'The almighty pill and the blessed healthcare provider': medicalisation of

mental distress from an Eliasian perspective

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Abstract: The analysis of factors and actors that lead to the increasing medicalisation of common mental health issues is generally focused on the healthcare system (the medical profession, in particular) or other related fields (the pharmaceutical industry, the media, or governments, among others). In this article, I in turn examine how and which processes in a society as a whole might drive to unpleasant emotions of everyday life being managed through medical and, particularly, pharmaceutical solutions, rather than employing other resources. Using reflexive thematic analysis and drawing upon Elias's process sociology, I present the analysis of 21 in-depth interviews with healthcare providers and users of services who are or have been treated for depression or anxiety disorders in Spain. It is concluded that the trends of scientisation and individualisation, coupled with demands for emotional self-control, enable the growing medicalisation of emotions. Professional help seeking represents rationalisation whereas suffering unpleasant (yet non-disordered) emotions is viewed as irrational.

Introduction

Medicalisation of society or medicalisation of social problems are some of the notions employed to define dynamic and uneven processes that entail a transformation of a problem,

which 'is not ipso facto a medical problem' (Conrad, 2007, p. 5), into a medical condition. In other words, it is as a process by which behaviours and emotions such as intense fear or sadness, that could be an expectable response to stressful life events and social circumstances, come to be treated as mental disorders. Whilst also drawing attention to the pharmaceutical industry (Conrad, 1975) or to value shifts in society (Zola, 1972), the early examinations of medicalisation generally focused on the medical profession (Ballard and Elston, 2005). Through increasing knowledge and technology, it becomes an agent of social control (Conrad, 1975; Zola, 1972) and not only treats existing complaints, but 'also seeks to discover illness of which laymen may not even be aware' (Freidson, 1970, p. 252). More recent contributions to the medicalisation thesis also stress the role of other institutions such as governments, popular culture, or patients as informed consumers of healthcare (Ballard and Elston, 2005; Busfield, 2010, 2017; Conrad, 2007; Williams *et al*, 2011).

The process therefore is understood as 'a form of collective action' (Conrad, 2007, p. 9) that might imply both benefits and losses for societies (Conrad, 2007; Horwitz, 2007; Moncrieff, 2014; Rose, 2019; Williams *et al*, 2011). On the one hand, diagnosis might legitimate suffering and behaviours that are otherwise seen 'as merely personal inadequacies' (Rose, 2019, p. 74), provide 'an explanation for underperformance or failure' (Moncrieff, 2014, p. 593) and, as such, decrease guilt and blame. Medical interventions can also alleviate symptoms. On the other hand, medicalisation transforms 'many human differences into pathologies' (Conrad, 2007, p. 148) and individualises the social by treating symptoms with medical aids. This in turn might lead to ignoring other levels of intervention that would tackle social problems directly. Medicalisation of mild yet common mental distress might also 'have the counterproductive effect of transferring scarce treatment resources from persons with serious mental illnesses to those who are not disordered at all' (Horwitz, 2007, p. 219). In other words, while mild

emotional distress is medicalised, severe mental disorders may remain underdiagnosed and undertreated (Doblytė, 2020a).

There is considerable literature addressing medicalisation of such mental distress, the diagnosis of which as 'the so-called "common mental disorder"' seems to be 'on the rise' (Rose, 2019, p. 52), and in particular, its increasing pharmaceuticalisation (Conrad and Bergey, 2014; Horwitz, 2007; Kokanovic *et al*, 2013; Moncrieff, 2014; to name but a few). Yet, such literature usually examines social implications of medicalisation, actors that induce the process, or points of resistance to it. To a much lesser extent, it theorizes on conditions or changes in present-day society that instigate individuals experiencing unpleasant emotions to engage in help seeking within the treatment system. In this article, therefore, I employ in-depth interviews with healthcare providers and users of services in order to seek a better understanding of long-term societal developments in Spain that might drive to emotions of everyday life being managed by means of medical and, particularly, pharmaceutical solutions.

That is not to downplay the role of other institutions and shorter-term processes. For instance, the development and dominance of symptom-based psychiatric diagnostic systems facilitates medicalisation by decontextualising, and as such, conflating normality[1] and pathology (Conrad, 2007; Horwitz, 2007), as well as by defining new categories or weakening diagnostic criteria for the old ones (Busfield, 2017). The pharmaceutical industry skilfully employs such systems in order to promote its treatments for increasingly milder symptoms (Conrad, 2007; Moncrieff, 2014; Rose, 2019; Williams *et al*, 2011). The governments, which regulate healthcare including access to medicines (Conrad, 2007), the interventionist tendencies of the medical profession (Busfield, 2010), or the patient organisations, which sometimes actively advocate for

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[1] In this article, I employ the distinction between normality or normal/non-disordered emotions, on the one hand, and pathology or disorder, on the other, based on Horwitz and Wakefield (2007). Non-disordered mental distress is understood as contextually appropriate ('with cause'), proportionate, and temporary.

medicalisation (Busfield 2017; Horwitz 2007), can likewise drive to medicalisation. Such processes are likely to interplay with longer-term societal dynamics that I explore in this article as a possible explanation as to how healthcare seeking is enabled and becomes perceived as an adequate response to mild mental distress in Spain.

More positive attitudes towards treatment seeking for mental distress and higher trust in mental healthcare providers in Spain than in other Western societies (ten Have *et al*, 2010) signal a greater acceptance of mental illness and mental healthcare, which might explain the relatively high levels of antidepressant drug consumption (OECD, 2019) and the lower unmet needs for mental healthcare in the country (Alonso *et al*, 2007). Yet, it could also lead to high medicalisation of non-disordered mental distress in this South European society, the practices and consequences of which have indeed been examined both qualitatively (Doblytė, 2020a) and quantitively (Ortiz-Lobo *et al*, 2011).

The relatively late psychiatric reform, with its strong emphasis on normalisation of mental illness (through deinstitutionalisation and integration of mental healthcare to the Spanish National Health Service) and with a weak role of the anti-psychiatry movement, may have contributed to destigmatisation and the increased use of mental healthcare for minor disorders (Costa-Font *et al*, 2011; Vázquez-Barquero and García, 1999). The existing research, nonetheless, does not necessarily deal with societal transformations that have been simultaneously materialising and that can also induce medicalisation in Spain. The article, therefore, adds to the empirical literature tackling medicalization processes in South European societies as well as, more generally, to the medicalization debates, most of which remain focused on North America (Conrad and Bergey, 2014).

In the following sections, I first introduce the sociology of Norbert Elias that frames the analysis and, second, describe materials and methods used in the study. I then present the findings, which

are organised into four themes: scientisation, individualisation, healthcare seeking as rationalisation, and finally, the tension between involvement and detachment. I conclude with the discussion of the findings, their limitations, and implications.

Elias's process sociology

While Elias's essay about the process of dying and mourning (1985) is the closest he brings himself to medical sociology, other social researchers have successfully employed his theoretical insights to study the matters of health and illness such as body weight (Barlösius and Philipps, 2015; Gibson and Malcolm, 2020; Stuij, 2011), the stigma of mental illness (Doblytė, 2020b), the role of modern medicine within the ongoing civilising process (Pinell, 1996), the development of public health policies and practices (Fernández, 2016; Goudsblom, 1986), illness narratives (Malcolm *et al*, 2017), or patient-provider relations (Flores and Brown, 2018). Elias's sociology (1978, 2000) can also be a helpful tool to examine societal developments facilitating medicalisation of mental distress. First, his emphasis on processes allows for the analysis of social and psychic transformations, which are understood as unplanned, but directed, continuous, and potentially reversible (Elias, 2009a). Second, the notion of figurations or interdependences between individuals helps Elias 'to escape the grip of "naïve egocentricity"' (Paulle *et al*, 2012, p. 78). Emerging, diminishing, or increasing social processes, including medicalisation of mental distress, can in turn be viewed as the result of such figurational dynamics, structuring and structured by related transformations in personality structures.

Elias's theory of civilising processes (Elias, 2000) may be considered as his major work that establishes said cornerstones of his thinking and introduces other relevant concepts. He links long-term social processes or changes in the figurations 'towards a differentiation and lengthening of the chains of interdependence and a consolidation of "state controls"' (Elias,

2000, p. 451) to equally long-term transformations of personality structures or *habitus* 'in the direction of an increasing civilisation of human feelings and behaviour' (Elias, 2009b, p. 32), i.e. towards more all-round, more stable and more automatic (habitual) emotional and behavioural self-restraint. In other words, there is a balancing in *the triad of basic controls*, which are 'interdependent both in their development and in their functioning' (Elias, 1978, p. 156): power over non-human entities and events (technological developments), social or external controls over other individuals (developments in social organisation), and intra-individual controls (civilising processes).

That said, an increased importance placed on self-constraints relative to social controls does not mean that such external controls disappear altogether (Elias, 2009b; Wouters, 2019). Rather, they transform, becoming 'increasingly exercised on the self-regulation of people' (Wouters, 2019, p. 173). Thus, treating every-day worry or sadness within the medical field might be viewed as a form of external social controls for 'a flawed control' of emotions (Wouters and Mennell, 2013, p. 557). The properly process-sociological question (Paulle *et al*, 2012), therefore, would be which figurational developments and, equally important, changes in personality structures might have enabled such medicalisation of mental distress. In order to achieve a better understanding of said transformations, Elias (2009a, p. 5) refers to 'pairs of antithetical concepts' that not only define 'the direction of social processes' but also 'tensions within a process-movement at any given time'. Such developments, therefore, can be presented as multi-polar trends (Elias, 2009b) or tension balances, where 'a change in one of them can be expected to go hand in hand with changes in the others' (Wouters, 2019, p. 169) and which 'summarise the theory of civilising processes as a "workable synthesis"' (Wouters, 2019, p. 163).

First, the increasing functional specialisation or differentiation, which 'makes people on many levels interdependent' (Elias, 1978, p. 145), entails a shift in the balance of power and

dependence 'in favour of certain social positions and at the cost of others' (Elias, 2009a, p. 5). Differentiation and power gains of some functions or positions may in turn develop with the power loss or even complete de-functionalisation of other positions (Elias, 1978). Identifying such shifts in functions could help to better understand how and why the management of unpleasant but normal emotions or distress moves to the medical field. Functional interdependences created by the process of specialisation may transform or even de-functionalise affective social bonds that can consequently result in increasing reliance on the (medical) expert groups. Such interdependences also 'underlie the extended "I-and-we" consciousness' (Elias, 1978, p. 137) and the dynamics between the I-identities (the trend towards individualisation) and the we-identities (the importance placed on feelings of belonging to a group such as the family or the nation) (Wouters, 2019).

The we-I balance and functional differentiation also concern the balance between involvement and detachment, i.e. between emotions, self-interest, or 'fantasy-laden' thinking, on the one hand, and self-distancing, consideration, reflexivity, increasing knowledge, and more impersonal or systematic thinking, on the other hand (Kilminster, 2004; Malcolm *et al*, 2017; Wouters, 2019). Both of them may co-exist. In particular, affective relations may be heavily marked by involvement. Yet, there is a tendency towards increasing detachment in contemporary societies and, consequently, rationalisation of thoughts and behaviours 'required and instilled by an ever-increasing division of social functions' (Elias, 2000, p. 402). To sum up, the processes of medicalisation and mental healthcare seeking may be viewed as part of the ongoing civilising process, i.e. 'a change of human conduct and sentiment in a quite specific direction' (Elias, 2000, p. 365), and framed within said tensions as one of the possible explanations. Yet, while the trends have specific directions, it is not a zero-sum relation (Wouters, 2019); an increase in one process does not necessarily mean a decrease in or complete disappearance of its opposite.

Materials and methods

To better understand such long-term societal transformations that may encourage healthcare seeking in mild mental distress and, consequently, its medicalisation, the study employs semi-structured in-depth interviews. The participants were recruited purposively from within the public health and mental health centres in a medium-sized region in the North of Spain. To top up the sample, chain referral and recruitment through personal or professional acquaintance were also utilised. Prior to the recruitment and interviewing, the regional research ethics committee had reviewed and approved the study protocol including an informed consent form to be signed by the participants, interview guides, socio-demographic forms, and a study information/invitation letter to be handed out, sent by e-mail or explained over the telephone to the potential participants.

The sample consisted of 11 healthcare providers and 10 working-age users of healthcare services with an assumption that they 'may have a unique, different or important perspective on the phenomenon in question' (Robinson, 2014, p. 32), i.e. understanding about or lived experiences of healthcare seeking in mental distress. The interviewed healthcare providers with clinical experience ranging from 6 to 40 years routinely attended patients with common mental health problems, among others, at primary (general practitioners) or secondary (psychiatrists and clinical psychologists) care levels. The users of services suffered from mental distress that had been diagnosed as mild to moderate depression, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, or post-traumatic stress disorder. All of them sought help in the public treatment system at some point in time with several of them also purchasing mental healthcare in the private sector. The users of services varied in age (an average of 40.4 years), gender (7 women and 3 men), and educational levels (2 participants with secondary education or below, 4 – vocational training, 4 – university degree or postgraduate).

The interviews were audio-recorded, transcribed and analysed in Spanish. Software for qualitative research methods –MaxQDA– was employed to manage the data. The interviews were analysed using reflexive thematic analysis (Braun and Clarke, 2006, 2019; Nowell *et al*, 2017), which was both researcher- and data-driven, i.e. theoretical and inductive. First, I developed an initial codebook guided by the research question, the theoretical framework, the existing literature, and the data themselves. Second, said codebook was used to code the dataset whilst allowing for the emergence of new codes. Third, codes with their segments were reviewed and clustered into potential themes or patterns of meaning. Finally, the themes were reviewed, defined, and further refined. While the process is described in a lineal fashion, it was nevertheless recursive moving back and forth between the phases.

Findings

Medicalisation of social suffering can be examined as enabled by two major trends in a society: the trend of scientisation and the trend of individualisation. The analysis suggests that such trends, coupled with demands for greater self-restraint, can lead to mental healthcare seeking being understood as rationalisation which, in turn, entails growing medicalisation of emotions. Yet, rationalisation does not necessarily mean that more involved or emotional thinking disappears or, in other words, completely cedes its position to self-distancing and detachment. Rather, the analysis reveals a certain blend of involvement and detachment in the process.

The trend of scientisation

The process of growing functional differentiation and integration has been dominant over the course of the past centuries (Elias, 2000) and has 'increasingly achieved broader, more encompassing levels' (Wouters, 2019, p. 134). Not only does this mean a larger number of specialisation groups, but it also entails growing interdependences between individuals with their particular functions and positions. The chains of figurations become longer and, 'for any

single group or individual, more uncontrollable' (Elias, 1978, p. 68). While such functional interdependences of more and more people mean that their relations are relatively more equal, 'less one-sided and more reciprocal', they also 'become more dependent on the centre for their coordination and integration' (Elias, 1978, p. 145), i.e. on coordinating and integrating positions such as the welfare state and providers of its benefits or services.

Through their function of restoring health and productivity, the medical profession is the example of said integrating positions, and consequently, gains dominance over other discourses in mental health. One clinical psychologist recounted how individuals resort to the medical field in order to deal with their emotional distress, rather than relying on informal social networks or other coping resources:

> Human suffering is now an issue of doctors – psychologists and psychiatrists. Solving this suffering is delegated to the figures of professionals or technicians and I think that many people come to the professionals with problems that were previously left within one's social network. (HCP11, clinical psychologist)

In other words, the social construction of emotional problems as medical conditions goes hand in hand with the greater specialisation (the schools of psychiatry or psychotherapy) and power gains of the medical profession in these matters, which is dependent on and, at the same time, reinforced by other specialisation groups such as the pharmaceutical industry, policy-makers, insurers, the media or by the consumers themselves (Busfield, 2010; Conrad, 2007; Rose, 2019). Yet, medicalisation of such mental distress that is driven by social adversities might consequently lead to individuals' dependence on the health system (Doblytė, 2020a). Treatments alleviate the manifestations of distress, but do not tackle their social causes (Busfield, 2017; Horwitz, 2007; Rose, 2019), which may result in fear to discontinue such treatments or, put differently, in reliance on them over a long period of time (Busfield, 2010):

Many problems that are not medical are accepted as health problems. They form part of our lives, they are not diseases. Not all suffering is a disease. But when you give a medical response to it, it enters a circuit that is very difficult to get out of. (HCP05, psychiatrist)

The dominance of the medical profession in dealing with mental distress is structured by the triumph of the scientific or biomedical discourse in mental health, which is driven by the aforementioned specialisation groups, including the healthcare provider themselves. The biomedical model constructs a narrative that 'distress arises from an internal pathology, increasingly a brain pathology, that should be treated with medication' (Rose, 2019, p. 189). Through popular culture, media, or everyday interactions, individuals embody such 'neurobiological imaginary' (Davis, 2020, p. 15) into their *habitus*. As one healthcare provider summarised this:

Here, we have the almighty pill and the blessed specialist. It is believed that they can fix everything. (HCP07, general practitioner)

The interviewed users also expressed similar trust in medicine, science, and diagnosis. The latter not only organises clinical practice by guiding responses to ailments and, at the same time, by differentiating or specialising medical care, but it also provides a meaning for the user by legitimating their suffering and giving a medical 'solution' to it (Jutel, 2009). The user below expressed such expectations of receiving a diagnosis and medical responses to her mental distress:

[*I want*] them to tell me 'you have this', for them to name things (…), 'you have this or that, you have anxiety and we are going to treat it in this or that way'. (P05, female user, 36-50)

Thus, although the increasing differentiation results in functional democratisation, where contrasts between groups with uneven power balances are reduced (Wouters, 2019), and, in turn, the medical authority is not absolute or uncontested, it still holds the position of power, which 'is embodied in diagnosis at the institutional and individual levels' (Jutel, 2009, p. 284). The users communicated their trust not only in the diagnosis or mental disorders as prevalent and, consequently, objectively existing medical conditions, but also in technological achievements and 'fixes' of such conditions:

> I am not afraid to put something in my organism, particularly if it is scientifically tested by the pharmaceutical industry, has clinical studies and so on. (P03, male user, 18-35)

The analysis of the interviews, therefore, demonstrates how dealing with the matters of body and mind, including 'deviant' emotions such as intense sadness or chronic fear, belongs more and more restrictively to the medical field that administers psychopharmaceutical or psychological solutions. The diagnosis and medical interventions can indeed appeal to individuals, for this intrinsically suggests that individuals' 'long-standing and complex problems' have relatively simple medical solutions (Moncrieff, 2014, p. 593). Such interventions nevertheless approach an individual rather than social groups or situations and, in essence, individualise social problems. The trend of scientisation may, in turn, lead to the management of emotional distress being removed from other public or private spheres.

The trend of individualisation

At the same time, the power gains of certain positions may involve de-functionalisation or power losses of other social groups (Elias, 2009a, 2009b). This is a side effect of the differentiation and integration processes, which 'can unintentionally damage or break social functions that people have performed for each other' (Wouters, 2019, p. 136). While the

management of unpleasant but non-disordered emotional distress is specialised by the medical field, interpersonal or social networks –in particular, the family– experience functional declines. They seem to lose their social function as a provider of emotional support:

> Social relations appear very open, but people are not capable of communicating their personal problems to others or even to their partner. The problem we observe is that there is no communication at home. (HCP10, general practitioner)

Although Southern European societies in general remain family-oriented (Fernández-Alonso, 2012; Jones *et al*, 2008; Pichler and Wallace, 2007), a lack of emotional help provided by such networks was stressed by a large number of the healthcare providers. The social links themselves are not lost, however. Rather, their function is transformed from emotional to more 'technical' or instrumental support. They may push to care, administer medications, or control adherence to treatments:

> Everything that you would call technical support – yes, whatever you want. But emotional support is another thing. 'Do not mess with that, go to a psychiatrist and deal with stuff', 'you haven't taken the medication, you haven't…'. (HCP05, psychiatrist)

> I mentioned about my concerns to my ex-husband. (*Interviewer: how did he react?*)
> He said that if I needed it, I should go [*to a doctor*]. (P08, female user, 51-65)

In other words, people's attachment to one another through affective or kinship bonds remains. Yet, when emotional distress is experienced, their primary function is frequently limited to instrumental help, whilst their role as the emotional support provider appears to shift to the welfare state and health systems:

I think that the role of helping others is being lost. It seems now that the only person who helps is the psychologist, the general practitioner, or the psychiatrist. The ability to give empathic support is being transferred to professionals while that was always within the family or social networks. (HCP11, clinical psychologist)

That is, the meaning of everyday life –in particular, support received through mutual understanding and dialogue within the lifeworld– appears to be gradually lost (impoverished) and replaced (colonised) by the medical expert systems (Habermas, 1987). The narratives of many healthcare providers evidenced such erosion or colonisation of the lifeworld. Several of them observed that mental healthcare is frequently sought before approaching informal coping resources. As the user below recounted, coping with emotional problems might be specialised prior to resorting to one's social networks, even if perceiving those networks as open and intimate:

I talked with them after – after having got an appointment and, I think, even after having gone to the doctor. Then I told them, because, as I said, we have very fluid relations and you can talk about these things. There are other families where it is much more difficult. (P03, male user, 18-35)

Such replacement of functions and, in particular, defunctionalisation of certain bonds can be viewed as the result of a shift in the we-I balance from we-identities towards I-ideals. While their personal identities are increasingly emphasised and become 'less strongly and less directly subordinated to their we-groups' (Wouters, 2019, p. 181), such we-groups –one's family, friend groups, or labour union– become less available or active in providing social or emotional support. The social problems, consequently, are viewed as individual matters too:

In the past, we faced problems perhaps more as social or collective problems and now it is something individual. For example, if you are harassed in the workplace,

it used to be viewed as an exploitation and there were unions and collective

mobilizations, but now you live it as mobbing. (HCP11, clinical psychologist)

Formal social capital appears to be indeed low in Southern Europe (Pichler and Wallace, 2007). On the one hand, the power of the trade unions and industrial protest, which was traditionally strong in Spain, has been weakening over the past decades due to high unemployment, constant restructuring, and downsizing associated with globalisation and post-industrialism (Köhler, 2018; Luque-Balbona and González-Begega, 2017). On the other hand, associationism has been historically weak in Southern Europe (Jones *et al*, 2008), and particularly, in Spain (Riley, 2005), which was explained by higher concentration of social capital in the family (Pichler and Wallace, 2007).

In addition to this, the Spanish historical context with its authoritarian regime characterised by the highly institutionalised and influential Church led to late but rapid individual secularisation (Pérez-Agote, 2010; Requena, 2005). In the multi-country study by Olafsdottir and Pescosolido (2011), such strong religious detachment amongst the Spanish, measured by a perception that religion is not a coping source in mental illness, particularly stands out: the effect is not only greater than, but in some cases, contrary to the one in other countries. Put differently, this particularity of the Spanish *habitus* means that feelings of belonging and emotional support provided by the religious community become increasingly less present:

There is that 'I have to talk to someone. Since I don't have friends, I can't talk to the

priest, to whom I used to go, so now I'm going to see if I can talk to a psychiatrist'.

(HCP02, psychiatrist)

To sum up, as Rose (2019, p. 66) states, it appears that 'isolation, the breakdown of trust and, increasingly, the loneliness of our current forms of life –where we are so often alone among throngs– all play their part'. While the social links themselves are not lost, their function is

transformed towards diminishing importance attached to emotional support provided to an individual by the social networks one belongs to. This seems to be driven by the trend towards individualisation or, in other words, a shift in the we-I balance in the direction of the latter. Although Pichler and Wallace (2007) conclude that Southern Europeans lack formal associative and informal non-family ties, these countries seem to maintain strong we-identities within the family (Fernández-Alonso, 2012; Jones *et al*, 2008; Pichler and Wallace, 2007). Yet, the culture of familialism does not appear to be sufficient for preventing the formation of I-identities, which 'pressure towards attempts at controlling the feelings of despair and powerlessness under one's own steam' (Wouters, 2019, p. 97). In case of failure to do so, such feelings are increasingly managed under the medical gaze.

Healthcare seeking as rationalisation

Whilst a lack of formal associative ties and rapid secularisation in Spain entails weaker collective identities, emphasis on I-ideals over group identities might be viewed as part of the contemporary social *habitus*, more universally, which also includes 'the comprehensive and constant restraint of all strong instinctual and emotional impulses' (Elias, 1985, p. 58). A tendency towards higher individualisation, therefore, goes hand in hand with the pressure for self-discipline or emotional and behavioural self-controls that become more and more all-round, steady, and automatic (Elias, 2000). Such demands for self-regulation result in strong emotions and impulses being viewed as deviant, despite being an expectable response to certain circumstances.

An equally strong demand for greater prediction or foresight built into individuals' personality structures (Elias, 2000), coupled with such pressures for self-restraint, may result in healthcare seeking once a fear of losing said self-controls is experienced. Foresight entails that not only are individuals expected 'to know and act on the understanding of the potential consequences

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of failing to behave "correctly"', but also 'to develop greater and more permanent self-control' (Gibson and Malcolm 2020, p. 74). Put differently, it helps individuals to both restore and enforce emotional and behavioural self-constraints. The below interview fragment illustrates aforementioned fears of losing self-controls and mental healthcare seeking as an action taken in order to re-establish them:

> This time I knew what it was and, if I didn't do anything, it would produce problems beyond physical symptoms, which had already been present. (P02, female user, 51-65)

In other words, the personality structures embody not only the expectations for more even self-constraints, but also for foresight. As a result, emotions and behaviours that are close to one or another extreme –being overly energetic, euphoric or manic, at one end, or worried, hopeless or shy, at the other end– are seen as deviant and, consequently, pathological. They are irrational. In the midst of increasing scientisation and individualisation, healthcare seeking, in turn, becomes a rational way to resolve 'flawed' self-controls and achieve successful self-regulation:

> It was my decision, because I noticed that I didn't sleep well, I wasn't well-balanced, I wanted to do a lot of things, but I wasn't able to do any of them. So, I went to my general practitioner, already knowing that I suffered from anxiety, which I couldn't manage. (P06, female user, 18-35)

Healthcare seeking and medicalisation, therefore, become a form of rationalisation. While it helps to restore or enforce emotional self-controls, it ignores or hides social problems that are causing distress. In other words, '[w]hat is rationalised is, primarily, the modes of conduct of certain groups of people' (Elias, 2000, p. 412): seeking mental healthcare for socially-driven distress is constructed as a rational or 'appropriate' decision. Psychiatry, in turn, provides treatment options that alleviate distress as well as serves administrative purposes (Jutel, 2009)

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by granting access to medicines or sick leaves, but does not challenge the social roots of suffering:

> You have a problem with your boss, come to a psychiatrist and solve it with pills
>
> and sick leave! (HCP02, psychiatrist)

Other parts of the contemporary social *habitus,* such as the importance placed on self-responsibility and performance (Moncrieff 2014; Rose 2019), may also lead to feelings of losing self-control in case of underperformance. Individuals, therefore, seek mental healthcare or other resources 'to cope with the seemingly personal inadequacies that inhibit their self-improvement' (Rose, 2019, p. 52). While soothing such anxieties with alcohol may be acceptable only to some extent, the help of pharmaceuticals or therapy allows for a more rational solution:

> Nobody is completely satisfied. Society leads us to certain illusions: we must be
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> wonderful, beautiful, tall, thin, happy, and have a good job and much of everything.
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> And, of course, as you cannot achieve this, you are not satisfied. Then, drinking
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> alcohol or taking pills is a way to put up with this unhappiness. (HCP04, general
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> practitioner)

Therefore, more equal relations between social groups (Elias, 2000) and more relaxed standards or increasing varieties of behaviours and emotional expressions 'without provoking shame, particularly the shame-fear' (Wouters, 2019, p. 10) do not mean that demands for self-controls decline and that external controls disappear. Rather, there is 'a rise of demands on self-steering capacity' (Wouters, 2019, p. 3). Medicalisation or pharmaceuticalisation of unsuccessful self-restraint, in turn, becomes a mechanism of external social control that gives peace of mind to both an individual as well as figurations they are entangled in, and consequently, guarantees the social order by diminishing emotional irregularities or 'spontaneous emotions' (Elias, 2000,

p. 370). There is 'the growing premium placed on having the foresight' (Gibson and Malcolm, 2020, p. 74) to continuously maintain 'deviant' or 'irrational' emotions under control. Healthcare seeking for such emotions, therefore, represents rationalisation (Gibson and Malcolm, 2020), which is an expression of the foresight (Elias, 2000).

The blend of involvement and detachment

The trends of scientisation and individualisation, in general, and the consideration of one's emotions as symptoms of mental disorders –the response to which is healthcare seeking– in particular, suggest a shift towards greater detachment and self-distancing. Yet, it is not based on a zero-sum principle. Involvement does not disappear completely. In other words, such shift should be viewed as 'a dynamic tension balance embodied in social activities' (Kilminster, 2004, p. 31). Functional specialisation and scientisation might go hand in hand with involved thinking. A fear of psychopharmaceuticals and, specifically, of antidepressants might represent such reasoning:

> I was afraid of addiction, being dependent on them. And precisely, I took both types
> of pills: I have been taking the sleeping pill –Lorazepam– now for 6 years, but I
> stopped using the other one. I don't remember when, but I stopped because I got
> very scatterbrained. (P09, female user, 51-65)

The user above spoke about her unwillingness to use antidepressants due to their side effects and dangers of dependence, whilst benzodiazepines were accepted despite being consumed over a long period of time, which may suggest dependence issues. Such simultaneous trust and distrust in medical discourse and its technologies were also stressed by the healthcare providers:

> There is a fear of our treatments that is sometimes irrational, because one takes
> maybe 15 pills for something else that may have much more side effects, but then

ours might have a ridiculous dosage –let's say -zepam of 1.5 mg– that has no chance

of giving you side effects, right? (HCP02, psychiatrist)

Similarly, while healthcare seeking may be perceived as a rational form of dealing with distress and unsuccessful self-controls, such rationalisation co-exists with a fear of possible outcomes. In particular, the participants spoke about fears of being judged or perceived to be insane:

Some patients ask me if they can come during the final hour when there is no one

here, because the neighbours may see them and think that because of going to a

psychologist they are crazy. (HCP11, clinical psychologist)

In other words, whilst placing trust in scientific discourse and the construction of mental distress as a medical condition, individuals might still be haunted by the images of insanity, fears of losing one's mind, and other stigmatic attitudes. Emotional distress is frequently caused by or results in feelings of social and psychological insecurity –conditions that 'fuel more involved thought processes' (Malcolm *et al*, 2017, p. 60). Therefore, while self-distancing, reflexivity, greater knowledge and foresight seem to be built into the contemporary social *habitus* and, in turn, facilitate the medicalisation of emotions, involved or emotional thinking might go hand in hand with such detachment. The interviews signal that involvement can, to some extent, result in resistance to medicalisation.

Conclusions

In this article, employing Elias's process sociology (2000, 2009b), I intend to better understand healthcare seeking in response to intense emotions that may be a proportionate reaction to stressful life events and circumstances, which consequently leads to medicalisation of such distress in Spain. While not rejecting the importance of promoting mental health and investing in mental health services, which help to manage many serious mental health problems and to alleviate a lot of suffering, the article focuses on the increasing medicalisation of non-

disordered mental distress. The analysis of the interviews with healthcare providers and users of services reveal how medicalisation of emotions can be theorised through the long-term processes of differentiation and integration, as well as through a shift in the we-I balance. Such framing has been missing from medicalisation literature that tends to focus on the study of shorter-term processes.

The article, therefore, contributes to the literature not only by demonstrating the potentiality of Elias's theoretical framework for medical sociology, but also by engaging with these larger or longer-term processes. Such processes can be understood as the 'conditions of possibility' (Abend, 2019, 2020). Put differently, they enable or make medicalisation possible, rather than directly causing it. For other practices and processes 'could have arisen, or nothing at all' (Abend, 2020, p. 9). Medicalisation is just one of the possibles. Said shorter-term processes – such as the development of decontextualised symptom-based psychiatric classifications, the promotional apparatus of the pharmaceutical industry, or the practices of the media and popular culture (Busfield, 2017; Conrad, 2007; Horwitz, 2007; Williams et al, 2011)– can be viewed as more directly driving to medicalisation of mental distress. Abend (2020) argues, nevertheless, that what-makes-something-possible questions are just as important as what-causes-something questions.

In brief, the results suggest that the directions of the aforementioned long-term trends lean towards increasing scientisation and individualisation. In other words, growing differentiation and integration processes entail a shift in the balance of power and dependence. The scientific or medical discourse gains more power in the management of emotional distress. At the same time, the religious community as a coping source loses its function due to late but rapid secularisation of Spanish society (Pérez-Agote, 2010; Requena, 2005). The family or other informal networks are likewise de-functionalised towards their diminishing role in emotional support. The growing importance is placed on I-identities. As a result, the medical expert

systems become the primary choice for emotional support in mental distress, and in turn, replace or colonise the lifeworld (Habermas, 1987).

The article also adds to the evidence that, despite the fact that informalisation or democratisation processes result in increasing varieties of affects and openness about them, including 'dangerous' or intense emotions, self-controls do not diminish. To put the matter elseways, openness regarding emotions goes hand in hand 'with a keen interest in their regulation' (Wouters, 2019, p. 10). Such '[c]ontinuous reflection, foresight, and calculation, self-control, precise and articulate regulation of one's own affects' form part of the contemporary social *habitus* and 'become more and more indispensable preconditions of social success' (Elias, 2000, p. 398). In case of failing or 'flawed' self-constraints such as the feelings of 'deviant' sadness or anxiety, external social controls may help to attain self-regulation. In the climate of scientisation and insecure we-feelings, 'crying out' such intense emotions or 'controlled decontrolling of emotional controls' (Wouters, 2019, p. 11) occur more and more frequently within the medical practice.

Healthcare seeking for emotional distress, therefore, comes to represent rationalisation or the foresight 'to live according to socially proscribed and increasingly epidemiologically evidenced lifestyles' (Gibson and Malcolm, 2020, p. 74). In mental health, such evidence suggests that strong and unpleasant emotions are prevalent within the populations and viewed as symptoms of mental disorders that should be treated by means of psychopharmaceuticals or therapy. In other words, living with feelings of sadness or fear is irrational. In the meantime, seeking care for such emotions is a rational solution towards successful and stable self-regulation. Yet, healthcare seeking for emotional distress may involve not only detachment that is expressed by self-distancing and reflexivity, but also involvement. As in other process balances, '[b]oth can occur simultaneously' (Elias, 2009a, p. 4). The analysis shows how the latter may drive to more

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emotional reasoning, and result in de-medicalising behaviours such as abandoning care or non-adherence to treatments.

Yet, the conclusions should be considered with caution. In particular, voluntary participation, which is central in ethical qualitative research (Robinson, 2014), may generate self-selection bias. The topic of the study could have attracted individuals and, specifically, healthcare providers that are more reflexive and critical towards medicalisation. The conclusions, therefore, could benefit from a larger and more diverse sample. Likewise, while some of the analysed processes are consistent with the findings in other countries (e.g., Davis, 2020) and are, therefore, likely to characterise settings beyond the Spanish context, this cannot be verified within the limits of this study.

Finally, the analysis signals several empirical implications. First, the reconceptualization of certain 'intense' emotions as a normal part of life may enhance individual resilience and the acceptance that some suffering does not necessarily require medical interventions, but rather the challenging of social structures or circumstances under which such emotions are instigated. Second, an absence of we-groups that provide support when emotional distress is experienced might be one of the factors that encourages healthcare seeking and, therefore, facilitates medicalisation. In turn, civic engagement, more active trade unions, and participation in different social or voluntary associations, the importance of which has been also stressed by the healthcare providers, could strengthen we-feelings and provide secure spaces for sharing intense emotions or for challenging oppressive social conditions rather than medicalising them. In other words, the development and activation of associative ties may slow down the medicalisation process and, in the long run, decrease reliance on health system and its goods (Doblytė, 2020a).

On the whole, Elias's process sociology provides a tool for a better understanding of medicalisation, where the analysed tension balances can be integrated into the triad of interdependent controls (Elias, 1978; Wouters, 2019). Greater awareness of one's emotions in contemporary societies does not exclude demands for their self-regulation and foresight. This goes hand in hand with growing functional differentiation, including the management of certain 'intense' emotions within the medical practice, which is a form of external controls over 'flawed' self-controls, i.e. 'the social control of people over each other' (Wouters, 2019, p. 164). Both self-restraint and social control function along with technological developments. While such scientific achievements –including psychopharmaceuticals and evidence-based therapies– depend on functional differentiation and coordination between specialised groups, the latter also relies upon the success of said developments. Likewise, both of them count on a relatively stable self-restraint. If such self-controls fail, social institutions and, particularly, the health system, which views such failures as symptoms of mental disorders, help to restore them.

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