

Under- or overtreatment of mental distress? Practices, consequences, and resistance in the field of mental healthcare

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Abstract: The economic, social, and health costs of mental distress are increasingly burdening individuals and societies in Europe. Yet, overmedicalization of mild symptoms is also well documented. This accumulates in more pressures and demands on healthcare systems. In this article, I explore how the process of help seeking in mental distress might be shaped by health system design and functioning in one of the South European societies –Spain. Employing Bourdieu’s theoretical lens, in-depth interviews with healthcare providers and users of services are analyzed. I reveal how the logic of the mental healthcare field, which is reinforced by the market, the state, and the media, may result in medicalization of mild distress while severe mental illness remains undertreated. I also show how mental healthcare-seeking practices could gradually influence the functioning of the treatment system. Yet, points of resistance to medicalization can also be identified.

Keywords: healthcare seeking, common mental disorders, medicalization, health system, Pierre Bourdieu, Spain

Introduction

Loss of health due to common mental disorders – depression and anxiety, in particular – is high. They are among the leading contributors to years lived with disability for both men and women (James et al., 2018), which results in a call for more resources and attention to mental health promotion, illness prevention, and treatment (Kleinman et al., 2016; OECD/EU, 2018; WHO, 2013). The economic impact on health systems and the labor market is also substantial with an estimate of over 4 per cent of GDP across the member states of the European Union (OECD/EU, 2018). Olesen et al. (2012, p. 161) suggest that mental and neurological disorders, a significant proportion of which is depression and anxiety, pose “a serious threat to our social and healthcare systems as well as to the future of European economy”. The calculations of Chisholm et al. (2016), nonetheless, show that their costs could significantly diminish through health and economic returns produced by higher investment in effective treatments.

The burden of common mental disorders is driven by both their disabling nature and high prevalence. In Europe, every year around 4.5 per cent suffer from depression and over 5 or 6 per cent – from anxiety disorders (Alonso et al., 2004; OECD/EU, 2018). It is estimated that one in every four individuals will be affected by any common mental disorder in the course of their lifetime (Alonso et al., 2004). Yet, only slightly more than 50 per cent of those in need of mental healthcare receive it (Alonso et al., 2007). Whilst not rejecting the suffering and welfare losses caused by mental disorders, others (Horwitz, 2007; Rose, 2019), nonetheless, are more cautious with the figures reported in the community studies that are based solely on symptoms, which may be a normal response to stress in individuals’ everyday lives. They argue that prevalence of mental disorders and unmet needs for mental healthcare are overestimated and, consequently, result in medicalization of mental distress caused by stressful but normal life situations that “should be tackled directly, without the need for individualized diagnosis requiring treatment” (Rose, 2019, p. 181).

In light of this, the focus of the article is Spain, where the Financial Crisis that greatly hit South European societies is argued to have had a negative impact on mental health with substantial increases in prevalence of anxiety and depressive symptoms (Chaves et al., 2018; Gili et al., 2012). Yet, high equity of access to the health system in terms of its universality, affordability, and comprehensiveness (Doblytė & Guillén, 2020; Guillén, 2002; Petmesidou et al., 2019) might have helped to reduce negative health outcomes. Mental healthcare is fully integrated into the Spanish National Health Service that is organized on a gate-keeping basis with accessible and strong primary care. In other words, a general practitioner is a gate-keeper to secondary care—including to mental health specialists—that can be accessed upon referral only. The past decades have witnessed deinstitutionalization processes, a shift towards integration of inpatient mental healthcare to general hospitals and reinforcement of outpatient mental healthcare at primary and secondary care levels (Costa-Font et al., 2011). Mental healthcare specialists provide psychopharmaceutical and psychological therapies in mental health centers, generally established close to or within the facilities of primary healthcare centers to combat stigma and increase accessibility.

All of this results in lower unmet medical needs for health system-related reasons in Spain than the European average (Doblytė & Guillén, 2020; OECD/EU, 2018) and, especially, than in other South European societies (Petmesidou et al., 2019). Unmet needs for mental healthcare are also estimated to be lower (Alonso et al., 2007) and perceived effectiveness of professional mental help higher (ten Have et al., 2010) than in other Western European countries. At the same time, nonetheless, Martín García-Sancho et al. (2018) or Ortiz-Lobo et al. (2011) suggest overmedicalization of mild mental distress or subthreshold disorders, particularly with psychiatric drugs. The health system, including its culture or patient-provider relations, might impede help seeking of individuals in need (WHO, 2013) or, on the contrary, facilitate certain practices of healthcare utilization and treatment (Ortiz-Lobo et al., 2011).

The aim of this study, therefore, is to better understand how help-seeking practices in mental distress may be shaped by the health system design and how they consequently influence its functioning. Drawing on the narratives of healthcare providers and users of services with depression or anxiety disorders, I argue that high perceived accessibility of care might mask important ideologically-laden issues and gaps in the treatment system that result in overtreatment of mild distress whilst more severe mental illness remains undertreated. While there is ample literature addressing medicalization and professional help seeking for mental health problems including recent publications in this journal (e.g., Savage et al., 2016; Stafford et al., 2019; Taylor, 2020), most of the empirical evidence comes from North America or other English-speaking countries (Doblyte & Jiménez-Mejías, 2017; Van den Bogaert et al., 2017). The article, therefore, contributes to qualitative research on healthcare seeking that considers different institutional contexts. In the following sections, I first consider the employed theoretical concepts and research methods. I then present the results and finish with the discussion of the findings.

Theoretical concepts

The concept of medicalization of society has been in the academic discourse since at least the early 1970s – the time at which scholars started discussing concepts such as healthism (Crawford, 1980), medicalization of deviance (Conrad 1975) and how “medicine and the labels ‘healthy’ and ‘ill’” were becoming “relevant to an ever-increasing part of human existence” (Zola, 1972, p. 487). In mental health, it might be understood as a process by which behaviors and feelings “that are expectable responses to stressful circumstances” (Horwitz, 2007, p. 214) are managed with medical interventions or “become defined and treated as medical problems” (Conrad, 2007, p. 4). In other words, medicalization refers to the expansion of medical power or jurisdiction in a society (Williams & Calnan, 1996). Although the dangers of medicalization

are considered more frequently than its benefits, it should be treated as a value-neutral term that “may include both gains and losses to society” (Williams et al., 2011, p. 711).

As with any process, medicalization is potentially bidirectional, with a possibility of resistance and de-medicalization, when certain behaviors or situations are no longer defined using medical language and treated with medical interventions (Conrad, 2007; Halfmann, 2012). Halfmann (2012) stresses that medicalization should be considered as a continuous value rather than a category or state. It allows for analysis of slight increases or decreases in medicalization as well as of medicalization and de-medicalization as processes that occur simultaneously. He theorizes three levels –macro, meso, and micro– and dimensions –discourses, practices and identities– as a tool for the analysis of medicalization and de-medicalization. Finally, pharmaceuticalization is a concept that denotes dynamic processes of “transformation of human conditions (...) into opportunities for pharmaceutical intervention” (Williams et al., 2011, p. 711) that occur with or without medicalization. Given that medicalization itself may or may not involve the use of medicines, these processes might overlap, yet they are not necessarily identical.

Beyond the concepts of medicalization and pharmaceuticalization, the analysis also draws on the relational sociology of Pierre Bourdieu (1984, 1990, 1998b) and his conceptual triad of field, capital, and *habitus*. The health system is examined as a semi-autonomous field of power relations with its logic or rules of the game and structures of dominant and dominated positions differentiated by “the distribution of a particular kind of capital” (Bourdieu, 1998b, p. 15), i.e., social, economic and cultural capital or power. While economic resources or financing of healthcare services are undoubtedly critical in defining the logic of the field, field-specific cultural capital (e.g., psychoanalytic or psychiatric cultural capital) that is embedded in place and time is equally crucial in this game (Doblytė, 2019). The field is always a dynamic space, where agents aim to transform the form or distribution of dominant capital and, therefore, the structure of positions in the field (Bourdieu, 1998b). Yet, notwithstanding relative autonomy

embedded in the concept of field, its logic is also influenced by other fields and their principles, particularly the ones that are dominant in the field of power, i.e., the economic and political fields.

Finally, habitus is the mediating construct that captures internalization of the logic and structures of different fields by individuals in the form of “patterned propensities to think, feel and act in determinate ways” (Wacquant, 2016, p. 65). It organizes practices without presupposing their conscious calculations (Bourdieu, 1990) and operates “within the context of the opportunities and constraints afforded by the structure of the field” (Williams, 1995, p. 587). It functions as a field-specific ‘feel for the game’, i.e., objective structures incorporated by subjective agency (Bourdieu, 1990, 1998b). These durable mental and bodily structures maintain relative stability of objectified structures (the logic and positions in the field), for they tend “to generate all the ‘reasonable’, ‘common-sense’ behaviors (...) which are likely to be positively sanctioned” (Bourdieu, 1990, p. 55-56). In other words, they tend to inculcate doxa of the field, which is the taken-for-granted understanding about the field and its logic that is produced by the dominant, but incorporated by the dominated too (Bourdieu, 1998b). Yet, the generative and transposable nature of *habitus* as a capacity to produce a range of different practices does not exclude a possibility of agency and transformations within these structures.

To sum up, the Bourdieusian conceptual triad is used as a tool of analysis, which helps to explore and explain help-seeking practices in mental distress and how they are shaped by the interplay between objective (the structure of the healthcare field) and mental structures (*habitus*), which might lead to under-treatment, over-treatment or both (Doblytė, 2019). It allows to analyze the processes of medicalization and pharmaceuticalization not only as bidirectional and dynamic, but also as inherently relational, where different agents and fields with uneven power resources compete, cooperate and, consequently, shape increases or decreases in said processes.

Methods and materials

In this study, qualitative research methods – in particular, semi-structured in-depth interviews – were employed attempting to gain in-depth understanding of the logic of the mental healthcare field and to interpret how it could shape and be shaped by help-seeking practices, which goes beyond describing the formal institutional design. First, individuals with common mental disorders (mild to moderate depression, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder or post-traumatic stress disorder), who sought help in the public treatment system and received psychological or psychopharmaceutical therapies at some point in time, were interviewed aiming to reconstruct their trajectories towards and within the treatment system from the moment of acknowledging symptoms, their experiences and interpretations of barriers or facilitators. Second, healthcare providers that participate in the management of common mental disorders were interviewed in order to explore the logic and structure of the field of mental healthcare, and how it might promote or hinder help-seeking practices and access to care.

Procedure

The study protocol, including the study information sheet, informed consent forms, interview guides and socio-demographic forms, were reviewed and approved by the regional research ethics committee. Both healthcare providers and users of services were identified and recruited from within the public health and mental health centers in a medium-sized region in the North of Spain between 2017 and 2018. Additional participants were identified using snowballing techniques, as well as through personal acquaintance. As an initial invitation, the study information sheet was handed out to the potential participants in person, sent by e-mail or explained over the telephone. Prior to interviewing, all the participants were asked to sign an

informed consent form. The interviews were conducted in person, audio-recorded and took place at participants' homes, providers' offices or in a public place.

Participants

The recruitment process was stopped once the point of data saturation was considered to have been reached, i.e., the initial data analysis conducted simultaneously with data collection suggested thematic exhaustion and variability (Guest et al., 2006). As a result, 11 healthcare providers with clinical experience ranging from 6 to 40 years (the average clinical experience – 22 years) were interviewed: 5 general practitioners, 3 psychiatrists and 3 clinical psychologists. The sample further consisted of 10 working-age adults (7 women and 3 men) with depression or anxiety disorders. All users first accessed primary care and half of them were referred to mental health centers at least once. 4 participants also purchased psychological care in the private sector (exclusively or supplementary to services in the public health system). There was a fitting variety of ages (the average age – 40.4 years) and educational levels (2 participants with secondary education or below, 4 – vocational training, 4 – university degree or postgraduate).

Analysis

The transcribed interviews were analyzed in Spanish with the support of software for management of qualitative data – MaxQDA. The method of reflexive thematic analysis was used (Braun & Clarke, 2006; Nowell et al., 2017). After familiarization with the data by means of transcribing, reading and re-reading the transcripts, the system of tentative codes guided by the theoretical framework, research-relevant literature and the data themselves was produced and then used to code the interviews whilst allowing for the emergence of new codes. In other words, thematic analysis was both researcher- (theoretical) and data- (inductive) driven (Braun & Clarke, 2006). The subsequent phases included clustering codes into potential sub-themes

and broader themes (patterns of meaning) as well as, finally, reviewing, defining and further refining themes. The process, nonetheless, was recursive moving back and forth between the phases rather than lineal.

Findings

First, the narratives of the participants suggest that the mental health system is relatively accessible without significant financial (user charges for medicines) or non-financial (waiting times or long travelling distances) barriers. There is easy and quick access to general practitioners, who function as gate-keepers to specialized care and who play an important role in the management of mental distress:

I believe that it would be difficult to make it [*access*] easier. (...). I just do not think that we need to improve this. (clinical psychologist)

While this is in line with a low proportion of unmet medical needs in Spain (Doblytė & Guillén, 2020; OECD/EU, 2018; Petmesidou et al., 2019), the analysis of qualitative data reveals the logic of the field and the role of other fields that go beyond accessibility *per se* and that could explain certain logic of practice and outcomes for individuals and society, all of which are presented in the following sections. It is argued that being able to meet with a healthcare provider of any type without major barriers may not necessarily mean that individuals receive appropriate care or that those in need access it.

The findings are organized in five main themes: first, the logic of the field of mental healthcare; second, the perceived role of other fields in maintaining the logic of the mental healthcare field; third, healthcare-seeking practices and differences between mild and severe mental distress; fourth, possible consequences of medicalization for the field and individuals; and, finally, points of resistance and how agency might be enacted.

The logic of the field

Adequacy of care. Treatment adequacy or appropriateness, i.e., quality of care, is as essential for positive health outcomes as access to healthcare itself (Fernández et al., 2006). Although clinical guidelines recommend integration of treatments with pharmacotherapy being neither exclusive nor the first choice in treatment of common mental disorders (National Institute for Health and Care Excellence, 2011), nearly all of the interviewed healthcare providers emphasize overreliance on psychopharmaceuticals:

It is so comfortable for so many people that we end up overusing an instrument, which undoubtedly has enormous utility in a lot of situations, but often we are left only with it, we are left only with medications. (psychiatrist)

Despite *de jure* availability in mental health centers, the participants also suggest that non-pharmaceutical therapies are *de facto* limited due to a lack of resources, which leads to low frequency and effectiveness of consultations:

The problem we have with the recommendation of psychological treatments is that there are very few psychologists and a lot of people in need. (general practitioner)

I would say that the effectiveness of seeing people every two months is very little or none. (clinical psychologist)

A lack of adequate psychological services could also be illustrated by a large part of the interviewed users who have never been referred to these services. They have been prescribed exclusively psychopharmacotherapies over the years or even decades, as in the following cases:

The only care I have received has been medications, I have never had a consultation with a psychologist. (male user)

The doctor always approached it with the medical treatment as if it was the flu – medicines and nothing else. (female user)

Several users, as a result, have opted for psychological care in the private sector. All of them stress the economic burden this entails, however. Private counselling, therefore, might be an alternative to psychopharmacotherapies in the public health system, yet access to it relies upon sufficient economic resources, which signals inequities in accessibility. Taken together, while the participants do perceive healthcare services as accessible, their discourses, suggest that this is not always the case. In particular, the interviews reveal that psychological therapies are not necessarily accessible or, when accessed, sufficiently adequate.

The dominance of biomedical discourse. Many of healthcare providers explain the limited access to and adequacy of psychological therapies as an issue of cost or resource control, because of which “there is no other option as to have either one or the other treatment” (psychiatrist). Yet, certain treatments become the first choice more often than others. This might suggest the role of certain medical hierarchy or the structure of dominant and dominated positions where biomedical rules of the game prevail:

The general practitioners have a medicalized vision. Then, I am working with someone from a psychological point of view and, if not in agreement with my work, the doctor convinces the patient that it is better to make an appointment with a psychiatrist. That happens a lot. (clinical psychologist)

In other words, there is acknowledgement of the importance of biological, psychological and social aspects in mental distress, but domination of biological responses to it, which seems to transcend geographical borders (Bendelow, 2010; Conrad, 2007; Rose, 2019). The psychiatrists and general practitioners generally internalize these dispositions in their *habitus*:

Since SSRIs, [*the issues*] we have at this level we have been solving practically everything with them. (general practitioner)

They internalize and, without consciously reflecting on it, accept the rules of the field as taken-for-granted or, in Bourdieu's language, doxa. It is "the point of view of the dominant, which presents and imposes itself as a universal point of view" (Bourdieu, 1998b, p. 57) and, therefore, is also inculcated by the dominated through socialization processes in the healthcare and other fields. Biomedical solutions, consequently, are perceived as appropriate and sufficient:

[*My general practitioner*] prescribed anxiolytics and antidepressants. I said to her that, look, at the moment if I see that I am feeling well with these, I don't see any need to go to a psychiatrist or others. (male user)

Likewise, several users express distrust towards psychological treatments in the field. They perceive them as ineffective or to be lacking rigor, that results from their own past experiences or beliefs acquired in other fields. The logic of the field creates a vicious circle where possibilities to receive adequate and effective psychological treatments are scarce due to the biomedical rules of the game in the field (quick results and effectiveness in as few consultations as possible) that, consequently, confirms superiority of biological treatments. Incorporation of these beliefs into one's *habitus* "generates meaningful practices and meaning giving perceptions" (Bourdieu, 1984, p. 170), which shape the expectations of the users – in particular, an expectation that if healthcare is sought, a physician will provide treatment usually in the form of pharmaceutical prescriptions. In other words, there seems to be a correspondence between supply of services and demand or 'taste' for them (Bourdieu, 1984)

To sum up, the analysis suggests that healthcare can be generally accessed without significant structural barriers. Some treatments, however, are less accessible and adequate than others. Available care appears to be highly dependent on psychopharmacotherapies, which seems to

be the case both in Spain (Martín García-Sancho et al., 2018) and other countries (Rose, 2019). Although clinical trials evidence superiority of psychopharmacotherapy over placebo in treatment of common mental disorders (Arroll et al., 2009; Bighelli et al., 2018), there are growing indications of its limited therapeutic capacities, particularly when its long-term risks and withdrawal effects are considered (Götzsche, 2013; Kirsch, 2014; Rose, 2019). Effective non-pharmaceutical therapies (Abbass et al., 2014; Hunot et al., 2007) could supplement or even replace medications. Yet, while *de jure* available, psychological services in the public treatment system are not necessarily accessible or adequate, due to lesser amenability to the logic of the field (Horwitz, 2007). Several healthcare providers explain it as an issue of cost control. Increasing antidepressant consumption and reliance on these therapies, however, suggest the dominance of biomedical model and psychiatric capital.

The role of other fields

Through accumulation of different types of capital (economic, informational or political), other fields – the market, the journalistic field or the political-bureaucratic field that finances and regulates services – might also contribute to preserving the logic of the field of mental healthcare (Doblytė, 2019).

The market. First, half of the healthcare providers talked about the pharmaceutical industry and its role in mental healthcare:

I think that [*mental distress*] is medicalized so much because there is an industry that puts on a lot of pressure. (psychiatrist)

The visits to health centers by pharmaceutical company representatives are perceived as encouraging certain medical practices:

Every single day pharmaceutical company representatives come to this mental health center and spend the entire morning waiting to talk to all the psychiatrists (...). And then we have what is called the phenomenon of variable prescription.

(clinical psychologist)

Notwithstanding their active presence, others nonetheless, consider them solely as providers of information where healthcare providers are autonomous in their decision-making process. While physicians indeed remain the gate-keepers of pharmaceuticals, the market is frequently positioned as a dominant agent in this game with increasing use of psychopharmacotherapy (Conrad, 2007; Gøtzsche, 2013; Rose, 2019). Conrad (2007), for instance, demonstrates how the pharmaceutical industry in the US manages to influence regulators, physicians or consumers and expand diagnostic categories. Gøtzsche further evidences these relations between the industry and physicians, which is the case particularly in psychiatry since “definitions of psychiatric disorders are vague and easy to manipulate” (2013, p. 191).

The state. Likewise, the relations between healthcare providers and policy-makers or regulators mirror uneven balances of power as well as medical hierarchy in the field itself. On the one hand, a considerable part of psychiatrists and general practitioners perceive cooperation rather than antagonism with the political-bureaucratic field:

Psychotherapy is much more expensive than the medication and we, the majority of us, try to be co-responsible for the resources we have. (general practitioner)

Their *habitus* that is attuned to the logic of the field of mental healthcare, therefore, is “what enables the institution to attain full realization” and reproduction (Bourdieu, 1990, p. 57). At the same time, it guarantees that their accumulated cultural capital (i.e., biomedical) remains dominant in the field. Some of the clinical psychologists, on the other hand, experience more

conflictual relations that may result from their dominated position in the field due to the limited biomedical cultural capital:

It is a lost battle (...) as much as the clinical psychologists of the national health system have requested an improvement of their conditions, their request has never been considered. (...) My feeling is that those who are in power are not interested that psychotherapeutic services would be provided in reasonable conditions.

(clinical psychologist)

Their practices are not only dominated and, consequently, devalued at an individual level, which has been seen in users' skepticism towards psychological services, but also at an institutional level. Due to state regulations in terms of financing and healthcare workforce, psychological services cannot meet quality standards (continuity or frequency of sessions).

They may also be devalued by other state institutions:

[A]ll this process [*of workplace adaptation*] that I had with the inspector of social security. (...) The inspector said that if the psychologist did the report, they would not give me the workplace adaptation. (female user)

Thus, while the mental healthcare field is generally low-positioned in the overall structure of the medical field (Hindhede & Larsen, 2019), psychological therapies seem to be dominated or low-positioned in the mental healthcare field itself, which is reinforced by regulators and other public actors. In other words, the structure and regulations of the field as unequal distribution of dominant capital have "the power to impose the laws of functioning of the field most favorable to capital and its reproduction" (Bourdieu, 1997, p. 49).

The journalistic field. Finally, media might also reproduce the logic of the mental healthcare field through messages that help individuals accumulate certain types of cultural capital in objectified (goods such as medical technologies) and embodied forms (information and

knowledge). On the one hand, the mass media channels might retranslate the taken-for-granted vision of dominant biomedical principles of mental healthcare (Williams et al., 2011) and even reinforce them:

One of the things that led us to this [*overreliance on psychopharmaceuticals*] is television, TV health shows, health promotion – everything that initially seemed to be something positive. (psychiatrist)

It is also a clear ideological question where the medical model is maintained through practices of doctors, pharmaceutical industry and the mass media that insists non-stop. (clinical psychologist)

On the other hand, information about mental distress and healthcare helps to destigmatize mental illness and to educate in health as part of cultural capital, as well as possibly facilitating help-seeking practices:

I think that there is much more [*information*]. They talk much more, they write much more. (female user)

It is very accepted, because look (...) they talk so much about depression and anxiety on TV. They talk that they are very common problems. (general practitioner)

Individuals might deeply and durably inculcate these media messages about mental distress, including popular headlines that emerge in several users' discourses:

It should be really seen as an epidemic. (male user)

Stress is a new epidemic or pandemic. (female user)

While the stress discourse on television and other mass media channels increases mental health literacy, such mental health promotion as a popular health topic driven by health centrality in the society or even commodification of emotionality (Bendelow, 2010; Horwitz, 2007) can become a double-edged sword. The journalistic field generally searches for *dramatization* and “exaggerates the importance of that event” (Bourdieu, 1998a, p. 19) in order to engage with the audience and to increase visibility of the topic. In other words, media channels “call attention to those elements which will engage everybody” (Bourdieu, 1998a, p. 18) such as stress or anxiety while ignoring or only negatively covering severe mental illness, which remains stigmatized.

Medicalization of mental distress

The interplay between different fields is likely to shape certain logic of help-seeking practices or individual strategies of dealing with mental distress. While deinstitutionalization processes and integration of many outpatient mental health services to the primary care level make mental healthcare more accessible, the stress discourse and mental health promotion in the journalistic field may contribute to outcomes in the field that are not necessarily intended:

The one who is depressed – but who actually is not – because he lost his job, because his wife left him or because he had a car accident, this one will come and will talk about it (...). The one who initially has a good relational and socioeconomic situation and who suddenly has a depressive disorder, of course, feels guilty.

(general practitioner)

In other words, mild mental distress is normalized and even standardized. Yet, not all emotions and behaviors seem to be equally destigmatized. External factors behind distress imply its temporality, treatability and guiltlessness as compared to a genetic, personality or brain defect or disorder (Horwitz, 2007). It is likely to produce differences not only in stigma but also in

healthcare-seeking practices, which has been stressed by all the healthcare providers in the study:

Some people come a week after losing a job and not finding a new one, or after three days in mourning. (...) then, although there are very few cases of severe depression, those indeed tend to come late. (general practitioner)

Thus, while severe mental illness remains undertreated, these processes may lead to medicalization of social problems as an unplanned consequence. Through dramatization and failure to consider over-diagnosis, “media involvement, witting or unwitting, facilitates processes of pharmaceuticalization” (Williams et al., 2011, p. 715) and, more generally, of medicalization (Halfmann, 2012).

The role of healthcare providers. Medicalization at the micro level, nevertheless, is a relational process that involves face-to-face interactions. Agents who drive it are, first of all, healthcare providers that grant the patient role and, therefore, engage in decision-making to medicalize or not. They mediate between a technology – a medication or psychological therapy – and a user. Several narratives of the healthcare providers indicate that they might perceive pharmaceuticalization of mild mental distress as reducing suffering rather than shifting normal to pathological:

I recognize that I finally end up treating those who I do not refer [*to specialized care*] but who should not have come here at all. You end up treating them with SSRIs because it improves compliance and helps them cope better with the problem. (general practitioner)

General practitioners are the principal gatekeepers of medicalization in the Spanish National Health System. The narratives of the participants as well as findings by other scholars (Ortiz-Lobo et al. 2011) suggest high levels of pharmaceuticalization in the primary care and high

referral rates of these patients to the specialized care, resulting from objective (time constraints) and inculcated structures (pharmaceuticals as an adequate response to health problems):

It would be adequate and normal that they do not refer to a psychiatrist because of grief. It is not that you need to medicalize all the human suffering. (psychiatrist)

Counterintuitively, however, the users with no diagnosable mental disorder but with prescribed psychopharmacotherapy by their general practitioners are not necessarily de-medicalized once they access specialized care in the mental health center (Ortiz-Lobo et al., 2011). In other words, dispositions attuned to the logic of the field might be built into *habitus* of different healthcare providers. It organizes their practices (Bourdieu, 1990) and is predisposed to function in the healthcare field with the dominant classification systems and the taken-for-granted rules of the game.

The users as consumers. Nonetheless, medicalization should not be considered exclusively as the result of medical dominance or expert authority (Ballard & Elston, 2005; Conrad, 2007; Rose, 2019). The users of services also play an active role through claims and demands for healthcare. The internet and journalistic field, among others, “empower them as consumers of medical care” (Conrad, 2007, p. 140), which become “an important driver of pharmaceuticalization” (Williams et al., 2011, p. 717). Rather than passively accepting medical expertise and authority, they might demand certain services and goods:

Since for this – feeling depressed, a bit unwell, having a discomfort in one’s life – it is easy to take anxiolytics and to feel relieved, there are a lot of people who want it (...). People demand it. (general practitioner)

Although an assessment of medicalization of nondisordered mental distress in the sample of the users is beyond the scope of this study, some of their narratives reveal seeking medical rather than social solutions to social problems experienced by themselves or by their social networks:

As soon as a problem comes up that causes stress at work or out of work, they demand medications (...) for example, my parents... My mother, my sister – all of them – are taking medications. It's more common to see a box of *Tranquimazin* than a box of *Aspirine* at home. (male user)

For the user, medicalization not only legitimates but also relieves their suffering. Yet, it is the social rather than medical solution that might be more effective in the end:

Since I decided to quit my job, I am better, I feel much better. I think that work influenced a lot. At least, stress, tachycardia and sleeplessness were because of work. (female user)

The process of medicalization, therefore, is the result of relations between the healthcare provider and the user of services. When entering the field, healthcare providers internalize *illusio* or a belief in the game (Bourdieu, 1998b) including “the genuine belief that the drugs will ‘work’” (Rose, 2019, p. 125) or, similarly, the belief in psychological therapies. Some of them, particularly the dominated in the field, are more reflexive towards the processes of medicalization whereas others perceive mental distress, even if being a normal response to stress, as a medical condition. At the same time, the users of services inculcate transposable but durable dispositions that might also drive towards medicalization of distress, usually unconsciously and “without being in any way the product of obedience to rules” (Bourdieu, 1990, p. 53). Social *habitus* of users is shaped by experiences in different fields: the journalistic field influenced by the market, the educational field, the family or the healthcare field.

To sum up, while severe mental disorders remain stigmatized and undertreated, the healthcare field expands its jurisdiction to life situations and emotions that “are unpleasant but normal” (Horwitz, 2007, p. 217) such as losing a job, experiencing a divorce or grief. Given the taken-for-granted or *doxa* that dominates in the field, biological solutions to these social problems are

usually offered and, paradoxically, “more and more people are taking drugs whose mode of action is unclear and whose efficacy is debatable” (Rose, 2019, p. 129). Such medicalization of mild and common mental distress results in certain consequences and impacts the functioning of the institution. At the same time, as any other process, it is bidirectional (Conrad, 2007) and space for resistance or negotiation can be found.

Consequences of medicalization

Individualization of the social and chronification. Medicalization of the social, first of all, individualizes the social by remediating it with medical remedies rather than challenging social structures (Conrad, 2007). By defining mental distress caused by social situations as a disorder and treating it with psychopharmaceutical or psychological therapies, it ‘forgets’ other levels of intervention (Zola, 1972) such as collective bargaining:

We have three or four supermarket checkers from (name) on sick leave (...), perhaps it should be better analyzed in what work conditions they work and it would save a lot of suffering and a lot of consultations that are probably not useful.
(clinical psychologist)

Rose (2019) suggests that it is indeed those who experience worse life and oppressive work conditions that are most pathologized and often biologized. Furthermore, medicalization and, particularly, pharmaceuticalization of living may result in chronification, which was frequently discussed by the healthcare providers:

In the end, chronification is the only thing we are left with, because we don’t solve the problem and, even worse, we are going to generate the problem of having someone with dependence on medications. (...) So, it is a malpractice and, in the end, we make people chronic and sick that were not sick initially. (psychiatrist)

Instances of chronification also appear among the interviewed users. Several of them – the majority of whom have never been referred to specialized care – have been depending on psychopharmaceuticals, in general, and on benzodiazepines, in particular, for many years, even for several decades:

[*My general practitioner*] simply prescribes medications. (...) She doesn't look at my medical history to see how long I have been on medications and perhaps I should try another type of treatment, change the medication (...). No, nothing. (female user)

While some of the healthcare providers explain the lack of adequate non-pharmaceutical treatments as an issue of cost control, chronification and dependence on publicly-financed medications require substantial resources, which suggests that the structure of the dominant and dominated positions in the field might be more important.

Consequences for the field of mental healthcare. As a result, these consequences for individuals also influence the functioning of the treatment system. Medicalization of mental distress might undermine economic objectives of the public health system:

People enter in a vicious circle where they can no longer stop taking their medications (...) and, from the point of view of the system, that is disastrous. (clinical psychologist)

By the same token, it results in higher demand for services and, therefore, more pressure on the healthcare system and providers:

Every time we have more demand for treatment. (...) Our schedules have multiplied, although the population is the same. What happens is that there are lots

of problems that were unthinkable to intend to solve through the health system a few years ago. (psychiatrist)

Resulting time constraints are likely to affect clinical practice by limiting the types of treatments that are used or the frequency of appointments in specialized care. Taken together, this might influence user-provider relations and trust in them in terms of both technical competence and compassion or empathy (Gilson, 2003). Help-seeking practices result not only from present conditions of the field such as its accessibility, but also from past experiences in the treatment system or other fields (Bourdieu, 1990):

I think that people mostly worry about empathy, whether they are going to treat me well. (...) If not, they will delay seeking help. (clinical psychologist)

On the one hand, several users recount experiences of trusting relations with healthcare providers, which seems to be mediated by their capital resources. The users with lower accumulated economic and cultural capital or, in other words, higher power differentials between them and healthcare providers stress the importance of empathy or 'warmth' in user-provider relations. In the meantime, individuals with more capital resources seem to perceive trust as technical competence and professional relations:

If I go to a doctor, I do what they say; to the letter, because they are professionals and I do not doubt it. (female user)

On the other hand, distrust or doubt can also be identified in the narratives of the users. In nearly all of these accounts, distrust is linked to time constraints, which can result in doubts concerning quality of services:

I see it as a system of (...) 'yes, the next one'. In other words, I arrive, explain and am told – yes, the next one. And it has been like this during the years. (...) They try with this or that medication, but they do not care about your problem. (male user)

In the case of limited cultural capital, nonetheless, distrust is more often expressed as a lack of compassion rather than quality of services itself:

We are not numbers, I don't see that they treat us as humans (...) more humane, they should be more humane. (female user)

Brown and Meyer (2015) find that such distrust does not necessarily result in exit or voice but rather influences experience and meaning of healthcare. These experiences might shape treatment delays or types of access to the healthcare field:

My experience is not to trust them. So yes, you are afraid to go to the doctor and to say that you feel sorrow. (female user)

Many times, when feeling unwell, I would go to the emergency room in order not to go to her [*general practitioner*]. (female user)

Thus, trust can be critical for the effective functioning of the health system or quality of care (Brown & Meyer, 2015; Gilson, 2003). Healthcare seeking is shaped by experiences of trust or distrust that are inculcated in *habitus* and mediated by agent's capital resources.

Points of resistance

Both healthcare providers and users of services, however, do not necessarily accept medicalization and its consequences passively and uncritically. Ballard and Elston (2005), Conrad (2007) or Williams and Calnan (1996) suggest possibilities of de-medicalization processes and skepticism towards the healthcare field. There is always some space for resistance

or agency through *habitus* and its “infinite yet strictly limited generative capacity” (Bourdieu, 1990, p. 55). Notwithstanding their mental structures or dispositions being *a priori* adjusted to the objective structures of the field, healthcare providers might intend to avoid medicalization, in general, and pharmaceuticalization, in particular:

I try to normalize but never take away the importance. I always say that it is very important what has happened to you (...) but that it is not necessary to medicalize something that is normal. (general practitioner)

The interviewed clinical psychologists also support short psychological interventions in primary care as a means to reduce pharmaceuticalization of mild or moderate mental distress (Martín García-Sancho et al., 2018). Yet, it can still be seen as a form of medicalization, for mental distress is managed by agents in the healthcare field, who professionalize suffering and individualize the social even if without psychopharmaceuticals:

I don't agree with those psychological interventions like when your father dies and that same day a psychologist sees you. I think that first you have to find your own personal resources. (psychiatrist)

This doubt and skepticism towards medicalization and medical doxa are further developed by the users of services that are not necessarily “passive consumers who are duped by medical ideology” (Williams & Calnan, 1996, p. 1613). Their negotiations with providers not to be medicalized with psychopharmaceuticals in a clinical encounter illustrates such agency:

I told them that I don't want medications, first I want to be treated by a specialist.
(male user)

Others resist medicalization by not adhering or abandoning treatments:

I stopped [*antidepressants*] on my own, I looked at the information pamphlet and knew what I had to do. (female user)

These processes of playing with medications or disengaging from the mental health services altogether can be interpreted as a means of taking control or enacting choice (Brijnath & Antoniadou, 2017; Katz et al., 2019). Some of the users also opt for private psychological care as a form of resistance to experiences of (over)medicalization in the healthcare field, although “the conceptual and ideological framework within which it is promoted remains a medical one” (Ballard & Elston, 2005, p. 238).

Resistance to pharmaceuticalization in the healthcare field (rather than to medicalization itself) varies not only between individuals, but also over time with the possibility of resistance to and demands for medications being enacted by the same individual. It is, therefore, dynamic or situational (Brijnath & Antoniadou, 2017; Chamberlain et al., 2011). The interviews suggest, nonetheless, that resistance and its outcomes depend on accumulated cultural and economic capital. Agents with capital resources can successfully avoid pharmaceuticalization through exiting the public system and choosing other strategies, whereas those with scarce capital resist by not adhering to treatments or abandoning care without alternative strategies to follow it, which may result in relapses and, consequently, chronification. These power dynamics lead to reproduction of capital and structures “with the economically and/or culturally privileged, alongside the less unwell, more able – via exit or voice capacities – to *afford* not to trust” (Brown & Meyer, 2015, p. 741) and to express their ‘choice’.

Conclusions

The findings of this study go beyond accessibility of healthcare, which proves to be relatively high, and reveal how the logic of the field of mental healthcare with its dominant and dominated positions results in increasing reliance on biological therapies and a lack of access to adequate

non-pharmaceutical ones. The analysis also explores how the interplay between the pharmaceutical industry, which accumulates economic capital and dominant scientific expertise, the political-bureaucratic field as “organizational structure and regulator of practices” (Bourdieu, 1998b, p. 54) and the journalistic field with accumulated informational capital might help to preserve the logic or doxa of the field.

Furthermore, processes of mental health promotion through the journalistic field, among others, foster normalization of common mental disorders. Not all behaviors and suffering seem to be equally standardized, however. While mild mental distress caused by life difficulties is shown as being prevalent, normal and, at the same time, medicalized suggesting medical solutions such as psychopharmaceutical or psychological therapies, severe depression and mental disorders remain undertreated. It results in a gap in treatment seeking with social problems shifting from the social field to the medical one and, therefore, in medicalization and, particularly, pharmaceuticalization of society.

The analysis unveils that medicalization of mental distress caused by social troubles individualizes those problems and ‘forgets’ other levels of interventions. Pharmaceuticalization of distress without approaching its roots might also cause chronification and lead to “an increasing dependence upon biomedicine to provide the answers to social as well as medical problems” (Williams & Calnan, 1996, p. 1613). Consequently, this logic of practice is likely to gradually change the functioning of the institution with no actual reforms in the mental healthcare system. It steadily creates more demand for services and goods, which may undermine the quality and economic objectives of the healthcare system in the future, and which shapes clinical encounters and relations of trust or doubt between healthcare providers and users of services. Medicalization of mild or non-disordered mental distress requires care and resources that “can be much better spent treating and preventing genuine illness” (Moynihan et al., 2012, p. 4).

Yet, medicalization and pharmaceuticalization are dynamic, relational and bidirectional processes between healthcare providers and users of services who may be not only passive producers and consumers of healthcare, but also its active challengers. The lay populace, in particular, are not always passive users of services, but are also increasingly skeptical towards them (Ballard & Elston, 2005; Chamberlain et al., 2011; Williams & Calnan, 1996). Medicalization and de-medicalization, therefore, can co-exist with agents “becoming both more skeptical and more dependent on medical and technological developments” (Ballard & Elston, 2005, p. 237). As in the study by Chamberlain et al. (2011), the findings show that resistance to medicalization and/or pharmaceuticalization can take a variety of forms including a possibility of consumption and resistance by the same agent over time.

The forms of resistance, however, depend on agents’ personal trajectories and past experiences inculcated in *habitus* as well as accumulated cultural and economic capital resources, leading to the reproduction of capital. The economically and culturally privileged can manifest their doubt more effectively and choose alternative strategies (e.g., private psychotherapy) avoiding pharmaceuticalization and chronification in the healthcare field but not necessarily medicalization itself. The agents with less accumulated economic or cultural capital may also resist medicalization and, particularly, pharmaceuticalization, but often without alternative resources or strategies, which is likely to lead to acceptance of medications in the end. As such, the public mental healthcare system seems to contribute to the reproduction of inequalities in the social field as a whole through chronification of the social that creates dependence on healthcare services and goods rather than restoring health.

To conclude, the aim of this study has been to better understand help-seeking practices in mental distress and how the institutional context of the health system might shape such practices. It outlines one of possible generative mechanisms, as well as evidencing possible outcomes and resistance pathways. The findings could go beyond the Spanish context and are likely to

indicate more general trends of medicalization of emotionality that is driven by multiple agents and fields as well as the role of agency in it. Yet, there might be other explanations, agents, consequences or points of resistance that the analysis has not captured. The self-selection bias should also be taken into consideration. The healthcare providers and users of services who were willing to participate in the study might have been more reflective and critical towards the mental health system and/or have had more negative experiences within it. Voluntary participation in qualitative interviews, nonetheless, is “central to ethical good practice” (Robinson, 2014, p. 36) and to the reliability of information provided by the participants.

Finally, the question of how and which factors of the social field as a whole drive to everyday life “being colonized by pharmaceutical solutions” (Williams et al., 2011, p. 722), in general, and to the analyzed help-seeking practices, in particular, falls beyond the scope of this article. This suggests, nevertheless, future research directions that engage with the analysis of “how the populace has internalized medical and therapeutic perspectives as a taken-for-granted subjectivity” (Conrad, 2007, p. 14) and that could include an in-depth analysis of media discourse or of narratives of other agents in the game, e.g. policy-makers. Research in other countries or with larger samples could also complement the findings of this study.

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