Title

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Journal

Nursing forum, 56(2)

ISSN

0029-6473

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Publication Date

2021-04-01

DOI

10.1111/nuf.12535

Received: 6 August 2020 | Revised: 30 October 2020 | Accepted: 2 December 2020

DOI: 10.1111/nuf.12535

CONCEPT ANALYSIS

NURSING FORUM AN INDEPENDENT VOICE FOR NURSING WILEY

Structural violence: A concept analysis to inform nursing science and practice

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Abstract

This analysis is meant to elucidate the concept of structural violence and its implications for nursing science and practice. The concept of structural violence, also known as indirect violence, was first identified in the literature by peace researcher Johan Galtung. According to Galtung, structural violence broadly represents harm done to persons and groups through inequitable social, political, or economic structures. Such inequitable structures, such as systemic discrimination based on race, ethnicity, religion, gender, sexual orientation, etc. create conditions within society that directly disadvantage and oppress members of certain groups. This oppression can inflict profound physical, psychological, and socioeconomic harm on individuals, leading to disparate health outcomes. Using techniques for developing conceptual meaning as outlined in Chinn and Kramer (2018), our analysis seeks to specify meanings and applications of structural violence for application to nursing. This analysis draws on literature from clinical, historical, and other social sciences. Databases including CINAHL, PubMed, JSTOR, and PsychInfo were explored for references to structural violence. Structural violence is readily identified in specific contexts where individuals or groups are disadvantaged by socially constructed systems, such as those of race, gender, and economic privilege. Structural violence can result in health disparities and the development of conditions that predispose individuals to health risks. Nurses must be familiar with the concept to address these issues with patients.

KEYWORDS
bias, race, social structures, structural violence

1 | INTRODUCTION

Structural violence is a term first explored in the 1969 work, "Violence, Peace, and Peace Research," and it refers to harm that is specifically inflicted through inherently biased societal structures.[1] These structures result in inequitable social dynamics, leading to some groups having reduced capacity to meet needs as varied as basic shelter, employment, or healthcare. Since its naming, scholars in multiple disciplines have examined an array of social, behavioral, and health-related phenomena, such as racism, intimate partner violence (IPV), human immunodefeciency virus (HIV) transmission, low birth weights, and more—through the framework of structural violence.[1–9] For example, the Boston Public Health Commission's Racial Justice and Health Equity Initiative includes direct engagement with community residents to develop systems that are responsive to health inequities as well as effective in the affected communities.[10,11] Elsewhere, the nurse-family partnership (NFP) provides thousands of vulnerable parents visiting nurse support from

early pregnancy through the child's second birthday. Compared to similar populations, NFP-served families had fewer preterm births and more often had appropriately immunized children at six months.[12] These initiatives demonstrate both the efficacy and growing importance of intervention strategies aimed at addressing the impact of structural violence on access to and utilization of healthcare and related services.

As the impact of structural violence and its health implications comes into focus, so too does the necessity for nurses and other providers to be familiar with the concept, and to analyze its applicability to research, practice, and education. The purpose of this paper is to present a concept analysis using techniques outlined by Chinn and Kramer.[13] We will discuss our application of the methods, identify sources of evidence for structural violence in relevant literature, and establish defining criteria for the concept of structural violence.

2 | METHODS

The methods for development of empiric knowledge articulated by Chinn and Kramer[13] provide an elegant and sophisticated guide to the development of conceptual meaning. This methodology, rooted in contextualization, is a clear fit for developing conceptual understanding of structural violence: "concepts are often abstract, and a meaning needs to be created from among a set of competing and nuanced meanings."[13] Given its high level of abstraction, structural violence often derives both its meaning and potential remedies from the contextualization of those affected and those seeking to remediate its effects. Manifestations of structural violence are thus varied and can include experiences of physical violence, such as IPV experienced by women in highly patriarchal societies; or inequitable access to resources, such as HIV prevention resources for sexual minority populations.[14–16] While both reflect structural violence, these problems arise from distinct social dynamics and do not share a solution. Additionally, perspectives on structural violence differ across disciplines, and it is critical that the concept be elucidated from a nursing perspective. Chinn and Kramer's general process for creating conceptual meaning suggests that scholars purposefully select a concept, examine formal and informal sources of evidence, and explore the concept in different contexts.[13] The following sections examine sources of evidence and contexts for structural violence, beginning with a review of its origin, denotative meanings, and utilization in literature from various disciplines. Through the use of exemplars, criteria for structural violence are elucidated, and conclusions drawn about the application of structural violence to nursing.

2.1 | Sources of evidence

Since its formal naming in Galtung's work,[1] structural violence has been entered into the Oxford Dictionary of the Social Sciences, where it is defined as a "terminological attempt to move beyond the commonsense understanding of violence as the individual use of bodily force."[17] It is the "violence that inheres in some social roles, norms, and patterns" and the "persistence and durability of those patterns."[17] Importantly, structural violence is also differentiated from other types of indirect violence, such as institutional violence and cultural violence. The former refers to the indirect violence of endorsing, replicating, and/or embedding disempowerment in institutions, such as schools, policing agencies, or hospitals, but this violence is specifically predicated on engagement with the institution and it universally affects its targets within that institution.[18] To illustrate, nurses may experience institutional violence from health systems, but not from construction companies. At the same time, nurses of color may experience structural violence in addition to institutional violence within the health system. Cultural violence diverges from both structural and institutional violence in that it is defined as violence done when "elements of a specific culture justify and legitimize" devaluation or marginalization of groups hierarchically.[19] The persistence of caste identity and related prejudices in some parts of India is an example of cultural violence.[19] While both of these are related to structural violence, it is important to differentiate among them to effectively examine how structural violence influences health.

To develop understanding of structural violence as it applies to nursing, literature from a variety of disciplines was reviewed. Databases searched included CINAHL, PubMed, JSTOR, and PsychInfo. Search terms included "structural violence," "indirect violence," "structural stressors," "structural racism," "structural inequality," and other variations on the main conceptual label. Literature was deemed relevant to the concept if it specifically referenced and focused on structural violence, and/or met our tentative criteria: described a pattern of inequitable treatment or access to resources based on immutable characteristics, illustrated a negative human outcome related to social constructs, and was not limited to direct or physical violence. Literature searches took place from January to July of 2020. The following exemplars were constructed to reflect the contexts and functions of structural violence based on common referents in the identified literature.

3 | RESULTS

The literature on structural violence is diverse, reflecting its many applications across disciplines. Three themes that emerged from multiple sources were considerations of race and/or racism, health disparities and inequities, and the influences of both sex and gender. Based on these findings, we constructed the following exemplars. Each reflects on potential for structurally violent influences as well as citing historical, social, and clinical instances of these influences. We then identified final criteria for the concept of structural violence.

3.1 | Exemplar: race and health in the United States

In the United States (US), one indisputable example of structural violence is racism. The US has a troubling history of racial division and biases that influence healthcare access and inequities, largely traceable to the influences and effects of colonialism and slavery.[20] Enslavement of both Native American and African born individuals was common practice as Europeans explored and settled in North America.[21] As British colonialism continued to overtake what became the Eastern part of the United States, ownership of persons from Africa, viewed as inferior by White settlers, became a mainstay of American life. Even with the legal abolition of slavery in 1865, the years following the Civil War saw continued segregation and enactment of the Jim Crow Laws, encoding principles of racial inferiority into American society.[20] These legal structures yielded development of social structures reifying the racial hierarchy such that African Americans lacked adequate access to resources that would now be described as social determinants of health (SDOH): housing, healthcare and related services, education, and living-wage employment.[22] This socially constructed, deliberate inequity in resource distribution led to more modern, structurally violent practices, such as "redlining," or the refusal of the federal government to insure mortgages on properties in predominantly African American neighborhoods while simultaneously funding "desirable" housing construction.[23] The socioeconomic effect of these structurally violent acts created a veritable roadblock to wealth accruement for African Americans across generations, leading to ongoing housing and educational inequities and instabilities within African American communities.[23] Both are inextricably linked to poor health outcomes in this population including asthma,[24] HIV infection,[25] cancer mortality,[26] preterm birth,[27] and more.

The social structures that disempower African Americans are in fact so ingrained in American cultural consciousness as to yield a further instrument of structural violence and one particularly pernicious in healthcare: implicit bias. Implicit bias occurs when a group attribute (race) is insidiously linked to a negative evaluation (laziness, being uneducated) and assumptions are made about members of the group as a result.[28] Studies show biased selection of "white sounding" names for job interviews as well as presumptions of illiteracy, socioeconomic status, and even intelligence by healthcare providers.[29–31] Implicit bias is also frequently implicated in the disproportionate rates of violent and lethal law enforcement actions toward African Americans, an issue currently at the forefront of US media following deaths of George Floyd, Breonna Taylor, Ahmaud Arbery, and dozens of others.[32,33] There is perhaps no greater impediment to health than the persistent and credible threat of death, and the ongoing potential for such violence and lethality is unquestionably an example of structural violence—one which nurses and other providers should factor into assessment for health risks, needs, and outcomes.

3.2 | Exemplar: health disparities, inequities, and oversights

As described above, racial-, ethnic-, class-, and gender-based types of structural violence are demonstrably linked to depressed socioeconomic status and poor health outcomes among those disempowered by social structures.[34] A growing body of literature ties together the narratives of socioeconomic disadvantage and poor health, yet within the nursing-specific literature, discussion of structural violence is scant. The impacts of structural violence on patients and populations are often overlooked, insofar as they may not present as disease processes or symptomologies. In an early description of structural violence, medical anthropologist Paul Farmer reconstructs the experiences of poor, rural Haitians through the eyes of Acephie Joseph—an early casualty of the AIDS epidemic.[35] Seeking to improve her socioeconomic prospects, Acephie engages in a sexual relationship with a salaried military officer. The officer is known to be sexually active with multiple partners, and Acephie trades her own sexual health and safety for economic security. Ultimately, Acephie contracts HIV from this partner and dies from complications. Here, Acephie is not initially ill, but experiences structural violence in the form of economic disadvantage, and her pathway to enhanced status results in her death.

Since this early characterization, Farmer and others have expanded the literature on the clinical implications of structural violence. Even within HIV literature, structural violence has been implicated in myriad contexts: from gendered power dynamics in survival sex work, to dietary insufficiency and food insecurity in the high-rent San Francisco Bay Area, to social stigmatization among the LGBTQIA+ community.[3,5,9] It is critical to note that in many cases, trauma also results from such structurally violent influences and yet is overlooked as a healthcare and health disparity issue. This is an important point for nursing to address.

As Befus and colleagues note, since: "policies and social structures tend to repeatedly and systematically disadvantage (and privilege) the same groups, placing them at an increased risk for interpersonal violence, …nurses are very likely to serve a clientele that has experienced both interpersonal and structural violence."[36] The intersections of trauma related to violence and abuse with socioeconomic status, race or ethnicity, gender and sexual identities, and other social structures are undeniable, and have been linked to poor health outcomes in numerous studies. For example, IPV and other forms of gender-based violence have been linked to sleep disturbance, chronic pain, persistent fear and stress states, depression, and lower CD4 counts in women living with HIV.[37–41]

3.3 | Exemplar: sex and gender

Until the early 20th century, under the legal practice of coverture, women were considered their father's and then husband's property. This remains embedded in expectations that women shed a "maiden" name for a "married" name: a demarcation of changing one custodian

for another. In fact, until 1961 a married woman was not able to be registered to vote under her birth name in the US. Since a woman did not legally exist as an entity separate from her father and/or her husband, her personage was not her own. Further, it was not until 1993 that marital rape—rape of a woman by a spouse—was considered a crime in all 50 states. This categorization of women as subjugate has far reaching legal, economic, and career ramifications for women.[42]

As women's lives are devalued, so too is women's health. Only in 1986 did the National Institutes of Health create policy to encourage inclusion of women as research participants—a requirement not made law until 1993.[43] It was assumed that except for reproductive matters whatever was found in men applied to women.[44] As an example, signs and symptoms of myocardial infarction (MI) in women are often described as "atypical" because the "typical" signs of a heart attack were developed based on research with men—yet women usually have worse prognoses following MI.[45] In the few areas where differences have been studied—such as in reproductive health—structural violence in the form of over-medicalization and nonevidence based obstetric care continues to affect women, children, and families.[46]

It is thus perhaps unsurprising that important differences at the cellular level are also overlooked.[47] For example, the X chromosome assists in effective immune responses, which may be part of the reason men have been more susceptible to and experienced higher mortality from coronavirus disease 2019 (COVID-19).[48] Important differences in the way XX and XY cells respond to different medications may also influence the impact of accelerated SARS-COV-2 vaccine trials. In fact, some current trials for COVID-19 treatment have participant populations of as many as 86% men.[49] Failure to consider the diverse responses of people who do not carry an XY chromosomal complement may thus put entire population cohorts at risk of illness and death.

3.4 | Finalizing criteria

According to Chinn and Kramer, the criteria identified with a concept also express its conceptual meaning.[13] Given the commonalities in the manifestations of structural violence discussed in the sources of evidence, it is possible to create more generally applicable criteria for structural violence. First, structural violence arises from human social structures combined with bias against and disempowerment of specific identities as defined by these structures.[50] People must therefore be present, both to experience structural violence and to maintain the perpetuating social structures. In the exemplars above, the pivotal construct—race, healthcare, and sex or gender—is definitively human-made, and not the result of a geographic or animal system. Second, these social structures must inherently create or reinforce inequities and/or result in uneven distribution of resources. This is also reflected in the exemplars, as both race and sex or gender are often treated hierarchically while healthcare is regularly distributed as a function of economic status.

Finally, a defining characteristic of structural violence is that it is harm done to people where the cause of the harm is not a direct or individual "actor," but instead embedded in the social fabric that surrounds those affected.[51] Structural violence is thus also characterized by an enduring pattern of harm, which positions certain individuals as necessarily outside the expected or dominant social paradigm.[52] The exemplars also establish persistence over time: within race as a continuum from enslavement to economic deprivation to poor health; in healthcare as the devaluation or ignorance of human needs and experiences resulting in illness or death; and in the case of sex and/or gender as disempowerment from cradle to grave.

Table 1 shows our finalized criteria for structural violence, delineating them into defining attributes and antecedents, as recommended by Chinn and Kramer.

TABLE 1 Criteria for structural violence are shown, categorically separated into defining attributes, or hallmarks of the concept, and antecedents, which are elements that must be in place in order for expressions of the concept to occur

Defining Attributes	Antecedents
Inequitable treatment Occurs in an identifiable pattern over time	People Affected Perpetuate social structures
Causes harm Physical Psychological Economic Social	Social hierarchies Reinforce bias
No single "actor" Acts or effects are supported by social, political, or economic structure(s)	Unequal distribution of resources Needs met Needs not met

4 | DISCUSSION

Structural violence arises differently depending on the specific social constructs influencing specific groups. This is a critical point for attention by the nursing profession in addressing needs of diverse and unique patient populations. While not a uniquely nursing issue, recent literature demonstrates that structural violence can result in health disparities and/or development of preventable conditions, and nurses may thus find themselves managing its effects. Nurse researchers can also play a pivotal role in investigating the root causes of and developing interventions for problems fueled by structural violence.

A useful means of identifying options for nursing investigation of and intervention in structural violence may be to apply a SDOH framework to individual- as well as population-level care. SDOH are aspects of the social environment that shape daily activities, such as work, play, learning, and eating.[22] SDOH therefore include elements, such as neighborhood safety, accessibility of fresh foods, intimate partner violence or other physical violence and abuse, and presence of culturally and/or linguistically appropriate resources. SDOH are frequently identified as ready conduits for improvement in both individual and population health yet are often overlooked within nursing practice and science. Interestingly, nursing academia often invokes social justice—the reduction of disparities among opportunities and options available to people based on location in social, economic, or other strata—as a likely frontier for scientific and practice developments.[42]

Since social justice is in many ways an effort to remediate impacts of SDOH, it follows that nursing can address the former through attention to the latter—thereby also reducing the effects of structural violence. Content on SDOH can be readily incorporated into nursing education, as suggested by recent papers on trauma informed care,[53] health needs and appropriate care for the LGBTQIA + community,[54,55] and poverty-related simulation tools.[56] From a research perspective, the relationships between SDOH and health disparities as well as the effectiveness of interventions targeting these offer a plethora of nursing-based and interdisciplinary opportunities. As one review noted, "reducing and eliminating disparities is a moral imperative that is also advantageous to the US economy," insofar as morbidity and mortality related to health disparities cost over $1 trillion every three years.[22]

5 | CONCLUSION

The nursing community occupies a unique space, in that nurses are poised not only to see the tangible impact of structural violence on patient health, but also to understand how the intersection of different social and economic factors manifest in patients' lives and health. This means that there is significant opportunity for nurses to step into roles as advocates for policy and other reforms to address structural factors. Nursing educators can ensure that future generations of nurses are knowledgeable about structural violence and its implications for health and healthcare. The health impacts of structural violence make clear that nurses cannot keep separate the healthcare and the greater socio-ecological spaces in which our profession and our patients exist.

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How to cite this article: Burton CW, Gilpin CE, Moret JD. Structural violence: A concept analysis to inform nursing science and practice. *Nurs Forum*. 2021;56:382–388. https://doi.org/10.1111/nuf.12535