

Power dynamics of the healthcare field: seeking mental care in Lithuania

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ABSTRACT: Over the course of the last decades, the post-socialist societies have been enduring high levels of mental distress, while reporting relatively low treatment rates, which suggests a considerable treatment gap and delay. This article examines how the design and functioning of the mental healthcare system and, particularly, the structure of its inner power relations influences mental healthcare seeking in Lithuania. Employing the theoretical stances of Pierre Bourdieu and Norbert Elias, 23 in-depth interviews with healthcare providers and users of services, who suffer from depression or anxiety disorders, are analyzed. It is concluded that while mental healthcare appears to be relatively accessible it is not necessarily acceptable or humane.

KEYWORDS: mental health, health system, power relations, help seeking, Central and Eastern Europe, Pierre Bourdieu

INTRODUCTION

Common mental disorders –depression and anxiety, in particular– have been increasingly burdening individuals and societies globally, which also includes post-socialist states in Central and Eastern Europe (Olesen et al. 2012; Chisholm et al. 2016; Vigo et al. 2016; James et al. 2018). Yet, adequate interventions, inclusive of provision of effective mental health services once symptoms are present, can reduce their burden (Chisholm et al. 2016; James et al. 2018). To that end, starting with the Law on Mental Healthcare in 1995, one of the Baltic

states –Lithuania– has intended to reform its mental health system and, in turn, to improve accessibility and quality of mental health service provision. The latter had lagged behind while under the Soviet regime, relying entirely on hospitalization, restrictions and dispensarisation as tools of social control (Daubaras 2004; Van Voren 2013).

Today, provision of mental health services is ample (Pūras et al. 2013). 23.3 psychiatrists per 100,000 inhabitants practiced in the country in 2018, which was substantially more than in other states in Central and Eastern Europe (Eurostat 2020). Mental healthcare is integrated into the public health system, whose coverage is nearly universal and which has been reported to be affordable and accessible (Doblytė and Guillén 2020; OECD 2019). Both psychiatrists and clinical psychologists can be accessed directly –without the necessity of referral from a general practitioner– in mental health centers that are organized at the primary care level and spread across the country. While this organization of outpatient specialized mental healthcare should increase accessibility of services, secure earlier diagnosis and reduce stigma (Pūras et al. 2013), it entails an ambiguous role for the general practitioner in the management of common mental disorders, as well as meaning that there is no gatekeeping and, therefore, no filters, which might result in the overcrowding of some mental health centers (Šumskienė and Pūras 2014).

If treatments in mental health centers prove to be ineffective, patients can be sent to outpatient day centers, or be hospitalized. Like in other post-socialist societies (Raikhel and Bemme 2016), the number of psychiatric care beds has decreased significantly over the past decades (Eurostat 2020), but hospitalizations remain prevalent with a large share of resources being appointed to inpatient and long-term care institutions rather than outpatient or preventive services (Pūras et al., 2013). Psychological, psychotherapeutic and social therapies are included within the state-financed benefits package both at outpatient and inpatient levels (Šumskienė, Petružytė and Klimaitė 2018). While fully covered in inpatient care, prescribed outpatient pharmaceutical treatments are fully or partially reimbursed for severe and moderate depression as well as other severe mental illness, but not for anxiety disorders (Minister of Health of the Republic of Lithuania 2000).

Despite the organization of mental health services appearing to be accessible and comprehensive, indicators of violence toward oneself and others suggest high and persistent levels of mental distress in the population (Bellos et al. 2013; Flensburg-Madsen 2011; Rihmer 2007). Lithuania triples the EU-28 suicide rate with more than 28 deaths per 100,000

inhabitants in 2016, which was nearly 10 deaths more than in the country with the second-highest rate – Latvia (Eurostat 2021). It is also a country with one of the highest rates of alcohol consumption (OECD 2019) or deaths due to assault – 3.6 compared to 0.6 in the EU-28 (Eurostat 2021). Yet, prevalence of depression or anxiety disorders and use of mental healthcare as self-reported consultations are low and appear to be a feature shared by post-socialist societies across the region (Eurostat 2019). Less than 5 per cent of the population reported depression in 2014 being among the 10 EU member states with the lowest prevalence, eight of which were the former socialist states in Central and Eastern Europe.

All of this, therefore, suggests a considerable treatment gap or delay, and that the institutional design *per se* might not reveal the actual strategies of dealing with mental distress or the factors that impede or facilitate healthcare seeking in common mental disorders. While, to the best of my knowledge, there are no studies that provide data on unmet needs for mental healthcare in Lithuania, Kangstrom et al. (2019) find that the treatment gap for affective, anxiety and alcohol-related disorders is 83 per cent in Czechia, whereas the treatment gap of the same disorders in Western Europe is estimated to be 48 per cent (Alonso et al. 2007). This suggests that the magnitude of the problem in Central and Eastern Europe is profound.

The stigma of mental illness whose intensity and impact in Lithuania have been examined by various scholars (see, for example, Doblytė 2020; Pūras et al. 2013; Šumskienė et al. 2017) might significantly constrain mental healthcare seeking. Besides this, nonetheless, the treatment system, “in all that it represents or fails to embody”, could also take its toll, as well as have “a much broader impact on the functioning of social systems and the attitudinal positions of actors within these” (Brown and Flores 2011, 62). Therefore, the aim of the article is to better understand how the design and functioning of the mental health system may shape help-seeking practices in common mental disorders in Lithuania. This article contributes to the literature about mental health systems in the region of Central and Eastern Europe, which remains understudied (Kangstrom et al. 2019; Raikhel and Bemme 2016).

THEORETICAL LENS

The research is guided by the assumptions of critical realism (Vandenberghe 1999; Bhaskar 2016; Fletcher 2017; Price and Martin 2018) that intends to resolve the dualism between naturalistic positivism and anti-naturalistic hermeneutics and, consequently, commits to ontological realism, epistemological relativism, and judgemental rationality. Its commitment

to ontology and to bypassing the epistemic fallacy results in viewing the social world and structures as existing independently of human knowledge or concepts and, as such, being intransitive (unlike knowledge). Yet, they are activity-dependent and known precisely through existing knowledge and concepts. Social reality is stratified into three domains: the empirical (activities as experienced and observed), the actual (events as occurring whether or not we observe or experience them) and the real (generative mechanisms and structures for the events at the empirical and actual levels).

While not directly observable, the real level is the primary focus of social research. It proceeds from description to identification of possible interpretations of observable social activities “in terms of the structures and mechanisms that produce them” (Bhaskar 2016, 7), which, due to unperceivability of generative mechanisms, must “be detected by their effects” (13). Knowledge is understood as transitive: temporary, changeable and presenting one of the possible explanations given existing theories and collected evidence. While there is a single reality, it is an open, complex and emergent system, and thus, instead of constant universal laws, there can be multiple interpretations of some of the generative mechanisms. Social research searches for the best explanation of reality and its entities at a given moment in time and within a particular social and linguistic context “through engagement with existing (fallible) theories about the reality” (Fletcher 2017, 186).

In this context, the analysis draws on Pierre Bourdieu’s relational sociology, whose theory of knowledge is compatible with critical realism (Vandenberghe 1999). I examine help-seeking as observed or experienced practices structuring and structured by the logic of the mental healthcare field (Doblytė 2019) that can be understood as horizontal relations or tensions between dominant and dominated positions (Bourdieu 1990). The mental healthcare field is both a *field of forces* whose rules of the game are “imposed on agents” (Bourdieu 1998, 32) with an inculcated and durable field-specific ‘feel for the game’ or *habitus*, as well as a dynamic *field of struggles* where “agents confront each other, with differentiated means and ends according to their position in the structure of the field of forces, thus contributing to conserving or transforming its structure” (Bourdieu 1998, 32). Bourdieu attempts to transcend the subjectivism/objectivism dualism with his concept of *habitus* that introduces vertical relations to the theory (Vandenberghe 1999, 48): it mediates between the structured relations or social structures at the real level, “by which actions are shaped”, and the visible actions of the agents at the empirical level, “which structure relations”.

Likewise, an Eliasian perspective may provide a helpful tool for thinking of individuals as forming and acting in constantly interweaving figurations or functional interdependences, “which constrain people to a greater or lesser extent” (Elias 2012, 73). In his processual sociology, Elias invites inquiry into facts or activities and to develop an understanding or model of deep structures and regularities of interdependences of people “into which the scattered facts can be fitted” (Elias 2000, 436). Both Bourdieu and Elias stress the importance of power (capital) and view it as a concept of relations: “fluctuating balance of power is a structural characteristic of the flow of every figuration” (Elias 2012, 126). Although there is a tendency of capital to persist and reproduce in the hands of the dominant, Bourdieu –similarly to Elias– thinks of power as dynamic and relational where the struggles between agents may transform “the ‘exchange rate’ between different kinds of capital” (Bourdieu 1998, 34).

Finally, the concept of symbolic power or violence (Bourdieu 1991) helps to further understand the nature of relationships or interdependences between agents with different power ratios. Symbolic power is seen as a subtle and ‘invisible’ form of domination toward an agent and with their complicity which appears in everyday life and (re)produces the social order. We can “discover it in places where it is least visible, where it is most completely misrecognized – and thus, in fact, recognized” (Bourdieu 1991, 163). In other words, it is recognized as legitimate, but “misrecognized as arbitrary” (Bourdieu 1991, 170). In this context, therefore, the aim of the article is to understand how the logic of the health system as a certain structure of invisible relations or balances of power (as one of possible generative mechanisms) might shape visible actions or experiences of (non-)help seeking in common mental disorders.

MATERIALS AND METHODS

While the use of statistical data allows “to explore the exterior of social life”, critical realist research generally focuses on understanding by means of language that “provides an ‘inside’ or ‘interior’ to social life” (Price and Martin 2018, 92). This understanding can be produced hermeneutically (Bhaskar 2016, 58) through “a logic of question and answer” (Schwandt 2000, 195). To that end, semi-structured in-depth interviews with users of mental health services and healthcare providers have been employed to explore the process of mental help seeking. The findings that are analyzed in this article form part of a broader research project on medicalization in common mental disorders that examines the impact of institutional,

cultural and social contexts. Ethics approval for the project was obtained from the author's local research ethics committee on 2 May 2017.

For the recruitment of the participants, three mental health centers, two health centers and a psychiatric hospital that provides both inpatient and outpatient services were purposively approached. Several additional participants (mostly, users of services) were identified by means of study advertising through the author's professional and personal networks, as well as using snowballing techniques, which are particularly helpful when researching populations or topics that may suffer from stigma (Robinson 2014). Given the idiographic aim of the study and, therefore, the need for intensive analysis of each case, a relatively small number of individuals were considered to be adequate (Robinson 2014). Notwithstanding the foregoing, high levels of data saturation or thematic exhaustion (Guest, Bunce and Johnson 2006) seem to have been reached with little new information discovered upon interviewing the final informants in each group.

Once informed consent had been provided, the participants were interviewed face-to-face or over the telephone. The interviews were audio-recorded and conducted in Lithuanian. As a result, healthcare seeking was examined through interviews with 11 adult users of healthcare services (7 women and 4 men) who suffer or have recently suffered from depression or anxiety disorders. The interview questions focused on reconstructing their trajectories toward and within the treatment system from the moment of acknowledging symptoms in order to better understand their perceptions, experiences outside and within the health system and the barriers or facilitators to healthcare seeking that they faced. While heterogenous in age and educational levels, all of them share life history, as all were receiving or had recently received outpatient care at mental health centers. Four users had also been hospitalized for mental health problems and another four participants had additionally received treatments at day centers.

Furthermore, 12 healthcare providers who participate in the management of common mental disorders –psychiatrists, clinical psychologists and general practitioners– were also interviewed. Their clinical experience varied between 4 and 37 years. The interviews with healthcare providers revolved around understanding the logic and structure of the health system and, in turn, around exploring their interpretations of barriers or facilitators that users might face when accessing and utilizing healthcare services.

Once transcribed, the interviews were managed with software for qualitative research and analyzed using reflexive thematic analysis – a flexible technique to identify patterns of meaning or themes within the data (Braun and Clarke 2006; Nowell et al. 2017). The analysis was both data and analyst driven (Braun and Clarke 2006). In other words, it was ‘directed’ by the theoretical approach while being flexible, where codes and themes “were changed, eliminated and supplemented with new codes” throughout the process (Fletcher 2017, 186). After the familiarization with the data and development of an initial code list, the interviews were coded and potential themes were generated by clustering relevant codes. The themes were reviewed, defined and refined several times until reaching internal homogeneity where data within themes “cohere together meaningfully” and external heterogeneity as “clear and identifiable distinctions between themes” (Braun and Clarke 2006, 91). Although presented as a linear process, the analysis was recursive moving back and forth between the phases.

FINDINGS

To achieve legitimacy of healthcare and its adequate functioning, which might be considered as essential for healthcare seeking, the treatment system must not only be accessible, but also clinically effective and humane (Pilgrim 1997, 2018). In this study, a large part of the participants perceived mental healthcare in Lithuania as accessible and comprehensive:

Our structure now is wide and a patient can get a lot of services [...] I wouldn't say that there are any special gaps in this structure. (psychiatrist)

As a result, when recounting their perceptions and experiences, they have focused on the effectiveness and acceptability of mental health services rather than accessibility itself. Therefore, three main themes that center around unequal power balances have been developed: first, inequalities of power in user-provider relations; second, inequalities of power in provider-state relations and *status quo* inertia in the mental healthcare field; and third, institutionalized stigmatization as bureaucratized symbolic power.

Power relations in a clinical encounter

Effectiveness of any public policy and, particularly, of health interventions calls for “not only the supply of care but also the acceptance and use of services by the patient” (Gilson 2003, 1459), at the core of which is user-provider interaction and trust as compassion and/or competence embedded in these relations. Trust might be shaped by past experiences, social

networks or media channels, and is likely to influence one's expectations of possible interactions if help is sought, which in turn may lead to different coping strategies depending on individual capital resources and notwithstanding accessibility of existing services.

The interviewed users of services confirm the importance of trust in their relations with providers. Several of them recalled encounters with empathic healthcare providers: in particular, when receiving inpatient or outpatient mental health services at the Vasaros psychiatric hospital, which is also given as an example of good practice by Tomov et al. (2007). Experiences with providers who listen, dedicate time and allow one to participate in decision-making lead to perceptions of more equal relations at the moment of service utilization and might facilitate healthcare seeking in the future:

It was the first time that I didn't feel like a patient but like a human seeking help, it was that she considers my opinion and that I have a right to choose (...). I really liked it. I think now that if I went again, I would choose her. (female user, 18-35)

Yet, the participants talked about trust more as the exception than the rule. Generally, experiences of a lack of attentive and empathic communication with a provider have dominated in the stories of the users:

My psychiatrist is absolutely 'amazing'. She never asks me how I feel, just 'give me your card [*of reimbursable medicines*]', prescribes medicines and that's it, good bye for three months. (female user, 18-35)

In the end, after all of that, particularly because of psychiatrists, who only prescribed medications but didn't talk, I got even worse. (male user, 18-35)

Beyond a lack of compassion at a clinical encounter, several users also spoke about healthcare providers as employing excessive power to hierarchize, exclude or even humiliate:

I had a hygiene issue –my period– and nothing, it didn't matter... I asked 'can you please give me at least some paper towels or napkins, because I don't have anything?' [*the user was urgently hospitalized at the Republican Vilnius Psychiatric Hospital after a suicide attempt*], and they replied – 'why don't your relatives bring it?'. It was TRAGIC, it was something horrible. (female user, 18-35)

Such experiences of domination and even demoralization, which have also been underlined by other scholars in Lithuania (Baltrušaitytė 2003) and other post-socialist societies (Friedman 2016), may result in low adherence to treatments or delays in accessing the system. In other words, it can lead to distrust in providers, which is likely to affect strategies of dealing with mental distress:

I have suffered since autumn [*nearly a year*], I didn't want to go to that doctor.

(...) I didn't trust that doctor, I simply didn't trust. (male user, 51-65)

In these narratives, the users often perceive providers as 'them' rather than separate individuals (all of them vs. one user), who secure their power surplus "keeping others firmly in their place" (Elias 2008, 4). Informal payments or gifts, which emerged under the Soviet regime and remain prevalent in post-socialist societies (Cockcroft et al. 2008; Sitek 2010; Eurobarometer 2017), might be seen as an utmost manifestation of such power imbalances. While functioning as a tool to secure access to quality and more attentive healthcare, they lead not only to inequities of access by constructing financial barriers for vulnerable populations (Gaál, Jakob and Shishkin 2010), but also to strong domination of and dependence on a provider in a clinical encounter.

Nearly 80 per cent of Lithuanians perceive corruption and abuse of power as widespread in the healthcare system, which is significantly more than in any other public or private sectors in the country (Eurobarometer 2017). Such perceptions are likely to "influence individual strategies for dealing with the system" (Sitek 2010, 587) and to evolve into a form of coercion rather than voluntary gratitude (Gaál et al. 2010):

It was like a norm, a non-written rule: if you go to a doctor, they examine you, then you must have something with you, an envelope or something. (...) It's from the Soviet times that you are a tiny human being, that you depend on me, I will cure and *miscure* you in any way I want. So, people were afraid of such *miscuring* and, therefore, they gave, and give, and will give [*bribes*]. (male user, 51-65)

Yet, only users amongst older generations spoke of informal payments and gifts to healthcare providers, and none of them acknowledged these practices in their own clinical encounters, which may indicate their low importance in the mental healthcare field. Beliefs about healthcare providers calling for informal payments, nonetheless, remain incorporated into *habitus*:

She is a very good doctor, she doesn't take bribes. (female user, 36-50)

Perceptions of power abuse in the healthcare system coupled with a lack of compassion in a clinical encounter might influence users' experiences and expectations. It is argued that functional democratization (reduced asymmetry or informalization of clinical encounters) and de-democratization in a broader society (income inequality or social distance between people) may deepen the gap between providers and users or between empathy and professionals' *habitus* (Flores and Brown 2018), which seems to be the case in Lithuania. Yet, both players are dependent one on another (Elias 2012): users demand providers' services whereas providers themselves need users to seek healthcare and adhere to treatments. In other words, there is a functional interdependence between them and, except for hospitalizations, providers generally cannot control the entire 'game'. Thus, avoidance of the treatment system by employing alternative coping strategies or abandonment of care could be explained as being influenced by this processual nature of the user-provider relationship.

Inequalities of power in provider-state relations

Although taking effect between a user and a provider at the micro level, a clinical encounter is also "shaped by the institutions embedded within the health system" (Gilson 2003, 1459) including the regulation of clinical practice or the structure of decision-making. In this sense, the meanings that emerged in the interviews center around being dominated or disempowered. The healthcare providers spoke about power being concentrated in the hands of agents interested in maintaining *status quo* of the mental health system. The narratives were marked by feelings of disillusion and disappointment induced by power asymmetries and the dominance of biomedical paradigm in the field:

[*I don't participate*] due to a lack of time and certain disillusion, due to all that nihilism, because year after year that reform of ours is faulty. (psychiatrist)

Oh, how many times it was reorganised. (...) Ideas were beautiful, but again everything resulted in pharmaceutical treatments. (...) Decisions are made in the parliament or in the ministry by doctors and their thinking is that of illnesses. (general practitioner)

While psychopharmaceutical treatments are perceived as accessible and affordable even considering user charges as well as “very well developed” as a treatment model (Šumskienė et al. 2018, 71), the participants talked about systematic overreliance on them:

All those benzodiazepines are a cross to bear for our country, a really huge dependence and problem. I would say that it’s like alcohol problems. (general practitioner)

Although being a dominant treatment model across the world, the effectiveness of psychopharmaceuticals in treating common mental disorders has been increasingly questioned, particularly given their risks compared to small benefits (Turner et al. 2008; Gøtzsche 2013; Kirsch 2014). Beyond the overuse of psychopharmacotherapies, the experiences and perceptions of the participants also suggest limited adequacy of non-pharmaceutical care, notwithstanding recommendations of integration of therapies in common mental disorders (National Institute for Health and Care Excellence, 2011):

There is no psychotherapy at all, it’s psychological consultations, provision of information, (...) it’s very bad. (clinical psychologist)

Even if they have an art therapy or simple psychotherapy listed [*in the list of provided services*] and based on all those tests psychotherapy was assigned to me, I didn’t get it, because there was no doctor or she was on holiday or something like this. (female user, 18-35)

Therefore, even though the state *de jure* guarantees access to multiple mental health services, it seems that *de facto* not all of them are available or adequate with a bias towards biological medicine, which does not challenge social structures that might have caused people’s distress and, therefore, is not necessarily “the most helpful way of responding to their difficulties” (Busfield 2015, 204). Friedman (2016, 177) describes an akin situation in contemporary Romania, where psychological services are usually restricted to psycho-education with psychotherapies being left “*pro forma* rather than *de facto*”, i.e. clinics list them “without actually following through on providing these services”.

These dominant biomedical principles of mental healthcare may also sustain a lack of orientation to mental health promotion and illness prevention (Pūras et al. 2013). While some providers argued that lately there has been an increase in preventive initiatives, particularly in

suicide prevention, they also spoke about geographical inequities (center vs. periphery) and organization from above:

The figures [*suicide rates*] in Vilnius are great, but the project centers in Vilnius and they teach everyone here. Unsensible amount, a waste of time. And what do we need it for? There are so many services here (...) And in regions, 80-90 per 100,000 commit suicides and one psychiatrist works there, who doesn't have time for anything, doesn't see anything and can't help. (psychiatrist)

Policies oriented to health promotion (rather than one-time initiatives), nonetheless, could help people to effectively cope with mental distress without accessing the formal treatment system or, if needed, to encourage them seek healthcare earlier and, as a result, avoid unnecessary hospitalizations for common mental disorders:

Nobody talked with me at school although I had a lot of problems. (...) No, nobody was interested. But those problems already started then and if you are not solving them – you yourself are a teenager and don't understand them – they progress to the point that I was hospitalized. If only someone would have approached me then. (female user, 18-35)

Yet, it seems a vicious circle when *status quo* inertia in the field caused by power asymmetries and a lack of political will of the dominant (Šumskienė and Pūras 2014) maintain traditional financing of biomedical institutions and medication-based interventions lacking support for mental health promotion and prevention, which in turn preserves stigmatic attitudes and low mental health literacy and, therefore, high treatment gap and delay. However, “the longer it is delayed, the more hospitalization is needed” (clinical psychologist), which consequently proves the need of traditional but expensive mental health services leaving insufficient financing for health promotion and prevention. Therefore, with few exceptions and rather modernized, the system appears to remain dependent on “Soviet-style mental health care provision” (Tomov et al. 2007, 420), which might discourage people from early healthcare seeking, as well as on asymmetrical decision-making, which seems to discourage providers from intents of participation in policy-making:

I participated over 20 years, (...) it was EMPTY sitting, pointless. All those discussions, a working group meets, 20 people and no sense, everything ends without results. (psychiatrist)

Their antagonism with the political-bureaucratic field was also present when the providers spoke about their work conditions and their effects on work quality including communication with users or the choice of treatment methods. Like users, they stress time constraints and frequently compare them with better work conditions in the private sector. While the users perceived it in terms of the user-provider relationship, the providers, nonetheless, experienced limited autonomy and talked about time constraints as something under which they are forced to work:

We are not looking at a patient anymore. We look at computer and just check sometimes if [*a patient is*] still alive and sitting there. There is no time, you rush and try to do everything in maximum 15-20 minutes. (psychiatrist)

Furthermore, like the users who felt dominated by healthcare providers, the providers themselves experienced control or disempowerment by the state, which, consequently, could impede clinical interactions at the micro level. They recounted how healthcare system issues such as waiting times or resource control are solved by disciplining them from above through surveillance and punishment (financial or additional workload):

The Sickness Funds checked general practitioners and fined them, because they prescribe medicines without any justification in medical records, (...) and now they do not prescribe – we are not allowed, they say. They ARE allowed, but they defend themselves with this (...) ‘Go to a psychiatrist’, they say; and now they come to us for sleep disorders. (psychiatrist)

This also creates inner tensions between different types of healthcare providers. The greater these tensions, the greater the chances that the political-bureaucratic field controls “the general course of the game” in the field (Elias 2012, 78). In other words, the collective power of healthcare providers as the holders of cultural capital would increase, “if the holders of the dominant type of capital (economic capital) were not able to set the holders of cultural capital in competition with one another” (Bourdieu 1997, 50). So far, nonetheless, the state appears to secure these power differentials with surveillance from above downwards, which underpins the logic of the field and its structure of dominant and dominated positions in the mental healthcare field of Lithuania. Although the users feel mistreated by providers, the providers themselves feel humiliated by the state:

Doctors have never been respected in these 30 years, we have been left behind everybody else. (psychiatrist)

Trust between them and policy-makers or regulators, nonetheless, could result in more autonomic and problem-solving approaches in medical practice rather than feeling under constant pressure from above and, as a result, support “the development of a trusting relationship between patient and provider” (Gilson 2003, 1460).

Institutionalized stigmatization

Unlike power asymmetries in the user-provider relationship that may transcend geographical borders, albeit to different extents, the final theme appears to be unique to ex-communist states. It is the enactment of a state’s symbolic power by means of medical collaboration with authorities, which serves social control functions (Conrad and Schneider, 1992). Documentation and information provision through medical certifications to authorities with the aim of restraining rights is a mechanism of lawful control of users as the outsiders. These restrictions can be experienced upon diagnosis of mental illness including depression and, in some cases, anxiety disorders:

Some people are afraid that they won’t be allowed to do something – let’s say, to work certain jobs. And they won’t be allowed, indeed we have restrictions. (psychiatrist)

(...) but a majority don’t know these things and they get here. You tell them that you can lose this and that, then they immediately turn around and leave. (...) You are ill, but you can’t seek help. (psychiatrist)

It is a form of institutionalized stigmatization that is inherent from the Soviet regime when being on a psychiatric register meant “a life-long stigma” with some of “civil rights revoked” and difficulties “to find a job [or] housing” (Van Voren 2013, 7). The diagnosis of mental disorders in contemporary Lithuania can still influence individuals’ work perspectives (e.g., in the field of law) or prevent from getting/renewing a driving license and owning a gun:

There is a pile of Soviet orders that are still in force. (...). There are different restrictions for doctors, bailiffs, attorneys, notaries, prosecutors, judges, adopters, nurses, midwives... (Interviewer: *These people can’t have depression, ¿can they?*)

No, they can't, because if they have, that's the end, they lose their job. They are not allowed to own or use a gun, so all law enforcement and so on. (psychiatrist)

While some of such restrictions have recently been repealed or relaxed (e.g., the legislation for medical practice was amended in 2020 by removing mental disorders as conditions that can result in the suspension of a medical license), others – at the time of this writing – continue to be in force. The order 404/96, for instance, that approves the list of medical conditions under which prospective child adopters are not allowed to adopt a child, among other mental disorders, includes mild and moderate depression, both single episode (except if a person has been in full remission and without signs of relapse for 3 or more years) and recurrent depression. Similarly, the legislation that establishes health requirements to obtain a lawyer license (the order V-556/1R-181) also covers mood disorders, yet allowing more room for individual cases. Indeed, while all providers deemed it to be a barrier to healthcare seeking, some of them spoke about this flexibility of the law. In other words, as being in a position of power in terms of cultural capital, they considered themselves as legitimate agents to manage the system correctly, i.e., as mediators between the state and users:

That's during the treatment, but afterwards the law is flexible and there is a lot left for individual decisions. A person comes and we talk and see how the person is feeling and how much risk there is for oneself and others because of illness. (psychiatrist)

In Bourdieu's words (1991, 170), "what creates the power of words and slogans, a power capable of maintaining or subverting the social order, is the belief in the legitimacy of words and of those who utter them". That is to say, even if acknowledging it as a barrier, providers seem to usually inculcate the taken-for-granted of the field within their *habitus* and (un)consciously support this tool of medical social control and, therefore, *status quo*. If help is sought, such instruments of bureaucratized symbolic power by the state towards its citizens "help to ensure that one class dominates another" (Bourdieu 1991, 167). The better-off, nonetheless, can escape this in the private sector and avoid the field of documentation:

Those, who don't want it [*diagnosis*] at all, they don't go to the public sector, these are users of private services. (general practitioner)

In other words, it reproduces social order by impeding life chances for those who depend on the public healthcare system (Šumskienė et al. 2018):

If you go to a psychiatrist, and if they register a diagnosis with a letter F... Nobody wants the letter F, because then they restrict. It's possible that you won't get a job in some public institutions, you can't get a gun, can't drive. (...) Your opportunities are immediately restrained, they write you off as invalid straight away. If invalid, you are not able to support your family. Everything is connected. (male user, 36-50)

The lived experience of this particular user might illustrate possible consequences of such symbolic violence:

I worried so much, I wanted to renew my driving licence, because although not a lot, I needed to drive at work (...) mine was expired and they [*psychiatrists*] weren't eager to renew. I worried so much that I finally suffered a stroke. I wasn't able to speak at all, even now I sometimes get stuck. (male user, 36-50)

Therefore, apart from additionally restraining the life chances of those in treatment, who often have no alternative effective coping strategies at their disposal, symbolic power of the state through healthcare providers to (potential) users discourages healthcare-seeking amongst those in need of treatment. The better-off usually have other effective options, while the worse-off are likely to employ maladaptive ineffective coping instead (e.g., alcohol abuse) and, therefore, remain in the vicious cycle of inequality. In other words, instead of physical coercion, subtle forms of domination drive the logic of the field and reproduce social structures where the state "as the holder of a sort of metacapital granting power over other species of capital and over their holders" (Bourdieu 1998, 41) regulates the functioning of the field through both financing (surveillance and control of treatments) and juridical interventions (regulation of behaviour of agents through different restrictions).

CONCLUSIONS

The article contributes to the debates on mental health and welfare state in the region of Central and Eastern Europe and outlines one of the possible generative mechanisms for delay and unwillingness to seek healthcare in common mental disorders in Lithuania. Based on the interpretation of collected experiences and perceptions, I discuss help-seeking practices as shaped by unequal power balances between agents within the mental healthcare field and beyond it. While the organization of mental healthcare at the primary care level results in *de jure* accessible care with a wide range of services, the participants spoke of *status quo* inertia

and the dominance of biomedical model in the field. It may be interpreted as the result of power differentials in the provider-state figuration that was illustrated by constant surveillance from top (regulators) to bottom (providers) or providers' feelings of disempowerment. This may also influence the logic of the user-provider figuration and result in a lack of trust in a clinical encounter.

Beyond this, institutionalized stigmatization or work and other restrictions upon diagnosis of mental disorders inherited from the Soviet Union functions as a mechanism of social control. It might encourage avoidance strategies, or alternative coping in the private sector in cases of sufficient capital resources, rather than healthcare seeking in the public treatment system. With some exceptions, this form of bureaucratized symbolic power of the state towards its citizens was rarely questioned by the healthcare providers other than perceiving it as another impediment to access care. As the dominated fraction of the dominant, they generally seem to have such dispositions inculcated in their *habitus*, which unconsciously guides their position-takings in the field. Through inculcation of "common forms and categories of perception and appreciation" (Bourdieu 1998, 54) between normality and abnormality, the state legitimates its symbolic power towards 'others', which could retranslate in other fields as stigma of mental illness.

The article, therefore, adds to the existing research and practice by demonstrating that accessibility of services does not necessarily lead to acceptability of care. It questions whether mental health services can be effective without being humane (Pilgrim 2018) and suggests that this may be one of the factors that delay healthcare seeking. Fostering trusting and more equal relations between the state and providers could induce bottom-up changes in service provision, support more patient-centered relations at the micro level and, consequently, increase acceptability of healthcare. In other words, trust might be "best understood not only in terms of individual action, but as necessarily mediated by and embedded within institutions and socio-historical structures" (Flores and Brown 2018, 166).

The study, however, has several limitations. The retrospective nature of patient interviewing is likely to result in recall bias, i.e. how they remember their decision-making and trajectories to care (Andersen et al. 2010). Self-selection bias or intrinsic problems of voluntary participation is also unavoidable in qualitative research, for "voluntary participation is central to ethical good practice" (Robinson 2014, 36). The users of services with negative experiences in the mental health system might have been more motivated to participate in the research than

the users without such experiences. Yet, triangulation by data source –inclusion of a diverse sample of healthcare providers from different facilities and with different length of clinical experiences– may have softened these biases. Finally, the article relies on the premise that undesirable and deviant symptoms or mental distress are “*ipso facto*, problematic and require medical intervention” (White 2017, 38). This assumption, however, hides social determinants of distress by individualizing and medicalizing it. Users’ stories and context of their mental health problems, nevertheless, have been beyond the scope of this study.

Despite the aforementioned limitations, the analysis reveals how dynamic functional interdependences between agents with different power ratios (regulators, healthcare providers and users) might produce social outcomes that are not intended or planned (avoidance of the mental healthcare field rather than timely access to healthcare) (Elias 2012). Further, it suggests that in order to explain health behaviors we should aim to understand the interplay between agents and their *habitus* at different levels of analysis. This means a shift from a one-level game model to a game at several levels (Elias 2012) by examining not only interdependences of agents at a local level (user-provider interactions), but also provider-state relations. Future research, therefore, might engage in analyzing longer-term processes such as historical policy trajectories and the extent of continuity of practices, i.e., the legacy of the Soviet regime versus the particular course of the post-Soviet transition in Lithuania. The conclusions could also benefit from further research with larger samples or in different settings.

To sum up, objective structures of the mental healthcare field –such as organization of care leading to overreliance on certain treatments– and mental structures in *habitus* –such as stigmatic attitudes towards mental illness (Doblytė 2020) or a lack of trust in state-provider-user interdependences– seem to fuel each other enforcing *status quo* inertia. An institution or, in this case, a state’s symbolic power towards certain groups “is complete and fully viable only if it is durably objectified not only in things, that is, in the logic, transcending individual agents, of a particular field, but also in bodies, in durable dispositions” (Bourdieu 1990, 58) and this appears to remain the case in contemporary Lithuania.

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