student discussed how learning about utilitarianism enabled an improved understanding of why eligibility requirements for different policies, like Medicaid, exist the way they do. She said doing so led her to view Medicaid’s goals more positively, enabling what she felt was a more informed evaluation of the legislation’s strengths and weaknesses.

In addition, students reflected on an improved ability to understand the relationships between social problems and social policies. One wrote, “Throughout the summer I learned that stopping at just knowing that ‘food deserts cause obesity’ falls short of doing anything about these problems. I learned how to identify the policies that created these realities for people; I learned to look at what motivates policy makers to [act] the way they do.” She continued on to discuss the role ideology—a structural force—can play in policy making and why she felt it was important to be able to name and identify ideologies that contribute to policy decisions.

Eleven students (27%) indicated increased competence in competency two—improving understanding of how structural forces have implications for social work practice. Most prominently, this related to feeling better equipped to hold the myriad of structural forces that can impact a client’s life in future provider-client interactions. As one student explained:

Every lecture on the different policies was presented in a way that taught me how to identify and understand structural influences that affect...people, communities, and individuals... [As] these structural forces directly and indirectly influence how much a social worker will be able to provide the best resources and help...having this knowledge will better prepare me to go into the field.

This student specifically reflected on learning about anticipated changes and challenges to Deferred Action for Childhood Arrivals (DACA). She discussed previous time spent volunteering
to help people renew their applications, lamenting the number of lives that would be affected by a reversal, and professed a commitment to staying up to date with relevant polices and re-authorizations in her future social work practice.

Competency four, however, was less discussed. Seven students (7%) touched upon how the class helped bring awareness to the ways in which they could personally impact policy and other structural forces—some even specifically mentioning community organizing and participation in social movements—but these reflections were often wrapped up in accompanying reflections of feeling overwhelmed by the complexities and problems found in the systems presented to them throughout the course. For instance, one student reflected that her biggest class “take away” had to do with the shortcomings of policy “in almost every area we studied,” and wrote that every class left her with questions to be answered. Though she and others would end these reflections with optimistic sentiments (e.g., “if we use the tools and knowledge given to us by this class, we can be the ones to fix these failing systems”), their sentiments of hope were rarely concrete examples of how interventions could enhance wellbeing.

For the six students (5%) who were unable to successfully articulate how they had become more structurally competent through the course, the primary cause tended to lie with their difficulty articulating what structural competency actually was. One notable area of confusion was the difficulty some had with teasing out the difference between structural and cultural competence.

In addition to the quantitative and qualitative information on student learning, we examined course satisfaction via anonymous course evaluations in both the pre-SC course and the SC-course. The mean class endorsement was higher in the SC-course than in the pre-SC course for four items: “Course content meets stated objectives” ($p < .01$); “Course objectives are clear” ($p < .05$); “Papers and written assignments are instructive” ($p < .05$); and “Instructor promotes critical thinking” ($p < .05$). Seven indicators (“Course is well organized,” “Course is challenging,” “Readings are instructive,” “Information presented is up-to-date,” “Course addresses human diversity content,” “Standards for student performance are reasonable,” and the items that measured “overall course quality” and “overall
teaching effectiveness”) did not significantly differ between course iterations. Student responses suggest that the SC iteration may have provided students with a clearer understanding of the course’s goals and intent, and improved capacity to critically understand the material presented, while not detracting from any other course aspect.

Influence on instruction. Teacher reflections on the structural competence framework were predominantly positive. The framework provided an anchor, absent in the previous iteration of the course, from which each lecture could be tethered. The Structural Competence Portfolio was a particularly useful final assignment for helping students to comprehensively assess what they had gleaned from the course and to identify which areas of the course most resonated with them. By utilizing the framework, students seemed better capacitated to understand how the causes and consequences of social welfare policies fit into social work practice. They also seemed to understand how different forces intersect to impact the lives of the people and communities they may one day serve—they were able to voice understanding of how forces had intersected to impact their own communities and lives to date.

We also noted three challenges to integrating the framework. The first related to the difficulty in managing the amount of information presented to students. Each lecture, students were asked to absorb novel information about intricate systems like healthcare, child welfare, and K–12 education, which is a difficult task on its own. They then were asked to learn about the structural forces that shape the policies within these domains and how the policies within these domains are structural forces in and of themselves. Adding the dimension of structural competency to the policy content and incorporating associated trans-disciplinary literature thus provided extra layers of novelty and complexity to already challenging coursework. Further, for undergraduates, envisioning the influence of policies on social work practice required a level of experience that many students did not have. Instruction required extra patience and vigilance around clarity and concept-reinforcement throughout; it also made time management critical, but difficult.

The second challenge related to identifying how structural inequalities manifest in the classroom. Given structural competence’s attention to how social and economic forces can interact
with one another to influence interactions and produce client outcomes, teaching it requires conscientiousness regarding how said forces exist in the classroom space itself. Choosing the voices and viewpoints represented in course material, being mindful of power dynamics between students and instructors, and considering the structures that impacted student capacity to learn and meet course requirements all necessitated structural competency in their own right. In order to integrate multiple perspectives, we went beyond selecting a single textbook—instead selecting readings from a variety of sources. Though this was a more laborious approach, the identification of over 19 different readings as student “favorites” in the final Portfolio assignment suggests that the variation was helpful to not only provide an interdisciplinary understanding of policy, but also for catering to an array of preferences and viewpoints.

The third challenge related to the fourth competency—striving to identify or conceptualize policy interventions that enhance wellbeing. Retaining student optimism and promoting creativity with respect to interventions for improving complex policies and systems was an arduous task. This was, in part, due to the difficulties associated with incorporating sound examples of macro-interventions that improve structural forces for the purposes of promoting welfare. While we found discussion of social movement successes (e.g., the Civil Rights movement and the passage of the Civil Rights Act) helpful, or the benefits of structurally competent assessment (e.g., an example of how Racial Equity Impact Assessments could be used in response to school district restructuring in Minnesota; see Toney & Keleher, 2013), these examples were relatively few and far between. Ultimately, the structural competence framework, with its focus on structural forces, did not lend itself to identifying examples of individual practitioners who modeled structural competence or what their structural competence looked like in practice.

Discussion

This study sought to reinvigorate conversations regarding structural models for social work by evaluating the capacity for and impact of the structural competence framework for a social welfare policy course. Results illustrated one way of adapting structural competence for students of social work studying
social welfare policy and revealed implications for student learning and instruction. Results indicated that application of the framework to the study of social welfare policy is one way in which social work educators can equip their students to holistically understand the range of “upstream” forces that have significant “downstream” impacts on wellbeing. At the same time, results also indicated structural competence was not a silver bullet for addressing the structural gap in social work and came with several challenges.

Prior to unpacking our results and structural competence’s strengths and weaknesses, some limitations to our evaluation should be noted. To start, the pre-SC course occurred during the first year that the instructors taught the course, while the SC-course occurred during the instructors’ second time teaching the course. Thus, it is possible that there was some improvement from the pre-SC course to the SC-course (unrelated to the use of the structural competence framework) that contributed to positive differences between the two years. For example, some course assignments and course material were refined from the pre-SC course to the SC-course. The slightly smaller class size in the SC-course versus the pre-SC course also created space for instructors to provide more individual attention to each student in the SC-course iteration, which may have impacted student learning. As such, related-findings should be interpreted with caution.

As for our findings, several course adaptations seemed fundamental to embracing a structural competence approach. These adaptations included diversifying the readings, assigning the final structural competence portfolio, beginning the course with the foundational principles of structural competence, and utilizing the last class of the course to discuss and reflect on the framework. Because Metzl and Hansen’s (2014) structural competence model was originally intended for medical practitioners, it required some reconceptualization for social work. Other social work educators may benefit from looking more prominently to the writing of social work-specific scholars, such as Wood and Tully (2006) and Mullaly (2007).

When it came to structural competence’s relationship to student learning, student perceptions, and teaching, the approach seemed beneficial in several ways. It helped expose the multifaceted drivers of the social problems that social welfare
policies seek to address. Students also expressed the ability to personalize issues they previously thought irrelevant to them, understand how policies impact micro-level social work, engage in policy conversations with non-social workers, and better assess policies overall.

We also found limitations to the model. First, information management was a major hurdle to framework implementation. Instructors interested in adapting a structural competency framework to social work education may benefit from minimizing the sheer volume of information presented to students, so as to help facilitate knowledge retention. Schools of social work interested in adapting the framework would ideally strive to implement the approach across curriculum, so that the burden of learning does not fall onto one course. Second, instructors of social work wanting to adapt the framework should embrace structurally competent pedagogy. This requires keen awareness of the variety of ways in which structural inequalities manifest within syllabi and classrooms, and the ability to address how structural forces converge to shape social work and social worker-client interactions, and teaching and instructor-student interactions.

Third, students struggled to express concrete examples of what structural competence would look like in action. Students voiced improved command for four out of the five structural competencies, but had difficulty identifying interventions that enhance wellbeing. Some students lacked optimism around social welfare policy’s potential to enhance equity at all. Further, while many were able to express a general understanding that structurally competent practice involves understanding the impact of structural forces on client wellbeing, many lacked a more specific and tangible articulation of structurally competent practice. The limited degree to which students could articulate structurally competent interventions and practices suggests that structural competence in its current form may be less practical than it appeared prior to application. Future iterations of the course may benefit from reifying how structures can reduce barriers to health, equity, and wellbeing in a more systematic way by setting aside dedicated time each class to identify proposed legislation aimed at enhancing wellbeing, assigning readings that illustrate successful interventions, or identifying practitioners who successfully put structural competence into
action. Like cultural competence, identifying what structural competence looks like in practice and tying those actions to outcomes is a challenge to the framework’s utility that warrants further attention.

Conclusion

Our experience adapting structural competence to the social work classroom leads us to conclude that structural competence can provide a unifying framework through which structural social work may be articulated and anchored. Specifically, in a policy course, this approach seemed to enhance student understanding of how policies fit within and interact with other structural forces to affect clients and social work practice. We also found that while structural competence facilitates understanding how structural forces influence social outcomes, it lacks a clear articulation of structural practice. Structural competence requires further development to translate knowledge into tangible skills for enhancing equity or, in other words, to make social workers competent in structural practice.

References


Addams, J. (1910). Charity and social justice: The President’s address. Paper presented at the National Conference on Charities and Correction, St. Louis, MO.


Book Reviews


Dayna Bowen Matthew focuses on remedies to U.S. health disparities with an attorney’s eye for justice deferred. She shows her impatience with a status quo that remains deadly for U.S. racial/ethnic minority groups and draws a line from laws in the Colonial and Industrial Eras to current health disparities. Matthew uses law as her platform to argue for quality of care in a way few writers outside the medical field can. The studies she cites measure quality of care in terms of time with providers, referrals for tests and specialists, and use of best practice interventions. She does not satisfy herself with describing the problem but suggests remedies for the implicit bias and structural exclusions that support differing quality of care for different U.S. racial/ethnic groups. This book takes on the enormous task of addressing both access to and quality of health care, and of providing remedies to the medical and social determinants of health disparities.

Matthew begins by describing Colonial Era laws that restricted access to the social determinants of health, including home, food, employment and education. These laws included Land Grants and Slave Codes that supported commerce through the separation of people from their homes, and that viewed enslaved people as individually expendable and replaceable. In the following era of Industrialization, case law and legislation segregated the spaces where groups of people could live, eat, work and learn. As health care improved in the early 1900s, courts and legislatures also segregated the spaces where people could access care. The Civil Rights Era was ushered in by case law that reinterpreted the constitution’s “equal protection.” The legislature enacted Title VI of the 1964 Civil Rights Act to
explicitly prohibit federal exclusions for “race, color or national origin.” Exclusions persisted as change in national attitude was only incrementally ahead of change to the law, and access was hard-won in conflict with local authorities.

In the current era, decades of Civil Rights enforcement have nearly eradicated explicit exclusions. Matthew suggests the dance between attitude and law has likewise eradicated vestiges of malice among professionals. Yet she cites persistent evidence that the U.S. groups experiencing poorer health care today are the same groups restricted from social determinants of health in earlier centuries. The Affordable Care Act expanded access to care, but care remains inequitable. Current courts narrowly interpret Title VI as applicable only to intentional exclusions. Matthew cites laws outside health care that hold individuals and corporations responsible for creating unintentional harm, suggesting health care systems should bear similar responsibility. Although explicit bias is nearly eradicated, disparate rates of morbidity and mortality persist when controlling for health care insurance and other socioeconomic factors. Narrow interpretations of Title VI continue breeding centuries-old disparities, and difficult-to-detect implicit bias remains a health risk for U.S. racial/ethnic minority groups.

Matthew then provides evidence of implicit bias that is nearly invisible to the casual observer, collected from the Implicit Association Test and other measures. If it seems incredible that nearly-invisible mechanisms could have such a negative health effect, recall that the Industrial Era found it incredible that a nearly-invisible mechanism named bacteria could create personal and community disease. When a critical mass of people understood the nearly-invisible problem, medical, social and legal interventions reduced population rates of morbidity and mortality in a generation. Matthew further helps us understand the nearly-invisible with a Biased Care Model of six interacting mechanisms through which implicit bias leads to disparity. Health care providers may be particularly susceptible to implicit bias, because recommendations in any patient encounter are informed by a complex cognitive load. They sort through their knowledge of signs and symptoms, knowledge of etiology and epidemiology, and knowledge of the availability and cost of tests and treatment. This hard-earned knowledge can be unwittingly sullied by the negative images of minority groups that
are commonly broadcast by popular culture. Matthew’s model illuminates complex, overlapping pathways from implicit bias to inequitable care.

Matthew follows her presentation of disparity’s causes with medical, social and legal interventions designed to reduce disparate rates of morbidity and mortality, and improve overall population health, in the next generation. She uses Thomas Frieden’s Health Impact Pyramid as a guide to interventions, addressing the Pyramid’s top three tiers: Counseling and education, clinical interventions, and long-lasting protective interventions. The cultural competence in-services many organizations employ have shown little effect, but there are three evidence-based types of intervention that effect change. Stereotype Negation Training, the most effective of the three types, helps intentional professionals replace unconscious negative associations, through prolonged exposure to positive images. Promoting Counter-Stereotypes helps professionals develop heterogeneous impressions of groups through repeated exposures to admired minority individuals and disreputable white individuals. Social and Self-Motivation interventions tap into professionals’ desire for a positive social and self-image, to promote equitable decisions and conduct. All of these, however, presume intentionality and altruism from health care systems. None of them address the lack of structural support for equitable practices.

Matthew recalls theologian Reinhold Niebuhr’s “serenity prayer,” a prayer for wisdom and courage to act when things can be changed. With that wisdom and courage, she moves to the Health Impact Pyramid’s fourth tier: The social context of health decisions. She suggests it is again time to summon the courage for broader structural solutions. While Matthew endorses interventions for implicit bias, she calls on health corporations to provide incentives for providers to supply equitable services and care. She calls on courts to apply Title VI regardless of intent when clear evidence exists of disparate services. She calls on legislatures to draft laws that hold health care systems to account for disparate provision of care.

Matthew cautions that her suggestions make well-intended professionals nervous and suspicious, but history shows that change to the status quo always has detractors. Medical, social and legal interventions were imposed amid doubt in the early 1900s, but the effect was so great that “the doctor” became a
trusted advisor to many families, particularly white families. Medical, social and legal interventions were imposed amid conflict and violence during the Civil Rights Era, and the Affordable Care Act was enacted amid conflict in 2010, but substantive justice is not yet served. It is the current era’s task to insist health care earn the trust of racial/ethnic minority families, as it did for white family in the last century. Matthew relies on legal history to call courts and legislatures toward a substantive justice in health care. She relies on courage in a critical mass of people to eradicate status quo health penalties for black and brown patients in the United States.

Karen Flint Stipp and Trista Smith
Illinois State University


What has gone wrong with global politics? Massive inequalities, globalization, social media manipulation, and other factors have delivered us the likes of Donald Trump, Brexit, Victor Orban in Hungary, and Jair Bolsonaro in Brazil. Although we cannot know whether the rise of authoritarian populism across the world will continue, the most important question to ask is why is this happening, and what should we do to restore a democratic future? In his new book, renowned economist Paul Collier suggests that the center-left social democratic parties that created the postwar global order have lost their way. They failed to respond to the new economic, social, and cultural challenges posed by the most recent wave of globalization, and the upshot has been a political backlash against party elites, experts, free trade, migrants, and racial and ethnic minorities.

Collier contends that prevailing ideologies today on the left and right are fundamentally flawed. The conservative belief in minimal state intervention, premised upon the autonomous individual, ignores both the social and moral bonds of human life and the practical benefits of government intervention for the economy and social welfare. It also mischaracterizes what motivates people—not greed as such, but self-respect and being
part of something larger than oneself. As for the left, in Collier’s view, today’s liberals are overly enamored with utilitarian and Rawlsian ethics. The former, deriving from Jeremy Bentham and John Stuart Mill, posits that an action is justified according to whether it benefits the “greatest good for the greatest number.” Classical and neoclassical economics are based on utilitarian assumptions. John Rawls’ modernized social contract theory proposes an ethics derived from the choices we would likely make from within what he called a “veil of ignorance.” According to this thought experiment, these are the choices one would make if one’s social position is unknown, but according to the numbers, is not likely to be among the elites. Within such limits, Rawls believes that most of us would advocate for the moral priority of the poor and marginalized for public policy formation.

The problem, Collier argues, is that neither utilitarianism nor Rawlsian ethics comports with ordinary moral intuitions. For example, most people want to be compassionate to the less fortunate but care more about those near and dear to them. It is difficult to avoid us/them thinking based on ideology, race, ethnicity, nationality, religion and so on. Fundamental perceptions of fairness often lead to suspicion that those deemed as other are not playing by the rules. Thus, identity politics on the left simply reinforce many voters’ view that liberals and social democrats care mainly about marginalized minority groups, including immigrants, and not about them. Whether this perception is accurate is less important than the fact it is widely held.

In Collier’s view, free trade and mass migration in recent decades may have enhanced the general welfare in purely utilitarian or economic terms, but they have also generated both greater inequality and a populist backlash among those threatened by cultural change and economic insecurity. Milton Friedman’s writings and the Reagan-Thatcher 1980s ushered in our unfortunate era of shareholder capitalism, in which the pursuit of short-term profits and the highest share price is the primary corporate objective. This shift away from an earlier broader stakeholder model of corporate governance absolved CEOs and boards of directors from any perceived sense of responsibility to their workers and local communities. The economic and social decline of rural communities, non-metropolitan cities, and workers without college degrees has resulted from the relentless, global search for profitable opportunities. Meanwhile,
agglomeration economics, globalization, and cultural amenities have led to thriving large cities and a growing chasm between them and the struggling hinterlands of rural towns and small cities. Collier believes that compensation for highly-skilled workers in wealthy cities is excessive, reflecting unearned economic benefits from location effects.

In this book, Collier also intriguingly examines the state of the 21st century family. Here Collier finds another dangerous divide, in this case between the life chances of the children of the affluent and those of the working class and poor. It is not just finances. The intensive, cultivation-style parenting of the educated classes, with violin lessons, tutors for college entrance tests, foreign travel and other affluent life opportunities contrasts sharply with the far more limited cognitive, social, and educational opportunities offered by less-educated, often single-parent families. In today’s uber-meritocratic world, children of the lower sectors can hardly compete with their affluent, far better-prepared peers. Assortative mating within the highly skilled classes reinforces these racial, regional, and socioeconomic inequalities, relegating the losers and their children to low-paid menial jobs or worse.

In response to this dismal picture, Collier advocates a return to communitarian values that were, he believes, the moral foundation of the postwar international order. The liberal and social democratic parties that established welfare states and fostered global economic growth gained wide popularity with effective government activism based on moral reciprocity and enlightened self-interest. He proposes changing corporate laws to curb shareholder capitalism, imposing higher but non-confiscatory taxes on the rich and high-skilled, affluent residents of wealthy metropolitan areas, and transferring the funds to innovative rural economic development programs. He also advocates the creation or expansion of community child development centers to work directly with low-income, single-parent, and distressed families.

In his view, the upsurge in immigration and racial and ethnic diversity in recent decades has undermined the social solidarity underpinning welfare states, contributing to the rise of nationalistic populism. As a development economist, Collier believes that the negative effects of the brain drain for poor nations are substantial and that the destination countries should reestablish reasonable limits on annual levels of immigrants,
refugees, and asylum-seekers. Collier explicitly recognizes a "duty of rescue" but argues that most refugees should be cared for in locations closer to their home countries.

On the international side, Collier believes that the multilateral organizations that guided the postwar liberal order have enlarged to the point of near-dysfunction or have fallen into mission-creep. In his view, the keys to development in the poorest nations are good governance, technical assistance, and foreign investment, and he argues that UN/IMF/World Bank assistance conditioned on unrealistic human rights and environmental standards is counterproductive. On the model of GAVI's work on immunization and the Global Fund on AIDS, he proposes the creation of smaller, more nimble organizations to address development challenges in a less quasi-imperialist manner. This reminded me of a TED talk at the State Department a decade ago in which Collier argued that groups like Bricklayers Without Borders should be formed to assist the reconstruction of post-conflict nations.

Collier's primary theme is the need to reduce reliance on bloated governmental or multilateral bureaucracies and instead strengthen and improve key mediating institutions like the family, the corporation, and nongovernmental organizations. This involves not simply changing laws and public policies, but reestablishing communitarian norms based on reciprocal obligation. He is crankily skeptical of do-gooders on the left, dismissive of free market ideologues on the right, and contemptuous of populists of both left and right. His snarky condescension toward those who see things differently from himself is off-putting, yet I do believe his reform program is worthy of attention.

There are multiple blind spots, however. Although Collier praises the achievements of postwar welfare states, he seems to take for granted that they will survive the current right-wing assault. We don't benefit from any specific ideas on the future of social insurance and public assistance programs, yet their design is crucial for addressing poverty and economic insecurity in all nations. His argument that rich nations must strictly control immigration to preserve social solidarity suggests that over time the forces of xenophobia and racism must be accommodated, not challenged. In addition, the manifold causes of the upsurge of migration in recent years, such as economic collapse, gang wars and armed conflicts, rising ethno-nationalism, and climate change, receive little sustained attention.
*The Future of Capitalism* is a highly informative and intellectually stimulating book. Its unique blend of economics and ethics, creative ideas for policy reform, and political advocacy from “the radical center” make this work highly recommended for students, teachers, and concerned citizens of our troubled world.

*Edward U. Murphy*
*Northeastern University*


This book addresses a missing piece in the social work literature. Although social justice is one of the core ethical values of the social work profession, few works have addressed how to integrate social justice into social work research, education, advocacy and practice. Part I of the book discusses historical and cultural conceptions of social justice, while Part II turns to an examination of social justice within the social work profession, including the historical evolution of social justice and social work, as well as social justice in social work practice with individuals, families, groups, organizations and communities, policy advocacy, research, and program evaluation. In this discussion, the authors not only address how social workers can achieve socially just ends in their practice, but they also emphasize the importance of maintaining socially just goals and processes to achieve such ends. Further, the book identifies a gap in the social work literature by addressing ethical challenges that may be faced when incorporating social justice into social work practice.

Reisch and Gavin have a great deal of experience and knowledge in integrating social justice into the social work profession. They recommend that this book may be particularly beneficial for social work educators preparing courses on social work practice, social policy, social work theory or philosophy, and courses that examine human behavior, multiculturalism or diversity. Because the book has such a wide scope, specific classes may benefit more from some sections of the book than others. Rather than a deep dive into how to incorporate social
justice in any particular area of social work practice, Reisch and Gavin aim to provide a respectably thorough overview of how to incorporate social justice into each type of social work practice. In this, they do provide an excellent introduction for those new to field.

In terms of the authors’ underlying assumptions for social justice, they posit that social justice is never maintained indefinitely and that constant analysis of equality, justice and power is required to maintain socially just circumstances. They do a great job of emphasizing that incorporating social justice into social work is a complicated process that requires careful consideration at every stage and in each type of social work practice. Although the underlying assumption that social justice is never permanently achieved may seem overwhelming to those seeking answers for how to incorporate social justice into their work, they provide practical and clear examples and models for social workers to integrate socially just processes into their practice. Occasional case examples are also insightful, but they were not consistently featured, and some sections may have benefited from including case examples more consistently.

Social Work and Social Justice is an important touchpoint to initiate conversations on how to integrate such an extensive topic as social justice into social workers’ everyday work. Although social justice is one part of the ethical foundation of the social work profession, few works have provided a thorough examination of how social workers may integrate this value into their practice. While future literature on the subject may seek to provide a deeper exploration of how to incorporate social justice into specific types of social work practice, this text provides an excellent contribution to the social work literature.

Jennifer K. Allen
Michigan State University

In this book, Popple pulls together a history of the U.S. welfare state and its associated profession, social work, with impressive depth and detail. The author is particularly keen to point out that while the histories and trajectories of each are cojoined, they are not necessarily one and the same. The impulses, currents, and even tensions that shape each, however, have commingled into a story that many have deemed “exceptional.” The outline follows a structure familiar to overviews of this type, including previous works by Popple himself, as well as by Michael Katz, Walter Trattner and others. It includes chapter-length presentations on the Pre-Colonial origins and the English Poor Laws, the Progressive Era, developments leading to and during the Great Depression, the New Deal, the Second World War period, and the War on Poverty. Popple is innovative in the presentation of parallel chapters to each period that address historical developments in the theory, practice and organizational infrastructure of the profession. Additionally, being the first new social work history written in over twenty years, it includes a pair of chapters devoted to the post-1974 period: “Ending Welfare as We Know It” and “Social Work in the Conservative 21st Century Welfare State.”

The most important contribution made in this work, as Popple describes it, is to survey social welfare history, addressing the needs and reviving the vision segment of the social work profession. In specific, Popple couples traditional coverage of periods within the development of the U.S. welfare state with attention to “the lives, work, and perspectives of the practitioners charged with actually implementing the plans of elites and negotiating with the intended beneficiaries of these plans” (p. 5). This work indeed provides a rich portrayal of the policy, theory, and practice of social welfare in America.

The book has many clear strengths. Popple is particularly adept at drawing out fundamental divisions in philosophies and approaches that have shaped the American welfare state and the social work profession. For instance, he contrasts rational humanistic progressivism, which is grounded in a social work practice akin to scientific management, with radical humanistic
progressivism, that gave way to practice in settlements and has links to labor and the women’s movement. Throughout, the author continually returns to important tensions, as for instance the recognition that for “however liberal the motivations and intentions of advocates for social welfare may be, the social function is conservative: maintaining a smoothly operating society with the least possible threat to the status quo” (p. 7).

Popple grounds coverage of periods and specific points within a broader narrative that identifies the actual people, the clients, caseworkers, activists, policy-makers, etc. who populated the times. The chapter “Progress in Social Welfare, 1895–1929” for example, begins with the birth of Robert Nash Baldwin, a Mayflower descendant who went on to direct a settlement house, Self-Cultural Hall in St. Louis, and then led the newly formed American Civil Liberties Union. Such stories bring the history to life, making for an enjoyable read even while covering such a breadth of material.

There are weaknesses here also, however. This work draws from the author’s previous writings, pairing chapters on historical coverage with those on evolution of the professional. As a result, repetition taxes the reader. This book could have been edited and condensed without losing impact. The bulk of the book, as noted, deals with pre-1974 history. Only the final chapters are devoted to the most recent period. Moreover, the treatment of all periods, while skillfully grounded in narrative, lacks revision that many call for in light of contemporary social consciousness contoured by the Occupy, Black Lives Matter, Make America Great Again, and #METOO movements. While the author does discuss the impact that earlier work, such as Michael Harrington’s 1962 book *The Other America*, has had in better understanding the American story, Popple maintains a muted tone toward the systemic power imbalances of pervasiveness of exploitive colonialism, racism, xenophobia, sexism, and heterosexual normativity that thread through our past and are being contested in the present. An example of this muted tone comes as Popple is describing what we generally think of as progress, where he writes, “…as the feudal system declined, trade routes opened, new industries developed, the New World began to open up, and in general the potential for great prosperity was everywhere” (p. 18). In another section, Popple acknowledges that the history of social welfare (especially of its
early periods) is “largely a white history” (p. 126) but devotes little attention to rectifying that history or even drawing out the implications of this blind spot.

In summary, Popple has bound together a thorough and useful history of the U.S. welfare state and its profession, social work. He does so through compelling narrative and with tremendous skill for drawing out the theoretical and philosophical lines that have shaped this development. It could easily be placed on the list of required reading for current professionals.

Ethan J. Evans
California State University Davis


This is a wonderful book! It talks about food in America—its procurement, its preparation, its personnel, and its problems. The data on which the book draws is a pool of semi-structured interviews with 168 women, mostly mothers and primary-care-giving grandmothers. Of that number, 138 were from poor- or working-class families, with the remaining 30 from middle- and upper-class families. They all live in Raleigh, NC and in two nearby counties. Additional material (research methods are detailed in an appendix) came from some 250 hours of ethnographic observations of 12 families from the low-income group. Nine of these families are featured throughout the book in the book in observational narrative form. The book is organized around seven “foodie themes”—You Are What You Eat; Deep Roots; Make Time for Food; The Family that Eats Together Stays Together; Know What’s on Your Plate; Shop Smarter, Eat Better; Bring Good Food to Others; and Food Brings People Together.

The overarching theme of the book is that of food insecurity, which is driven by several factors. One of these factors is gender. Most of all food organization, from purchase through prep to cleanup, is done by women. Men are present, sometimes appreciative, but (grilling aside, I noticed, and I must confess
to having an array of grilling spatulas) men are rarely helping. Since many of these women are also working, this creates what in Arlie Hochschild’s famous phrase is called “the time bind.”

A second factor, somewhat related to the amount of time is how that time is scheduled. Family members have different schedules and activities in the evening. Some families do shift work and other activities in order regularly to have the traditional sit-down dinner, but for most families, this is just not possible. A third driver of insecurity is budget. Families with low incomes are frequently forced to purchase second quality ingredients because they are cheaper. Foods with a short shelf life, like fresh fruit, are often more of a delicacy than a staple. Home cooks are often driven to processed options or to whatever is currently available at the food pantry. As one reviewer, Anahad O’Conner, cogently noted, the book argues that for those with limited time and money, avoiding processed food is extremely difficult.

An excellent chapter looks at the bigger picture of social policy, arguing that we as a nation should develop universal social supports, such as child allowances, that would act as a springboard to security. Instead, we tend to let each family fend for themselves. As does my 1998 book, *Do Americans Hate the Poor?* unfortunately, this book provides plenty of evidence for what can only be considered an aversion to the poor themselves and for helping the poor.

The book is very well written. This is a difficult achievement for a single author, but an all but impossible achievement for three authors working together. It is a work of massive scholarship as well, with a full 33 pages of references and citations. It is truly a model of community-based research, scholarship, caring and application. Bravo!

*John E. Tropman*

*University of Michigan*

Compassion, caring about the welfare of others: there is no question that compassion is a key social work value and, I would assume, a key value of all areas of the human services. But is there really a politics of compassion? I had never really thought about that before being introduced to the concept by this important and constructive book by Edward U. Murphy, a professor of Global Studies and International Affairs.

Much of the policy history Murphy takes us through in the opening chapters of this book will be familiar to those who have read other texts in policy history. But I found it very useful to review that material again through a Murphy’s-eye view. His perspective includes an international scope that is often missing in histories centered mainly on England and then America. Attitudes that relate to economic and social welfare on the home front largely parallel attitudes toward international development. Very similar philosophies emerge, and it is very helpful to see these parallels laid out in one text. I have always been somewhat curious and perhaps confused as to why “social workers” outside of the U.S. and European context so often seem to be engaged in professional work that I think of as economic development work rather than social work proper. After reading this book, much of that fog in my thinking has cleared.

Another valuable aspect of reading this history through the perspective Murphy provides is the hermeneutic of compassion itself. So often when we think of policies and programs aimed at alleviating problematic human situations, we easily get sidetracked by influential issues such as cost effectiveness and efficiency. Indicative of the neoliberal environment within which we function, our attentions become too quickly focused only on economic issues. The focus of compassion that Murphy continually directs us toward is essential in reminding us of what is at stake in our wrangling over policies and programs. In reading this book I was repeatedly made aware of how important it is to keep the focus where it truly belongs when considering these issues.

Murphy incorporates a lot of material not usually found, or underemphasized, in many books written by academic social workers. One such example is a strong emphasis on the Human
Rights perspective and how this relates to and influences our thinking about responsibility toward others. This is not only useful in terms of how we move from attention on the domestic scene into international social work, but also deepens and strengthens our focus on the domestic scene itself. Currently, my colleagues and students are highly concerned with and moved by the situation on the southern border of the USA, in which migrant and refugee people are being treated, under orders of the current administration, with anything but compassion by immigration enforcement officers. Introducing a few concepts and experiences from the history of the struggle for Human Rights and making the connections between the compassion we feel with this larger history has sparked some very good thinking, discussion and commitment among my students that would otherwise have been largely missed.

Another area explored by Murphy that expands our usual horizons is that of compassion in religious versus secular thought. One might initially expect that "religious“ thought, being soft and emotional, would lean strongly toward exhibiting compassion towards others, while secular thinking would lean toward more hard-nosed analytics less impacted by compassionate influence. And in some cases that is certainly correct. But Murphy demonstrates that the compassionate perspective flows through both religious and secular perspectives on our responsibilities to care for others (or to ignore the needs of others) in equal measure.

Perhaps the strongest thread running through the discussion is the expectation of caring for strangers. Most people agree (but not all!) that we have an obligation to care for people we know and with whom we are close. There is disagreement, however, as to the degree of caring and compassion we can be expected to exhibit toward those we do not know and with whom we do not have strong social bonds. Simply the fact that some 80% of American evangelical Christians, perhaps the most strongly religious-identified group in America today, appear to be standing firmly behind the current administration and its cruel policies on the southern border indicate that there is no easy equation between being religious and expressing compassion toward others. This same dynamic of confounded expectations when viewing this history through the hermeneutic of compassion is echoed in Murphy’s presentation of the moral
politics of liberalism and conservatism. In fact, we could go as far as to say that viewing these ongoing contentions through the hermeneutic of compassion might well create the common ground we so desperately lack most of the time that will move the conversation forward.

Although one could easily be discouraged by the current state of impasse in social welfare politics in the world, and perhaps especially in the USA, there are a new voices coming forward pointing in some positive directions. One emerging influential voice is that of Astra Taylor, a young film maker and theorist who is looking for a language to move us beyond the restrictive assumptions that the pervasive neoliberal milieu imposes on us. In a recent writing, she suggests that a revival of the overarching concept of "solidarity“ may be one pathway forward for the social thought of the new generation. I thought of that writing often in reading this book by Edward Murphy. One of the drawbacks of "solidarity“ as it has been used in movements of history is that it too quickly can become a term of exclusion, creating an in-group and an out-group. Compassion in conjunction with solidary would make solidarity a much more inclusive concept. I can only hope that Murphy’s book receives the wider reading it deserves.

Daniel Liechty
Illinois State University


As a result of the emphasis on rising opioid overdose deaths and attempts at understanding and offering solutions, there is growing attention directed toward treatment for substance use disorders. Preparing clinicians to practice with competence across disciplines is an emerging necessity. In this welcome addition to the literature, Faulkner and Faulkner connect curriculum, practice, and certification standards of various professional tracks to the art and science of addiction counseling to embrace a broader context. Rooted in education and practice-based competencies,
the design supports the educator in teaching and the student in learning. Taking a cue from human resources, Faulkner and Faulkner use knowledge, skills, and values-oriented criteria to demonstrate proficient counseling techniques with persons living with substance use disorders.

The focus on competency and standards associated with evidence-based treatment protocols can help educators disseminate knowledge about treating substance use disorders from within their respective disciplines. This transdisciplinary perspective encompasses approaches from the counseling and social work fields, while not excluding individuals who may be entering the profession from another avenue. Faulkner and Faulkner are scholars with a significant amount of practice experience. They thoughtfully chose to include placement criteria, known by the acronym ASAM, that have remained fairly consistent regarding guidelines based on symptoms and not necessarily the substances of use. The education and practice-based competencies address curricula guidelines while simultaneously prioritizing areas of practice which exposes students to common interventions in addiction treatment settings.

One highly valued characteristic of the book is the case study approach that walks the reader through a treatment episode from beginning to end. Case studies allow clinicians to combine theory with practice, demonstrating specific competencies in conjunction with subjective data from in-vivo experience. However, a drawback involves the inability to fully capture the panoramic nature of addiction treatment due to what is inevitably left out of the narrative.

There are problems with this book, however. The case study used in this book reveals questionable cultural competency regarding the family constellation and support system. In particular, the decision to describe the client as raising her children “on her own with little or no support” (p. 12) while there was clear evidence that their father was involved in daily co-parenting and living in close proximity indicates a failure to appreciate such cultural difference in relation to family structure. In addition, friends were described as “close” (p. 13), yet only the children were included in family sessions. While certainly an opportunity to analyze the recommendations and explore other options, this has potential of creating discomfort for counselors and students of color. Similarly, the chapter on diversity deserved more
attention and expansion in some areas including people of color and adolescents. The inclusion of other special populations such as impaired professionals and recovering professionals would have also been beneficial to expand the discussion. A more thoughtful consideration for alternatives to 12 step models of recovery seems relevant as well. Finally, there is absent attention on the dynamics of managed care and its impact on addiction counseling, adherence, outcomes and placement.

The full scope of addiction counseling is vast and an ongoing process, and it warrants a more comprehensive text that includes material to stimulate critical thinking skills about this specialty. The current state of access to addiction treatment in the general population certainly justifies discussion about cost and treatment philosophy around the country to address disparities within the field.

Shena Leverett Brown
University of Georgia
## Corresponding Authors

<table>
<thead>
<tr>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mimi Kim</td>
<td><a href="mailto:mimi.kim@csulb.edu">mimi.kim@csulb.edu</a></td>
</tr>
<tr>
<td>Jaime M. Booth</td>
<td><a href="mailto:jmbooth@pitt.edu">jmbooth@pitt.edu</a></td>
</tr>
<tr>
<td>Jaclyn E. Chambers</td>
<td><a href="mailto:Jaclyn_chambers@berkeley.edu">Jaclyn_chambers@berkeley.edu</a></td>
</tr>
<tr>
<td>G. Allen Ratliff</td>
<td><a href="mailto:garatliff@berkeley.edu">garatliff@berkeley.edu</a></td>
</tr>
<tr>
<td>Margaret Mary Downey</td>
<td><a href="mailto:mmdowney@berkeley.edu">mmdowney@berkeley.edu</a></td>
</tr>
<tr>
<td>Joshua Neff</td>
<td><a href="mailto:jneff@mednet.ucla.edu">jneff@mednet.ucla.edu</a></td>
</tr>
<tr>
<td>Kate Dubé</td>
<td><a href="mailto:Kate.Dube@ucsf.edu">Kate.Dube@ucsf.edu</a></td>
</tr>
<tr>
<td>Jama Shelton</td>
<td><a href="mailto:jshelton@hunter.cuny.edu">jshelton@hunter.cuny.edu</a></td>
</tr>
<tr>
<td>Kel Kroehle</td>
<td><a href="mailto:kkroehle@upenn.edu">kkroehle@upenn.edu</a></td>
</tr>
<tr>
<td>Maria Monica Andia</td>
<td><a href="mailto:mariamonicaandia@gmail.com">mariamonicaandia@gmail.com</a></td>
</tr>
<tr>
<td>Leah A. Jacobs</td>
<td><a href="mailto:leahjacobs@pitt.edu">leahjacobs@pitt.edu</a></td>
</tr>
<tr>
<td>Hanna Mark</td>
<td><a href="mailto:Hanna.F.Mark@gmail.com">Hanna.F.Mark@gmail.com</a></td>
</tr>
</tbody>
</table>
Please note, as of 2020, the *Journal of Sociology & Social Welfare* will only be available in an online format. Subscription rates include a single print issue of the most-downloaded articles of the publication period (March to December of each year), to be shipped via postal mail after the data have been tabulated and the issue has been printed (every February or March for the previous year). As such, please include a postal address with all subscriptions, or note that you would prefer to opt out of the print issue when submitting your subscription.

**Volume:** XLVII  
**Volume Year:** 2020  
**Publication Period:** 1–20 to 12–20  
**Publication Frequency:** Quarterly  
**Online Publication Dates:** March, June, September, December  

### Subscription Rates:

<table>
<thead>
<tr>
<th>Online version only</th>
<th>1. Individual</th>
<th>$54.00</th>
<th>$54.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Institution</td>
<td>$98.00</td>
<td>$88.00</td>
</tr>
</tbody>
</table>

Institutional subscribers can access the *Journal’s* articles with ip authentication. Please provide ip information when subscribing, or send ip information to swrk-jssw@wmich.edu.

Individual subscribers can access the *Journal’s* articles online by providing ip information or an email address or by contacting swrk-jssw@wmich.edu.

**Currency:** U.S. Dollars (firm exchange rate not available)  
**Payment:** Prepayment (must accompany order or be paid with credit card online)  
**Mult. Yr. Subscription:** Not Available  
**Cancellation Policy:** Non-cancelable  
**Claim Policy:** Free Replacement within Six (6) Months of Publication (former print subscribers only)  
**Back Issues:** $20.00 per issue, plus postage ($2.00 for U.S./$5.00 for foreign)  
**ISSN:** 0191-5096  
**Tax Free Registry No.:** A-154961  
**Federal Tax ID No.:** 386007327  
**Web Site:** https://scholarworks.wmich.edu/jssw/  
**Contact Person:** Melinda McCormick Ph.D., Managing Editor  
*Journal of Sociology and Social Welfare*  
School of Social Work  
Western Michigan University  
1903 W. Michigan Ave. MS 5354  
Kalamazoo, MI 49008-5354 USA  
e-mail: swrk-jssw@wmich.edu  
Tel: 269-387-3205 Fax: 269-387-3217