"Women are tired and men are in pain": Gendered *habitus* and mental healthcare utilization in Spain

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Abstract: Beyond differences in need, the gender gap in mental health might also be attributed to differential help-seeking practices between women and men. Employing Pierre Bourdieu's sociology, the aim of this article is to interpret how gender influences healthcare seeking and utilization in common mental disorders such as depression or anxiety in Spain. Through thematic analysis of in-depth interviews conducted with healthcare providers and users of services, I reveal how the male/female oppositions in social and mental structures might result in gendered mental healthcare-seeking practices and differential enactment of agency that reproduce power relations between men and women. While men are less willing to seek healthcare, which is shaped by masculinity ideals, women appear to be dominated in the field that is likely to lead to their higher medicalization and, consequently, chronification. The article contributes to the literature analyzing gender as a relational phenomenon and the social construction of gendered behaviors in light of Bourdieu's sociology.

Keywords: Mental health, gender, habitus, healthcare seeking, qualitative research, Pierre Bourdieu, Spain

Introduction

It is frequently concluded that women have poorer health, in general, and more common mental health problems, in particular. They report suffering from chronic depression as well as

consulting medical professionals and mental health specialists substantially more often than men (source: Eurostat). At the same time, however, not only do men live shorter, but they also die by suicide nearly four times more often than women, lose their lives in transport accidents three times more often than women, which might result at least partially from reckless driving as a means of stress release (Dolan, 2011), and engage in other risk behaviors such as heavy alcohol drinking more frequently than women (source: Eurostat). All of this may signal that, like women, men suffer from mental distress, but they are less likely or willing to recognize it and consequently to seek healthcare (Addis & Mahalik, 2003; Doblyte & Jiménez-Mejías, 2017; Galdas et al., 2005; Pattyn et al., 2015). In other words, there is not necessarily a difference in need but rather a difference in help-seeking practices between genders.

Courtenay (2000) argues that men use their health-related beliefs and behaviors such as emotional stoicism or denial of weakness to demonstrate masculinity ideals and, among other consequences, they "reinforce strongly held cultural beliefs (…) that asking for help and caring for one's health are feminine" (p. 1389). Other scholars (~~Author 1;~~ Dolan, 2011; Galdas et al., 2005; Springer & Mouzon, 2011) also refer to such masculinity beliefs as a significant factor influencing men's health behaviour where avoidance of help seeking functions as a means to protect their masculinity. In order to legitimize help seeking, a certain threshold of suffering that indicates the seriousness of a condition needs to be reached (Noone & Stephens, 2008), which is particularly the case in mental health problems (Doblyte & Jiménez-Mejías, 2017; O'Brien et al., 2005). Pattyn et al. (2015, p. 1093) add that not only men but "also women (re)construct masculinity norms" by prescribing differential coping strategies in mental distress for each sex.

This article, therefore, contributes to the literature addressing the interplay between gender and health behaviors. The aim of the article is to examine how gender might be enacted in the field of mental healthcare, and facilitate or constrain healthcare seeking and utilization in mental

distress. To achieve this, I analyze in-depth interviews with healthcare providers and users of services with depression or anxiety in Spain. The weight of traditional gender and family values in Southern Europe is often stressed, particularly in light of familistic public policies such as limited care services that, in turn, may reproduce the roles of women as carers and men as breadwinners (Moreno Mínguez, 2010) as well as the gender care gap, which is found to be large in the region (Da Roit et al., 2015). Likewise, the stereotypes such as women being more vulnerable and men being 'tough', risk-loving and athletic remain prevalent in the culture (García-Calvente et al., 2012).

The healthcare system could also reproduce gendered social practices (Courtenay, 2000). The design of mental healthcare in Spain, nonetheless, *a priori* appears to be equitable. It is fully integrated into the Spanish National Health System, which is accessible, comprehensive and free at the point of use (Doblytė & Guillén, 2020). Mental health specialists provide services in the mental health centers that can be accessed upon referral from general practitioners, whose role in managing common mental disorders is also substantial (Vázquez-Barquero & García, 1999). In turn, the Spanish hold more positive attitudes towards mental healthcare than residents in other Western European countries (Ten Have et al., 2010). Yet, the gender gap in common mental disorders has been found to be greater in Southern Europe (Van de Velde et al., 2019), which might reflect differences in stressors caused by the gendered social roles. Uncovering how gender is likely to influence perceptions of mental help need and, consequently, healthcare seeking and utilization may also help to explain the gender gap in mental health.

Theoretical lens

The research is informed by critical realism (Bhaskar, 2016; Danermark et al., 2002; Fletcher, 2017) that emerges as an alternative to both positivism and strong constructivism. Reality,

whose part the social phenomenon under research forms, is seen as an open, emergent, stratified and differentiated system, "in which events are determined by a multiplicity of mechanisms" (Bhaskar, 2016, p. 80). Social research is interested in uncovering some of these deep generative mechanisms based on collected evidence and available theoretical knowledge that is always fallible. In other words, reality exists independently from human knowledge, theories and concepts (it is not exhausted or determined by them), but it is known and explored through them (it is theory-laden). Theories and theoretical concepts provide us with an interpretive framework to go from observable regularities of events or experiences within the empirical domain to the possible mechanisms that produce those events.

First, the theory of hegemonic masculinity (Connell, 2005; Connell & Messerschmidt, 2005) can be a useful tool for "understanding the ways men construct masculine identities within the context of health" (Noone & Stephens, 2008, p. 713). It implies a plurality and hierarchy of masculinities with hegemonic masculinity incorporating 'ideal' characteristics of 'being a man' in a particular context that are often represented by symbols of masculinity such as professional football players or actors, who "have authority despite the fact that most men and boys do not fully live up to them" (Connell & Messerschmidt, 2005, p. 846). Health practices in the treatment system, which is often perceived as a feminine space, can be seen as incompatible with the ideals of particular hegemonic masculinity. Yet, it is not a 'natural' and static structure but rather reproduced relationally between agents or institutions and in contrast to non-hegemonic masculinities and femininities (including emphasized or hegemonic femininity). The model stresses that gender is not only relational – "'masculinity' does not exist except in contrast with 'femininity'" (Connell, 2005, p. 68) – but also plural and dynamic.

The relational dimension of gender can be further explored through Pierre Bourdieu's sociology (1990, 2001) and his conceptual triad of field, capital, and *habitus*. Although Bourdieu focused more on social class and its reproduction, he also devoted substantial

attention to gender and, particularly, to masculine domination (Bourdieu, 2001). Cockerham (2018), Dixon-Woods et al. (2006) or Robinson and Robertson (2014) demonstrate the potentiality of his theoretical approach in the analysis of gender and health behaviors, specifically. The interplay between the field as a dynamic structure of power positions, where agents with differential capital resources (economic, cultural or social) aim to maintain or transform their positions, and *habitus* as personality structures or "systems of durable, transposable dispositions" (Bourdieu, 1990, p. 53) that organize one's practices allows for "conceptualization of differentiation within the construction of gender identity" (McNay, 1999, p. 96).

In this article, therefore, the concept of gendered *habitus*, which is enacted in the field, is employed to examine different healthcare seeking and utilization practices between men and women. Such gendered dispositions are inculcated through early socialization into masculine and feminine roles, and then confirmed or transformed through later experiences in different fields (Bourdieu, 1990). Bourdieu stresses the importance of analyzing social practices as power relations between the dominant and dominated agents. Masculine domination, in turn, is understood as enacted and reproduced through such relations, which are deeply inculcated into *habitus* and accepted as 'natural' becoming "the prime example" of symbolic power (Bourdieu, 2001, p. 1). The oppositions between properties, expectations or activities are "organized according to the division into *relational genders*, male and female" (Bourdieu, 2001, p. 22). These divisions are embedded not only in social structures but also in gendered *habitus*, "which lead to the classifying of all the things of the world and all practices according to distinctions that are reducible to the male/female opposition" (Bourdieu, 2001, p. 30).

Thus, healthcare-seeking delay may be understood not as the result of masculinity norms themselves, but as the result of these oppositions in social and mental structures and, consequently, men's pre-reflexive self-protection from potential user-provider relations and

their position in them, i.e. being dominated in the healthcare field, which is feminine *per se,* but which is further organized according to the male/female oppositions (Bourdieu, 2001). The aim of the article, therefore, is to explain how the dominant-dominated relations and the fundamental male/female opposition in the social field as a whole (as embedded in social and mental structures) might be enacted in the healthcare field.

Finally, although being generally pre-reflexive (McNay, 1999) and one of the reasons for the stability of structures (Bourdieu, 1990; Cockerham, 2018), *habitus* is generative, flexible and dependent on personal trajectories. As a result, not only does it give some autonomy and creativity to agency (McNay, 1999), but also permits plurality of dynamic masculinities and femininities. This study identifies some of these possibilities and enactments, albeit not assuming to be altogether exhaustive. O'Brien et al. (2005), nonetheless, show how active agency and resistance may preserve rather than threaten traditional masculinity ideals, i.e., reproduce gendered dispositions. It is also intended, therefore, to understand whether and how gendered *habitus* is reproduced or challenged.

Materials and methods

Procedure

The article focuses on understanding individual experiences or perceptions and interpreting how gendered *habitus* as one of the possible generative mechanisms might shape them. In other words, the "primary focus is on *structures* and *mechanisms*, not regularities or patterns of *events*" (Bhaskar, 2016, p. 79; emphasis original) and, to achieve this, the intensive or qualitative approach –specifically, semi-structured in-depth interviews– is employed. The study protocol has been approved by the Research Ethics Committee in a medium-sized region in the North of Spain. Prior to interviewing, the interview procedures and ethical matters have been explained to the participants, who have then provided informed consent. The overall focus

of the empirical study was not gender, in particular, but rather healthcare seeking, in general, and how it is embedded in social, cultural, and institutional contexts. The participants, therefore, had not been asked to think about gender and health beforehand, but have been prompted spontaneously or it has emerged when discussing other topics.

Participants

The participants –healthcare providers and users of services who suffer or have recently suffered from depression or anxiety disorders– have been recruited purposively in the public health and mental health centers, as well as using snowballing techniques to identify additional users of services. The total of 21 participants have been interviewed. The sample included five general practitioners, three psychiatrists and three clinical psychologists (in total, five women and six men), whose clinical experience ranged from 6 to 40 years, the average being 22 years.

Besides, the interviews have been conducted with 10 working-age adults with depression or anxiety disorders. There has been a variety of ages (four participants younger than 36, four between 36 and 50, and two older than 50) and educational levels (two participants with secondary education or below, four with vocational training, and four with university degree or postgraduate). Yet, it has been substantially easier to identify and recruit women than men, which is in accord with expectations – particularly, given the high gender gap in treatment for common mental disorders in Spain (Van de Velde et al., 2019). As a result, seven women and three men have taken part in the study. While it is a relatively small sample of each group, Robinson (2014, p. 29) argues that it is sufficient for research with an idiographic aim and recommends precisely 3 to 16 individuals "for an intensive analysis of each case to be conducted".

Analysis

The interviews have been analyzed using a technique of reflexive thematic analysis (Braun & Clarke 2006, 2019; Nowell et al., 2017) with support of the software for qualitative data analysis MaxQDA. The coding process has been both data and researcher driven, i.e. the code list has been developed moving back and forth between the interview transcripts and the theoretical concepts introduced earlier. The interviews have been coded using this list while allowing new codes to emerge. The codes have then been clustered into major themes and sub-themes, which have been reviewed, defined and refined several times. In other words, coding can be summarized as abstraction, which is "the practice of dividing a whole into elements that are distinct from one another" and generalizing, which is "the practice of finding what is common or repeated among these elements" (Packer, 2011, p. 59). Nevertheless, it has been a recursive rather than linear process with a researcher actively developing themes by interpreting the collected data (Braun & Clarke, 2006).

Results

Several interrelated sub-themes that are clustered into two major themes have been generated during the analysis: first, the oppositions homologous to the one between the male as dominant and the female as dominated in social and mental structures; and second, gendered healthcare seeking and utilization practices as shaped by these oppositions.

The male/female oppositions

Provider vs. carer

Despite increasing female participation in the labor market, the participants –particularly, healthcare providers– explain the gender gap in mental health fundamentally as the result of distinct drivers of distress that are objectified in social structures as an opposition between the social roles or as the gendered division of labor. Women are perceived as carers –including

caring for family health and well-being– and, therefore, as being more burdened by care responsibilities along with their work commitments, if any. This results in a negative impact on health and in women's overrepresentation in common mental disorders. The female users of services spoke about their carer role as a factor explaining their distress or non-adherence to a medication regime:

> I think that, since we ['*nosotras' – we feminine*] take on more responsibilities in life, we are always going to have more problems or more chances to have depression than they [*'ellos' – they masculine*]. (female user, 36-50)

> The medications were very strong, I couldn't take care of my daughter. (female user, 51-65)

In the meantime, males' distress is likely to be explained through their role as providers (work-related issues as opposed to 'feminine' family problems). Likewise, their concerns about being in treatment focus on employment rather than care:

> If men come, they mostly come not because of the problems with children or family, but because of work problems, always. (general practitioner)

The importance of the provider role has also been stressed by all men in Dolan's study (2011), and withal Van de Velde et al. (2019, p. 486) find that unemployment for men, i.e. "not living up to the normative standard of the male breadwinner model", leads to a much higher risk of mental health problems than for women. The persistence of the provider/carer opposition may in turn be viewed as the result of its incorporation in *habitus* that can be summarized as the strong/vulnerable opposition:

> Showing negative feelings and vulnerability is more acceptable for women. There are many men who do not tolerate it. (…) It is harder for them to accept that

> someone knows more and put themselves in a position where they are helped, weak or however you want to name it. (clinical psychologist)

The essence of such body or mental structures is usually blurred –questioned but accepted– by embedding them "in a biological nature that is itself a naturalized social construction" (Bourdieu, 2001, p. 23). While the male participant below questions masculinity ideals as the social construction imposed on individuals, his narrative suggests that they are deeply built into his *habitus* as nearly 'natural' properties:

> There are some stereotypes of masculinity that everyone wants to meet, they are compulsory if you want to be respected by the rest. (…) Even so, of course, if something has saved me from my anxiety decaying into a depressive state all this time, it is this pride and self-esteem. (male user, 36-50)

Therefore, gendered expectations (provider/breadwinner vs. carer) and conditions individuals live in (the divide between the public and home/private spaces) generate mental structures (strong vs. vulnerable) that are "objectively compatible with these conditions and in a sense pre-adapted to their demands" (Bourdieu, 1990, p. 54).

Physical vs. mental healthcare

The male/female or dominant/dominated opposition also structures the healthcare field: the general medical field as oriented to physical conditions, on the one hand, and mental healthcare, on the other hand, the latter of which is dominated (Album and Westin, 2008; Doblytė, 2019; Hindhede and Larsen, 2019). This in turn generates dispositions in *habitus* that oppose body (male) and mind (female):

> In common mental disorders, men are very often referred here with osteoarticular pains and problems. (psychiatrist)

> My first reaction was denial. I cannot have this, it must be another disease that they didn't detect and that makes me feel accelerated. (male user, 36-50)

Such oppositions in the social and healthcare fields, therefore, result in double domination for men and could explain their reluctance to seek help. It is not only an illness (health domain as feminine), but also a mental rather than physical condition (the body/mind opposition). Indeed, O'Brien et al. (2005, p. 515, my emphasis) suggest that "consulting with emotional or mental health problems as a man may be constructed as 'behaving like a woman' in both *healthcare* and *everyday* contexts".

Psychiatry vs. psychology

Finally, the field of mental healthcare itself appears to be structured by the male/female opposition. Psychiatry, which is equated with psychopharmaceuticals and perceived as neutral and evidence-based, is dominant whereas psychology as associated with talking is subjective and dominated (see Strand, 2011 for more details on the dominant/dominated relations between psychiatry and psychology). Rather than seeing psychopharmaceutical treatments as a less time-consuming solution than psychotherapy as suggested by Pattyn et al. (2015), men in this study perceive medications as a technology that can relieve symptoms, even if temporary and preferably avoidable, whilst being skeptical towards psychological therapies. In other words, they explain their practices as oppositions between effective and ineffective or objective and subjective:

> For me, it is not frightening to put something into the body and even less so if it is scientifically tested. (male user, 18-35)

> I don't trust psychology, I think it is a science on the grounds of statistics only. (male user, 36-50)

Women, nonetheless, express fears of dependence or of not feeling emotions and, therefore, tend to view psychopharmaceutical approaches as a threat. Although the interviewed women reported taking psychopharmaceuticals (with an exception of younger participants), many of them prefer psychological to psychopharmaceutical treatments:

> It was a psychologist, not a psychiatrist, because I don't like to take medications (…). I think that you can find other solutions for depression. You might need medications, but first you better try other options. (female user, 18-35)

Such oppositions in the overall structure of medical field as well as in the field of mental healthcare are incorporated in *habitus* as an opposition between pain and tiredness:

> They [*ellos – they masculine*] don't feel unwell, they come with a pain – that is, I need this because it hurts. I need an X-ray because my knee hurts. (…) We can say that women are tired and men are in pain – pain of whatever you want but it's pain. (general practitioner)

Pain relates to body or physical health and, therefore, can be perceived as more legitimate or tangible, which also results in medications being seen as an appropriate solution. Tiredness, on the other hand, is not as tangible as pain with relaxation or psychological therapies appearing to be more relevant. García-Calvente et al. (2012) also discuss these differences in Spain. Yet, they stress the opposition between 'tough men' and 'exhausted women' rather than between pain and exhaustion, which may result from their focus on perceptions by healthy individuals rather than women and men with mental health problems. Meanwhile, the narratives of the users in this study clearly reveal the opposition between pain (male) and tiredness (female):

> What you have is a physical pain, which does not let you think, does not let you act rationally. (male user, 18-35)

> I hardly ever went out because I was so tired that all I wanted was to get home and sleep and it's over. (female user, 18-35)

To sum up, Bourdieu (2001, p. 104-105) argues that the logic of fields and practices in them are organized according to different oppositions, which "always stand in a relation of homology with the fundamental distinction between male and female" and which are "accompanied by the inscription in the body of a series of sexually characterized oppositions", i.e., they are embedded in gendered *habitus*. Figure 1 summarizes the oppositions that emerge in this research.

SOCIAL STRUCTURES	Provider – Carer Public – Private	⇒	General (physical) Healthcare – Mental Healthcare	⇒	Psychiatry – Psychology
MENTAL STRUCTURES	Strong – Vulnerable Self-reliant – Helped	⇒	Body – Mind	⇒	In Pain – Tired

Figure 1. The male/female oppositions in social and mental structures.

They are inscribed in social structures, first of all, as the divide between the dominant public space (labor relations) and the dominated private or home life (including well-being and health matters). While being considered as a feminine space, the healthcare field itself is organized as the opposition between dominant healthcare of physical conditions and dominated mental healthcare, which is then divided into dominant psychiatry as medications (evidence, technology) and dominated psychology (lack of evidence, talking). The oppositions in social structures "serve as the support for cognitive structures" (Bourdieu 2001, p. 105) that are inculcated in *habitus* as the strong/vulnerable, body/mind and in pain/tired oppositions and that generate health practices and their perceptions for both men and women. As Bourdieu (2001, p. 34) argues, not only men as dominant but also women as dominated interpret reality "through

schemes of thought (…) which are expressed in the founding oppositions of the symbolic order".

Gendered habitus and health practices

The gap in help seeking

The oppositions structuring the logic of the social and healthcare fields as well as inculcated in gendered *habitus* are likely to generate health practices that are adjusted to these social and mental structures, i.e. tend to reproduce rather than transform them. *Habitus* functions as a self-regulating mechanism, whose anticipations or "practical hypotheses based on past experience give disproportionate weight to early experiences" (Bourdieu, 1990, p. 54). Indeed, a large part of the healthcare providers stress this reproduction of masculine health practices with the remaining gap in help seeking between women and men. *Habitus* is durable. Men more often than women deny their mental health problems and rely on self-care options (Pattyn et al., 2015), including maladaptive coping such as alcohol or drug abuse (Doblyte & Jiménez-Mejías, 2017):

> Although it has improved a lot –but not as much as people think– men turn to alcohol to escape from anxiety and depression. (general practitioner)

Engagement in such avoidance strategies (Doblytė, 2019), which is largely "a non-conscious, unwilled avoidance" (Bourdieu, 1990, p. 61), protects their masculinities, i.e. *habitus* protects and, therefore, confirms itself by avoiding fields and practices that are perceived to be feminine. Even if seeking help, they frequently conceal these practices from their peers, families, or in their work environment, reproducing the male/female oppositions discussed in the previous section:

> [I]t is a matter of intimacy: I don't want to share this problem, its origin and consequences with others, neither strangers nor acquaintances. (male user, 36-50)

> My brother consulted a psychologist for a while, but not until I said at home 'I'm not feeling well, I want to see a psychologist' did he tell me he had done it, you know. My brother hid it from the family. (female user, 18-35)

By concealing men's healthcare seeking, women may also participate in the reproduction of masculinity ideals (Pattyn et al., 2015) and, in turn, of the oppositions, where their *habitus* and position in the fields are dominated. In other words, symbolic power as a subtle and gentle form of domination is accepted by both the dominant and the dominated (Bourdieu, 2001):

> [S]aying 'my husband is depressed' – that doesn't happen. Evidently, even a wife herself would not want to say that her husband is depressed. (…) Men do not classify themselves, they can be stressed, have anxiety, be sad, but they never talk about it or say that they are depressed. (female user, 51-65)

As being dominated in the structures of different fields and with dominated dispositions inculcated in their *habitus*, women, on the other hand, do not experience these conflicts neither in the social field as a whole nor in the healthcare field. Their *habitus* might be seen as pre-adapted to asking for help, which, therefore, does not endanger their femininity:

> For example, my son – he might need help himself, but no, 'I solve it myself'. (…) A mum yes, but I am fine, I am solving it myself. I think that men do not dare to go to a psychologist or a psychiatrist. These are women's things. (female user, 51-65)

> There are lots of us [*feminine*] and we open up. There is a sort of market, I would say, it's natural and you can have conversations in any place. (female user, 51-65)

The legitimate vs. trivial help seeking

Given that the health system is perceived as feminine and, therefore, opposed to masculinity, Noone and Stephens (2008) argue that to protect their masculinity men legitimize their health behaviors by stressing its dissimilarity to 'feminine' health behaviors and constructing it as the opposition between the legitimate male user and the frequent or trivial female user. This opposition also emerges in the narratives of both the healthcare providers and the users in Spain:

> I think that a male is more reluctant to seek help. Above all, when things are not serious (...) At milder levels, a female expresses more complaints and demands more. (psychiatrist)

> [*My mother and sister*] take medications, but they don't take them because they are sick, they take them because it calms them (…) because they are stressed (…) But I have an illness and I accept my illness. (male user, 36-50)

Yet, others argue that the opposition between the legitimate male user and the trivial female user might be considered a gender bias that results in different treatments of and outcomes for men and women:

> The studies show that men are referred [*to specialized mental healthcare services*] earlier than women, because women are complainers (*laughs*). So, when a man expresses emotional discomfort, he must feel awful and it is true that they are referred sooner and arrive less serious, at least in common mental disorders. (clinical psychologist)

Since psychopharmacotherapy "takes considerably less practitioner time than alternatives such as psychotherapy" (Horwitz, 2007, p. 218), these inclinations to retain women longer than men

in primary care that experiences more time pressures may lead to women's higher pharmaceuticalisation and, consequently, chronification and dependence on the healthcare field and its goods:

> Women are overburdened and it has often been solved with medications: tranquilizers, anxiolytics. They are very effective because we feel much better right away (…). But it is very easy to turn to them again and again, and it becomes chronic (…) Lots of women take anxiolytics and they are prescribed by doctors, by ourselves, in specialized or primary care. (psychiatrist)

This might be shaped by both their dominated positions in the social field as a whole –more care responsibilities and work-family conflicts (Van de Velde et al., 2019)– and by mental structures in both healthcare providers' and users' *habitus* (women as trivial users), which results in their dominated position in the healthcare field.

Agency

At the same time, and albeit within the limits of structures, *habitus* is generative, transposable and dynamic implying a certain level of agent's reflexivity and autonomy (Bourdieu, 1990; McNay, 1999). Yet, this agency is gendered. Women are likely to be more consenting in the matters of health than men: as Dixon-Woods et al. (2006, p. 2747) write, "in response to their position as patients, individual agency evaporates" for many women. Indeed, a prominent number of female participants express their different expectations of care and treatments, but rather than facing it directly they passively accept services or abandon the field and care:

> (*Interviewer: have you ever asked for a referral to a psychiatrist or a psychologist?*) No, to be honest, never. (female user, 36-50)

> I think I needed more than what they gave me. I felt that I left empty, with a medication and an appointment within 6 months. That was not my intention, I really wanted help. (female user, 51-65)

The male participants, nonetheless, more actively express their independent decision-making or 'choice' to seek healthcare, which may protect their masculinity (Doblyte & Jiménez-Mejías, 2017) and "reconstruct a valued sense of themselves" (Emslie et al., 2006, p. 2250). Some of them recount conflictual situations in which they challenge their doctors, demonstrate their superior biomedical knowledge and, therefore, aim to maintain power and status:

> I went [*to a general practitioner*] and he told me that it was a stress problem and gave me medication (…) and referred me to a psychologist. But I told him that I didn't need a psychologist, that the problem I had was an anxiety disorder, and that I needed a psychiatrist and another type of medications. He rejected that and referred me to a psychologist. I did not go, I directly refused and then, yes, he sent me to a psychiatrist. (male user, 36-50)

Noone and Stephens (2008, p. 716) find that men use the biomedical discourse "to convey authoritative knowledge about health matters and disease" and, as such, to construct their masculinity as 'not feminine'. Even if the final decision lies with the gatekeeper, the illusion of 'choice' and control helps men to cope with the situation of being dominated in the user-provider relations and to validate agent's masculinity (Courtenay, 2000):

> [*My general practitioner*] prescribed me anxiolytics and antidepressants. I told 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 and so on. (male user, 18-35)

Likewise, younger women do not necessarily passively accept care, but may actively enact their agency, which might indicate changes in gendered *habitus* that, nonetheless, seem to be uneven (McNay, 1999). Connell and Messerschmidt (2005) consider that gender hierarchies may be transformed by such practices and identities of younger women. Their narratives signal active decision making about their health, although it is not always enacted in the treatment system *per se*:

> When I realized that I was unwell, I did not seek help in the public health center because of my past experiences. I mean, I didn't even consider it. (…) So, I tried one [*psychologist in the private sector*], but it didn't work. (…) Then, I kept searching and found another one. (female user, 18-35)

The oppositions embedded in both social and mental structures, therefore, generates gendered practices in the field. Men tend to delay mental help seeking, since seeking help for minor symptoms would "put their masculinity up to scrutiny" (O'Brien et al., 2005, p. 514). Once they access the field, they legitimize themselves and are legitimized by healthcare providers as 'genuine' and deserving help seekers, as well as express their agency more actively to preserve their power and status even in user-provider relations where they are dominated. Women, on the other hand, tend to be dominated in the social field as a whole, as in the healthcare field, which is also illustrated by their limited agency in a clinical encounter (with the exception of younger women). They are frequently treated as trivial users, which might lead to their pharmaceuticalisation and, consequently, chronification.

Conclusions

There is a variety of masculinities and femininities that result in a variety of health practices. In this article, nonetheless, I interpret the male/female oppositions in social and mental structures as shaping health practices that are generally more common either to men or to

women. In other words, the analyzed practices and differences in them do not necessarily apply to all men or to all women, since agents' *habitus* are singular due to "the singularity of their social trajectories" (Bourdieu, 1990, p. 60). Yet, such singular *habitus* of agents from the same group "are united in a relationship of homology, that is, of diversity within homogeneity" (Bourdieu, 1990, p. 60). Thus, certain practices and perceptions "are more likely to be common" to one gender or another (Cockerham, 2018, p. 143), for they are likely to have experienced similar situations and socialization processes.

Gendered health practices in Spain are analyzed as power relations embedded in the oppositions homologous to the one between the male (dominant) and the female (dominated) (Bourdieu, 2001). Such oppositions in social structures –provider/carer, physical/mental and psychiatry/psychology– mirror the male/female oppositions built into mental structures or *habitus*: strong/vulnerable, body/mind and, finally, in pain/tired (see Figure 1). Therefore, men more than women delay and avoid healthcare seeking, for their dominant position in the social field as a whole may be threatened in the healthcare field. Healthcare seeking might mean surrendering oneself to the domination in the user-provider relations, i.e. losing power and control. Once men seek care, nonetheless, it is often validated by themselves and by healthcare providers as a legitimate action (as opposed to women as frequent or trivial users) and, most importantly, narrated as active and independent decision-making. Despite the discourse of 'mental illness as a disease like any other' in their own narratives, they aim to show their help-seeking as deserved and to preserve their masculinities, albeit if only in front of the interviewer. *Habitus* functions pre-reflexively and changes slower than some of the conditions that structured it (Bourdieu, 2001; McNay, 1999).

Women's *habitus*, on the other hand, does not encounter such contradictions to the same extent. They are likely to be the dominated in the social field as a whole, which is also confirmed and accepted (with the exception of younger women) in the healthcare field. They engage in mental

help seeking easier, for it does not challenge their mental structures and their dominated position in social structures. Yet, this same position of the dominated results in many of them being treated as trivial users and, at the same time, frequently overmedicalized with psychopharmaceuticals (notwithstanding their distrust of them) that not only leads to chronification but also reproduces power relations rather than challenging social conditions that cause distress. The findings of this study contribute to the literature on medicalization of women's emotions, behaviors, and bodies (e.g., Blum & Stracuzzi, 2004; Smirnova & Gatewood Owens, 2019; Ussher, 2010). Medicalization as a gendered practice is produced in the interplay between social and mental structures with the embedded male/female oppositions within them, as well as becoming itself a means of reproducing power relations.

To conclude, while men's health behaviors are often perceived as more problematic, the article shows how not only men are trapped in their domination, but also women's health, their treatments and perceptions of their health behaviors are affected by these dominant-dominated relations. Although men seek healthcare less frequently and with more delay, which is shaped by masculinity ideals, women are dominated in the field and generally perceive less opportunities to enact agency. *Habitus* and the field, therefore, interact producing gendered health practices and outcomes, i.e. they are reproduced "not at the level of direct institutional discrimination, but through the subtle inculcation of power relations upon the bodies and dispositions of individuals" (McNay, 1999, p. 99).

By interpreting the empirical evidence in light of Bourdieu's sociology, the article contributes to the literature that shows the potentiality of this theoretical approach for studying how gender shapes practices. Instead of focusing either on men or on women, it is argued that gender is a relational phenomenon and should be studied relationally in order to better understand gendered regularities and tendencies. While the findings suggest that the gender roles (provider vs. carer) and stereotypes (strong and active vs. vulnerable and passive) remain relatively

strong in Spain, the article reveals that younger women could be transforming such gender hierarchies (Connell & Messerschmidt, 2005). Future research, therefore, could engage with further analysis of such changes in gender relations in Spain. Focusing on the role of different capital resources (in particular, social class or social networks), which falls beyond the scope of this article, might also unveil more diverse functionings of gendered *habitus*. Finally, research in other settings could confirm to what extent the findings may go beyond the Spanish context.

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