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Gabriel Abarca-Brown & Francisco Ortega

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COMMENTARY

A historical perspective on structural-based mental health approaches in Latin America: the Chilean and Brazilian cases

Gabriel Abarca-Brown [a,b] and Francisco Ortega [c,d]

[a]Center for Culture and the Mind, University of Copenhagen, Copenhagen, Kobenhavn, Denmark; [b]Program in History and Critical Theory of Psy Knowledge, Diego Portales University, Santiago, Chile; [c]Catalan Institution for Research and Advanced Studies, Santiago, Barcelona, Spain; [d]Medical Anthropology Research Center, Universitat Rovira i Virgili, Tarragona, Spain

ABSTRACT

The growth of identity struggles and intersectional debates has presented challenges for public health services in Chile and Brazil. In this context, researchers, stakeholders, health practitioners, and activists have recently brought contemporary debates on professionals' competency to the fore. Debate in Chile and Brazil has primarily centered on US-based discussions on cultural and structural competency. However, emerging concerns regarding identity, intersectionality, and mental health among vulnerable or marginalized groups have confronted local health traditions with the need for specific interpretations of concepts such as 'culture' and 'structure'. In this commentary, we delve into the recent history of psychiatry and public health in Chile and Brazil to reveal how ideologies and politics have influenced local traditions in mental health practice and their interaction with ongoing identity struggles and intersectional debates. We argue that recent historical and sociopolitical factors in both countries have shaped a structural-based approach to mental health practice. The introduction of gender and multicultural policies in public health has contributed to a more complex understanding of Otherness and power relationships in recent decades. Although this understanding largely aligns with those prevalent in the USA and UK, there is a strong emphasis on class in identity struggles and intersectional debates in public health, providing a distinctiveness to Latin American debate. Understanding professional competencies requires consideration of broader sociopolitical processes. Rather than a de-contextualized understanding of 'culture' and 'structure', the history of psychiatry demonstrates how these categories interact within specific political and ideological contexts.

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Introduction

The growth of identity struggles and intersectional debates has presented challenges to public health services in Chile and Brazil. Following the failure of right-wing governments led by Sebastián Piñera (in Chile) and Jair Bolsonaro (in Brazil) to address these issues, the recent electoral victories of progressive, left-wing leaders – Gabriel Boric in Chile and Lula da Silva (together with the first-ever appointment of a woman as Minister of Health) in Brazil – have heightened these discussions. Mental health considerations for various vulnerable and marginalized groups, including Indigenous populations, Latin American and Caribbean migrants, LGBTI+ people, Black people, and Quilombola, among

CONTACT Gabriel Abarca-Brown gabriel.abarca-brown@hum.ku.dk

others, have become pivotal concerns for a variety of social actors seeking to develop relevant clinical and social interventions in public health services.

In this context, researchers, stakeholders, health practitioners, and (service) user activists have recently brought debates on professionals' competency to the fore. Although these discussions focus on various issues including cultural safety, cultural competency, intercultural competency, structural competency, and translational competency,[1] debates in Chile and Brazil have primarily centered on US-based notions of cultural and structural competency.[2] While cultural competency aims to recognize clinical biases and enhance communication in clinical encounters (Office of Minority Health, 2001), structural competency provides a framework for understanding how broader social, economic, and political factors (e.g. socioeconomic inequalities, structural violence/vulnerability, racism, gender violence, stigma, among others) influence the well-being of individuals and communities (Farmer, 2004; Holmes, 2011; Metzl & Hansen, 2014; Metzl et al., 2017). These debates often portray structural competency as a response to the limitations of cultural competency, delineating them as two distinct approaches, despite sharing some common sociological and anthropological foundations (Holmes, 2011; Kirmayer, 2012).

However, these emerging concerns regarding identity, intersectionality, and mental health among vulnerable or marginalized groups have confronted local health traditions using specific interpretations of concepts such as 'culture' and 'structure'. Various researchers have demonstrated how Marxist legacies in public and collective health, experiences in social medicine and community psychiatry, and other closely related traditions in the healthcare field – such as the pedagogy of the oppressed – developed in the 1960s and 1970s, have influenced structural-based mental health approaches in Chile and Brazil (Behague et al., 2020; Montenegro, 2023; Montenegro & Ortega, 2020; Ortega & Wenceslau, 2020). This work has primarily focused on aspects of social class such as poverty, social stratification, and socioeconomic disparity, rather than the broader sociocultural and material dimensions highlighted by scholars primarily based in the USA (Abarca-Brown, 2021; Abarca-Brown & Montenegro, 2023; Ortega & Müller, 2023). Therefore, the introduction of discourses related to ethnicity, race, gender, and sexuality has intersected with those of class to varying degrees, revealing the influence of history and local context in shaping public health debates and traditions.

In this Commentary, we delve into the recent history of psychiatry and public health in Chile and Brazil to reveal how ideologies and politics have influenced local traditions in mental health practice and their interaction with ongoing identity struggles and intersectional debates. Drawing specifically on research conducted in the region by the authors and our colleagues, we analyze structural-based mental health approaches in Chile and Brazil. We emphasize their progressive intersection with gender and ethnic/racial concerns due to the recent incorporation of intersectional perspectives from public debates in the US and Latin America, the growth and implementation of gender and multicultural policies, and sociopolitical events at the local level.

We argue that recent historical and sociopolitical events in Chile and Brazil have played a key role in influencing structural-based approaches in mental health practice, with the introduction of gender and multicultural policies in public health contributing to a more complex understanding of Otherness and power relationships in recent decades. Although this understanding aligns substantially with those used in the USA and UK, in Brazil and Chile there is a focus on the social class aspects of identity struggles and intersectional debates in public health, signifying a distinctiveness in the Latin American context. In our view, understanding professional competencies requires consideration of the broader sociopolitical processes. Rather than a de-contextualized understandings of 'culture' and 'structure', the history of psychiatry demonstrates how these categories interact within specific political and ideological contexts (Antic et al., 2023). Both of the instances focused on here highlight the influence of reformist governments, dictatorships, and ongoing neoliberal/multicultural processes on local health traditions and practices. Moreover, they reveal multiple forms of engagement – adoption, hybridization, and refusal – with professional competency models in mental health

The situation in Chile

The Chilean structural-based approach to mental health emerged during the reformist administrations of Eduardo Frei Montalva (1964–1970) and Salvador Allende (1973). While the social and health policies developed by these governments aimed to incorporate cultural and ethnic dimensions – specifically addressing the 'Indigenous question' or 'Mapuche question' within the framework of land reform (Mallon, 2005) – these policies tended to perceive Otherness primarily through the lens of social class (e.g. viewing the Mapuche peoples for example as poor [poverty affected] subjects) rather than through a cultural or ethnic perspectives (Crow, 2007, 2014). Within this context, the structural-based mental health approach predominantly arose from diverse and relatively decentralized community psychiatry initiatives developed during this period. Noteworthy examples include Martin Cordero's community efforts to rehabilitate psychiatric patients in Temuco, Luis Weinstein's *salud poblacional* (population health) with the general population in impoverished sectors of Santiago, and Juan Marconi's intracommunity program on alcoholism, neurosis and sensory deprivation in southern Santiago. Marconi's work in particular significantly influenced successive generations of psychiatrists and psychologists in Chile (Sepúlveda et al., 2012). Following a Marxist tradition, Marconi employed concepts such as 'social class', 'capitalist society', 'the social structure', 'the working class', and 'class struggle' to better understand mental illness. Through a community-based approach, Marconi engaged mental health practitioners, community leaders, police officers, teachers, priests, and the broader community itself to respond to mental health problems (Montenegro, 2023).

Following the civic-military dictatorship (1973–1989), Marconi's legacy materialized in what some Chilean psychiatrists termed 'the silent revolution' of mental health programming in Chile (Araya et al., 2009). This term refers to the introduction of community-oriented mental health policies and programs preceding advocacy for promoting and implementing mental health programs in low- and middle-income countries (Global Mental Health Group, 2007). This approach to mental health has been characterized by its focus on restructuring psychiatric care, transitioning from long-stay hospitals to an integrated network of support within the health system closer to users and their communities (Minoletti & Zaccaria, 2005). However, these mental health programs have faced criticism. Studies note for example that psychologists and other mental health professionals tended to focus more on individual interventions rather than community activities (Scharager Goldenberg & Molina Aguayo, 2007). Moreover, researchers have highlighted the limited influence users had over policy decisions (Montenegro & Cornish, 2019).

Since the end of the dictatorship in Chile, this structural based-approach has gradually engaged with other issues, notably gender and ethnicity. The recent inclusion of a gender perspective, influenced by the activism of various feminist collectives – some of which emerged during the dictatorship – has contributed to a deeper understanding of the connections between class and gender among health practitioners trained since the 2000s. Gender policies since the 1990s have primarily focused on three key issues: changes to the law (e.g. domestic violence laws), the introduction of social policies targeting economically disadvantaged women, and state modernization using a gender mainstreaming approach (Forstenzer, 2017). Within the health field, practitioners have increasingly engaged with women's sexual and reproductive health and mental health, developing a range of health initiatives over the past two decades including the 'Chile Crece Contigo' (Richter et al., 2017) and 'Depresión' programs (Araya et al., 2003, 2006), among others. Moreover, in 2015, the Ministry of Health officially recognized gender as a social determinant of health.

The approach to mental health taken in Chile has not fully integrated ethnic and racial considerations. Despite state encouragement of Indigenous health policies since the 1990s, ethnic and racial aspects of health remain largely overlooked. Policies have primarily focused on small subsidies and limited social service provision rather than ensuring the rights of vulnerable ethnic groups such as Mapuche and Aymara peoples (Navarrete Saavedra, 2022). These policies have been termed 'multicultural neoliberalism', representing the extension of neoliberalism into previously disregarded

sociocultural realms, through notions such as 'intercultural health' (Bolados García, 2012). However, according to local historians, the omission of ethnic and racial aspects has deep historical roots. The formation of the Chilean nation-state in the 19th century promoted a discourse based on *mestizaje*, or mixed heritage, effectively excluding members of the Afro-descendant population (Larraín, 2001). Race operates similarly, as Wade et al. (2014) have noted in other Latin American countries, constituting an 'absent presence' in Chile – often erased and denied but still evident in official spheres. One instance of this exclusion is the Chilean government's legal recognition of 'Chilean Afro-descendant tribal people' only in 2019.

In recent years, the structural-based mental health approach has undergone significant transformations by incorporating intersections with gender/sexuality and ethnicity/race aspects. Increasing awareness of intersectionality among public health practitioners can be attributed to the gradual introduction of gender and multicultural policies since the 1990s. Furthermore, this shift has been influenced by recent sociopolitical events and public debates in the USA (e.g. the MeToo and Black Lives Matter movements) as well as in the region (e.g. Bolsonarism). Additionally, local sociopolitical events such as the surge in Afro-Caribbean migration flows to the country since the 2010s, the death of Joane Florvil in 2017 – a Haitian woman who died under mysterious circumstances in a police station in Santiago – and the feminist demonstrations[3] in Chile in 2018 have contributed to this evolving awareness.

The situation in Brazil

The Brazilian structural-based approach to mental health shows similarities to the situation in Chile. This approach originated from the inclusion of health as a social right in the Brazilian Constitution of 1988, marking a shift from disease-centered perspectives to a focus on socially and culturally embedded subjects, emphasizing the importance of healthcare for both communities and individuals (Stolkiner & Ardila Gómez, 2012). The principles and directives of the *Sistema Único de Saúde* (SUS) or Unified Health System, established in 1989 emphasized health equity and social participation, contributing to social justice and the expansion of citizenship (Pitta et al., 2015).

Following vigorous parliamentary deliberations and the mobilization of social movements involved in Brazilian psychiatric reform, the country's mental health policies were established in 2001 through the approval of the Psychiatric Reform Law – Federal Law 10.216 (Amarante & Nunes, 2018). This law safeguards the rights of mental health users and reshapes the model of mental health care l from being a hospital-focused system to one centered on primary health care and community-based mental health care, promoting alternative community-centered treatment models. Fundamental principles of the psychiatric reform include the protection of the rights of individuals living with mental disorders, echoing international human rights commitments (Csillag, 2001).

In Brazil, psychiatric reform was influenced both by Italian psychiatric reform, and resistance to the military dictatorship (1964–1985). The Italian leftist-oriented *Psichiatria Democratica* prioritized class relations over cultural aspects, and this Neo Marxist ideology has influenced both the reform of psychiatric services and mental health policies and service organizations in Brazil. Mental health professionals in the country do not extensively use the idea of 'intercultural competency' to tackle the challenges posed by cultural diversity and its impact on service users' mental health. However, they do seek to promote various forms of 'structural competency', even if the concept is not widely recognized in Brazil.

In Brazilian mental health, cultural determinants have historically been overlooked by local practitioners and policymaker, with the local phenomenon known as the *silenciamento da cultura* (silencing of culture), seeking to minimize the role of cultural differences in mental health (Ortega & Wenceslau, 2020). This silencing originates from the national perception of Brazil as an ethnically homogeneous nation that assimilates cultural, racial, and ethnic differences. This perception of *uniformidade cultural* (cultural uniformity) is perpetuated by Marxist social scientists, despite living in a deeply stratified society marked by profound class inequalities and structural injustices (Ribeiro, 2000). The neglect, and

internal disputes concerning cultural determinants, contribute to ignorance or misinterpretations of the cultural dimensions of mental distress in mental health practices and services, occasionally resulting in their dismissal, reification, or misrepresentation (Ortega & Wenceslau, 2020).

The issue of racialization and racial discrimination has traditionally held a peripheral position in Brazilian mental health policies and service organization, gaining significant policy attention only recently (David, 2023; Pereira & Passos, 2017). This absent presence of racialization reflects the local silencing of culture, which obscures racism and the role of racialization in underlying class differences and inequalities. Despite the incorporation of discussion about racialization following the inclusion of the right to health as a fundamental social right in Brazil, and the establishment of the SUS, concrete actions to address racial inequalities have not been systematically taken due to 'insufficient funding' (Cobo et al., 2021). Moreover, while Brazilian psychiatric reform and mental health policies oppose discrimination against Black, Indigenous, and LGBTI+ communities, there has historically been minimal discourse on mental health care policies and practices specifically tailored to these groups. As a result, these policies have occupied a peripheral position, leading to poorer health outcomes. In contrast, there has been a growing body of research exploring ethnic, racial, gender and religious differences and their impact on various forms of exclusion and segregation in Brazilian society (Layton & Smith, 2017).

Recent local sociopolitical events have significantly influenced the structural-based mental health approach and intersecting debates surrounding it. The implementation of affirmative action policies in the country has sparked widespread discussion of racial differences, identity politics, and multiculturalism, which reverberate within Brazilian mental health care and policies (Bernardino-Costa & Blackman, 2017). In 2018, the murder of Marielle Franco – a Black woman, lesbian, favela resident, and left-wing politician – and the concurrent election of far-right candidate Jair Bolsonaro as President fueled discussions on structural racism and racialization in the country (da Silva & Larkins, 2019; Perry, 2020). Furthermore, the COVID-19 pandemic has underscored ongoing epidemiological research on the impact of racialization on health outcomes in Brazil, as observed elsewhere (Martins-Filho et al., 2021). This emphasizes the necessity for iterative changes in structural competency practices so as to integrate concern for structural racism. Following the unsuccessful downplaying of these issues during the Bolsonaro government, the 2022 electoral victory of Lula da Silva has brought intersectional debates on class, gender, race, and ethnicity to the fore, specifically in relation to the development of health policies for marginalized groups.

Discussion

In this Commentary, we have posited that distinct ideologies and politics have influenced the adoption of a structural-based approach to mental health practices in Chile and Brazil. Traditionally, healthcare practitioners in both countries have prioritized class-related factors while minimizing considerations of other social structures such as gender/sexuality and ethnicity/race. In contrast to the structural approaches to mental health currently observed in the US, approaches in Chile and Brazil have primarily emphasized poverty, social stratification, and socioeconomic disparities rather than addressing issues such as racism, gender violence, homophobia, and stigma (Ortega & Müller, 2023). However, recent developments in both cases indicate a shift in their structural-based approaches, expanding their focus from class to encompass gender, sexuality, race, ethnicity and disability – albeit often still linked to class. This evolving perspective reflects structural understandings akin to those in the USA, where notions of 'structure and the structural' encapsulate these dimensions, extending beyond mere class stratifications (Metzl & Hansen, 2014; Ortega & Müller, 2023; Stonington et al., 2018).

The emergence of identity struggles, the increasing prevalence of intersectional perspectives in academia and activism, local policy reforms in gender and multicultural spheres, and various sociopolitical events have contributed to the progressive inclusion of gender and racial perspectives, shaping novel intersectional debates within the field. Events such as Caribbean migration flows to

the South, the implementation of affirmative action policies, the tragic murder of Marielle Franco, the rise of Bolsonarism, the passing of Joane Florvil, the growth of the Chilean feminist movements, the 2019 social uprisings, and the recent electoral victories of progressive governments led by Gabriel Boric in Chile and Lula da Silva in Brazil have served as catalysts for change, prompting a shift in perspective.

Events in Chile and Brazil underscore the influence of local histories and contexts in shaping the engagement of prominent social and health institutions, experts, policy makers and practitioners with identity struggles and intersectional debates in public health. Both countries face challenges in acknowledging how their recent history impacts upon the introduction and use of competency models derived from the Global North. This is particularly pertinent given the 'silencing of culture' that has occurred in both contexts, and the subtle yet influential presence of race and racialization dynamics. Moving forwards, researchers, practitioners, service users, and activists should grapple with the challenge of critically and conceptually engaging with categories such as 'culture' and 'structure' in relation to mental health care concerns, exploring their interactions with broader historical and sociopolitical processes.

Notes

1. There are various contributions in this field. In addition to those already cited, we recognise the work of Taylor (2003), Kleinman and Benson (2006), and Yates-Doerr (2018).
2. Structural competency discussions are mainly US-based debates. The literature outside the US is scarcer. Two special issues of the journal *Global Public Health* – on 'Structural competency in global perspective' (Piñones-Rivera, Martínez-Hernáez, Morse, Ferral, et al., 2023) and 'Global voices for global justice expanding right to health frameworks' (Piñones-Rivera, Martínez-Hernáez, Morse, Nambiar, et al., 2023) – broaden the discussion at an international level. In US work of structural competency, racism is viewed as a primary driver of health inequalities, and racialization monopolizes discussion of these issues.
3. These feminist demonstrations, also known as the Chilean feminist wave or the Chilean feminist revolution, correspond to a series of mass protests rallies, marches and art interventions against the government and violence against women in Chile.

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ORCID

Gabriel Abarca-Brown http://orcid.org/0000-0001-5369-1616

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