Shame in a post-socialist society: a qualitative study of healthcare seeking and utilisation in common mental disorders

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Abstract: After the regime collapse, the former socialist societies in Central and Eastern Europe experienced rapid social and economic transformations. Consequently, mental health deterioration coupled with ambitions to break with the past triggered reforms of mental health systems. Yet, thirty years later, mental health in the region remains poor. Stigma of mental illness may be one of the factors that delays help seeking and, therefore, maintains status quo. Thus, the aim of the article is to better understand the roots of stigma and the process of stigmatisation in one of these countries – Lithuania. Drawing on Norbert Elias's model of established-outsider relations, the article presents the analysis of 23 in-depth interviews with healthcare providers and users of services diagnosed with depression or anxiety disorders. The analysis reveals how stigma of mental illness might result in damaged self-image and shame of feeling different. Mental illness and healthcare seeking are perceived as a threat to culturally- and historically-determined self-values, at the core of which seems to be intolerance of difference. The article contributes not only to research concerning mental health in a relatively understudied region of Central and Eastern Europe, but also to existing literature on stigma as embedded in a local context.

Keywords: stigma, help seeking, mental health, qualitative, Central and Eastern Europe, Lithuania, Norbert Elias

After the regime collapse, the former socialist societies in Central and Eastern Europe experienced rapid social and economic transformations. The adverse effects of said transformations on mental health, along with ambitions to break with the past, triggered reforms of mental health systems (Pūras et al. 2013; Raikhel and Bemme 2016; Skultans 2003; Tomov et al. 2007). As a result, the number of psychiatric hospital beds has substantially decreased, and a range of accessible outpatient mental health services has been developed in many countries of the region. Nonetheless, high rates of alcohol consumption, suicide mortality or assault-related deaths (source: Eurostat Statistics, WHO GISAH Data) signal that, thirty years later, mental health in the region remains depleted. Researchers have shown positive associations between these forms of violence towards oneself or others and levels of mental distress in the population, which often manifests in forms of depression or anxiety disorders (Bellos et al. 2016; Pūras et al. 2013; Rihmer 2007).

Counterintuitively, however, the rates of self-reported depression and consultations with mental health specialists are substantially lower in the majority of the former socialist countries than the EU average (source: Eurostat Statistics). This might suggest lower willingness to seek healthcare for mental distress. The recent epidemiological study that is unique in the region (Kangstrom et al. 2019) found the treatment gap of 83 per cent for common mental disorders in Czechia, which is substantially more than 48 per cent for the same range of mental disorders in Western Europe (Alonso et al. 2007). Even considering the possibility of overestimation of unmet needs for mental healthcare in such studies (Rose 2019), the difference between the regions appears to be pronounced. While structural constraints such as user charges or waiting lists might limit access to care, attitudinal or cognitive barriers are often found to be more critical in help seeking (Doblyte and Jiménez-Mejías 2017).

In particular, stigmatic public attitudes towards mental illness may become internalised self-stigma and thus impede or delay help seeking by consciously or unconsciously mediating the relationship between health-related knowledge and action. Since Goffman's seminal work on stigma, which he defines as 'a special kind of relationship between attribute and stereotype' (1963: 4), scholars have widely analysed its extent and effects (Pescosolido 2013). Among them, Link and Phelan (2001) build on Goffman's work and, besides an attribute/label and a stereotype, add other components of stigmatisation – separation of 'us' from 'them' and status loss or discrimination – that converge in power relations. Evans-Lacko et al. (2012) investigate its possible consequences for individuals with mental illness and find that, beyond a clear association with other stigmatic attitudes, social contact or comfort in talking to people with mental health problems is 'the most consistent country/population predictor of lower stigma and higher empowerment among people with mental illness' (2012: 1748).

At the same time, scholars (Kleinman and Hall-Clifford 2009; Manago et al. 2019; Yang et al. 2007) stress the importance of culture in the social construction of stigma. What matters is not only the magnitude and consequences of stigma, which seem to transcend geographical borders, but also its roots, which are embedded in a local context. To explore this, Yang et al. (2007: 1528) use the concept of moral experience that 'defines what matters most for ordinary men and women'. Individuals intend to maintain this moral standing, i.e., to meet culturally-defined norms and expectations. A label of mental illness might mean 'the loss or diminution' of such moral experience (Yang et al. 2007: 1530) and, therefore, influence behaviour of both the stigmatised and observers. In other words, a fear of social contact with people with mental health problems or low self-worth of those with mental illness arise from context-specific moral experiences, whose integrity is endangered by a label of mental illness. It has been found to threaten such values and expectations as safety and individual initiative in the USA (Manago et al. 2019; Yang et al. 2007), work in Germany (Angermeyer et al. 2016), family

and fulfilling family-related obligations in China (Yang et al., 2007), Tunisia (Angermeyer et al. 2016) and India (Weiss et al. 2001) or community in Iceland (Manago et al. 2019).

Stigma of mental illness seems to remain substantially more prevalent in many countries of Central and Eastern Europe than in the rest of Europe (Eurobarometer 2006, 2010; Winkler et al. 2016). Scholars discuss its role in the implementation of mental health policies in the region (Pūras et al. 2013), reproduction through media discourses (Šumskienė et al. 2017) or enactment in user-provider relations (Doblytė forthcoming; Baltrušaitytė 2003). However, with rare exceptions (e.g., Skultans 2007), research that analyses the nature or roots of stigma rather than its magnitude seems to be limited. The aim of this article, therefore, is to better understand the generative mechanism of stigma of mental illness in one of the former socialist societies in Central and Eastern Europe – Lithuania. To achieve this, subjective interpretations and experiences of individuals with common mental disorders such as depression or anxiety and healthcare providers are analysed.

The highest or second-highest rates of suicide mortality, assault-related deaths or alcohol consumption (source: Eurostat Statistics, WHO GISAH Data) seem to indicate poorer mental health in Lithuanian population than in other European countries. Likewise, greater proportion of the population that would find it challenging talking to people with mental health problems in Lithuania (52 per cent) than in any other country in Europe (Eurobarometer 2010) signals very strong public stigma of mental illness that might lead to high self-stigma at the individual level (Evans-Lacko et al. 2012). Lithuania, therefore, can be considered as an ‘extreme’ or ‘critical’ case where structures and generative mechanisms ‘appear in an almost pure form’ (Danermark et al. 2002: 104), which facilitates their exploration. The article contributes to the literature about mental health and stigma of mental illness in the former socialist countries that remain understudied (Raikhel and Bemme 2016; Winkler et al. 2016), as well as to the

literature on how stigma of mental illness is shaped by local contexts and values (Angermeyer et al. 2016; Kleinman and Hall-Clifford 2009).

Theoretical lens

The analysis draws on Norbert Elias's model of an established-outsider figuration (2008a [1976]), which provides us with a helpful tool to better understand how specific actions (e.g., avoiding help-seeking in mental distress) or processes (e.g., stigmatisation) are (re-)produced within dynamic interdependencies between individuals. In other words, Elias takes as a point of departure human figurations (Loyal 2011) rather than an attribute or a label. Stigmatisation, therefore, is analysed as a relational and historical process characterised by social relations between two or more groups with uneven balances of power. Although the theory of established-outsider relations emerged from an enquiry of a small community in England (aliased as Winston Parva), Elias (2008a) argues that it can be used as an empirical paradigm for figurations of different complexity and scale. Barlösius and Phillips (2015: 9) adds that it also allows explanations for 'why people feel stigmatised even in social interactions in which no stigmatisation is operating'.

In short, one of the main regularities within the figuration is that the established see themselves as superior or 'better' individuals with group charisma whereas they attribute inferiority, disgrace and blame to the outsiders and, as such, exclude them 'from chances of power and status' (Elias 2008c: 224). Unequal power ratio between the groups, which emerges 'due purely to differences in the degree of organisation of the human beings concerned' (Elias 2008a: 4), is a fundamental explanatory factor in these processes. To maintain their superiority and status, the established employ stigmatising stereotypes, degrading names and blame gossip about the entire outsider group, which are 'modelled on observations of its worst section' (Loyal 2011: 198) or 'its anomic minority' (Elias 2008a: 5). Gossip can be a

particularly effective weapon to praise the established and to blame the outsiders (Elias and Scotson 2008) used within communities and at other social levels, e.g., in media or state discourses (Elias 2009b; Loyal 2011).

The nature of established-outsider relations affects self-image or self-values of both groups. Similarly to Yang et al. (2007), Elias (2008c) argues that self-values vary from society to society and depend on what is perceived to be most important for individuals' pride or self-esteem in a particular culture. Explaining this might help us better understand why the established attribute 'lower standing and lower worth' to the outsiders (Elias 2008c: 228) and why the outsiders themselves frequently internalise their inferiority and group disgrace, which results in self-stigma and shame. Based on Elias's model of emotions (2009a), such emotions are learnt and built into one's habitus through early socialisation. An outsider in turn is excluded not only due to blame gossip by the established, but also because individual's behaviour is in 'conflict with the part of himself' and an outsider 'recognizes himself as inferior' (Elias 2000: 415). In other words, the established often have 'an ally in an inner voice of their social inferiors' (Elias 2008a: 10).

Materials and methods

To understand the nature of stigma as lived experience and how it might impede help-seeking processes in mental distress, the data have been collected employing semi-structured in-depth interviews with relevant healthcare providers and individuals who suffer from depression or anxiety disorders and have subsequently sought healthcare. The participants have been recruited from three mental health centres, two health centres/polyclinics and a psychiatric hospital that provides both inpatient and outpatient services (max. three providers or users per facility). Several additional participants (mostly, users of services) have been identified through author's professional or personal networks and using a snowballing or chain referral,

which has been very helpful due to the stigmatizing nature of the topic (Robinson 2014). The study information sheet has been used as a recruitment aid and sent via e-mail, explained over the telephone or handed in person. Prior to the interview, the participants have provided informed consent which, along with other documents and procedures, was approved by the author's regional research ethics committee. Given the sensitivity of the topic and possible anonymity concerns, as well as for logistic reasons, telephone and face-to-face interviews have been used although prioritising face-to-face encounters when possible.

As a result, eleven users of services aged 18 to 65 (seven women and four men) have been interviewed in an attempt to reconstruct their pathways towards and within the treatment system and to understand their experiences. There has been a variety of ages (four participants younger than 36, four between 36 and 50 and three older than 50) and educational levels (two participants with secondary education or below, three with vocational training and six with university degree). At the time of the interview all participants were receiving or had recently received outpatient care at mental health centres; four individuals had also been hospitalised; another four participants had additionally received treatments at day centres. Further, twelve healthcare providers who participate in management and treatment of common mental disorders (psychiatrists, clinical psychologists and general practitioners) participated in the study. Their clinical experience varied between 4 and 37 years (mean = 20 years). The participants are mainly from the two largest cities of Lithuania (Vilnius and Kaunas). Yet, slightly more than 20 per cent of them, including both healthcare providers and users of services, have been located in smaller towns and villages.

The interviews were transcribed and analysed in Lithuanian with a support of MaxQDA software and using the method of reflexive thematic analysis (Braun and Clarke, 2006; Nowell et al. 2017). After familiarisation with the data, I have developed a codebook guided by the

transcripts, the theoretical framework, and literature review. It has then been used to code the interviews, while allowing new codes to emerge. This has been followed by clustering the codes into potential subthemes and themes, and then reviewing, defining and revising the themes. The process, however, has been iterative (rather than lineal) moving back and forth between the phases of analysis and initiated while still sampling and collecting data, which has allowed for assessment of saturation. Code saturation has been reached with the completion of approximately half of the interviews, with very few new codes being developed after that. Yet, Hennink et al. (2017: 594) argue that code saturation might be insufficient to 'fully understand issues' and suggest also considering meaning saturation 'when no further dimensions, nuances, or insights of issues can be found'. Few new dimensions of codes have been emerging towards the final informants, which signals that relatively high levels of meaning exhaustion have been also achieved, albeit new data could have provided new meanings.

Findings

The presentation of the findings is guided by the identified themes and framed as established-outsider relations. First, I explore the impact and historical context of stigma of mental illness and mental healthcare. Second, I show how blame gossip and stigmatising labels might be used in the process of stigmatisation. Third, the impact of healthcare seeking on self-image is analysed suggesting that shame or self-stigma might be explained through a deeper understanding of how mental illness and, particularly, mental healthcare seeking threaten one's self-values or moral experience that is context-dependent and historically-laden. Finally, I explore some of the strategies used by individuals to avoid stigma and shame, or to diminish their effects on self-image.

Stigma of mental illness in a post-Soviet context

Stigma. Nearly all the informants spoke about the persistence and magnitude of stigma of mental illness and, particularly, of specialised mental health services. It might result in being discredited as out of one's mind, unintelligent or dumb (*durnas* in Lithuanian) and, therefore, is a significant barrier to healthcare seeking:

> A lot of friends of mine don't go to psychiatrists, but they take tranquilisers. […] They think that you go to a psychiatrist only if you are stupid (*durnas*). I mean, they say 'I am not dumb (*durnas*) to go to a psychiatrist'. (HCP03, psychiatrist)

Yet, stigma appears to be strong not only within the general public, but also within the treatment system and among the healthcare providers, which seems to be a feature shared by various former socialist states (Stuart et al. 2015; Winkler et al. 2016):

> If a doctor says 'go to a psychiatrist', you receive a message 'you lost your mind' (*durnas*). Not directly but it's a depreciating attitude. […] I think that doctors themselves still need help in this area. (HCP02, psychiatrist)

> I have that image in my head that even my family doctor was afraid to offer [*a psychiatric referral*]. (P08, female user, 36-50)

While treatment of common mental disorders at the general care level could potentially reduce stigma and facilitate healthcare seeking (without the need of specialised care), general practitioners, nonetheless, easily admit to not doing so. They spoke about their workload or a fear of treating mental illness, notwithstanding relevant training:

> We did psychiatry and everything, but it is a very delicate topic. (HCP06, general practitioner)

This may signal the impact of stigma in their practice and impede any help seeking in the treatment system, for specialised but stigmatising mental health services become the only option of care.

Historical context. Stigma of mental illness was also associated with the Soviet regime in a large part of discourses. Although mental health services have been reformed since regained independence, the images of Soviet psychiatric hospitals and, in particular, a fear of them are built into habitus and appear to be more resistant to change:

> Then she said that the only way was a hospital. When she told me about that Vasaros [*psychiatric*] hospital, I panicked, what will happen to me there? I had only heard that name in the Soviet times. (P05, female user, 51-65)

Psychiatry under the Soviet rule was a political tool of repression through 'diagnosing political non-conformists as mentally ill' (Raikhel and Bemme 2016: 158) and a means of abusive practices towards individuals including 'adverse living conditions' or 'inhumane treatment' (Van Voren 2013: 7). It resulted in its very low positions in the hierarchy of specialists:

> When I was studying, it was the least popular field, seen as a punishment […] because psychiatry wasn't solely a medical field, it was a political system which was exterminating people. There was no freedom to prescribe treatments, there was only violence – hospitalisations, no need to examine people or to listen to them. (HCP04, psychiatrist)

Thus, stigma of mental illness and psychiatry seems to be embedded in past practices. They took place relatively recently and resulted in 'longstanding and profound' delegitimization of psychiatry in the region (Raikhel and Bemme 2016: 159) to the degree that, even today, mental

health services are often perceived as a last resort, and avoided by both users of services and other healthcare providers.

Gossip and labels as means of stigmatisation

Gossip. The images or attitudes towards mental illness and psychiatry are deeply internalised long before experiencing actual mental health problems. It is frequently achieved through gossip in the community or media, which is 'a specific type of collective fantasy evolved by the established group' (Elias 2008a: 19). If mental healthcare is sought, they shape one's expectations of others' reactions, including a possibility of the same gossip and, consequently, a shift into a disgraced outsider group:

> A lot of people are afraid that someone will find out that they come here [*to a mental health centre*], that someone will laugh at them. (HCP12, psychiatrist)

> If somebody finds out at work, they might talk that you are out of your mind (*durnas*). (P03, female user, 36-50)

In other words, stigmatisation is experienced and reproduced through means such as blame-gossip, whose vehicle can be face-to-face encounters between people as well as media channels, with the difference being 'more one of degree than one of kind' (Elias 2009b). Gossip can also drive towards 'the emotional barrier against closer contact with the outsiders' (Elias 2008a: 8) due to a fear of being associated with them:

> If you tell people that you were in a psychiatric hospital, God help me, they look at you I don't know how. […] Many are even afraid to visit me in the hospital. (P06, female user, 51-65)

The healthcare providers, belonging to the established, might also attach group disgrace to the stigmatised through gossip about the outsiders as lacking motivation and personal control:

> All those who go to the private sector do sports […]. Those in polyclinics [*public health centres*] are slackers. (P04, psychiatrist)

The above quote also signals that the outsiders are not a homogeneous group with some being 'better' than others. This group divide is even expressed from the positions of users with more accumulated capital or relative power that makes them 'established in some contexts and outsiders in others' (Loyal 2011: 192):

> I interact with educated, tolerant people. […] I don't live in the countryside, where – what time is it now? – where at 9 a.m. they sit and drink beer with a cigarette in their mouths, maybe they [*are affected by stigma*]. (P10, male user, 36-50)

Therefore, there can be more than two 'stages or phases of group stigmatisation superimposed on each other' (Elias 2008c: 228). While the individuals with mental health problems are generally excluded as an outsider group, some of them might feel they are a representation of 'a better kind of humanity' than other outsiders (Elias 2008c: 228). The quotes from the interviews illustrate how cultural resources and health literacy, which imply not only health-related knowledge but also capacities needed for active decision-making or self-efficacy (Shim 2010), are perceived as intrinsically individual and independent from social structures and positions (and, therefore, from the process of stigmatisation). It also shows how the outsiders themselves might reproduce blame gossip and, consequently, stigmatisation.

Labels. Stigmatising names and labels attached to an outsider group is another weapon of stigmatisation. One of the labels that constantly replays in nearly all of the interviews is the word '*durnas*' (dumb, stupid, out of one's mind) and other words derived from it, e.g., '*durnynas*' (used pejoratively for a psychiatric hospital). Its meaning differs substantially from 'being crazy' in the English language, where one can be out of one's mind but also crazily in love with someone or very enthusiastic about something, both of which imply positive

meanings. '*Durnas'* can be used with diminutive suffixes to show some degree of compassion towards the disgraced, but there are always pejorative connotations that imply exclusion and uneven power ratios.

The language of 'damaged nerves' (Skultans 2003), which was typically used to refer to common symptoms of mental distress under the Soviet regime, also emerges in the discourses of users, yet only amongst older generations ('damaged nerves' or 'something wrong with nerves'). To some extent, it helps oneself protect – at least in one's mind – from being labelled as '*durnas*' and, therefore, as an outsider, for it implies less blame or individual responsibility through the emphasis on 'temporal and social dimensions of the self' (Skultans 2003: 2423). Yet, the narrative of 'damaged nerves' does not replace stigmatising labels and, therefore, does not diminish stigmatisation or stigma of psychiatry and mental illness.

Taken together, gossip and the attribution of stigmatising labels such as being out of one's mind or unintelligent (*durnas*) to the outsiders by the established are inseparable from implying that the established are more intelligent and more in control of their emotions. Individual self-regulation or self-constraint of emotions and behavioural impulses form part of a civilising process or being civilised: '[a] conversion of external constraints into self-constraints is to be found in all human societies' (Elias 2008b: 4). In light of this, mental distress might be associated with not being capable of self-regulation. As a result, mental healthcare seeking becomes accepting of this inability and, therefore, of need for external regulation (through medical interventions). In other words, the characteristics attributed to the outsiders exclude and mark them as being uncivilised. Such attribution or its anticipation 'can have a paralysing effect on groups with a lower power ratio' (Elias 2008a: 10), including non-help-seeking or low adherence to treatments. As Elias observes, 'the very names of groups in

an outsider situation carry with them, even for the ears of their own members, undertones of inferiority and disgrace' (2008a: 10) and might result in inferior self-image and shame.

Shame and self-values

Shame and shaming. Stereotyped blame gossip towards psychiatry and individuals with mental health problems tends to be internalised through early experiences in different figurations and, therefore, 'has a deep anchorage in the personality structure' (Elias and Scotson 2008: 134). Yet, due to the nature of common mental disorders, blame gossip usually becomes personally relevant later in one's life. This 'falling into disgrace' might be more socially painful than 'living in disgrace from generation to generation' (Goudsblom 2016). The social pain or shame as a fear of 'other people's gestures of superiority' (Elias 2000: 415) can be identified in nearly all of the interviews with the users.

The somatic component of shame (Elias 2009a) has been more present in some interviews than others. Its expressions included muted voices or sharp drops in volume during interviews, very accelerated speech, constant avoidance of names of mental disorders or repetition of certain words:

> Then a psychiatrist diagnosed me with that, that illness. (P06, female user, 51-65)

Others – particularly, the users who have experienced multiple hospitalisations – intended to justify common mental disorders as not so severe as 'real' ones, i.e. 'being the lesser of the two social evils' (Goffman 1963: 94):

> [A]nd those patients are there not because of real mental disorders as it was in the second hospital, but all of them with depression. (P02, female user, 18-35)

Feeling or seeing oneself as 'inferior in human terms' (Elias 2008a: 2) has also been communicated verbally as feeling ashamed of being different, a fear of rejection or feelings of failure:

> I thought that there was something very wrong with me and that nobody else had it. (P01, female user, 18-35)

> I believed that it was a very ugly name [*depression*], that now they will consider me, how do you say, as a somewhat ignorant, stupid person. (P05, female user, 51-65)

The users have also spoken about being shamed by others, including healthcare providers:

> [*My psychiatrist*] would always say to me that I was worse and worse. […] Every comment of hers was killing me – more or less 'nothing good will be with you'. (P02, female user, 18-35)

> They [*healthcare providers*] look at you from above, as if you were nothing. You feel humiliated. (P04, male user, 51-65)

Personal pronouns and the distinction between 'I' (not 'we') and 'they' (other people or healthcare providers) in users' narratives mirror the figurational aspects of established-outsider relations that emerge due to differences in the degree of group cohesion and, therefore, in power ratios. The outsiders do not collectively self-identify as a group, since what they have in common is not something they want to have – being inferior and unable to achieve behavioural standards of the established. They still recall and long to belong on the other side of the fence.

Self-values. Shame results from self-values or moral experience that are damaged by the stigmatising images of mental illness and mental healthcare-seeking. In other words, the divide

between the established and outsider groups is based on the fact that a mental disorder is perceived as a threat to culturally-defined behavioural codes (adherence to them through self-regulation), i.e., what is at the core of collective self-values. It is attributed to all 'normal' people or the established groups and, therefore, mental illness and healthcare-seeking are experienced as 'decline within a pre-existing scheme of self-values' (Elias 2008c: 227). What matters most in this empirical case seems to be approval by others (the established), fitting in or a culture of sameness:

> For people in Lithuania, maybe it's that… That mass opinion is very important. (P11, male user, 18-35)

> We have that mentality that centres around external things. You have money, you drive this or that car, you look like this or that. (HCP08, clinical psychologist)

Comparing oneself to others in terms of appearance, achievements or consumption patterns and resulting feelings of inferiority or superiority are particularly prevalent in the former Communist Bloc. Six out of seven European countries with the highest levels of status anxiety measured as a fear of feeling inferior in terms of job position or income belong to this region, including Lithuania (Layte and Whelan 2014). Any political, religious or even behavioural deviance was clearly controlled and regularly punished under the Soviet rule. Yet, after regaining independence, this external control and intolerance of behavioural differences did not disappear, but rather changed its form from physical state violence to surveillance and self-control by means of blame or praise gossip. In other words, not only does a fear of being different or singled out remain, but it might have also been 'reinforced by the extreme capitalist ethic' (Skultans 2003: 2422).

Mental illness and mental healthcare seeking, therefore, are a direct threat to the sameness and even 'markers of social failure' (Skultans 2007: 29), which 'become inseparable from feelings

of overwhelming shame, humiliation and despair' (Yang et al. 2007: 1532). These feelings of failure, inadequacy or a fear of rejection can be observed in nearly all the interviews with the users. Shame is one of the most powerful emotions of social control, 'because people will monitor and sanction self in interactions' (Turner 2010: 182). Anticipation of shame also functions as a mechanism of social control and impedes or delays healthcare seeking, leading to various (and often destructive) strategies of coping with mental distress and, as such, avoiding stigma.

Avoiding stigma

While not analysed in depth here, individuals – particularly, those of younger generations living in big cities and/or with higher economic resources – are able to confront rather than avoid stigma by employing strategies that consequently allow them adhere to behavioural codes and norms again. It might include internet resources or private therapies that are often perceived as 'better' than public mental health services solely due to the fact of being private, which in turn reproduces stigma of psychiatry:

> Private help is seen as if it is better. There is this view, which is true and false, it depends. But there is that belief that psychiatrists who only work in polyclinics are useless. And psychologists. (HCP08, clinical psychologist)

Yet, others draw on resources that help them hide/deny mental distress or avoid healthcare-seeking, which 'have partly the form of conscious self-control and partly that of automatic habit' (Elias 2000: 375). These behaviours – consciously or unconsciously enacted – can be seen as an expression of shame or a fear of being labelled and excluded, i.e., foresight of stigmatisation.

Somatisation, self-medicalisation and alcohol abuse. First, both healthcare providers and users of services spoke about somatisation. A physical cause as legitimating disturbing symptoms might be sought to avoid stigma of both mental illness and mental health services:

> They go to different hospital departments, neurology, therapies […] a person says – I don't suffer from a mental disorder, my disease is head dizziness, pains and so on. (HCP04, psychiatrist)

Likewise, certain pharmaceuticals – in particular, tranquilisers – accessible in non-specialised, general care as well as natural remedies can be used to temporarily relieve stigmatising symptoms. Several users – all female – have also revealed practices of heavy drinking that helped them mask symptoms and, as such, delay healthcare seeking:

> After that hospital, I felt better for a while, but after half a year I got into alcohol very much, I hid it perfectly probably for three or four years. (P02, female user, 18-35)

The role of gender. The providers, nonetheless, stress that alcohol abuse and dependence as a means to deny mental distress and avoid mental healthcare disproportionately affect men rather than women:

> Men drink and, in this way, 'cure' themselves, alcohol becomes as a tranquiliser or a solution. (HCP11, psychiatrist)

This may be explained by the nature of stigma or what is at stake, if mental healthcare is sought. Feelings of failure, inadequacy or shame can be stronger in men because of experiencing healthcare seeking as a threat to their honour or 'manly prowess' (Bourdieu 1990: 77):

> It's stigma – that men shouldn't complain, they should suffer, it's not acceptable. Particularly older men experience a lot of stress that they have sought help at all and how this has happened, women accept that more easily. (HCP01, psychiatrist)

As in the quote above, the healthcare providers highlighted that middle-aged men ('over 40 years old') are particularly affected by stigma of mental illness. Economic resources, nonetheless, can help to avoid the stigmatising public healthcare sector by purchasing more anonymous healthcare in the private sector, which might reinforce the class divide:

> In a polyclinic, sitting and waiting next to psychiatrist's doors is probably more psychologically humiliating for a male than going somewhere privately. (HCP11, psychiatrist)

In this study, the interviewed men, nonetheless, anxiously stress that their sex did not influence their decisions, which might be seen as an attempt to protect their own masculinity from shame by normalising mental healthcare seeking. At the same time, they recognise that stereotypes and stigma might interfere with decision-making of other men:

> There are men, who are scared, maybe those stereotypes prevent them [*from seeking help*]. (P11, male user, 18-35)

Yet, all of them substantially delayed help seeking and reported access to mental healthcare through emergency departments and even suicide attempts. For men, help seeking in the treatment system usually becomes the final and often coerced rather than voluntary step, once the suffering threshold has been met (Doblyte and Jiménez-Mejías 2017) and alternative often self-destructive but perceived as masculine coping strategies (Tereškinas 2010) have been proved to be ineffective. Therefore, men, and particularly middle-aged men, whose practices of help-seeking seem to remain guided by stigmatic attitudes incorporated under the Soviet

rule, might find themselves in unique social situations marked by shame, guilt, and powerlessness due to their age, gender and often class (Tereškinas 2010). A decline of opportunities promised by regained independence for many men meant a loss in power as well as 'discrepancy between the actual and the imagined position', which pushes them 'in pursuit of a fantasy image of one's own greatness' (Elias 2008a: 28) that may result in violence towards oneself or others. In other words, hidden shame might be expressed as anger (Goudsblom 2016):

> I had a car accident, I was in a hospital for a long time […] and then, that fall, there was a suicide attempt. (P04, male user, 51-65)

> I will tell you frankly, I used violence against my pregnant girlfriend, yes, there was violence. (P10, male user, 35-50)

On the whole, stigma and shame avoiding strategies either within or outside the treatment system, and for both men and women, usually prove to be ineffective in the long-term. They might result in significant delays of healthcare seeking, resource-intensive (re)hospitalisations or suicide attempts and intentions with prolonged and more severe health outcomes.

Discussion

In this article, mental healthcare-seeking is situated within an established-outsider figuration to better understand how it might be shaped (i.e., delayed) by stigma of mental illness. The established (non-users), who 'think of themselves in human terms as *better* than the others' (Elias 2008a: 1), secure their status, power and behavioural standards using the tools of gossip, stigmatising beliefs or degrading code words (e.g., *durnas*) (Elias 2008a). As a result, a shift to the outsider groups (users) leads to damaged self-image and shame that were present in the interviews with nearly all the users and notwithstanding their power resources or reported

beliefs about mental illness. Likewise, they might inculcate and feel this inferiority without actual stigmatisation taking place, for 'though innocent of the accusations or reproaches, they cannot discard, not even in their own mind, the identification with the stigmatised group' (Elias and Scotson 2008: 133). Anticipation of shame may push individuals to employ coping behaviours that avoid stigma but that are often destructive and ineffective in the long term.

Yet, why stigma of mental illness is so persistent in the region requires looking beyond weapons and effects of stigmatisation, and revealing how mental illness and mental healthcare threaten self-values (Elias 2008c) or moral experience (Yang et al. 2007). In other words, it calls for an explanation of 'the fundamental cause of stigma' (Link and Phelan 2001: 381) that is culturally- and historically-determined. The post-socialist societies appear to suffer from high levels of status anxiety as a fear of feeling inferior (Layte and Whelan 2014), which might explain how mental healthcare seeking threatens what is most important for men and women. Rather than affecting work as in Germany (Angermeyer et al. 2016) or an ability to fulfil family obligations and expectations as in South and East Asia or North Africa (Angermeyer et al. 2016; Yang et al. 2007; Weiss et al. 2001), mental illness and healthcare in Eastern Europe appears to threaten the notion of sameness or fitting in. In other words, it fuels a fear of feeling or being treated as different and inferior. While, to some extent, it may be similar to the British 'intolerance of weakness' (Weiss et al. 2001: 82), it is more general intolerance of any difference in post-socialist societies.

The article, therefore, contributes not only to research concerning mental health in the region of Central and Eastern Europe, which continues to be limited, but also to existing literature on stigma as embedded in a local context. It adds an empirical case from non-Western countries, which remain underrepresented (Angermeyer et al. 2016). Furthermore, the article provides a possible explanation as to why, despite numerous and internationally evidenced health

education campaigns, stigma of mental illness and healthcare remains steadfast, even after 30 years of the regime collapse. Effective programmes that reduce stigma should focus on 'the cultural underpinnings of stigma' (Weiss et al. 2001: 85) or, to put it differently, on its generative mechanism. It, therefore, must address general intolerance of difference, which might be seen as the heritage of the Soviet rule when difference was punished and 'self-control and self-reliance' (Skultans 2003: 2422) endorsed, and which seems to have been reinforced under capitalism.

The study also intends to show the potential use of Elias's process sociology in stigma research. It reveals historically-determined stigmatisation patterns that do not emerge due to objective individual symptoms or qualities but because individuals are perceived as members of an inferior and less civilised group. In other words, rather than seeing individuals and society as entities where people show 'individually a pronounced dislike of other people as individuals' (Elias 2008a: 6), the figurational approach focuses on group relations or individuals as forming functional figurations with fluctuating power relations. It stresses the importance of analysing any sort of stigmatisation as 'the figuration formed by the two (or more) groups concerned or, in other words, the nature of their interdependence' (Elias 2008a: 6). Just as importantly, the theory of established-outsider relations suggests possible weapons and outcomes of stigmatisation as well as how the process is embedded in a local context.

While qualitative interviewing has been chosen due to its capacity to explore subjective interpretations or experiences and, consequently, to better understand healthcare seeking in mental distress, it has several limitations. First, recall bias due to the retrospective nature of patient interviewing – i.e., their discourses might be influenced by how they remember and legitimate their pathways to care – should be taken into consideration. Second, self-selection bias is inevitable due to voluntary participation in interview-based research (Robinson 2014).

The interviewed users are likely to embody less self-stigma or stigmatic attitudes towards mental illness than ones who were not willing to participate. Third, a substantially larger number of the participants has been located in big cities than in villages and towns, which may have resulted in not capturing certain nuances of stigmatisation. Yet, these limitations suggest underestimation of stigma and its effects on healthcare seeking rather than the reverse.

Finally, interviewer's influence on the participants is always present in qualitative interviewing – particularly, if differences in power are marked. Elias's concepts of involvement and detachment (Elias 2008a; Perry et al. 2004) might be an effective tool in reflecting on the researcher's position in this study. On the one hand, an interest in studying an emotionally sensitive topic has inevitably meant researcher's involvement. On the other hand, commitment to scientific standards as well as being 'distanced' from the local context as an academic located abroad may have resulted in a certain level of detachment. Regarding the users of services, the balance between involvement and detachment might have helped them to feel listened to due to 'a heightened sensitivity' towards their perceptions (Perry et al. 2004: 138), yet simultaneously safe and anonymous, which could also have been enhanced by a relatively low power position of the researcher due to age and socioeconomic background. By the same token, the healthcare providers have not only felt like experts in a power position but several of them have also expressed their interest in interpretations from a 'distance' or 'outside', which encouraged their participation in the research.

Despite the discussed limitations, it could be concluded that change and stability interact in a post-socialist society. Although laws and regulations reformed after regaining independence guarantee access to specialists and modern outpatient treatments, stigmatic attitudes towards mental illness, which remain prevalent even after 30 years of the regime collapse and which are shaped by the images of Soviet psychiatry, delay healthcare seeking in mental distress.

While stigma of mental illness may transcend geographical borders, its generative mechanism – in particular, self-values focused on behavioural and normative similarity to others, which is threatened by the process of healthcare seeking – seems to be an outcome of civilising processes that are culturally or historically embedded in the analysed region 'in conjunction with the peculiarities of their social fates' (Elias 2008b: 5).

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