Universidad de Oviedo
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Department of Sociology

A matter of context: Cultural and institutional influences on healthcare seeking for mental distress in Lithuania and Spain

Sigita Doblytė

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A matter of context: Cultural and institutional influences on healthcare seeking for mental distress in Lithuania and Spain

Una cuestión de contexto: Influencias culturales e institucionales sobre la búsqueda de atención sanitaria en afecciones mentales comunes en Lituania y España

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Sigita Doblyte

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2.- Autor	
Nombre: **SIGITA DOBLYTE**	DNI/Pasaporte/NIE:
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RESUMEN (en español)

De la revisión de la literatura se derivan dos argumentos en el estudio de la búsqueda de atención sanitaria para las afecciones mentales comunes. Por un lado, se suele defender que la brecha de acceso y el retraso en el tratamiento de los trastornos de depresión o ansiedad siguen siendo considerables, lo que se asocia con importantes costes sanitarios, económicos y sociales. Por otro lado, hay quienes arguyen que se sobreestima dicha brecha de tratamiento en los trastornos mentales comunes. Estos autores señalan el proceso de creciente medicalización de la tristeza y la ansiedad, que son emociones intensas, pero dentro de la normalidad, y sugieren una serie de peligros y pérdidas sociales. Por lo tanto, el objetivo de esta tesis, estructurada como compendio de publicaciones, es comprender mejor dichos procesos de infra- o sobre-medicalización analizando cómo influyen los contextos culturales e institucionales en la búsqueda de ayuda para el tratamiento de afecciones mentales comunes en Lituania y España, es decir, en dos contextos que parecen divergir en la extensión de brecha de tratamiento en esos trastornos mentales.

La tesis consta de seis artículos independientes. Partiendo de la sociología de Pierre Bourdieu, la primera publicación es principalmente una contribución a los debates teóricos. En los cinco artículos restantes se presentan los hallazgos empíricos basados en 44 entrevistas en profundidad con profesionales y usuarios sanitarios, estos últimos con historial de depresión o trastornos de ansiedad. Las entrevistas se llevaron a cabo en Lituania y España. A través de estas contribuciones, se estudia cómo el proceso de búsqueda de ayuda para las afecciones mentales comunes se ve influido por el diseño y el funcionamiento del sistema sanitario y por el contexto cultural en el que las personas viven y adquieren su disposición para pensar y actuar. Los artículos se basan en los marcos teóricos desarrollados por Pierre Bourdieu y Norbert Elias, así como en las investigaciones sobre medicalización, estigma de las enfermedades mentales y género y salud.

Como consecuencia, se demuestra que la accesibilidad a los servicios sanitarios no necesariamente resulta en la idoneidad o aceptabilidad de los mismos. Si bien la atención a la salud mental se percibe como relativamente accesible en los dos países, esto parece enmascarar brechas ideológicas o desigualdades de poder dentro del sistema sanitario. Esta lógica del campo de la salud mental puede llevar a un infra-diagnóstico de la enfermedad mental y/o a un sobre-diagnóstico del sufrimiento mental intenso, pero proporcionado y adecuado dentro de su contexto. Se argumenta que la prevalencia de uno o ambos procesos también depende del contexto cultural o de las inclinaciones culturales que llevan a pensar la salud y la enfermedad mental de formas determinadas. En España, la brecha y el retraso en el tratamiento de las enfermedades mentales graves parece coexistir con la medicalización de los comportamientos y las afecciones mentales comunes que están dentro de la normalidad. Sin embargo, este último proceso no parece estar especialmente presente en Lituania, donde el problema crítico es la poca disposición de las personas a buscar atención sanitaria. Se concluye que la interacción entre lo institucional y lo cultural influye en la lógica de la práctica y en la dirección del proceso de medicalización.

La tesis se cierra con la discusión de su contribución al conocimiento temático y teórico, así como con la exposición de las limitaciones, las implicaciones políticas y las líneas de investigación futura. La tesis contribuye a la literatura sociológica que aborda la salud mental, la medicalización, las políticas

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sanitarias, la estigmatización y las relaciones de poder. Asimismo, la investigación supone una aportación teórico-sociológica al demostrar cómo se pueden integrar las perspectivas teóricas de Pierre Bourdieu y Norbert Elias para analizar diferentes aspectos del mismo proceso y lograr así una mejor comprensión de los comportamientos de búsqueda de ayuda y de uso de la atención sanitaria.

Palabras claves: Sociología médica, medicalización, salud y enfermedad mental, afecciones mentales comunes, sistema sanitario, cultura, búsqueda de ayuda.

RESUMEN (en Inglés)

Two arguments can be identified in the study of help seeking for mental distress. On the one hand, it is frequently stressed that treatment gap and delay for depression or anxiety disorders remain considerable. The undertreatment of such common mental disorders is associated with substantial health, economic, and social costs. On the other hand, there are those who defend that said unmet needs for mental healthcare are overestimated. They highlight the process of increasing medicalisation of non-disordered mental distress and suggest a range of threats and losses that this may bring about for societies. In this thesis by publication, therefore, I aim to better understand such processes by examining how cultural and institutional contexts impact healthcare seeking for mental distress in Lithuania and Spain, that is, in two settings that appear to diverge with regard to the extent of under- or overtreatment.

The thesis consists of six stand-alone articles. Building upon Pierre Bourdieu's sociology, the first publication is primarily a theoretical contribution to the debates. The remaining five articles, nevertheless, present empirical findings. They draw on 44 in-depth interviews with healthcare providers and users of services with self-reported diagnosis of depression or anxiety disorders, which I conducted in Lithuania and Spain. Through these contributions, I explore how the process of help seeking for mental distress is shaped by health system design and functioning, as well as by the cultural context in which individuals live and acquire their dispositions to think and act. The articles are guided by the works of Pierre Bourdieu and Norbert Elias, as well as by the literature concerning medicalisation, stigma of mental illness, or gender and health.

I demonstrate that accessibility of care does not necessarily result in its appropriateness or acceptability. While mental healthcare is perceived to be relatively accessible in the two countries, this appears to mask ideologically-laden gaps or disparities of power within the treatment system. The logic of the mental healthcare field, in turn, may lead to undertreatment of disordered mental distress and/or overtreatment of emotions that are intense but contextually appropriate and proportionate. I argue that whether one or both of such processes become salient is also shaped by cultural context or shared propensities to think about mental health and disorders in determinate ways. In Spain, undertreatment of severe mental illness appears to co-exist with medicalisation of non-disordered distress. Yet, the latter does not seem to be notably present in Lithuania, where the critical issue is the immensity of individuals' unwillingness to seek healthcare. It is concluded that the interplay between the institutional and the cultural influences the logic of practice and the direction of the medicalisation process.

I close the thesis with the discussion of its scholarly contribution, limitations, policy implications, and possible directions for future research. The thesis contributes to sociological accounts addressing mental health, medicalisation, health policies, stigmatisation, and power relations. It also adds to the sociological theory by demonstrating how the theoretical perspectives of Pierre Bourdieu and Norbert Elias can be integrated in order to analyse different aspects of the same process, and in turn, to achieve a better understanding of help-seeking behaviour and healthcare utilisation trends.

Keywords: Medical sociology, medicalisation, mental health and illness, mental distress, healthcare systems, culture, help seeking.

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Abstract

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Two arguments can be identified in the study of help seeking for mental distress. On the one hand, it is frequently stressed that treatment gap and delay for depression or anxiety disorders remain considerable. The undertreatment of such common mental disorders is associated with substantial health, economic, and social costs. On the other hand, there are those who defend that said unmet needs for mental healthcare are overestimated. They highlight the process of increasing medicalisation of non-disordered mental distress and suggest a range of threats and losses that this may bring about for societies. In this thesis by publication, therefore, I aim to better understand such processes by examining how cultural and institutional contexts impact healthcare seeking for mental distress in Lithuania and Spain, that is, in two settings that appear to diverge with regard to the extent of under- or overtreatment.

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Keywords: Medical sociology, medicalisation, mental health and illness, mental distress, healthcare systems, culture, help seeking.

Resumen en español

Una cuestión de contexto: Influencias culturales e institucionales sobre la búsqueda de atención sanitaria en afecciones mentales comunes en Lituania y España

De la revisión de la literatura se derivan dos argumentos en el estudio de la búsqueda de atención sanitaria para las afecciones mentales comunes. Por un lado, se suele defender que la brecha de acceso y el retraso en el tratamiento de los trastornos de depresión o ansiedad siguen siendo considerables, lo que se asocia con importantes costes sanitarios, económicos y sociales. Por otro lado, hay quienes arguyen que se sobreestima dicha brecha de tratamiento en los trastornos mentales comunes. Estos autores señalan el proceso de creciente medicalización de la tristeza y la ansiedad, que son emociones intensas, pero dentro de la normalidad, y sugieren una serie de peligros y pérdidas sociales. Por lo tanto, el objetivo de esta tesis, estructurada como compendio de publicaciones, es comprender mejor dichos procesos de infra- o sobre-medicalización analizando cómo influyen los contextos culturales e institucionales en la búsqueda de ayuda para el tratamiento de afecciones mentales comunes en Lituania y España, es decir, en dos contextos que parecen divergir en la extensión de brecha de tratamiento en esos trastornos mentales.

La tesis consta de seis artículos independientes. Partiendo de la sociología de Pierre Bourdieu, la primera publicación es principalmente una contribución a los debates teóricos. En los cinco artículos restantes se presentan los hallazgos empíricos basados en 44 entrevistas en profundidad con profesionales y usuarios sanitarios, estos últimos con historial de depresión o trastornos de ansiedad. Las entrevistas se llevaron a cabo en Lituania y España. A través de estas contribuciones, se estudia cómo el proceso de búsqueda de ayuda para las afecciones mentales comunes se ve influido por el diseño y el funcionamiento del sistema sanitario y por el contexto cultural en el que las personas viven y adquieren su disposición para pensar y actuar. Los artículos se basan en los

marcos teóricos desarrollados por Pierre Bourdieu y Norbert Elias, así como en las investigaciones sobre medicalización, estigma de las enfermedades mentales y género y salud.

Como consecuencia, se demuestra que la accesibilidad a los servicios sanitarios no necesariamente resulta en la idoneidad o aceptabilidad de los mismos. Si bien la atención a la salud mental se percibe como relativamente accesible en los dos países, esto parece enmascarar brechas ideológicas o desigualdades de poder dentro del sistema sanitario. Esta lógica del campo de la salud mental puede llevar a un infra-diagnóstico de la enfermedad mental y/o a un sobre-diagnóstico del sufrimiento mental intenso, pero proporcionado y adecuado dentro de su contexto. Se argumenta que la prevalencia de uno o ambos procesos también depende del contexto cultural o de las inclinaciones culturales que llevan a pensar la salud y la enfermedad mental de formas determinadas. En España, la brecha y el retraso en el tratamiento de las enfermedades mentales graves parece coexistir con la medicalización de los comportamientos y las afecciones mentales comunes que están dentro de la normalidad. Sin embargo, este último proceso no parece estar especialmente presente en Lituania, donde el problema crítico es la poca disposición de las personas a buscar atención sanitaria. Se concluye que la interacción entre lo institucional y lo cultural influye en la lógica de la práctica y en la dirección del proceso de medicalización.

La tesis se cierra con la discusión de su contribución al conocimiento temático y teórico, así como con la exposición de las limitaciones, las implicaciones políticas y las líneas de investigación futura. La tesis contribuye a la literatura sociológica que aborda la salud mental, la medicalización, las políticas sanitarias, la estigmatización y las relaciones de poder. Asimismo, la investigación supone una aportación teórico-sociológica al demostrar cómo se pueden integrar las perspectivas teóricas de Pierre Bourdieu y Norbert Elias para analizar diferentes aspectos del mismo proceso y lograr así una mejor comprensión de los comportamientos de búsqueda de ayuda y de uso de la atención sanitaria.

Palabras claves: Sociología médica, medicalización, salud y enfermedad mental, afecciones mentales comunes, sistema sanitario, cultura, búsqueda de ayuda.

CHAPTER 1.
INTRODUCTION

1. SITUATING MENTAL HEALTHCARE SEEKING

Misery – fear and sadness – is one of few psychological states that show “a reasonably defensible ontological stability” (Pilgrim 2015, p. 35). Put differently, its manifestations are fairly consistent not only across time and place but also amongst humans and other mammals. Whilst the cultural acceptance, appropriateness, and efficacy of medical responses to misery or mental distress can be contested (Busfield 2015; Pilgrim 2015, 2019; Rose 2019), such therapies – pharmaceutical or psychological – remain a hegemonic approach to resolving intense sadness or chronic fear, which are epistemologically framed as common mental disorders such as depression, post-traumatic stress disorder, panic disorder, or generalised anxiety disorder.

On the one hand, substantial social, economic, and health costs that are associated with such mental distress might justify the medical responses, and in turn, frequently result in a call for more resources and attention to mental health promotion, illness prevention, and treatment (Kleinman et al. 2016; OECD/EU 2018; WHO 2013). Persistent misery can increase the risk of marital instability, domestic violence, school/job failure, unemployment, and suicidal behaviour, or put differently, lead to disruptions in role performance (Kessler and Bromet 2013; Kohn et al. 2004; Purebl et al. 2015; Wang et al. 2007). In addition, loss of health due to common mental disorders is argued to be particularly high. They are among the leading contributors to years lived with disability worldwide (James et al. 2018): in 2017, depression ranked as the third and fifth while anxiety disorders as the eighth and thirteenth leading causes of disability for women and men, respectively. Vigo, Thornicroft, and Atun (2016) consider the figures an underestimation and attribute still a greater proportion of the total global disability to mental illness.

The economic impact on health systems and the labour market is also significant with an estimate of over four per cent of gross domestic product (GDP) across the member states of the European Union (OECD/EU 2018). Olesen et al. (2012) calculate that the total costs of anxiety disorders in Europe accounted for €74,380 million PPP in 2010, more than 60 per cent of which were direct healthcare costs. The economic burden of mood disorders was yet higher – €113,405 million PPP – with more than 30 per cent of direct healthcare and non-medical costs. The remaining was attributed to indirect costs associated with lost productivity, absenteeism from work, or early retirement. The authors conclude that mental and neurological disorders pose "a serious threat to our social and healthcare systems, as well as to the future of European economy" (Olesen et al. 2012, p. 161). The projections of Chisholm et al. (2016), nonetheless, show that their health and economic costs could gradually, yet significantly, diminish through higher investment in effective treatments.

The aforementioned burden of common mental disorders is driven both by their disabling nature and high prevalence. Every year around four and a half per cent of the European population suffer from depression and five to six per cent – from anxiety disorders (Alonso et al. 2004; OECD/EU 2018). One in every four individuals will be affected by any common mental disorder in the course of their lifetime (Alonso et al. 2004). Yet, not everyone in need of help seeks and/or receives it (Alonso et al. 2007; Kohn et al. 2004). Alonso et al. (2007) calculate that 48 per cent of people with mental health need in Europe, which accounts for more than three per cent of the general adult population, have unmet needs for mental healthcare. Even if individuals seek care, the initial contact with the healthcare system is frequently delayed significantly. Wang et al. (2007) estimate that the median delay from the onset of the symptoms amongst individuals with anxiety disorders, who eventually seek help, varies from 10 years in the Netherlands to 28 years in Italy while the median delay for major depressive episode ranges from one year in Belgium, the Netherlands, or Spain to three years in France.

On the other hand, other scholars (Horwitz 2007; Horwitz and Wakefield 2007; Pilgrim 2015; Rose 2019) are more cautious with such figures. They are derived from the community studies that are based solely on de-contextualised self-reported symptoms, which may be a normal response to stress in an individual's life rather than a genuine disorder. As Moncrieff (2014, p. 584) writes ironically, "[a]nyone can be bipolar if they so choose". They argue, therefore, that prevalence of common mental disorders and in turn unmet needs for mental healthcare are overestimated. Such 'alarming' numbers lead to the expansion of public mental health promotion that intends to capture 'undertreated' cases and, therefore, results in increasing medicalisation of mental distress caused by stressful, but normal life situations.

Medicalisation of society or medicalisation of social problems might be understood as a complex process by which behaviours and emotions that are "not *ipso facto* a medical problem" (Conrad 2007, p. 5) are transformed into and treated as mental disorders. While the concept itself is not very recent (Zola 1972), it maintains "a vibrant and crucial place in sociological analyses of medicine and of the changing culture of late-modern societies" (Busfield 2017, p. 771). Scholars (Busfield 2010, 2017; Conrad 2007; Rose 2019, Williams, Martin, and Gabe 2011, among others) stress the role played by a range of actors and institutions that facilitate this process – such as the medical profession, the pharmaceutical industry, the consumers/users of services, the state and its regulatory policies, or insurers.

Said scholars do not dispute the suffering and welfare losses caused by misery and that a fair share of such mental distress is indeed disordered, where different causal mechanisms – biological, social, and psychological – interplay. Yet, they position themselves against bio-reductionist psychiatric positivism. In other words, whilst there are indeed benefits of psychiatric diagnosis – for example, legitimating and alleviating suffering or decreasing guilt and blame – the losses for societies are also substantial (Busfield 2017; Conrad 2007; Horwitz 2007; Rose 2019; Williams, Martin, and Gabe 2011). Medicalisation is a form of social control that transforms "many human differences into pathologies" (Conrad 2007, p. 148) and that individualises the social by treating individual symptoms with medical aids. This in turn might lead to ignoring other levels of intervention that would tackle social problems and their social causes directly. In other words, medicalisation and psychiatric diagnoses "never add up to social critique" (De Swaan 1989, p. 1167).

What ties these two sides of the argument – under- and overtreatment of mental distress – is healthcare-seeking behaviour. In order to be medicalised or receive treatment, an individual in distress should access the health system and seek healthcare, either voluntary or encouraged/pushed by their social networks and other institutions. Healthcare seeking, which may also be called treatment seeking, forms part of a broader concept – help seeking – consisting of different trajectories and institutions that provide help (for example, the church or the family). The context outlined above points to the complexity and unevenness of the healthcare-seeking process. The object of this thesis, therefore, is this health behaviour or, put differently, a study of how individuals in mental distress make a contact with the health system.

2. AIM AND RESEARCH QUESTIONS

Although being of a micro-sociological nature, individual help seeking, in general, and healthcare seeking, in particular, are embedded in place and time (they are context-dependent) and might be influenced by a range of sociocultural and institutional factors (Doblytė and Jiménez-Mejías 2017; Young 2004) such as cultural beliefs, norms, or (in)equity of access to healthcare. In this thesis by publication, therefore, I **aim** to analyse how the cultural and institutional contexts may impact healthcare seeking for mental distress in two settings – Lithuania and Spain (for more details on case selection see Section 5 in this chapter). In other words, I propose to examine how discourses on healthcare-seeking practices in common mental health issues are revealed "in the context of constraints of regulations, norms, shared beliefs, and cultural patterns" (Sitek 2010, p. 569).

I intend to respond to the following **research questions**:

> **RQ1**. How does the institutional context of the healthcare systems influence access to healthcare and the process of healthcare seeking for mental distress in each setting?
>
> **RQ2.** How does the cultural context influence the process of healthcare seeking for mental distress in each setting?

First, in order to reveal the influence of the institutional context, I study a range of interrelated elements in the health system. This includes the perceptions and experiences of how its design – in particular, the rules of access, benefits package, and other indicators of access regulation (Doblytė and Guillén 2020; Hassenteufel and Palier 2007; Reibling 2010) – can impact healthcare seeking, or how the user-provider relationship or preferred/hegemonic treatments may shape such process. In other words, I intend to better comprehend the logic of the game in the healthcare system or field as one of the possible factors that facilitate or constrain healthcare seeking for mental distress (see Doblytė 2019 and Section 4.3.1 in this chapter). Second, I analyse how the cultural context functions as one of the mechanisms that drive towards certain trajectories of help seeking for mental distress. This covers the examination of shared beliefs, norms, and expectations that are deeply incorporated through primary and secondary socialisation processes and that influence individual behaviours (see Doblytė 2019 and Section 4.3.2 in this chapter). I expect that such cultural effects will be mediated by gender roles and expectations, generational differences, social capital, or other resources dependent on one's position in the social structure.

In the following sections, I first review some of the dominant theoretical models that could be used to analyse help seeking and other health behaviours. The review of such models enables me to identify the gaps in the literature, which I intend to contribute to. This is followed by a summary of theoretical framework. I then present the justification of case selection and overview the health and mental health systems in Lithuania and Spain. Finally, I discuss methods and materials used in the thesis and, at the end of the chapter, I describe a collection of the articles that comprises the thesis and how they respond to the research questions.

3. LITERATURE REVIEW

3.1. Overview

Medical sociologists and researchers in other fields have paid substantial attention to understanding the issues of help-seeking or illness behaviour for various chronic health conditions (some of the classic examples of empirical research on illness behaviour include Bury (1982), Charmaz (1983), McKinlay (1973), or Zola (1966)). The studies addressing healthcare seeking for mental disorders, in particular, embrace a range of themes: the role of social groups and networks (Clausen and Yarrow 1955; Horwitz 1977a; Kadushin 1969; Pescosolido, Gardner, and Lubell 1998), cultural systems (Hansen and Cabassa 2012; Olafsdottir and Pescosolido 2009; Portes, Kyle, and Eaton 1992; Uehara 2001), gender (Albizu-Garcia et al. 2001; Horwitz 1977b; Kessler, Brown, and Broman 1981), social class (Kulka, Veroff, and Douvan 1979), or religion (Scheff 1966), among other factors.

The focus of this section, nevertheless, is not the existing empirical research on social selection – that is, who does or does not seek and receive treatment – but rather analytical and theoretical models that offer a broader understanding of health behaviours. I start with a review of dominant theories that combine social correlates, but give a rather static explanation of help seeking or of "a *singular* decision to seek professional help" (Wyke et al. 2013, p. 80, emphasis original). This includes the health belief model (Rosenstock 1966), the theories of reasoned action and planned behaviour (Ajzen and Fishbein 1970; Ajzen 1991), as well as the behavioural model of health services use (Andersen and Newman 1973; Andersen 1995, 2008). I then follow with the analysis of more dynamic sociological models that focus on the process of healthcare seeking, that is, “a series of smaller decisions and actions that are taken and reflected on over time” (Wyke et al., 2013, p. 80). I in turn introduce the works of Parsons (1991), Kadushin (1969), or Pescosolido (1992, 2006). Finally, I complete the section with a discussion on research gaps in the literature that become research opportunities for this doctoral thesis.

3.2. Social correlates and healthcare seeking

3.2.1. The belief-centred models of healthcare seeking

The health belief model emerged in social psychology and health behaviour research in the 1950s as a response to the low use of preventive services in the United States, but later it was also applied to other issues of illness behaviour such as adherence to treatments or healthcare seeking (Champion and Skinner 2008). The health belief model, fittingly, takes individual health beliefs – rather than the actual occurrence of symptoms – as predictors of health behaviour. The original model includes two types of factors: first, readiness to take a specific action that covers beliefs about susceptibility to a health condition and about its seriousness; second, the beliefs about a health behaviour being beneficial in reducing the threat, and about its benefits compared to barriers (Rosenstock 1966).

Yet, despite perceived susceptibility and severity, which make one ready to act, as well as perceived benefits and barriers, which result in a preferred alternative of action, this might not lead to actual health behaviour without an instigating or provoking event – that is, cues to action. This third variable can include any cues such as health promotion campaigns, interpersonal interactions or information about someone else suffering from a condition. Finally, perceived self-efficacy was added to the later versions of the health belief model, which consists of individual’s beliefs about their ability to overcome barriers and to engage in health behaviour successfully (Champion and Skinner 2008).

The theory of reasoned action (Ajzen and Fishbein 1970) and its extension – the theory of planned behaviour (Ajzen 1991) – are another group of models born in social psychology that aim to both predict and explain human action, including decisions on health behaviour. Like the health belief model, they are based on individual perceptions or beliefs. A central factor in both theories is the behavioural intention, which is assumed to be a proxy of actual behaviour, that is, "the stronger the intention to engage in a behaviour, the more likely should be its performance" (Ajzen 1991, p. 181). The theory of reasoned action specifies two predictors of behavioural intention for behaviours under volitional control (Sutton 1998): normative beliefs that cover perceived social pressure to/not to perform a behaviour multiplied by an individual's motivation to comply with the social pressure (Ajzen and Fishbein 1970).

The theory of planned behaviour extends the theory to behaviours that are not entirely under volitional control through the addition of the third factor – perceived behavioural control. The latter covers perceived barriers and facilitators to engaging in a behaviour (resources, opportunities, and skills), that is, the impact of social context as perceived by an individual, which is based on past experiences or experiences of relatives, friends, and acquaintances (Ajzen 1991; Sutton 1998). The performance of behaviour, therefore, depends on both motivation (intention) and ability (behavioural control), which shares similarities to Bandura's concept of self-efficacy (Ajzen 1991). The latter also forms part of the health belief model.

The value of such models lies in their focus on subjective perceptions, which stresses that objective data on access to healthcare are not sufficient. Individual accounts on healthcare seeking and understanding their perceived barriers and facilitators might be critical in responding to the research questions. Yet, the authors do not discuss how different beliefs are constructed or transformed. The health belief model also receives criticism for a laundry list of items and no clarity of relations between them (Kirscht 1974). Although such relations are clearer in the theories of reasoned action and of planned behaviour, the stability of behavioural intentions is often questioned. Even the scholars that developed the models stressed the importance of measuring intention and actual behaviour as close in time as possible, which challenges their empirical utility (Sutton 1998). Finally, said theories assume individuals' rationality by suggesting that an action "relies on a rational, individual, self-conscious choice" (Pescosolido and Boyer 2010, p. 430). They are built on a premise that individuals have stable information, beliefs, and preferences aiming to maximise benefits and that they stop and decide to act or not to act (to seek healthcare or not to seek), which is rather unrealistic (Buetow 2007; Pescosolido and Boyer 2010). Finally, they do not leave space for human actions that are not entirely voluntary.

3.2.2. The behavioural model of health services uses

The behavioural model of health services use, originally developed in the late 1960s and later revised several times (Andersen 1995, 2008), has been one of the most influential sociological frameworks addressing access to medical care and healthcare utilisation in the US, although not so frequently applied in Europe (Babitsch, Gohl, and Lengerke 2012). Like the belief-centred models, it covers individual characteristics, beliefs, and attitudes as determinants of healthcare seeking. Unlike the discussed psychological theories, the behavioural model does explicitly include contextual macro-level factors as having predictive and explanatory power. In other words, the model integrates multiple levels of analysis: a range of individual, provider- or health system-related, and environmental characteristics shaping healthcare-seeking behaviour (Phillips et al. 1998). Furthermore, the later phases of the model adapted some dynamic elements to its originally linear structure. In particular, the outcome indicators (Figure 1) led to an addition of feedback loops showing how health behaviours influence outcomes which, in turn, "can affect subsequent predisposing, enabling, and need characteristics of the population and their use of health services" (Andersen 2008, p. 652).

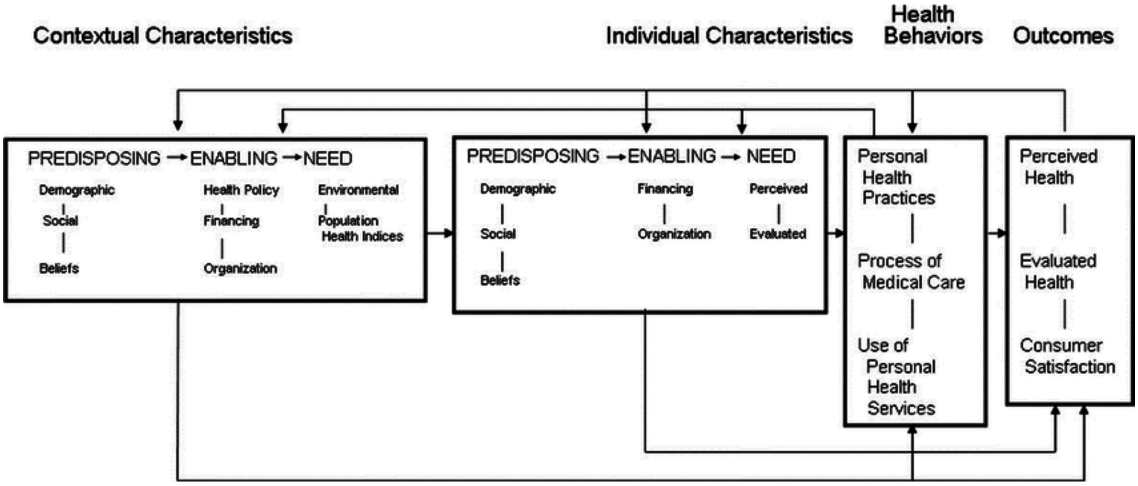

Figure 1. The behavioural model of health services use (Phase 5).
Source: Adapted from Andersen (2008, p. 651)

At the individual level (Figure 1), healthcare seeking and utilisation are a function of individual's propensity to seek care and use services (predisposing factors), their ability to secure services (enabling factors) and their need for care (Andersen and Newman 1973). The predisposing characteristics cover demographic (such as age or sex), social (education, ethnicity, social support or how healthy the physical environment may be) and attitudinal-belief variables (Andersen 1995; Andersen and Newman 1973). The financing (individual income or insurance status) or socio-organisational (knowledge about services, ability to physically reach them or disposition of time to receive care) factors may then enable (or constrain) healthcare seeking (Babitsch, Gohl, and Lengerke 2012). In light of this, an individual should also perceive need for care, which is largely a social phenomenon explained by predisposing factors (Andersen 1995). Evaluated need, nevertheless, represents the medical judgement of need for care and, as such, has both biological and social components. Andersen (1995) stresses the importance of enabling and need variables that explain more variation in health services use than health beliefs.

At the contextual level, the healthcare system, provider-related variables and environmental (political, social, or economic) factors may influence health behaviours directly and indirectly (i.e., through individual characteristics) (Andersen 2008). Contextual characteristics can predispose (demographic and social structure of communities, cultural norms and values, economic climate or relative wealth), enable (the design of healthcare systems, and particularly, modes of access including entitlement, benefits package and cost-sharing) and suggest a need for (mortality or morbidity rates) health behaviours at the individual level (Andersen 2008; Babitsch, Gohl, and Lengerke 2012; Phillips et al. 1998).

The concept of access to healthcare plays an important role in the behavioural model (Andersen 1995). The design of healthcare systems defines accessibility of services at the institutional level, but the proof of access to care is not only the institutional availability of resources but also "whether they are actually utilised by the people who need them" (Aday and Andersen 1974, p. 216). Andersen (1995, 2008), therefore, introduces the concepts of *potential access* (the institutional design of healthcare systems), *realised access* (the actual use of services), *equitable access* (if predisposing demographic and need factors explain the variance in utilisation), *inequitable access* (if social structure, health beliefs, and enabling resources explain the variance in utilisation), *effective access* (the use of services improve outcome indicators) and *efficient access* (the levels of outcome indicators increases relative to the volume of services used).

To sum up, while the behavioural model may inform the analysis of access to care that incorporates multiple levels of analysis, it is criticised for little attention to cultural systems (Portes, Kyle, and Eaton 1992) or to the role of social networks (Pescosolido 1992), as well as for its assumption of rationality (Pescosolido and Boyer 2010). Furthermore, Kirscht (1974) observes that the behavioural model is a framework with numerous types of factors rather than a theory *per se*. That is, it constitutes a conceptual framework (Phillips et al. 1998) which, as suggested above, can serve as a methodological approach for the study of access to care and healthcare seeking. Yet, as Pescosolido (1992) notes, the model remains structurally oriented, which leaves little autonomy for agency in dealing with institutions and shaping structures.

3.3. Process-oriented theories in healthcare seeking

3.3.1. Talcott Parsons and the sick role

Research concerning illness behaviour can rarely go without a reference to Talcott Parsons and his concept of the sick role, which, along with the model of medical practice as a social (sub)system, was introduced in his seminal book "The Social System" in 1951. Notwithstanding harsh criticism, which Parsons' model has received since then, Williams (2005, p. 123) highlights that "Parsons' analysis of illness as social deviance, and the sick role as a socially prescribed mechanism for channelling and controlling this deviance, is a key point of reference in the history of medical sociology". Parsons (1991) defines his focus as theoretical rather than empirical, where the constructs should be considered as 'ideal types' to facilitate empirical inquiry. Besides the conceptualisation of the sick role, Parsons (1991) develops the dynamic model of illness behaviour, where an individual progresses from their regular social roles through sick and patient roles to recovery and their regular social roles again.

In his theory, Parsons assumes the primacy of social structures (Burnham 2014) and embeddedness of subjects and their actions in the culture of moral economy and achievement values, which applies to the US and other capitalist contexts (Varul 2010). Any interaction of individual actors – that is, any system of social action (for example, medical practice as a patient-physician interaction) – "is not possible without some degree of conformity to the 'conventions' of the [shared] symbolic system" (Parsons 1991, p. 11). In other words, Parsons argues that such interactions are embedded in social structures with economic achievement and productive capacity as universalistic cultural values (Shilling 2002; Varul 2010). Health in turn means the basic capacity to work and produce (Varul 2010). Illness, however, impedes the capacity to perform said roles and, as such, becomes 'dysfunctional' for society. It is "not only a threat to social status in terms of respect ('honour') but simultaneously a threat to material status in a very immediate sense" (Varul 2010, p. 76).

Thus, the medical practice or patient-physician dyad as a social system attempts to restore health and to re-establish *status quo* or 'normality' (Parsons 1991). Given that Parsons (1975, p. 260) sees illness as "an impairment of the sick person's integration in solidary relationships", the medical practice is "predominantly a reintegrative process". The sick person in this dyad is perceived as helpless, technically incompetent, and emotionally disturbed, while the physician is supposed to acquire high technical competence, as well as accepting responsibility and occupational concern (Parsons 1975, 1991). This functional inequality between them results in an asymmetric relationship with the institutionalised superiority of the physician. Parsons acknowledges the possibility of certain lay knowledge or self-care in contemporary societies, but defends that patient's knowledge remains limited and the interaction in turn "cannot be treated as a fully symmetrical relationship in the hierarchical dimension" (Parsons 1975, p. 271). He compares this "inherent built-in asymmetry" (Parsons 1975, p. 276) to the one existing in the teacher-student interaction system. Yet, exclusive physician's access to technical knowledge, which is one of the conditions for this asymmetric relationship, has been disputed since then (Varul 2010).

In light of this, the obligations and rights of the sick role are probably the most frequently discussed features of the Parsonian model. Once in the sick role, an individual is (1) exempted from their regular social roles and responsibilities, as well as (2) from being responsible or blamed for their condition, that is, there is an assumption of innocence. At the same time, they are expected (3) to see illness as undesirable and to want to get well, and (4) to seek technically competent help from professional (Parsons 1975, 1991). Parsons originally stressed that the sick role is temporary (hence, the criterium of getting well), which resulted from his primary focus on acute conditions rather than chronic illness. Yet, he continued to defend this by claiming that although complete recovery is not possible in many chronic conditions, it is "the obverse of the process of deterioration of health" that is desired (Parsons 1975, p. 259). Put differently, the goal is not complete recovery, but adequate management and 'normalisation', that is, "a return to normal role performances in spite of persisting illness" (Varul 2010, p. 80).

The assumption of innocence has also been debated. In some conditions such as mental disorders or venereal diseases, the sick person is not necessarily exempted from blame and stigma. The legitimacy of these conditions is lower than in physical illness and "the social norms related to adopting the sick role become uncertain", for the individual is still expected to seek help but, at the same time, "must be prepared to face the potential stigma and rejection often associated with being formally labelled mentally ill" (Segall 1976, p. 164). Yet, if accepting the sick role as an 'ideal type' with possible deviations, this uncertainty due to the violation of the assumption of innocence does not necessarily show the inadequacy of the model, but can actually explain the treatment gap and lag in mental disorders, since the assumption of innocence is a crucial condition to accept or seek treatment (Parsons 1991).

On the one hand, Parsons left a legacy as being one of the earliest and most influential contributors to medical sociology (Boersma and Brown 2020) that bridged "the conceptual gap between biological, psychological, cultural, and social processes" in illness (Levine and Kozloff 1978, p. 317). This in turn continues to influence debates in medical sociology. Numerous empirical studies used the Parsonian model and, consequently, added new variables to explain illness behaviour. Yet, by studying determinants rather than a process *per se*, the same studies gradually shifted the focus from the dynamic model to more static social correlates, neglected the importance of lay community, interactions and culture in the process of accepting the sick role, which was stressed by Parsons (1975), as well as often missed the distinction between the sick role and the patient role (Pescosolido, Boyer, and Lubell 1999). The latter is an actual and legitimate recipient of treatment by a professional physician, who "does not appear until the very last stage in falling ill" (Burnham 2014, p. 73).

On the other hand, the model has been questioned over the years: first, for its consensual functionalistic approach, which neglects the possibility of 'negotiative' or even ‘conflictual’ physician-patient interactions; second, due to an assumption that it applies to the entire capitalist society and, as such, failure to address such determinants as class, gender, or ethnicity; or, third, for considering illness as deviance, despite the high prevalence of illness in society and conformity of the sick role rather than deviance (Williams 2005). Parsons (1975, p. 270) defends the sick role as not being passive, for acceptance of treatment is “one type of active participation of the sick role”. Such enactment of agency, however, appears to be limited and consensual, particularly in the contemporary medical practice with widespread access to health-related information, with the possibility of second opinions or of ‘shopping around’ for healthcare, as well as with growing commercialism and public scepticism (Shilling 2002). The discourses of health and illness, in turn, are ‘negotiative’ and embedded in the institutional, cultural, and social contexts. While such contexts are captured in Parsons’s dynamic model, he fails to coherently analyse the interplay between the institutional (instrumental) and the socio-cultural (Boersma and Brown 2020; Williams 2005).

3.3.2. Health behaviour and the primacy of social networks

While playing a relatively minor role in the previous models described in this section, the significant others become the key factor for understanding the decision-making process in Kadushin’s (1969) research and theory of the Friends and Supporters of Psychotherapy, as well as the unit of analysis in Pescosolido’s network-episode model (1992, 2006). The former draws on the results of the empirical study conducted with individuals who sought treatment in multiple New York’s psychiatric clinics in the late 1950s. The research focuses on social circles, which are “based on common interest and a low degree of institutionalisation” (Kadushin 1969, p. 62) and which can explain how different types of clinics attract certain patients. In particular, the membership in the circle of the Friends and Supporters of Psychotherapy functions as social capital that is unequally distributed between social groups and that “considerably eases the process of applying for therapy” (Kadushin 1969, p. 81).

In light of this, Kadushin (1969) distinguishes four steps in psychiatric help seeking: (1) the realisation of the problem (perceived need); (2) consultation with laymen that may help/force people to realise their problems and help/force them to seek help; (3) a choice of a healer type; and (4) a choice of a clinic or practitioner. The membership in the aforementioned circle of the Friends and Supporters of Psychotherapy is a key variable explaining different decisions in each stage. That is, an individual decision "is made in full knowledge of the 'correct' alternatives provided by one's cultural and social setting" (Kadushin 1969, p. 264). Forming part of certain social circles provides individuals with such alternatives.

While Kadushin's empirical research and its framing are one of the earliest attempts to show the importance of social networks in understanding health behaviours, it is restricted to a very specific cultural context and a type of outpatient psychiatric treatment (psychoanalysis). Despite the widespread popularity of psychoanalysis at that point in time, it remained an expensive treatment that was accessible to quite a sophisticated middle- and upper-class audience, which suggests a certain limitation of the theory. Horwitz (1977b, p. 170) also questions the identified stages of psychiatric help seeking, for "few actual patient careers will encompass each stage". Finally, since the theory centres around how and why different patient groups seek treatment in different manners and types of clinics, the question of why some people do not seek any treatment remains. Nevertheless, as being "one of the first attempts to explicitly theorise the interplay between an episode of illness and evolving social networks" (Perry and Pescosolido 2012, p. 137), Kadushin's study contributes to the development of more recent theoretical frameworks, including the network-episode model.

The latter builds upon a broader model – the social organisation strategy (Pescosolido 1992) – in order to explain illness career patterns by moving towards an interdisciplinary, multi-level framework, which might be understood as a response to previous static, individualistic and rational decision-making models. That being said, it does not reject rational-choice models, but rather expands them by covering other trajectories to care such as coercion, choice, or 'muddling through'; by embedding such trajectories into the context of social networks; and by focusing on dynamic non-linear processes, where different alternatives or entries into healthcare are possible (Pescosolido, Gardner, and Lubell 1998). Although being a synthetic framework that combines "a wide range of macro/micro and qualitative/quantitative work in sociology and anthropology" (Pescosolido 2011, p. 44), empirical studies informed by the network-episode model support its utility in understanding illness behaviour (Mowbray 2012; Perry and Pescosolido 2012).

Prior to introducing the network-episode model, the main principles of the social organisation strategy, which the former is built on, should be outlined. The social organisation strategy is a social network- and event-centred framework that assumes the primacy of social interactions and in turn encompasses both the dynamics of agency, which shapes and is shaped by networks, and the stability of social structures or context "as defining the bounds of the possible" (Pescosolido 1992, p. 1098). It therefore intends to connect individual action, interaction, and larger social structures. Furthermore, the approach focuses on the entire event or episode, which involves multiple actions, rather than on a single decision or choice. While being a process-oriented approach, it also considers sociodemographic contingencies and how they influence decisions "by constraining or facilitating network ties" (Pescosolido 1992, p. 1114). In other words, the social organisation strategy intends to connect both lines of inquiry: the static contingency models, which analyse social correlates and their impact, and the dynamic process-oriented approaches.

By accommodating said assumptions of the social organisation strategy, the network-episode model sees any illness episode or event, including entry to healthcare, as a social process with interdependent decisions that are shaped by social networks in the community (personal social support system) and in the treatment system. Over time, illness episode also shapes said social networks. In other words, the model focuses on entire illness career, where timing matters (Perry and Pescosolido 2012) and where individuals are seen as skilful and pragmatic actors that "shape and are shaped by the possibilities and limits of social network formation in the community, in organisations, and in historical periods" (Pescosolido 2011, p. 45). Individual social location (e.g., gender or education) and the nature of illness are considered static starting points that influence network ties and, therefore, illness career trajectories (Pescosolido 2006).

The importance of social networks lies not only in their structure (magnitude or density, among others), but also in their content, for they can equally be "structures of domination and coercion or of emotional and instrumental support" (Pescosolido 2006, p. 194), which depends on shared norms, values, and expectations (Olafsdottir and Pescosolido 2009). The cultural context, which shapes the content of social networks, is therefore critical in understanding healthcare-seeking for mental distress due to stigma of mental illness or an absence of physical symptoms as legitimating treatment-seeking. While the Friends and

Supporters of Psychotherapy in New York (Kadushin 1969) kept positive attitudes towards treatment for mental health issues, this is not necessarily the case in other cultural systems and social circles (Pescosolido (2006) gives an example of social networks with negative attitudes towards mental healthcare in Puerto Rico). In other words, the structure of social networks provides the 'push' or amount of social influence, while their content determines the direction of this 'push'.

Likewise, Pescosolido distinguishes between 'outside' networks, that is, commonly understood social networks that exist in community (personal social network system), and 'inside' networks that function within the treatment system and cover such issues as "the physician-patient relationship, the therapeutic alliance, notions of organisational culture and climate, and system integration" (2006, p. 198). The further division between formal and informal social networks adds specificity and allows "for theorizing about the interaction of these two systems, which the network-episode model posits as critical to issues of diagnosis, utilisation, adherence, and healthcare outcomes" (Pescosolido 2011, p. 46). To sum up, by shifting to social interaction as the unit of analysis, the network-episode model focuses not only on who receive services (contingencies), but also on when and how the illness career evolves as a dynamic process with the possibility of multiple trajectories to and within the treatment system. It covers and intends to connect multiple levels of analysis, to bridge the divide between agency and structure, as well as to benefit from both qualitative and quantitative methods. Therefore, its insights might be useful for theoretical framing and empirical analysis in this thesis.

3.4. Research gaps

In this section, I have briefly introduced the theoretical approaches that intend to understand and explain healthcare seeking and utilisation. In turn, this thesis may contribute to the literature in two ways. First, while the network-episode model proposes insights that may partially inform the theoretical framework of the thesis, the majority of the analysed models could be appraised as being either too individualistic with rational and independent decision-makers or too structurally oriented, where an individual is simply a puppet of structural forces. The thesis, therefore, can add to the literature by analysing how decision-making to access care, that is, to seek healthcare, is embedded in and influenced by the interplay of different contexts (structures), including the cultural milieu or the institutional design of healthcare systems, and what strategies are employed by individual agency to reproduce or transform such structures.

Second, all of the aforementioned theoretical frameworks that analyse health behaviours were originally developed within the tradition of North American sociology. Although there is a possibility of publication bias, most of the empirical evidence also comes from North America or other English-speaking countries (Doblytė and Jiménez-Mejías 2017; Van den Bogaert, Ayala, and Bracke 2017). Other countries and regions, therefore, remain understudied. This thesis in turn contributes to qualitative research on healthcare seeking by considering different cultural and institutional contexts in Europe.

4. THEORETICAL FRAMING[1]

4.1. Epistemological stance

In the book “Understanding mental health” (2015), David Pilgrim identifies three ideological positions “in debates about psychiatry and its role in contemporary societies” (p. 4), which imply certain ontological and epistemological assumptions. First, psychiatric positivism is a form of naïve realism that commits to diagnostic psychiatry and its preferred psychological and, particularly, pharmaceutical technologies to be administered to more and more people. Yet, while misery is indeed a part of our reality and can be found across societies, this position of medical expansionism results in the epistemic fallacy: it turns transitive (subjective) symptoms into intransitive (objective) signs of disease (Pilgrim 2015) and, as such, assumes that “what the profession calls mental disorder is the valid reality of all disvalued behavioural deviations from social norms” (Pilgrim 2019, p. 141). Second, cultural relativism emerges as an alternative to the first view by focusing on language and deconstruction rather than on universally existing diagnostic criteria. While it correctly *inter alia* “demands context-specificity” and “explores the matter of power” (Pilgrim 2015, p. 15), it is an anti-realist position that leads to linguistic reductionism, sacralisation of lived experience, and a strong rejection of ontology by “converting it into a set of ‘representations’ or ‘constructions’” (Pilgrim 2015, p. 14).

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[1] Parts of this section were published in Doblytė (2019) and Doblytė (2021).

In this thesis, therefore, I intend to adopt the third position – critical realism – that commits to ontological realism, epistemological relativism, and judgemental rationality (Bhaskar 2016; Danermark et al. 2002; Fletcher 2017). Critical realism aims to bypass fundamental problems of psychiatric positivism and cultural relativism, and in turn "both reclaims reality and concedes the central role of language in human functioning" (Pilgrim 2015, p. 137). In other words, it sees the social world and structures as ontologically real and existing independently of human knowledge or concepts (social reality is not exhausted or determined by them). Thus, the social world is intransitive (unlike knowledge), although not immutable. It, however, "can only be known thanks to the intervention of categories, theories, and conceptual frameworks" (Vandenberghe 1999, p. 36). Put differently, social reality is theory-laden. The possibility of experiencing misery, for example, has been proved to be a demi-regularity that exists across societies and, therefore, is intransitive. Yet, its representations (symptoms) and forms of coping with them – psychiatric technologies being "only one of many options" (Pilgrim 2015, p. 19) – are culturally laden and transitive.

Social reality is also a relational and stratified system, where three overlapping domains or layers can be identified: the empirical (events 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). Although not directly observable and, thus, having to "be detected by their effects" (Bhaskar 2016, p. 13), that is, "accessed via the *empirical* stratum of experience" (Scambler 2012, p. 133, emphasis original), generative mechanisms at the real level are the primary focus of social research. While there is a single reality, critical realism views it as an open system, where numerous deep generative mechanisms interact and produce the events at the empirical and actual levels. Assuming epistemological relativism, social research in turn considers different interpretations about some of such mechanisms, rather than constant universal laws (Bhaskar 2016).

Finally, what is particularly relevant for this thesis is the focus of critical realist research on structural and cultural contexts that "set the scene for, constrain/enable, others' decision making" (Scambler 2012, p. 134) – that is, decision making to seek or not to seek healthcare. Such research searches for the best explanation(s) 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, p. 186). The interplay between observations (collected data) and theory, which is temporary, constantly developing, and always fallible (but not all theories are equally fallible), is an integral part of doing social research guided by critical realism (Danermark et al. 2002).

4.2. Elias's process sociology and Bourdieu's generative structuralism

Social research guided by critical realism, therefore, aims at uncovering generative mechanisms – that is, "what makes something happen in the world" (Danermark et al. 2002, p. 206) – by means of collecting observations on empirical events and employing the existing theories to analyse such observations. In other words, theory is a crucial part and tool of social research. In light of this, the thesis chiefly draws on Pierre Bourdieu's generative structuralism (1990b, 1991, 1998b). Not only is its metatheory of knowledge compatible with critical realism, but it may also function as a "well-integrated research program that incorporates and 'envelops' a multiplicity of other theories from Garfinkel to Elias" (Vandenberghe 1999, p. 47). Thus, while analysing the data, I employ not only Bourdieu's approach, which is detailed in the following subsection, but also other concepts and theories in order to better understand and explain some of the possible generative mechanisms.

In particular, Norbert Elias's process sociology (1978, 2000, 2009c) guides the analysis in several of the publications. The two authors share "emphasis on relational and processual thinking" (Paulle, van Heerikhuizen, and Emirbayer 2012, p. 86) and employ similar key concepts in order to examine the interplay between the objectified and embodied structures – that is, the field/figuration, capital/power ratios, and *habitus*. Given their interest in power relations, both Elias and Bourdieu can be awarded a title of sociologists of "*shifting configurations of power*" (Paulle, van Heerikhuizen, and Emirbayer 2012, p. 80, emphasis original). In order to analyse such power relations, and in turn, social change or reproduction, they both stress the importance of macro-level structures in micro-level practices or actions (Baur 2017). This identification of "causal relations in micro-macro-interactions" (Baur 2017, p. 47) appears to be consistent with a critical realist search for generative mechanisms at the real level that influence events in the empirical and actual domains. Bourdieu's and Elias's proclivity for "favouring an entanglement of theoretical and empirical approaches" (Ernst, Weischer, and Alikhani 2017, pp. 8-9) is likewise compatible with the assumptions of critical realism.

Despite such commonalities between the two theorists, their focus on different research questions or elements of social reality makes each of their contributions unique (Baur 2017; Paulle, van Heerikhuizen, and Emirbayer 2012). Elias's work directs more attention at identifying how figurational developments – that is, changes in interdependences between individuals – produce and are produced by transformations in personality structures such as increasing emotional and behavioural self-restraint. He understands such processes as unplanned, but directed, continuous, and potentially reversible (Elias 2009a). This emphasis on the long-term transformations in social and personality structures is particularly helpful in the analysis of cultural context and its influence upon such processes as stigmatisation or medicalisation. In the meantime, Bourdieu's work focuses more on social inequalities, domination, and symbolic power. He is interested in how inequalities are produced and reproduced, as well as in their consequences. The two authors can in turn complement one another to better theorise certain questions and processes, including the ones approached in this thesis.

4.3. Bourdieu and the conceptual triad

That being said, Bourdieu's sociology remains a point of departure that guides the empirical investigation of the thesis. Its main principles, therefore, are briefly summarised in this introduction. Since the first publication in Chapter 2 outlines the complete framework and its potential applications, this section runs through it quite sketchily. Bourdieu invites to move beyond the traditional antinomies "in which social science generally allows itself to be trapped" (Bourdieu 1990b, p. 135) – that is, either the primacy of social structures or the choice of agency. The main issues of structuralist accounts summarised by Sewell (1992) include too rigid and, thus, rarely mutable causal determinism of social reality, which dismisses the power of individual action or agency and which implies the stability of structures making any explanation of change over time difficult and traditionally located outside of such structures. On the other hand, the individualistic approaches reduce social structures to "the conjunctural space of interactions, that is, a discontinuous succession of abstract situations" (Bourdieu 1984, p. 244) and, therefore, cannot explain structural stability and their ability to recover (Wacquant 1989).

Bourdieu argues that social science should move beyond such antinomies by introducing agents into a social space or social structures. In order to do so, he recovers and conceptualises the notion of *habitus* "as a way of escaping from the choice between a structuralism without subject and the philosophy of the subject" (Bourdieu 1990a, p. 10). *Habitus* is understood relationally. That is, Bourdieu claims the primacy of relations, which becomes his theory's cornerstone and is embedded in his conceptual triad. The field, capital, and *habitus* "cannot be defined separately" (Vandenberghe 1999, p. 45). The analysis of one of them, therefore, should be linked to the analysis of another, as well as to the analysis of their historical genesis (Bourdieu 1990a). In other words, "social reality is conceived as fundamentally relational" (Hilgers and Mangez 2015, p. 2). Such relationalism is opposed to substantialist or naively realist thought, whose units of inquiry are independently existing entities such as individual versus society (Bourdieu 1998b; Veenstra and Burnett 2014).

Therefore, any 'choice' of practice as position-taking including help seeking can only be understood by examining embodied structures or *habitus*, which is "the internalisation or incorporation of social structures", as well as social structures or the field characterised by the specific distribution of capital resources and defined as "the exteriorisation or objectivation of the *habitus*" (Vandenberghe 1999, p. 49). As Bourdieu (1998b, p. 7) summarises, "the space of social positions is retranslated into a space of position-takings through the mediation of the space of dispositions". For the sake of clarity, nonetheless, in the following two sub-sections, I conceptualise the notions of field, capital, and *habitus* separately.

4.3.1. The field: between forces and struggles

Instead of employing the concept of society, Bourdieu uses the notion of semi-autonomous fields (e.g., academic, artistic, or healthcare). They feature field-specific regulative principles (Veenstra and Burnett 2014) and structures of "differentiated positions, defined in each case by the place they occupy in the distribution of a particular kind of capital" (Bourdieu 1998b, p. 15). The fields, therefore, "are to be viewed as systems of dominant and subordinated positions" (Vandenberghe 1999, p. 52). Such positions are delimited by an unequal distribution of capital, the form of which depends on and becomes relevant only within their corresponding fields. Put differently, capital (power) and its different forms (economic, cultural, or social), which are dynamic, dependent on and convertible to one another (Collyer et al. 2015), are based on the principle of relationalism. That is, capital does not exist independently, but rather "emerges within a generative matrix of social factors and forces (within fields)" (Veenstra and Burnett 2014, p. 190). Hilgers and Mangez (2015, p. 5) in turn see the field as "the analytical space defined by the interdependence of the entities that compose a structure of positions among which there are power relations".

In order to transcend the divide between structure and agency, Bourdieu describes the field both as *a field of forces* "whose necessity is imposed on agents" (Bourdieu 1998b, p. 32), that is a social space or structure of objective relations (Bourdieu 1984), and as *a field of struggles*, where social positions are "strategic emplacements, fortresses to be defended and captured" (Bourdieu 1984, p. 244) and 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 1998b, p. 32). Hence, the dominant positions of agents with a sufficient amount of certain capital, which becomes symbolic (meta)capital in a particular field, are not immutable, for the struggles between agents may transform "the 'exchange rate' between different kinds of capital" (Bourdieu 1998b, p. 34). As such, the field is not only a structured space of stable positions but also historically dynamic and flexible.

In the healthcare or medical field, we can talk about field-specific cultural capital in its institutionalised (academic qualifications) and embodied forms (knowledge and skills) as one of the dominant types of capitals that define an agent's position (dominant vs. dominated) within the field. Since the field is a *field of forces*, there is an inclination towards the reproduction of the order of the field or, put differently, reproduction of the dominant type of cultural capital. Yet, this definition of cultural capital may be transformed in the contests between agents (a *field of struggles*). In other words, what is at stake is "the power to impose the dominant definition" (Bourdieu 1993, p. 42); for example, the definition of a legitimate therapist and, therefore, of the limits of the field. Strand (2011) describes such struggles in the US in the 20th century, when psychoanalysts lost their dominant position to biomedical psychiatrists. Therefore, the distribution of field-specific capital is embedded in place and time: changes in the *space of possibles* (Bourdieu 1993) may transform the distinctive value of different position-takings (theories and paradigms of approaching mental distress, for example).

The concept of the field also "presupposes a degree of autonomy" (Dubois 2015, p. 2017), that is, independence of its activities and struggles for distinction or domination within the field. Such autonomy, nevertheless, is relative with fields being positioned on the continuum between heteronomous or external and autonomous or internal principles of hierarchisation, that is, principles of defining the structure and limits of the field (Bourdieu 1993). The more autonomous the field is, the less external principles of hierarchisation dominant in the field of power (i.e., those of the economic and political fields) apply (Bourdieu 1993; Hilgers and Mangez 2015). Thus, the role of the market (in particular, the pharmaceutical industry) and the state (the political-bureaucratic field) should be considered in order to define the position of the healthcare field on this continuum and, in turn, to better understand how such external principles structure the rules of the field in question.

Finally, the field is always a site of symbolic power, which is defined as a subtle and 'invisible' form of domination towards an agent and with agent's complicity that (re)produces social order and structures (McNay 1999; Bourdieu and Wacquant 2003). Symbolic power is "most completely misrecognised – and, thus, in fact, recognised" as legitimate (Bourdieu 1991, p. 163-164). The dominated groups not only accept it as legitimate misrecognizing its nature of reproduction of inequalities but also see the dominant groups (e.g., healthcare providers) as legitimate agents to use such power. This is particularly relevant in the medical field, in general, and in the field of mental health, in particular, for "the very exercise of the clinical act implies a form of symbolic violence" (Bourdieu 1988, p. 63). That is, it restricts who can say something, what is meant by it, and with what consequences (Wacquant 1989).

The specialised biomedical language or classifications used in a clinical encounter – in particular, the hegemony of symptom-based diagnostic criteria for mental disorders – is a form of censorship or linguistic code (i.e., it is not ontologically real), where the dominated are subjected to it and believe in its legitimacy. This belief is particularly important in mental health due to a lack of biological diagnostic tests. Through an act of '*official naming*' done by "the holder of the *monopoly of legitimate symbolic violence*" (Bourdieu 1991, p. 239, emphasis original), who is authorised "to label and deal with people on behalf of the society at large" (Brown 1995, p. 39), individuals (now patients) with their own complicity accept their subordinate role and go under medical social control that "secure(s) adherence to social norms – specifically, by using medical means to minimise, eliminate, or normalise deviant behaviour" (Conrad and Schneider 1992, p.

242). Such symbolic power usually hides and leaves untouched the societal roots of distress (Horwitz 2007; Rose 2018), for the focus is shifted from social issues to individual troubles as signs of disease.

4.3.2. Habitus

An action or practice, nevertheless, is a product of two objectifications of history (Bourdieu 1981, 1990b, 1994): history objectified in things, buildings, customs, or laws – that is, objectification in the fields as social structures (as discussed above) – and objectification in bodies or incorporated collective history as *habitus.* The concept of *habitus* is a crucial "*mediating construct* that helps us revoke the common-sense duality between the individual and the social" (Wacquant 2016, p. 65, emphasis original) and that introduces vertical relations to the theory. 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" (Vandenberghe 1999, p. 48). In other words, it captures 'the internalisation of externality' (i.e., the embodiment of social structures as dispositions) and 'the externalisation of internality' (i.e., individual practices or actions in the field) (Wacquant 2016).

While being individualised as a product of individual history and unique life trajectories, the importance of *habitus* in help seeking lies in its reflection of "a shared cultural context" (Adams 2006, p. 514), that is, the concept captures both individuation (effects of a unique life history) and sociation (effects of belonging to certain social groups and settings) (Wacquant 2016). Thus, it incorporates shared propensities to think about mental health and disorders in determinate ways or to act 'appropriate' in such situations, yet being also shaped by one's capital resources. This reveals that *habitus* varies across time and place, as well as depending on the distribution of power. It is, therefore, socially conditioned or *structured*, where possibilities and impossibilities defined by the objective conditions "generate dispositions objectively compatible with these conditions" (Bourdieu 1990b, p. 54). As a result, practices perceived as improbable are directly excluded as impossible.

Habitus is *inculcated* gradually as layers that "give disproportionate weight to early experiences" (Bourdieu 1990b, p. 54). Through socialisation in the family and school system, dispositions such as classifications inscribed in language or beliefs about mental health and illness, which dominate in the discourse of the family, educational system, or social field as a whole, are acquired and "literally mould the body and become second nature" (Thompson 1991, p. 12). This in turn explains certain *built-in inertia* embedded in *habitus* (Wacquant 2016): it tends to produce practices that are compatible with social structures, which generated *habitus*, and that, as a result, reproduce said social structures. To describe this implicit adherence between social structures and *habitus,* Bourdieu (1977) talks about *doxa* as a taken-for-granted understanding that people have about their social worlds and their place in the fields (Veenstra and Burnett 2014). *Doxa* is produced and imposed "categories of thought that we spontaneously apply to all things of the social world" (Bourdieu 1998b, p. 35). It is generated by the dominant agents, but is incorporated within *habitus* of the dominated too (particularly through the school system) and, therefore, generally remains unquestioned and undiscussed, except for the moments of crisis, when the fit between subjective and objective structures is destroyed.

Yet, this very possibility of questioning *doxa*, that is, getting it into the discourse, implies agency. In other words, the durability of dispositions does not mean that *habitus* is static or eternal: it is "socially mounted and can be eroded, countered or even dismantled by exposure to novel external forces" (Wacquant 2016, p. 66). The later acquisitions through new experiences or exposure to different fields can influence practices, as well as accumulating capital resources, for example, cultural health capital (Shim 2010). In the meantime, the *generative* nature of *habitus* – that is, its capacity to generate "a potentially infinite number of patterns of behaviour, thought, and expression" (McNay 1999, p. 100), "which no rule, however complex, can foresee" (Bourdieu 1990a, p. 9) – suggests that it may also structure the social world (Vandenberghe 1999).

Finally, the transposability of *habitus* – that is, it is "*transferable* to various domains of practice" (Wacquant 2016, p. 66) – signals its reflexivity (Bourdieu 1990a). If an agent is able to apply or extend dispositions to different contexts, then reflexive knowledge of such schemas is inherent in agency and "characterises all minimally competent members of society" (Sewell 1992, p. 18). Specifically, agency arises from this capacity of the transposability of dispositions and "is formed by a specific range of cultural schemas and resources available in a person's particular social milieu" (Sewell 1992, p. 20). The latter, nonetheless, suggests that such agency depends on capital resources that are socially conditioned. They enable this capacity to reinterpret and reapply schemas in a new context (e.g., to recognise and acknowledge symptoms in one's own body) and to engage in transformative action. To sum up, as the result of the aforementioned features of *habitus* and whilst within the limits of structures, different strategies as individual responses to mental distress may emerge: from medicalisation through healthcare-seeking to resistance to the forces of the field by means of alternative coping (either effective or not) or avoidance (normalisation).

4.4. Conclusion

Building upon Bourdieu's sociology, I therefore propose to examine how the logic of the mental healthcare field, its historical configurations and interplay with the state and the market, as well as individual's capital resources and embodied history in *habitus,* structure when and what symptoms are perceived as pathological and what strategies are employed to deal with them (mental healthcare seeking is only one of the options). Put differently, three interrelated areas may be approached in order to achieve a better understanding of medicalisation processes. First, it should be analysed how access to healthcare and help-seeking practices are influenced by the logic of the mental healthcare field defined as horizontal relations or tensions between dominant and dominated positions, which are structured by a certain distribution of relevant capitals (Bourdieu 1990b). The logic should also be explored through its interconnectedness with the political-bureaucratic field and the market.

Second, the Bourdieusian approach invites to examine how incorporated mental and body structures – *habitus* – that mirror cultural context and social conditions, where dispositions have been inculcated, guide the agent's practices and perceptions. That is, a potential help-seeker incorporates "a practical anticipation of what the social meaning and value of the chosen practice will probably be" (Bourdieu 1984, p. 467), which is acquired through their past experiences in different fields (e.g., healthcare, education, family, or media) and which influences their actual practices. Third, in order to better understand the dynamics of the field and *habitus* and, therefore, their stability and change, the historical genesis of both social and incorporated structures should be considered.

Such an approach may enable to better understand some of the generative mechanisms of help-seeking for mental distress. This, nevertheless, should be used as a method or research programme rather than a theory *per se* (Hilgers and Mangez 2015). In other words, while Bourdieu's sociology allows for the theorisation of certain generative mechanisms, engagement with other concepts and theories – in particular, Elias's process sociology – may deepen such theorisation and, in some cases, can be better equipped to uncover other processes. Finally, it is important to emphasise that by responding to the research questions of this thesis, I intend to reveal some of such mechanisms, which drive to specific help-seeking practices in mental distress. Yet, the deep comprehension of other aspects (e.g., the historical genesis of social and embodied structures) falls beyond the scope of the thesis and, in turn, suggests future research directions.

5. CASE SELECTION

5.1. Why Lithuania and Spain?

In this thesis, I strategically select two cases – Lithuania and Spain. Besides representing the two different European regions, the countries diverge with regard to the dimensions that are considered relevant for the study (Danermark et al. 2002): that is, the direct and indirect indicators that measure the extent of under- and overtreatment of mental distress. This should enable "to attain information about the importance of various conditions for producing the particular phenomenon under investigation" (Danermark et al. 2002, p. 170) or, put differently, to capture a diversity of contexts (Stake 2006) that function as drivers of differential help-seeking practices in mental distress.

Spain is a country with lower unmet medical needs for health system-related reasons than the European average (Doblytė and Guillén 2020; OECD/EU 2018). Unmet needs for mental healthcare in common mental disorders are also estimated to be lower than in other European countries, that is, living in Spain was "associated with a lower risk of not using services when there was a need for healthcare" (Alonso et al. 2007, p. 304). At the same time, Martín García-Sancho et al. (2018) or Ortiz-Lobo et al. (2011) speak about overmedicalisation of mild mental distress or subthreshold disorders in Spain. All of this, therefore, suggest that there might be not only lower undertreatment levels but also a chance of overtreatment in mental distress in Spain.

In the meantime, to the best of my knowledge, there are no analogous studies in Lithuania. Kangstrom et al. (2019), nevertheless, find that 83 per cent of individuals with mental healthcare need do not seek/receive it in another country of Central and Eastern Europe

– Czechia. This is substantially higher than the treatment gap of 48 per cent for the same range of common mental disorders in Western Europe (Alonso et al. 2007). Even considering that some of such unmet needs are non-disordered sadness or fear (Horwitz and Wakefield 2007), the difference between the two European regions seems to be profound. Although the aforementioned figure belongs to Czechia, the indirect indicators of violence towards oneself and others let me hypothesise that the treatment gap in Lithuania may be as large as or larger than the Czech estimate.

First, suicidality (suicide events, attempts, or plans) and mental disorders, particularly major depression, are two related health issues (Oquendo, Currier, and Posner 2009; Purebl et al. 2015; Rihmer 2007). Lithuania constantly reports the highest standardised suicide mortality rates in the European Union. With more than 28 deaths per 100,000 inhabitants in 2016, it nearly triples the EU-28 suicide rate and quadruples the Spanish rate, which is one of the lowest in Europe (source: Eurostat). Second, despite debates in terms of causal direction, researchers have been regularly showing the dose-response association between alcohol consumption and common mental disorders (Bellos et al. 2013, 2016; Flensborg-Madsen 2011; Morris, Stewart, and Ham 2005). Lithuania once again records one of the highest alcohol consumption rates in Europe: 13.2 litres per capita on average between 2016 and 2018, which was second highest after Czechia (source: the WHO Global Information System on Alcohol and Health). Third, it also has the second-highest rate of assault-related deaths in Europe, which indirectly indicates poor mental health in the country (Pūras et al. 2013): 3.63 deaths per 100,000 inhabitants in 2016 as compared with 0.62 in the EU-28 or 0.57 in Spain (source: Eurostat).

Notwithstanding the indications of poor population mental health in Lithuania, the self-reported prevalence of depression is low, which appears to be characteristic across the region of Central and Eastern Europe (source: Eurostat). In 2014, 4.7 per cent of the Lithuanian population reported chronic depression, falling among ten EU member states with the lowest prevalence, eight of which were the former socialist states in Central and Eastern Europe. This is considerably lower than in Spain, where 7.8 per cent reported suffering from depression. All of the above, therefore, suggest not only vast differences in overall mental health but also in over- and undertreatment of mental distress in Lithuania and Spain. The two countries, therefore, could be defined as extreme or critical cases in the European context (Danermark et al. 2002), which should enable to better understand how institutional and sociocultural contexts influence healthcare seeking for mental distress. Prior to introducing the methods and materials used for this, I will briefly describe the healthcare and mental healthcare systems in both countries.

5.2. The overview of the mental healthcare system in Lithuania

After re-established independence in 1990, Lithuania started dismantling the Semashko healthcare model characterised by central planning and universal access to free healthcare, but suffering from a chronic shortage, inefficiency, and low-quality services (Ginneken et al. 2012). The country aimed for a reversal to the pre-communist Bismarckian tradition by, first of all, granting entitlement to healthcare upon the payment of compulsory health insurance contributions managed by the National Health Insurance Funds (Lazutka et al. 2013), which *de jure* created a category of uninsured (Thomson 2015). Over time, however, access was nearly universalised by the inclusion of multiple population groups, whose health insurance premiums are paid from the state budget. Therefore, it constituted a change in names rather than a shift in entitlement *per se*. Indeed, due to the highly centralised decision-making process, the strong regulatory role of the state, and mainly public service provision (Lazutka et al. 2013), the Lithuanian healthcare system is not an ideal type of social health insurance system.

In his analysis of welfare states in Central and Eastern Europe as hybridisation of the welfare state regimes, Hacker (2009) detects features from different welfare models. This includes characteristics inherited from the socialist period such as overreliance on hospitalisation, informal payments, or low remuneration of physicians. At the same time, he observes the process of liberalisation through the privatisation of risk. Private household out-of-pocket spending as a share of total health expenditure is indeed high in Lithuania: it doubles the European average by reaching 32 per cent in 2016 (source: Eurostat). Some resemblance to the Bismarckian model, nevertheless, can be observed not only with regard to the mode of entitlement but also in terms of other rules of access to healthcare (Doblytė and Guillén 2020; Hassenteufel and Palier 2007). The residents have to register for the list of a certain general practitioner, but *de jure* there are no geographical restrictions for this (*de facto* the choice may be limited in the rural areas). Further, although the gatekeeping role of general practitioners has been extended with no direct access to the majority of specialists without a referral (Kasiulevičius and Lember

2015), patients may skip this step by accepting additional payments, which grants freedom of choice, yet at the cost of equity of access.

Ambulatory care includes both general practitioners working at the primary care level and paid on a capitation basis and specialists paid per consultation (Kasiulevičius and Lember 2015; Murauskiene et al. 2013). An exception is outpatient mental health specialists that practice almost entirely at the primary care level. The state guarantees free access to basic primary and specialised healthcare, but there is no explicit positive list of services (Law on Health Insurance 1996; Murauskiene et al. 2013). Prescribed outpatient pharmaceuticals and medical aids, however, are fully or partially reimbursed for few population groups (children, pensioners, and the disabled) and for patients suffering from certain diseases only (Law on Health Insurance 1996; Order on the Approval of the List of Reimbursable Medicines 2000). Notwithstanding their income level, adults that do not fall in any of these categories must pay the full price of medicines.

As far as mental healthcare is concerned, psychiatry under the Communist regime lagged behind its counterpart in Western Europe. Daubaras (2004) characterises Soviet psychiatric care as entirely reliant on hospitalisation (with very limited outpatient care services), as well as on restrictions and dispanserisation as mechanisms of social control (regular health check-ups or supervision of certain groups). Besides, psychiatry in the Soviet Union was not solely a medical specialty, but also a political tool of repression (Van Voren 2013) and, therefore, served ideological purposes (Conrad and Schneider 1992). Starting with the Law on Mental healthcare in 1995, the state in turn aimed to re-develop the mental health system (Murauskiene et al. 2013), which suffered from stigma and profound delegitimisation (Raikhel and Bemme 2016).

Besides other legal documents, the National Mental Health Strategy approved in 2007 was particularly important, for it *de jure* introduced modern principles of human rights protection, mental health promotion, deinstitutionalisation, and destigmatisation, yet *de facto* lacked political will and financing to be properly implemented (Pūras et al. 2013). Although approximately 7 per cent of public health expenditure is currently allocated to mental healthcare, which is comparable with available data in other EU countries (Jacob et al. 2007), the majority of resources continue to be appointed to inpatient and long-term care institutions (approximately 70 per cent in 2010) rather than outpatient services (Pūras et al. 2013). As a result, the success of such path-breaking reforms in mental healthcare has been questioned (Šumskienė and Pūras 2014; Tomov et al. 2007).

Table 1. Mental healthcare resources in Lithuania and Spain.

	Year	***General practitioners***	***Psychiatrists***	***Psychiatric hospital beds***
LITHUANIA	1995	38.5	14.3	133.8
	2000	52.0	16.0	127.7
	2005	67.2	17.2	106.2
	2010	74.0	17.4	106.6
	2014	88.7	22.0	107.9
	2018	91.4	23.3	97.6
SPAIN	1995	-	-	59.5
	2000	-	5.2	51.5
	2005	71.5	6.3	45.5
	2010	74.3	9.7	39.6
	2014	75.0	10.5	35.7
	2018	76.5	10.9	36.1

(Figures per 100,000 inhabitants. Source: Eurostat)

Nevertheless, the provision of mental health services is ample today (Pūras et al. 2013) with 23 psychiatrists per 100,000 inhabitants in the country (see Table 1), which is substantially more than in other states in the region of Central and Eastern Europe. Besides general practitioners who *de jure* should diagnose and treat common mental disorders, psychiatrists and clinical psychologists, contrary to other specialists, also form part of primary care teams and can be accessed directly (without referral) in 115 mental health centres across Lithuania. Such organisation of outpatient specialised mental healthcare is supposed to increase the accessibility of services, earlier diagnosis and to reduce stigma (Pūras et al. 2013). Yet, it means no gatekeeping by general practitioners and, therefore, no filters, which might result in overcrowding of mental health centres by patients with common or mild symptoms, as well as severe disorders (Šumskienė and Pūras 2014).

If outpatient treatments prove to be ineffective, patients might be sent to outpatient day centres or hospitalised. While the number of psychiatric care beds has decreased significantly over the past decades (see Table 1), the figure remains one of the largest in Europe (source: Eurostat) and hospitalisations themselves are still highly prevalent (Pūras et al. 2013). Yet, there are examples of good practice in inpatient care such as Vasaros psychiatric hospital (Tomov et al. 2007). Finally, the publicly financed benefits package include psychological, psychotherapeutic, and social therapies both at the outpatient and inpatient care levels (Šumskienė, Petružytė, and Klimaitė 2018). Fully covered in inpatient care, prescribed outpatient pharmaceutical treatments, nonetheless, are fully or partially reimbursed for severe and moderate depression (along with other severe mental disorders), but not anxiety disorders (Order on the Approval of the List of Reimbursable Medicines 2000).

5.3. The overview of the mental healthcare system in Spain

Like in Lithuania, the Spanish transition to democracy (1975-1982) consequently led to the transformation of the health system that was fostered by "the concurrence of a number of political, economic, and social changes" (Guillén 2002, p. 64), such as the perception of broad social inequalities in the Spanish society, legitimation needs of the new regime, or the presence of left-wing parties in the government. The reforms, nonetheless, were not implemented until the mid-1980s due to more pressuring claims in other policy areas during the transition (Guillén 2002). One of the most important of such reforms is considered to be the General Healthcare Law, which was passed in 1986 and brought the formal shift from a Social Health Insurance to a National Health Service.

While the basic healthcare structure, including primary care, was already reformed in 1984 (Guillén and Cabiedes 1997), the 1986 Law "unified the public sector and aimed at protecting the entire population" (Guillén 2002, p. 60), as well as was accompanied by "a thorough transformation from a centralised to a regionalised system" (Petmesidou, Pavolini, and Guillén 2014, p. 331). The latter was completed in 2002, when health competences were devolved to the final 10 autonomous communities. Population coverage and publicly provided health services were wide including in 1975, when the Francoist Dictatorship ended, but were further extended, when the General Healthcare Law was enacted (Guillén and Cabiedes 1997). In light of this, the Law "tended to preserve and expand what already existed" (Guillén and Cabiedes 1997, p. 326). On the other hand, it also meant more qualitative paradigmatic changes that were implemented incrementally, including the aforementioned unification and universalisation of the system, the legal basis of the devolution process, or healthcare financing through general taxation (Cabiedes and Guillén 2001; Guillén and Cabiedes 1997).

The publicly financed common benefits basket was explicitly established for the first time in 1995 (Royal Decree 63/1995) with its revisions afterwards. It includes a comprehensive package of primary and specialised healthcare – free at the point of use – as well as pharmaceutical and complementary benefits (with co-payments for certain groups), but excludes optical products and dental care (with the partial exception of children and pregnant women) (Costa-Font et al. 2011; García-Armesto et al. 2010). Apart from the common benefits package, the autonomous communities can incorporate additional services funded from their own budgets, which may lead to geographical inequities.

While being nearly fully funded through general taxation and organised on a gate-keeping basis, the Spanish National Health Service, however, did not rapidly abandon the social insurance principle (García-Armesto et al., 2010). Instead, population coverage was gradually universalised by including various social groups into the social insurance regime or through other entitlement paths (Doblytė and Guillén 2020). The General Public Health Law in 2011 *de jure* universalised access by extending it to all residents in Spain, which was modified soon afterwards by the Royal Decree 16/2012. The latter re-established the social insurance principle and restricted access for illegal adult immigrants limiting it to pregnancy and emergency care (Petmesidou, Pavolini, and Guillén 2014). Such restrictions were reversed and access to healthcare was *de jure* universalised again in 2018 through the Royal Decree 7/2018. Royal Decree 16/2012 also modified the reimbursement mechanism for outpatient prescription drugs by relating it to individuals' income levels (Doblytė and Guillén 2020).

Returning to the subject of this thesis, the psychiatric reform in Spain was initiated in the 1980s and, therefore, coincided with the general healthcare system transition. Prior to this, mental healthcare had been fragmented and provided by units belonging to the local or central administration, to the private sector, or to religious organisations (Costa-Font et al. 2011; Vázquez-Barquero and García 1999). The Report of the Ministerial Commission on Psychiatric Reform in 1985 outlined the conceptual basis of the reform, whilst the General Healthcare Act in 1986 established the legal one (Salvador-Carulla et al. 2006; Vázquez-Barquero and García 1999). This included full integration of mental healthcare to the National Health Service and deinstitutionalisation through a shift from hospitalisation to outpatient mental healthcare services, when possible, integration of mental healthcare to general hospitals, coordination/integration of care with social services, or provision of community services.

The last decades, therefore, witnessed diminishing reliance on hospitalisation, which led to a substantial decrease in the number of psychiatric care beds in hospitals (reaching one of the lowest figures in Europe – see Table 1), as well as a shift towards integration of inpatient mental healthcare to general hospitals with some autonomous communities opting for closing their psychiatric hospitals completely, for example, Asturias, Navarre, or Andalusia (Costa-Font et al. 2011). Outpatient mental healthcare has also been reformed. Like all specialised care, mental healthcare specialists can be accessed upon referral from a general practitioner. Unlike other specialists, who provide services in hospitals, psychiatrists and clinical psychologists provide psychopharmaceutical and psychotherapeutic therapies (except for psychoanalysis and hypnosis, which are excluded from the common benefits package) in the mental health centres, generally established in the same facilities like health centres to combat stigma and to increase accessibility. The number of psychiatrists, however, is one of the smallest in Europe (source: Eurostat; also see Table 1).

Whilst with variations between autonomous communities (Costa-Font et al. 2011; Vázquez-Barquero and García 1999), common mental disorders such as depression or anxiety, nevertheless, are generally diagnosed and treated at the primary care level, unless general practitioners see a necessity for referral to specialised care. Mental distress indeed forms a significant proportion of general practitioners' workload: 28 per cent of primary care users in Spain sought help for psychological problems (exclusively or among other claims) in 2016, which increased from 20 per cent in 2011 (source: Base de Datos de Clínicos de Atención Primaria (BDCAP), Ministerio de Sanidad, Consumo y Bienestar Social). Yet, referrals to mental health centres appear to be low: 1.3 per cent of primary care users in 2016. While this may suggest a strong gate-keeping role of primary care, there is no data to what extent mental distress of those who remain at the primary care level is normalised and to what extent it is medicalised and treated.

5.4. Conclusion

In sum, not only do Lithuania and Spain appear to diverge in terms of mental health outcomes, but they also own two mental healthcare systems that demonstrate differences in the organisation of care. Lithuania features substantially more psychiatrists and general practitioners, the numbers of which increased considerably over the past decades (see Table 1). The analysed statistical indicators of population health, however, signal that mental health in the country remains poor. Counterintuitively, the share of the population that report depression is much lower in Lithuania than in Spain, notwithstanding the efforts of the former to provide a wide range of mental health services. I therefore expect that help-seeking practices will differ in the two countries and that some of the possible generative mechanisms, which drive to under- or overtreatment of mental distress, can be found in their institutional and sociocultural contexts.

6. RESEARCH METHODS AND DATA

6.1. Overall rationale and approach

The methodological framework is guided by the research questions, as well as the epistemological and theoretical stances outlined in the previous sections. I consider my focus on the interpretation and better understanding (whilst using some of the existing theoretical tools) of how institutional and cultural contexts might shape lived experiences or perceptions of care seeking for intense fear or sadness. In other words, my primary objective is to reveal some of the possible causal mechanisms at the real level, and by employing retroduction, contextual conditions that are necessary “for a particular causal mechanism to take effect” (Fletcher 2017, p. 189), that is, to facilitate or impede help seeking, which is observed or experienced at the empirical level through the filter of existing knowledge and concepts (Danermark et al. 2002). In light of this, while the use of quantitative or statistical data previously in the chapter allows “to explore the exterior of social life”, critical realist research generally focuses on understanding that “provides an ‘inside’ or ‘interior’ to social life” (Price and Martin 2018, p. 92) or, put differently, it aims attention at “*structures* and *mechanisms*, not regularities or patterns of *events*” (Bhaskar, 2016, p. 79; emphasis original).

This suggests two types of research designs (Danermark et al. 2002; Fletcher 2017): extensive (quantitative data) and intensive (qualitative data). In this thesis, the intensive or qualitative research should enable to better accomplish its objective (Danermark et al. 2002) that is a better understanding of generative mechanisms that underpin a certain demi-regularity (a lack and delay of care seeking for mental distress or the reverse). The latter is observed in the social reality understood as an open system “in which any number of occurrences and events can overlap and interact” (Fletcher 2017, p. 185). Although critical realism does not oblige to adhere to any specific method within each approach (Fletcher 2017), one of the possible techniques to achieve such understanding of generative mechanisms might be hermeneutic (Bhaskar 2016) through “a logic of question and answer” (Schwandt 2000, p. 195), that is, by studying “other people’s interpretations of the social world” (Danermark et al. 2002, p. 200). To that end, semi-structured in-depth interviews (IDIs) as a data collection method have been employed in the thesis.

6.2. Inclusion criteria and sampling

Mechanic (1975) suggests four methodological approaches to understanding individuals’ trajectories to healthcare. While two of them are either epidemiological/quantitative in nature or focus on perceived causality and illness attribution rather than on the process of healthcare seeking, the remaining two might be productive in selecting the types of subjects for this empirical investigation. On the one hand, Mechanic (1975) proposes studying healthcare seeking as a dispositional variable through in-depth interviews with individuals who sought healthcare. Such interviews should attempt to reconstruct their trajectories to care or antecedents of such dispositions. On the other hand, he also suggests studying the effects of the structure of the healthcare system by examining how the healthcare organisation either promotes or hinders access to care. In turn, apart from the users of services, I have interviewed healthcare providers to assess such factors that result “because of the way in which agencies and professionals define their work and organise their efforts” (Mechanic 1975, p. 396).

Put differently, the two social groups may enable to better understand the process of healthcare seeking by means of having experienced or observed it. As a result, the initial plan of IDIs was the following:

1. Approximately 10 to 12 individuals aged 18 to 65 (in each setting) with self-reported diagnosis of common mental disorders (i.e., depressive or anxiety disorders), who had sought help in the public treatment system and received psychological or psychopharmaceutical therapies at some point in time. Individuals should have been either in remission (with a recent history of treatment, i.e., over the past 10 years) or, at least, responding to treatment. The aim was to achieve a satisfactory variety of sexes, ages, and educational levels. These elements of social structure are highly

important "in the health and lifestyle debate" (Williams 1995, p. 581). Empirical research demonstrates how they function as determinants of healthcare seeking (e.g., Alonso et al. 2007; Kessler, Brown, and Broman 1981; Kulka, Veroff, and Douvan 1979), which has also been highlighted by the aforementioned models of healthcare seeking (e.g., the health belief model (Rosenstock 1966), the behavioural model of health services use (Andersen 1995), or the network-episode model (Pescosolido 1992, 2006)).

2. Approximately 10 to 12 healthcare providers (in each setting), who treat and interact with users of services in mental distress, aiming for a variety of relevant medical specialties: general practitioners, psychiatrists, and psychologists; that is, agents who participate in the management of common mental disorders at different levels of care and who, therefore, occupy distinct positions within the mental healthcare field.

While heterogenous demographically or regarding medical specialties and clinical experience, the participants share life history, that is, the sample is homogenous in this respect (Robinson 2014). They all sought public healthcare for mental distress or regularly treat and interact with such users. Since the chief aim of the thesis is idiographic, and as such, implies the need for intensive analysis of each case (Robinson 2014), a relatively small number of individuals has been interviewed. Nevertheless, the final sample size per group and setting slightly varies, for the recruitment process was stopped once the point of data saturation or thematic exhaustion and variability (Guest, Bunce, and Johnson 2006) was considered to have been sufficiently achieved. The initial data analysis that was conducted simultaneously with data collection allowed for the assessment of saturation and suggested that few or no new codes were emerging towards final informants in each group, that is, new data were fitting "easily into existing categories" (Packer 2011, p. 62).

Finally, rather than aiming for statistical representativeness, the sampling principle in intensive or qualitative research is usually strategic or purposive (Danermark et al. 2002; Robinson 2014). Based on my theoretical understanding of the topic, I therefore intended to interview individuals that would enable me to document "unique or diverse variations that have emerged in adapting to different conditions, and to identify important common patterns that cut across variations" (Palinkas et al. 2015, p. 534). In Lithuania, the participants were recruited from three mental health centres, two health centres/polyclinics and a psychiatric hospital that provides both inpatient and outpatient services. In Spain, the healthcare providers and users of services were identified and recruited from within two mental health centres and two health centres. In both countries, several additional participants (mostly, users of services) were identified through my professional or personal acquaintance and using a snowballing or chain referral.

6.3. The protocol and data collection procedures

The study protocol includes the study information sheet and informed consent document (Appendix 1), interview guides for users of services (Appendix 2) and for healthcare providers (Appendix 3), as well as socio-demographic forms to be completed by users of services (Appendix 2) and by healthcare providers (Appendix 3). All of the documents were produced in English and then translated into Lithuanian and Spanish. The protocol was reviewed and approved by the regional research ethics committee of the Principality of Asturias on May 7, 2017 (no. 74/17) (Appendix 4). To adhere to the ethical approval, as well as to the International Sociological Association's Code of Ethics, the study records – that is, the signed informed consent forms, audio recordings, transcripts, and completed socio-demographic forms – are kept private. Likewise, data are anonymised. In other words, the names and other personal information that may result in the identification of participants are not used in any of the reports or publications that derive from this study.

The data collection procedures were facilitated by the protocol and organised in the following manner. First, the study information sheet functioned as an initial invitation/recruitment aid that was handed out to the potential participants in person, sent by e-mail, or explained over the telephone. Once an individual had agreed to participate, a personal interview was scheduled for the date and time that were convenient for them. Due to the sensitivity of the topic and possible anonymity concerns, as well as for logistic reasons, the interviews were conducted face-to-face (at participants' home, providers' offices, or in a public place) or over the telephone/skype, although prioritising face-to-face encounters when possible. High comparability of results was shown between said interview modes (Sturges and Hanrahan 2004).

Prior to interviewing, all of the participants provided informed consent that covered the purpose of the study, the procedures, possible risks and benefits, participant's right to withdraw from the study, as well as confidentiality matters. I then interviewed them in

Lithuanian or Spanish, which was followed by the completion of socio-demographic forms. The semi-structured interviews were conducted roughly adhering to the interview guides that included several sections of questions addressing problem recognition, the role of social networks, gender, cultural capital or economic resources, the healthcare system (its institutional design, pathways within it or the user-provider relationship, among others) and cultural context (such as norms, beliefs, attitudes, or the role of media). The interviews were tape-recorded and transcribed into original languages. Since translation from original languages into English would involve a certain degree of interpretation and loss of meaning, the analysis of the interviews in their original languages enhances the validity of the study (Nes et al. 2010). Thus, only quotations from the interviews that were used to illustrate the findings were translated.

6.4. Data analysis procedures

The interviews were analysed using the method of reflexive thematic analysis (Braun and Clarke 2006, 2019; Fereday and Muir-Cochrane 2006; Nowell et al. 2017), which is a flexible technique that involves the identification of themes or patterns of meaning within the data. I first familiarised myself with the data by means of transcribing the recorded interviews, reviewing the transcripts, and reading/re-reading several of them. Then, I produced an initial code list that was guided by the theoretical framework, research-relevant literature, and the interview data themselves. In other words, the construction of the codebook was both inductive or data-driven and theoretical or analyst-driven (Braun and Clarke 2006). At this stage, I also imported the transcripts into software for the management of qualitative data – MaxQDA. The socio-demographic and clinical data were also entered in MaxQDA as attribute codes (Saldaña 2009).

Second, I coded all of the interviews using the produced codebook, yet allowing for the emergence of new codes. That is, the process was flexible, where codes “were changed, eliminated, and supplemented with new codes” (Fletcher 2017, p. 186). In addition, reflexive writing and memoing throughout this coding process were used “to identify interesting aspects in the data and emerging impressions that may form the basis of themes” (Nowell et al. 2017, p. 7-8). During this first-cycle initial coding (Saldaña 2009, p. 8), I employed several coding methods: descriptive, in vivo that uses the actual language of participants, process coding that uses gerunds to describe actions and processes, as well as different methods of affective coding such as emotion coding “to explore intrapersonal and interpersonal participant experiences" (Saldaña 2009, p. 86), value coding (values, attitudes, and beliefs), or versus coding to identify conflicts between individuals or groups and, as a result, "patterns of social domination, hierarchy, and social privilege" (Saldaña 2009, p. 94).

Third, I followed with the second cycle coding or pattern coding, aiming "to eventually develop a smaller and more select list of broader categories, themes, and/or concepts" (Saldaña 2009, p. 149). I reviewed all of the codes and their relevant data segments several times intending to categorise them, that is, to find codes in the data that defined similar processes, rules, causes, or explanations. I then further clustered categories and, as a result, developed themes, which broadly defined identified patterns of meaning and established relationships or connections between categories or sub-themes. This in turn enabled me to tell a 'story' or "to explain social events through reference to [their] causal mechanisms" (Fletcher 2017, p. 183). During this phase, I reviewed, defined, and refined the themes 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, p. 91).

Besides data-driven induction and theoretical deduction used in the coding process, the construction of the argument *per se* employed abductive and retroductive inferences (Danermark et al. 2002; Fletcher 2017). The process of abduction allows for the theoretical re-description or re-contextualisation of the empirical data and, in turn, the new interpretation of the reality using existing theories. In the meantime, retroduction focuses on the identification of possible causal mechanisms and "the necessary contextual conditions for a particular causal mechanism to take effect and to result in the empirical trends observed" (Fletcher 2017, p. 189). For example, through the process of abduction I identified the theoretical concept of symbolic power or violence (Bourdieu 1991) as a way to describe or interpret some of the empirical data in Lithuania. In the meantime, by using retroductive inference, I concluded that a certain structure of power relations between agents enabled the enactment and continuity of such symbolic power that leads to avoidance of healthcare seeking for mental distress (see the second article in Chapter 2). Although here presented as a linear process, the overall analysis employed an iterative – rather than step-wise – approach moving back and forth between the theoretical framework, research-relevant literature, and qualitative interview data, on the one hand, and between the phases of analysis, on the other hand.

6.5. The final sample of participants

The sample consists of 44 participants in total: 23 in Lithuania and 21 in Spain. Twelve healthcare providers (HCPs) in Lithuania were interviewed in September 2017. Their clinical experience varies between 4 and 37 years (the average clinical experience – 20 years). Three of them were interviewed over the telephone with the interview length of 22 to 50 minutes (the average length – 37 minutes) and the remaining nine participated face to face with the range of interview length between 20 and 47 minutes (the average length – 33 minutes). In the meantime, eleven HCPs, whose clinical experience ranged from 6 to 40 years (the average clinical experience – 22 years), were interviewed in Asturias, Spain between July 2017 and January 2018. All of them were interviewed face to face and the interview length varied between 36 and 64 minutes (the average length – 49 minutes). The difference in interview length between the countries should be attributed to potential cultural factors rather than methodological differences.

Table 2. The sample distribution by the type of healthcare providers.

	Lithuania	***Spain***
General Practitioners	3	5
Psychiatrists	6	3
Psychologists	3	3
Total	**12**	**11**

Based on the identified typical trajectories to mental healthcare in each country (see Sections 5.2 and 5.3), I aimed for a different distribution of the providers (see Table 2). Given the possibility of direct access (without referral) to mental health specialists in Lithuania, the recruitment focused on specialised care in this country and resulted in the sample of three general practitioners, three clinical psychologists, and six psychiatrists. In the meantime, the necessity to receive general practitioner's referral to specialised mental health services in Spain, where a large part of patients with mental distress is not referred to the specialised care at all and remains at the primary care level, led to more general practitioners in the Spanish sample. It consisted of five general practitioners, three clinical psychologists, and three psychiatrists.

Table 3 presents the socio-demographic distribution of the interviewed users of services. There was a fitting variety of ages and educational levels in both countries. Yet, I identified and recruited more women than men in the two countries, which coincides with the overrepresentation of women in treatment for common mental disorders. In Spain, the sample consisted of ten working-age individuals with self-reported diagnosis of depression or anxiety disorders. The interviews were conducted between July 2017 and January 2018. Four participants reported anxiety disorders, two – depression, and the remaining four – co-morbid mood and anxiety disorders. Given the institutional design of the health system in Spain, all of the users first accessed primary care and half of them were referred to mental health centres at least once. Four participants also purchased specialised care in the private sector (exclusively or supplementary with services in the public treatment system) and two had been hospitalised in the past. As for the interview modes, all but one were completed in person with interview length varying from 25 to 65 minutes (the average length – 40 minutes).

Table 3. The sample distribution of users of services.

		Lithuania	***Spain***
Conditions (self-reported)	Depressive disorders	7	2
	Anxiety disorders	1	4
	Co-morbid depressive and anxiety disorders	3	4
Gender	Women	7	7
	Men	4	3
Age groups	18-35	4	4
	36-50	4	4
	51-65	3	2
Education	Secondary and below	2	2
	Vocational training	3	4
	University degree and postgraduate	6	4
Total		**11**	**10**

In Lithuania, a total of eleven interviews were conducted between August and October 2017. Seven participants reported depression and four – anxiety or co-morbid depressive and anxiety disorders. At the time of the interview, all participants were receiving or had recently received outpatient care at mental health centres (pharmaceutical and/or psychological treatments); four individuals had also been hospitalised (three – multiple hospitalisations and one – a first-timer); another four participants had additionally received treatments at day centres. Four interviews were conducted over the telephone with the duration of 26 to 41 minutes (the average length – 33 minutes), whilst the remaining seven were completed face to face with interview length ranging between 27 and 56 minutes (the average length – 39 minutes).

7. THE STRUCTURE OF THE THESIS

This thesis by publication consists of six papers, which are published or accepted for publication. The copies of the papers are presented in *Chapter 2*. All of them are stand-alone articles and, therefore, can be read in any order. Each paper is outlined as per its publication (except for minor edits in order to maintain style consistency), that is, includes its abstract, keywords, introduction, theoretical lens or concepts, methods, findings/results, and discussion/conclusions. This compilation of the publications is followed by conclusions (*Chapter 3* in English and *Chapter 4* in Spanish), which synthesise the findings of the thesis as a whole and cover its scholarly contribution (in particular, thematic and theoretical), limitations, policy implications, and future research directions. The thesis closes with a list of references and appendices.

7.1. The publications and journal metrics

Table 4 provides the full list of publications and journal metrics for the year of each publication (or latest available at the time of writing). All of the journals are included in the Social Sciences Citation Index-Journal Citation Reports (SSCI-JCR), which is a product of Clarivate Analytics and consists of journals that can be accessed from Web of Science, and in the Scopus List of Indexed Journals, whose provider is Elsevier.

Table 4. The list of publications and journal metrics.

Full reference	***SSCI-JCR***	***SCOPUS***
1. Doblytė, S. (2019). Bourdieu's theory of fields: towards understanding help-seeking practices in mental distress. *Social Theory and Health* 17(3): 273-290. DOI: 10.1057/s41285-019-00105-0	IF 2019: 1.143 Q4 (Social Sciences, Biomedical 36 out of 45)	SJR 2019: 0.404 Q2 (Sociology and Political Science 345 out of 1243)
2. Doblytė, S. (2021a). Power dynamics of the healthcare field: seeking mental care in Lithuania. *Journal of Baltic Studies.* Advance online publication. DOI: 10.1080/01629778.2021.1934053	IF 2020: 0.447 Q4 (Area Studies 71 out of 80)	SJR 2020: 0.251 Q1 (Cultural Studies 244 out of 1103)

3. Doblytė, S. (2020a). Shame in a post-socialist society: a qualitative study of healthcare seeking and utilisation in common mental disorders. *Sociology of Health and Illness* 42(8): 1858-1872. DOI: 10.1111/1467-9566.13170	IF 2020: 3.041 Q1 (Sociology 33 out of 149)	SJR 2020: 1.146 Q1 (Health Policy 40 out of 256)
4. Doblytė, S. (2020b). Under- or overtreatment of mental distress? Practices, consequences, and resistance in the field of healthcare. *Qualitative Health Research* 30(10): 1503-1516. DOI: 10.1177/1049732320918531	IF 2020: 3.277 Q1 (Social Sciences, Biomedical 8 out of 45)	SJR 2020: 1.303 Q1 (Public Health, Environmental and Occupational Health 78 out of 560)
5. Doblytė, S. (2020c). "Women are tired and men are in pain": gendered *habitus* and mental healthcare utilization in Spain. *Journal of Gender Studies* 29(6): 694-705. DOI: 10.1080/09589236.2020.1780420	IF 2020: 2.539 Q1 (Women's Studies 10 out of 44)	SJR 2020: 1.019 Q1 (Gender Studies 13 out of 150)
6. Doblytė, S. (2021b). "The almighty pill and the blessed healthcare provider": medicalisation of mental distress from an Eliasian perspective. *Social Theory and Health*. Advance online publication. DOI: 10.1057/s41285-021-00165-1	IF 2020: 2.320 Q2 (Social Sciences, Biomedical 21 out of 45)	SJR 2020: 0.571 Q1 (Sociology and Political Science 312 out of 1315)

Abbreviations: IF – Journal Impact Factor (Web of Science); SJR – Scientific Journal Rank (Scopus); Q1-Q4 – the first to fourth quartiles;
Source: Web of Science and Scopus Databases.

7.2. The overview and coherence of the publications

The first publication in *Chapter 2* (Doblytė 2019) proposes a model that is built on Bourdieu's theoretical approach and that can be employed to study help seeking in mental distress. In the article, I analyse the conceptual triad that guided Bourdieu's sociology and suggest how it may be used to explore health behaviours that are embedded in place and time. In particular, the analysis should focus on the logic of the field of mental healthcare – its structure of positions defined by the distribution of capitals, its historical configurations, and its relations with the state and the market – and *habitus* as embodied history which mirrors shared cultural meanings and interplays with social conditions (capital resources) under which it was acquired and/or is enacted. This structures when and what representations of misery are perceived as pathological and what strategies are employed to deal with them. Care seeking in the healthcare system is only one of such strategies. In the article, I argue for the utility of the field approach by using an empirical example of mental help seeking in Lithuania. The proposed model is summarised in the upper part of Figure 2, which also pictures graphically how the research questions of the thesis (RQ1 and RQ2) relate to the model.

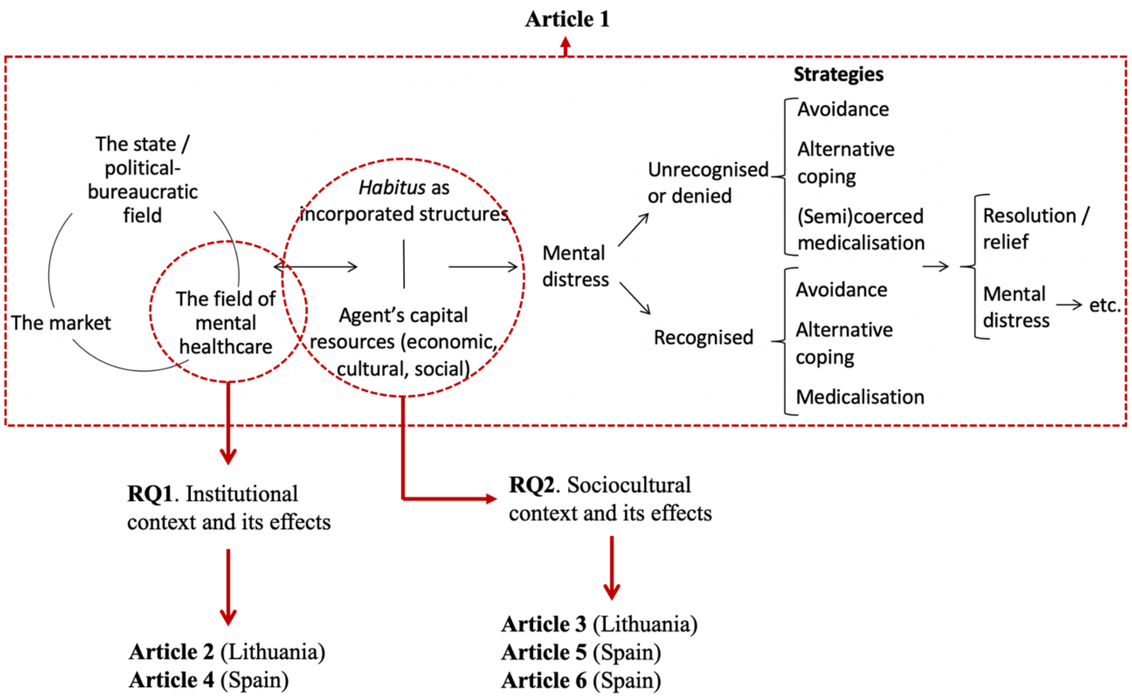

Figure 2. The publications and their relevance to the research questions.

The second article (Doblytė 2021a) aims to respond to the first research question (Figure 2) by analysing the logic of the mental healthcare field in Lithuania. I intend to reveal how uneven balances of power between agents constrain healthcare seeking for intense disordered mental distress. While healthcare appears to be relatively accessible, the findings suggest that it is not necessarily acceptable or humane. In the meantime, while also examining the case of Lithuania, the third article (Doblytė 2020a) centres its analysis around the stigma of mental illness and the process of stigmatisation. The findings are framed employing Elias's model of established-outsider relations (Elias 2008a). The article demonstrates how stigma may lead to feelings of shame. The anticipation of such shame results in avoidance of mental healthcare seeking by means of other (often maladaptive) coping strategies. The article also discusses the role of gender in this process. Since stigmatic beliefs can be considered a part of *habitus* that is durably inculcated through experiences in different fields and mirrors shared cultural meanings and norms, this article in turn responds to the second research question (Figure 2).

The remaining publications deal with the process of help seeking for mental distress in Spain. The fourth article (Doblytė 2020b) explores how this process may be shaped by the health system design and functioning, that is, responds to the first research question (Figure 2). It demonstrates how the logic of the mental healthcare field may result in medicalisation of non-disordered mental distress, whilst severe mental illness remains undertreated. The main objective of the remaining two articles (Doblytė 2020c, Doblytė 2021b) is the exploration of social *habitus* that leads to the certain logic of practice (Figure 2). In particular, the former (Doblytė 2020c) theorises how gender influences healthcare seeking and utilisation for common mental health issues by employing Bourdieu's sociology. I find that while men are less willing to seek healthcare, which is shaped by masculinity ideals, women appear to be dominated in the field, which is likely to lead to their overtreatment. In the meantime, the latter (Doblytė 2021b) examines how the cultural context might drive to increasing medicalisation of non-disordered distress. It suggests that the processes of individualisation and scientisation, coupled with demands for emotional self-control, might be some of the generative mechanisms of such medicalisation.

CHAPTER 2.
PUBLICATIONS

I. Bourdieu’s theory of fields: Towards understanding help-seeking practices in mental distress

Full reference: Doblytė, S. (2019). Bourdieu's theory of fields: towards understanding help-seeking practices in mental distress. *Social Theory and Health* 17(3): 273-290. DOI: 10.1057/s41285-019-00105-0

Abstract: Employing Pierre Bourdieu’s sociology and his conceptual triad of field, *habitus,* and capital, this article outlines a theoretical approach to empirically analyse help-seeking practices in mental distress. The framework helps to examine why the treatment gap in common mental disorders is wider in one setting than another and why some agents access healthcare more easily than others within the same setting, which may drive to both over- and undertreatment resulting in inequities of access and poor use of resources. In order to better understand help-seeking behaviour that varies across settings, time, and conditions, it is suggested to relationally analyse how the field of mental healthcare as a structure of positions impacts access to healthcare; how mental structures that mirror cultural context and social conditions where they were acquired influence perceptions of access and, therefore, strategies of help seeking; and what historical genesis of both mental and objectified structures is.

Keywords: Pierre Bourdieu, psychological distress, access to healthcare, healthcare seeking, relationalism

1. INTRODUCTION

Social, economic and health costs of persistent mental distress, which takes forms of depression or anxiety disorders (Mirowsky and Ross 2003), have been increasingly burdening individuals and societies, despite advances and availability of effective treatments (Olesen et al. 2012; Vigo, Thornicroft, and Atun 2016; James et al. 2018). Besides changing population structures, remaining high levels of underdiagnosis or undertreatment of these conditions also take a toll (Alonso et al. 2007; Kohn et al. 2004). Even if individuals seek care, the initial contact with the treatment system is frequently delayed significantly (Wang et al. 2007). At the same time, however, overmedicalisation of mild symptoms or psychiatrisation of social problems fuelled by the pharmaceutical industry, changes within the biomedical paradigm, or even public pressure has also been demonstrated (Conrad 2007; Rose 2019).

This suggests that multiple factors impact pathways to healthcare. Social scientists in turn have paid substantial attention to understanding them, among which are the health belief model (Rosenstock 1966), the behavioural model of health services use (Andersen 1995), the Parsonian model of medical practice and the sick role concept (Parsons 1991, 1975), or the Network-Episode Model (Pescosolido 1992, 2006). Yet, many of them could be appraised as being either too individualistic with rational and independent decision-makers or too structurally-oriented where an individual is simply a puppet of structural forces. Therefore, drawing on the sociology of Pierre Bourdieu that intends to bridge the divide between organising structure and individual agency, this article outlines a framework or 'logic of research' (Wacquant 1989) for understanding help seeking for mental distress, that is, why the treatment gap is wider in one setting than another and why some agents access mental healthcare more easily than others within the same setting, which may drive to both over- and undertreatment resulting in inequities of access and poor use of resources.

Although the French sociologist did not analyse the field of healthcare himself, his theoretical approach has been widely employed to empirically or theoretically examine different issues of health and illness (Collyer et al. 2015, Hindhede and Larsen 2019, Pinell 2011, Shim 2010, Strand 2011, Veenstra and Burnett 2014 or Williams 1995, to name but a few). In this article, in particular, I intend to analyse healthcare as a relational space of positions and to embrace Bourdieu's sociology holistically rather than using separate concepts only. My main focus, nonetheless, is a (potential) user of services and their dynamic trajectory towards, outside, and within the field of mental healthcare that "extends beyond individual choices in the context of their capital resources" (Collyer et al. 2015, p. 692) or, put differently, how the logic of the field and its agents impact this trajectory along with individual's *habitus* and capital resources. The framework is proposed considering the European health systems and, therefore, draws examples mainly from them, but it does not discard potential applications in other settings.

Bourdieu (1990b) invites to move beyond the traditional antinomies and connect structuralist approaches, which prioritise the power of social structures but suffer from rigid causal determinism of social reality and dismisses the power of individual agency (Sewell 1992), with the individualistic ones, which reduce social structures to "the conjunctural space of interactions, that is, a discontinuous succession of abstract situations” (Bourdieu 1984, p. 244) and cannot explain structural stability and their ability to recover. The primacy of relations or relationalism built in the conceptual triad of field, capital, and *habitus* becomes his theory’s cornerstone. Therefore, any ‘choice’ of practice as a position-taking including help seeking can only be analysed in relation to embodied dispositions (*habitus*) and structures of positions or of capitals distributed unequally within social fields. As Bourdieu (1998b, p. 7) summarises this, “the space of social positions is retranslated into a space of position-takings through the mediation of the space of dispositions”.

To describe interdependences that individuals form, Bourdieu uses the notion of semi-autonomous fields with their regulative principles (Veenstra and Burnett 2014) and structures of “differentiated positions, defined in each case by the place they occupy in the distribution of a particular kind of capital” (Bourdieu 1998b, p.15). It is defined both as *a field of forces* or a structure of objective power relations “whose necessity is imposed on agents” (Bourdieu 1998b, p. 32), and as *a field of struggles*, where social positions are “strategic emplacements, fortresses to be defended and captured” (Bourdieu 1984, p. 244). The unequal distribution of field-specific forms of capital (power), which vary across places and moments (Bourdieu 1998b), results in some agents taking the dominant positions while others – the dominated ones, which, nonetheless, is not immutable since “the ‘exchange rate’ between different kinds of capital” (Bourdieu 1998b, p. 34) may be transformed. As such, the field is not only a structured space, but also historically dynamic and flexible, although *habitus* as a field-specific ‘feel for the game’ or objective structures incorporated by subjective agency (Bourdieu 1990a, 1998b) maintains relative stability of social fields.

The framework also accommodates the concept of figuration by Norbert Elias (2012) to define user-provider relationships. Both Elias and Bourdieu are often viewed as sociologists of power that rely on a very similar set of concepts, as well as employing them relationally (Paulle, van Heerikhuizen, and Emirbayer 2012). Instead of considering these scholars separately, one’s contribution can complement another to better theorise interdependences and power relations between agents. Thus, in the following sections of the article, I first analyse the logic and structure of the mental healthcare field and conceptualise symbolic power as embedded in the logic of the field. Second, I approach a user as being between structures and agency and, although this is primarily a theoretical contribution, the third section of the article briefly illustrates the utility of the approach drawing on the results of the ongoing study on help seeking in common mental health issues.

2. TOWARDS THE LOGIC OF THE FIELD

The field of mental healthcare is a structure of positions or objective power relations "imposed on all those who enter this field" and, therefore, is "not reducible to the intentions of individual agents or even to direct *interactions* between agents" (Bourdieu 1991, p. 230). In other words, the field is not just a group of individuals that fairly independently interact and act by their own logic, but rather has a historically-determined structure and rules. They define *nomos* as "a shared principle of vision and division" (Bourdieu 1994, p. 13) between mental health and illness, sanity and insanity, or normality and deviance, and, as a result, (potential) access to mental healthcare and the logic of action within the treatment system. These durable rules objectified in institutions and embodied in *habitus* of agents, as well as power relations between agents, determine help-seeking practices of individuals in the social field as a whole, including that of healthcare seeking in the treatment system (see Figure 3).

2.1. Means and stakes in the game

A heterogeneous group of institutionalised positions in the field – mental healthcare providers such as general practitioners as gatekeepers in some settings, psychiatrists, or psychologists, as well as social workers, administrators, or mental healthcare and research facilities – forms a "network of competitive relations which give rise, for example, to conflicts of competence" (Bourdieu 1984, p. 244). Despite differences between the positions, all agents share *illusio* or interest, as opposed to disinterestedness or indifference and as being both the condition and the product of the field (Bourdieu 1998b; Wacquant 1989). It functions as a driving force of action. That is to say, even agents, who occupy opposing or conflicting positions (as it can be the case of biological psychiatrists and clinical psychologists), agree that "it is worth the effort to struggle for the things that are in play in the field" (Bourdieu 1998b, p. 78).

The main resources that define one's position in the field (dominant/dominated) are the forms of relevant capital. Field-specific cultural capital in its institutionalised (academic qualifications) and embodied forms (scientific knowledge and skills) (Bourdieu 1997) counts as one of the dominant types of capitals, along with economic resources that are often structured by and structuring cultural capital. Despite the inclination towards reproduction of the order of the field through accumulation of the legitimate cultural capital in the hands of the dominant, its definition is imposed and may be transformed in the contests between agents, "in which victory leads to more or less monopolistic control of the definition of the forms of legitimacy prevailing in the field" (Hilgers and Mangez 2015, p. 6).

In other words, what is at stake in such struggles is "the power to impose the dominant definition" (Bourdieu 1993, p. 42) of a mental healthcare provider and, therefore, of the limits of the field. For instance, Strand (2011) describes these struggles in the US in the 20th century, including the dominance of psychoanalytical cultural capital and how it ceased its dominant positions with psychiatrists taking the monopoly of power over psychoanalysts and clinical psychologists. Thus, the distribution of field-specific cultural capital defines the principles of the game in the field, which is embedded in time and space. Put differently, distinctive value of different position-takings (theories and paradigms of approaching mental distress) may change.

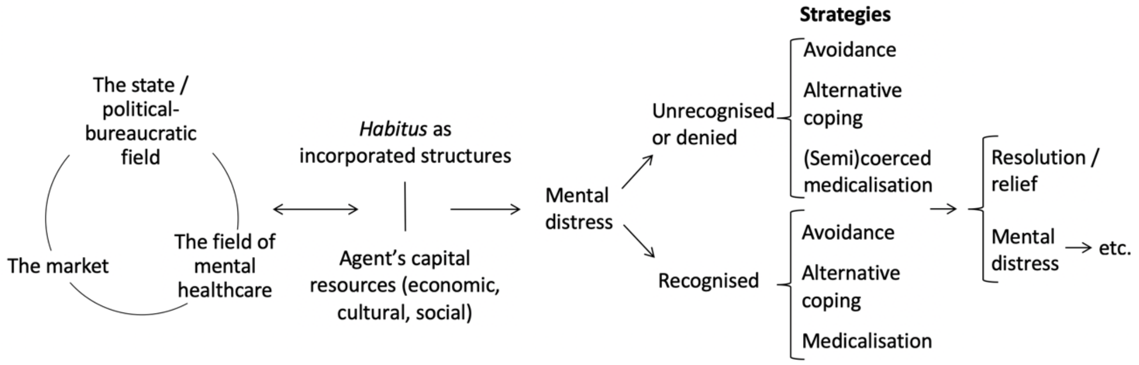

Figure 3. The theory of fields and help seeking for mental distress.

The concept of the field "presupposes a degree of autonomy" (Dubois 2015, p. 2017) or 'independence' of a medical activity and struggles for distinction or domination within the field. Nonetheless, the autonomy is relative and "varies considerably from one period and one national tradition to another" (Bourdieu 1993, p. 40) with the field being positioned on the continuum between heteronomous or external and autonomous or internal principles of hierarchisation, that is, principles of defining the structure and limits of the field. The more autonomous the field is, the less external principles of hierarchisation dominant in the field of power (the economic and political fields) apply (Bourdieu 1993; Hilgers and Mangez 2015). In the case of the mental healthcare field, Strand (2011) stresses a move towards heteronomy with more effects of capitals dominant in other fields (economic and political, in particular) on the structure of positions in the field. Therefore, the role of the market and the state (political-bureaucratic field) should be considered in defining the logic of the field (Figure 3). Success of a mental healthcare provider is not only measured by prestige and respect granted by their peers within the field, but also by numbers of appointments (economic capital) or political power in terms of political-bureaucratic structuring of the field.

First, the state or the political-bureaucratic field "is in position to regulate the functioning of" the healthcare field (Bourdieu 1998b, p. 33) through the accumulation of the economic power or capital – although varying on the level of private expenditure, the European healthcare systems are mainly financed through social insurance contributions or general taxation (Thomson, Foubister, and Mossialos 2009) – and of cultural or, more broadly, informational capital. The latter includes archives as accumulation of knowledge, the school system, the framing of medical training or, in short, the establishment and inculcation of the forms of classification (Bourdieu 1994). Likewise, the state usually possesses the means used to provide mental healthcare (Bourdieu 1997): financing of services, facilities, or regulation of pharmaceuticals (access to medications).

The appropriation of the latter, however, needs the field-specific cultural capital incorporated by providers. Given this domination of cultural capital in mental service provision, as well as the period of embodiment needed to acquire said capital, "the collective strength of the holders of cultural capital" (Bourdieu 1997, p. 50) is high in defending the relative autonomy of the field. Nonetheless, its extent and relations between the field of mental healthcare and the political-bureaucratic field vary depending on historical configurations. In such struggles for domination, the rules of access to mental healthcare are defined, including entitlement to healthcare, the gatekeeping role of general practitioners (access to specialists), mental service package, or a degree of cost-sharing. For instance, the gatekeeping role varies from strong and restrictive in the UK or Spain, where users need a referral to access specialised care, to the least restrictive with free access to secondary care in Germany or France (Reibling 2010), which influences pathways within the field, as well as treatment strategies.

Although the state exercises power over the field, its interventions can favour the autonomy of the field “against the risks of domination by the heteronomous logics of the economic field” (Dubois 2015, p. 215) and maintain principles of solidarity and universal access to healthcare. Yet, the pharmaceutical companies, “where health is defined as a product of market exchange and profit” (Collyer et al. 2015, p. 690), remain an important beneficiary from mental healthcare (Conrad 2007; Horwitz 2007) with notable increases in prescribing antidepressants nearly everywhere, notwithstanding doubts about their safety and efficacy (Gøtzsche 2013; Rose 2019). Although few countries allow direct to consumer marketing of prescription pharmaceuticals, which is particularly effective in expanding boundaries of diagnosis and increasing medicalisation of problems of living (Conrad 2007), their influence over providers or the political-bureaucratic field may encourage certain treatment strategies (Gøtzsche 2013) and “blurring of the boundaries between normal distress and mental disorder, both of which receive medication as the preferred response” (Horwitz 2007, p. 218). Gøtzsche (2013, p. 191) in turn calls the field of mental healthcare and, particularly, biological psychiatry as “the drug industry’s paradise”.

Finally, the position of the field in the overall structure of the medical field is also crucial in order to understand the rules of the game and how they are settled. Through the analysis of the historical genesis of the medical field in France in the 19th century, Pinell (2011) reveals how treatment of mental illness was marginalised and devalued. Album and Westin (2008), Hindhede and Larsen (2019) or Stuart, Sartorius, and Liinamaa (2015) demonstrate that even today psychiatry and mental disorders such as anxiety or depression rank low in prestige hierarchies. Therefore, the field of mental healthcare appears to be dominated, which may affect resources allocated to the field for service provision or research, recruitment into the field (Stuart, Sartorius, and Liinamaa 2015), patient categorisation, or in general, “setting priorities at all levels” (Album and Westin 2008, p. 188).

2.2. Symbolic power in the field

As the result of both autonomous and heteronomous principles discussed above, the field of mental healthcare is a specific site of symbolic power as a subtle and 'invisible' form of domination towards an agent and with agent's complicity that (re)produces social order and structures (McNay 1999; Bourdieu and Wacquant 2003). As Bourdieu states (1988, p. 63), "the very exercise of the clinical act implies a form of symbolic violence" and, correspondingly, influences agent's practices. It is symbolic and "most completely misrecognised – and, thus, in fact, recognised" as legitimate (Bourdieu 1991, p. 163-164). The dominated groups not only accept symbolic power as legitimate misrecognizing its very nature of reproduction of inequalities, but also see the dominant groups (e.g., healthcare providers) as the rightful agents to use such power.

The assumption of healthcare seeking in the treatment system as an adequate and expected response to mental distress, as well as thinking in diagnoses, presupposes a medical model as a dominant and legitimate ideological stance "to impose (or even to inculcate) the arbitrary instruments of knowledge and expression (taxonomies) of social reality" (Bourdieu 1991, p. 168). As Lupton (1999, p. 52) states, its discourse "relies, in part, on the assumption that it is politically and culturally neutral" and, therefore, scientific and universal unlike some alternative therapies such as herbal medicines, faith healers, or initially the recovery approach, which, although constructed as an alternative to biological psychiatry, has been professionalised fitting "perfectly with the rationalities and technologies of neoliberalism" (Rose 2019, p. 164). The specialised language of medical discourse is a form of "a censorship constituted by the very structure of the field in which the discourse is produced and circulates" (Bourdieu 1991, p. 137) and limiting by whom something can be said, what is meant by it, and with what effects (Wacquant 1989).

This specialised language implies classifications – in particular, symptom-based diagnostic criteria and classifications of diseases – as a form of linguistic code resulting in a source of symbolic power with the dominated, who are subjected to it, believing in its legitimacy. This belief is particularly important in mental health due to a lack of physical basis and biological diagnostic tests. Through an act of '*official naming*' by "the holder of the *monopoly of legitimate symbolic violence*" (Bourdieu 1991, p. 239, emphasis original), who is authorised "to label and deal with people on behalf of the society at large" (Brown 1995, p. 39), users with their own complicity accept their subordinate role and go under medical social control that “secure(s) adherence to social norms – specifically, by using medical means to minimise, eliminate, or normalise deviant behaviour” (Conrad and Schneider 1992, p. 242). Doctors or patients rarely view and perceive diagnoses and treatments as a form of social control (Waitzkin 1989). Yet, providers’ cultural capital resources would allow this reflexivity. Given their powerful position as the dominant group in the social field as a whole and their *habitus*, they nonetheless support status quo because “they *believe* in what they *believe* they are doing” (Bourdieu 1988, p. 207) and, therefore, usually encourage “clients adjust to things as they are” (Waitzkin 1989, p. 227) by treating them with medical remedies such as psychopharmaceuticals.

There are undoubtedly some benefits of medicalisation such as a reduction of individual responsibility, blame, or stigma of mental illness, as well as distress relief or health improvement through medical interventions (Conrad 2007; Conrad and Schneider 1992). In the case of common mental disorders, whose symptoms are often “diffuse and transient” (Rose 2019, p. 74), diagnosis gives credence to or legitimates one’s symptoms, behaviours, and suffering (Brown 1995), “enables a story to be created about it” (Rose 2019, p. 74), as well as providing individuals with a new collective identity and coping resources such as support networks locally or virtually (Jutel 2009). At the same time, however, symbolic power through symptom-based diagnostic criteria hides and leaves untouched the societal roots of distress (Horwitz 2007; Rose 2019), since the focus is shifted from social issues to individual troubles as signs of diseases, which allows the dominant groups to protect the social order.

On the one hand, therefore, given the interests of pharmaceutical companies and the institutional design of healthcare systems, which focus on treating symptoms rather than social causes, this encourages medicalisation of problems of living since “symptom-based definitions expand the sorts of conditions that are considered to be in the dominion of psychiatric control” (Horwitz 2007, p. 218). On the other hand, besides these medical technologies such as pharmaceuticals, the more powerful the other forms of medical control are, the more likely people are to bypass the treatment system for severe mental distress with subsequent social and health costs: for instance, medical collaboration with other institutions (medical professionals as information providers) or using medicine for state's ideological needs (Soviet dissidents' treatment as mentally ill serves as an illustration) (Conrad and Schneider 1992).

To sum up, this section demonstrates that the field of mental healthcare should be analysed as a structure of the dominant and dominated groups (i.e., as power relations) whilst not rejecting antagonism and struggles for domination between them, which calls for the examination of historical genesis of this structure. The role of each agent in the field, as well as the degree of autonomy or heteronomy of the field, should be considered in order to examine how they – in relation with one another – impact (potential) users' trajectories towards and within the field. An analysis of help-seeking practices in mental distress, nevertheless, needs approaching "the relative positions and resources of the producers and consumers" (Hilgers and Mangez 2015, p. 21), that is, not only agents and institutions in the field of mental healthcare, but also users as consumers of services.

3. ON USERS: BETWEEN STRUCTURES AND AGENCY

An agent can participate in the field while "taking no direct part in the game that is played there" (Lahire 2015, p. 73). As consumers (not producers), users indeed enter the mental healthcare field and after receiving services return to the social field as a whole. This is how students or simple spectators seem to normally act in the academic or cultural fields analysed by Bourdieu (1988, 1993). As such, their role in the field appears to be marginal, if any, although it is intuitive that without them there would be no game itself. Therefore, linking providers and users as forming figurations or functional interdependences, which constrain both of them to some degree (Elias 2012), helps to better understand users' role in the game: they have a function for providers as an indispensable part of a medical activity. Unequal and fluctuating ratios of power are "a structural characteristic of the flow of every figuration" (Elias 2012, p. 126).

Providers usually experience power surplus due to accumulation of the field-specific cultural capital, as well as due to higher internal group cohesion as compared to a temporary patient role in depression or anxiety and, therefore, their lower group cohesion. The bigger power differentials between them, the more the user-provider figuration resembles an individual plan (that of a provider or their institution) rather than a game or social process whose outcomes are not planned (Elias 2012). Rather than acting separately, nevertheless, users can play a game all together and “[i]f groups formed by weaker players do not have strong inner tensions, that is a power factor to their advantage” (Elias 2012, p. 78).

Put differently, service user movements can struggle for domination or changes of the rules of the field rather than being excluded from it. On the one hand, Gøtzsche (2013) unveils influences of ‘big pharma’ on patient organisations through financial support, which may show their dominated position in the field and incorporation of *doxa* as the taken-for-granted order of the field. On the other hand, Rose (2019) describes examples of mental patient activism towards a shift of the rules of the game: their role in the development of policy documents such as a National Service Framework for Mental Health in the UK, activities of national and international organisations such as the World Network of Users and Survivors of Psychiatry, or promotion of alternative forms of knowledge including the concepts of ‘empowerment’ or aforementioned ‘recovery framework’, among others. Although such movements do challenge *doxa* moving it to the discourse, Rose (2019, p. 170) recognises that their role in “a transformation of the fundamental power relations in psychiatry” has been limited and they remain dominated in the field.

3.1. On capitals

Even without considering users as playing in a group, their capital resources accumulated individually and dependent on class origins, education, gender, or residence (Wacquant 1989) differentiate them in terms of power and define their location in the social field as a whole, which in tun determines access to information and, as a result, the path of help seeking. Besides other strategies, this may include healthcare seeking in the treatment system and specific trajectories within it, depending on the logic of the field and its historical configurations. First, agents with accumulated economic capital can bypass long waiting times or receive services excluded from the publicly financed benefits package by purchasing care in the private sector. Even in generous and comprehensive health systems such as the Nordic welfare states, economic resources can still indirectly function as a facilitator to effective help seeking. Field-specific cultural capital as embodied knowledge about mental health and linguistic competence or capital as “the capacity to produce expressions *à propos*, for a particular market” (Thompson 1991, p.

18) can be accumulated and reproduced along with economic capital, although at the same time being dependent on individual trajectories in social fields.

Shim (2010, p. 2) synthesises such field-specific capitals through the use of the concept of cultural health capital, which is defined as “the particular repertoire of cultural skills, verbal and nonverbal competences, and interactional styles that can influence healthcare interactions at a given historical moment”. Thus, cultural (mental) health capital can be a useful tool in the model of help seeking for mental distress. Not only do these resources facilitate clinical encounters, once help is sought, but they also improve one’s ability to acknowledge suffering as pathological, that is, to perceive need for care – particularly in case of common mental disorders, which often lack a clear physical basis – and to cope with distress by seeking healthcare or employing alternative strategies “not in the sense of a conscious plan, but as general styles and habits of action” (Shim 2010, p. 3). Cultural health resources as the field-specific capital are semi-autonomous (although not entirely independent) from other capitals due to the possibility to accumulate such resources through past experiences in the field (Guldager et al. 2018; Shim 2010).

Likewise, social capital, being linked to “membership in a group” (Bourdieu 1997, p. 51), might be an effective resource encouraging (or impeding) help-seeking practices. Other scholars have extensively analysed its importance in illness behaviour. For example, Pescosolido in her Network-Episode Model (2006, p. 194) states primacy of social networks and interactions in healthcare seeking as creating “cultures of information, beliefs, and action scripts” and, therefore, being both instruments of domination or of emotional support. Drawing on the Bourdieusian theoretical stance, the volume of social capital is not reducible to the volume of social networks *per se,* but rather means connections that can be effectively mobilised by an agent and “the volume of the capital (economic, cultural, or symbolic) possessed in his own right by each of those to whom he is connected” (Bourdieu 1997, p. 51). To put it differently, the same overall number of connections can accumulate different volumes of the social capital depending on cultural and economic capitals of said connections.

Therefore, although not automatically, different forms of capitals tend to accumulate together and “define the location of an individual within the social space” (Thompson 1991, p. 18), which produces ‘choices’ of certain strategies in case of mental distress. Nevertheless, it would be “a mistake to try to understand the practices in terms of the immanent logic of the structure of positions" (Bourdieu 1981, p. 313) or solely through the location in the social structure. In turn, agents' *habitus* or incorporated dispositions (Figure 3) that are "*acquired through experience*, thus variable from place to place and time to time" (Bourdieu 1990a, p. 9) need to be analysed.

3.2. On habitus and structures

An individual or collective practice is a product of different objectifications of history (Bourdieu 1981, 1990b, 1994): history objectified in things, buildings, customs, or laws – that is, objectification in fields as social structures – and objectification in bodies or incorporated collective history as *habitus*, which "reflects a shared cultural context" (Adams 2006, p. 514) while, at the same time, being individualised (individual history). Therefore, the importance of *habitus* in help seeking lies in its reflection of sociocultural context: incorporated norms, attitudes, and beliefs towards mental disorders dominant in the social space, as well as what is and what is not appropriate or accessible to do in such situations, which also depends on one's capital resources. That is, *habitus* is class-dependent where "objective limits become a sense of limits" that "implies *forgetting* the limits" (Bourdieu 1984, p. 471).

Habitus is *inculcated* gradually where early experiences are crucial (Thompson 1991). Socialisation in the family, the journalistic field, and particularly, the school system plays an important role in this process, where dispositions such as classifications inscribed in language or attitudes towards mental health and illness are acquired and "literally mould the body and become second nature" (Thompson 1991, p. 12). Although perceptions of *habitus* "give disproportionate weight to early experiences" (Bourdieu 1990b, p. 54), the later acquisitions can also influence practices, since depending on contents it can accumulate as cultural health capital. Mass media messages about mental health and illness, therefore, can be an effective tool encouraging acknowledgement and certain help-seeking strategies (and vice versa). For example, success stories about mental health problems and their management amongst celebrities as "possessors of distinctive properties" (Bourdieu 1984, p. 251) may result in imitation of practices. The imitation, however, may also lead to over-medicalisation of mild symptoms, which depends on general attitudes of agents (i.e., their *habitus*), as well as on decision-making of healthcare providers, the practice culture, and commercial interests (Boyer and Lutfey 2010), once care has been sought.

Further, such dispositions are *structured*. That is, they reflect the social conditions where they have been acquired (the social position of the family, prestige and social conditions of neighbourhood or school, and even mass media channels that are consumed) and, therefore, tend to reproduce social structures. Possibilities and impossibilities structured by the objective conditions "generate dispositions objectively compatible with these conditions" (Bourdieu 1990b, p. 54). Therefore, practices perceived as improbable are directly excluded as impossible. *Habitus* is also *durable* since it functions "below the level of consciousness and discourse" (Bourdieu 1984, p. 468). Its unconscious functioning, nevertheless, does not rule out that "the responses of the *habitus* may be accompanied by a strategic calculation" (Bourdieu 1990b, p. 53), although such calculations are still performed within the limits of possibilities defined by the field and social conditions. Finally, *habitus* is *generative* as capable of producing a range of practices, yet within the limits of structures (Adams 2006), and *transposable* as capable of generating these practices and perceptions "in fields other than those in which they were originally acquired" (Thompson 1991, p. 13).

Finally, in order to describe the implicit adherence between social structures and *habitus*, Bourdieu (1977) talks about *doxa* that is taken-for-granted understanding, which people have about their social worlds, their (im)possibilities, or their place in the fields (Veenstra and Burnett 2014). *Doxa* is produced and imposed "categories of thought that we spontaneously apply to all things of the social world" (Bourdieu 1998b, p. 35) such as perceptions about the role of healthcare providers as authorizing withdrawal from regular social roles or assumptions of mental disorders as real and legitimate entities. It is generated by the dominant agents, but incorporated within *habitus* of the dominated too and, therefore, generally remains undiscussed. There is "the absolute form of recognition of legitimacy through misrecognition of arbitrariness" in *doxa* (Bourdieu 1977, p. 168), except for situations or certain circumstances, when the fit between subjective and objective structures is destroyed and, therefore, the undiscussed can get into discussion (Bourdieu 1977), for example, scientific crises with medical knowledge and its self-evidence being questioned.

Thus, help seeking for mental distress "has a logic which is not that of the logician" (Bourdieu 1990b, p. 86). That is, a potential help-seeker incorporates "a practical anticipation of what the social meaning and value of the chosen practice will probably be" (Bourdieu 1984, p. 467). This happens in the context of their past experiences in different fields, which are inculcated over time as dispositions within their *habitus* that guides the practices or, in other words, responses to intense and persistent sadness or anxiety.

3.3. On agency

The very possibility of getting *doxa* into discourse and, thus, of questioning "the definition of the legitimate principles of division of the field" (Bourdieu 1991, p. 242) implies agency. This depends, however, on the positions of agents in the field or on agents' "realistic knowledge of what it is and of what they can do to it by virtue of the position they occupy in it" (Bourdieu 1991, p. 242). In other words, it is very much structured by their capital resources. Although such an inclination of reproduction of structures seems to be "the whole point of the structure concept" (Sewell 1992, p. 16), it seems that agents little, if at all, ever avoid reproduction of the social order. That is, despite the generative nature of *habitus*, an active transformative role of agency seems to be limited.

This determinism within which it is argued that Bourdieu remains trapped (Williams 1995) is a common critical comment of the theory of fields. *Habitus*, which the author employs to go beyond the divide between subjectivism and objectivism, determines all social practices and, notwithstanding its generative nature, any 'choice' appears to be structured by the social conditions, where these durable dispositions have been acquired. Therefore, actions that would not mechanically reproduce structures seem to be unlikely (Sewell 1992; Sweetman 2003; Williams 1995). Nonetheless, as a response to this, Bourdieu emphasises the possibility of reflexivity and spontaneity that are inherent within *habitus* (Bourdieu 1990a; Bourdieu and Wacquant 2003). McNay (1999) or Veenstra and Burnett (2014) agree that his theory may be more resistant to the critique of determinism, and if treated relationally, Bourdieu's conceptual triad "illuminate(s) creative, adaptive and future-looking practices" (Veenstra and Burnett 2014, p. 188).

First, *habitus* can lead to different perceptions, actions, and thoughts, "adapted to the infinite number of possible situations which no rule, however complex, can foresee" (Bourdieu 1990a, p. 9). Therefore, agency is spatial and intersubjective (Veenstra and Burnett 2014) resulting in using the concept of strategies instead of rules. An agent who experiences persistent mental distress does not follow strict rules of healthcare seeking (an expected path of actions). Instead, depending on the objective state of the field of mental healthcare, agent's capital resources, and their embodied dispositions that construct "their perception of the available possibilities" (Bourdieu 1993, p. 184), as well as symptoms themselves, the agent employs strategies that can – yet not necessarily – result in healthcare seeking and that differ from one moment to another even within the same field and for the same conditions.

Second, *habitus* is continuously transformed. This, on the one hand, can reinforce it "when embodied structures of expectation encounter structures of objective chances in harmony with these expectations" (Bourdieu 1990a, p. 116). Such harmony and knowledge of the limits of the field and one's possibilities (and accepting them) may also result into abilities to improvise strategies and actions (Veenstra and Burnett 2014). This is the case, when healthcare providers and users of services have a 'feel for the game' that allows them to creatively manage their actions within the limits of the field. That is, *habitus* makes possible spontaneity of practices that are generated "not along the paths of a mechanical determinism, but within the constraints and limits initially set on its inventions" (Bourdieu 1990b, p. 55). On the other hand, the situation when *habitus* is not perfectly aligned or pre-adjusted to objective structures is also possible and does not mean that people lose their ability to improvise, but rather that "the discrepancy can trigger innovative actions and reactions intended to strike a manageable balance between one's *habitus* and the field" (Veenstra and Burnett 2014, p. 193).

Third, besides these practical transformations in relation to the field and within the limits of possibilities granted by the field, there is a possibility of reflexivity or "awakening of consciousness" in *habitus* (Bourdieu 1990a, p. 116). The transposability of *habitus* acknowledged by Bourdieu himself and further analysed by Sewell (1992) implies this reflexivity. If an agent is able to apply or extend mental schemas in different contexts (i.e., *habitus* is transposable), then the knowledge of these schemas or dispositions is inherent in agency and "characterises all minimally competent members of society" (Sewell 1992, p. 18). That is, agency arises from this capacity of transposability of dispositions and "is formed by a specific range of cultural schemas and resources available in a person's particular social milieu" (Sewell 1992, p. 20). This being said, while a certain extent of agency is a given to all humans, its form depends on such resources, which are socially conditioned and enable a capacity to reinterpret and reapply schemas in a new context (e.g., to recognise and acknowledge symptoms in their own body).

As the result of such features of *habitus*, different strategies as individual responses to mental distress may emerge (Figure 3 summarises some of them): from medicalisation through healthcare-seeking to resistance to the forces of the field in the form of alternative coping (either effective or not) or avoidance (normalisation). The latter – alternative coping and avoidance strategies – generates largely as “a non-conscious, unwilled avoidance” (Bourdieu 1990b, p. 61) so that *habitus* protects itself from unknown and potentially critical situations or challenges in the treatment system and results “automatically from the conditions of existence” (such as avoidance or alternative coping due to a lack of capital resources) or “has been produced by a strategic intention” (for example, strategies of alternative coping in order to avoid medical control or to engage with more effective treatments that are unavailable in the public sector) (Bourdieu 1990b, p. 61).

Yet, such forms of resistance as passive avoidance of help seeking or maladaptive alternative coping (e.g., alcohol abuse) doubtfully avoid reproduction of social structures and, therefore, modes of domination – similarly to Bourdieu’s example of the working-class boys skipping classes (Bourdieu and Wacquant 2003). In the meantime, the latter whose effective employment often depends on agent’s capital resources involves “the voluntary internalisation of norms governing appropriate behaviour in the interests of achieving the best possible self” (Lupton 1999, p. 57) and, as a result, does not avoid the dominant discourse regarding the limit between normality and abnormality, health and illness (technologies of domination though the medical *logos*). Such practices, nevertheless, suggest an agent who “is engaging in a reflexive evaluation of the situation and responding accordingly to maximise her or his life changes” (Lupton 1997, p. 105).

4. MENTAL HELP SEEKING IN POST-SOCIALIST LITHUANIA: AN EMPIRICAL CASE

The utility of the approach can be illustrated through the design and findings of a qualitative study on help seeking for mental distress. Specifically, this ongoing study examines how the institutional (the logic of the mental healthcare field), cultural (*habitus*) and social (individual capital resources) contexts influence help seeking, in general, and healthcare seeking, in particular, for depression or anxiety disorders. Users of services and healthcare providers have been interviewed in two settings that contrast in under- and overtreatment of mental distress due to "the particularities of different *collective histories*" (Bourdieu 1998b, p. 3). Spain was "associated with a lower risk of not using services when there was a need for healthcare" in common mental disorders (Alonso et al. 2007, p. 304), while Lithuania constantly reports one of the highest rates of violence towards oneself (suicide mortality or alcohol consumption) and others (intentional homicide) in Europe (source: Eurostat Statistics; GHO data, WHO/Europe), indicating poor mental health of the population. Yet, clinical and self-reported prevalence of common mental disorders is low (source: Health Statistics of Lithuania, Institute of Hygiene; Eurostat Statistics), which suggests high treatment gap and delay. The summary of findings presented here belongs to the latter case.

First, the interviews in Lithuania reveal that organisation of mental healthcare with direct access to mental health specialists results in *de jure* accessible care with a wide range of services, although leading to a vague and limited role of general practitioners in mental health. Nonetheless, while psychopharmacotherapies are available and accessible, psychosocial interventions are often restricted to a limited number of psychological consultations per user, revealing the dominance of biological psychiatry, which along with power differentials in the provider-state relations drives the logic of the field. This logic results in highly hierarchical communication patterns between providers and users and a lack of trust in a clinical encounter. What appears to be a specific heritage from the Soviet regime is institutional stigmatisation upon diagnosis of mental disorders (legal restrictions with regard to employment in public sector (law, medicine, police, etc.), getting and renewing a driving license, or owning a gun), which functions as an instrument of symbolic power. Therefore, the analysis of the logic of the field unveils relatively accessible, but not necessarily acceptable or humane mental healthcare.

Status quo of the mental healthcare field is structuring and structured by beliefs towards mental illness, which dominate in the cultural context and which are durably inculcated in *habitus* of agents. Mental healthcare seeking can be viewed as a threat to moral experience or what is most at stake for agents (Yang et al. 2007). Given high levels of status anxiety in Lithuania, as in many other post-socialist countries (Layte and Whelan 2014), it is the likeness to others or fitting in (in terms of appearances, behaviours, or beliefs), which is threatened by mental healthcare seeking and which in turn results in guilt and shame that were present in the interviews with nearly all of the users of services. Therefore, anticipation of this threat and, as a result, of shame impedes timely healthcare seeking. It drives agent's strategies of practices, which are defined in relation to their capital resources or position in the social field as a whole.

The agents with accumulated capital resources are able to confront stigma and to employ effective coping strategies, including that of healthcare seeking in the private or public sectors. Cultural health capital, which equips an agent with competences to acknowledge mental distress, to know how and where to seek help, and with self-efficacy (Shim 2010), and social capital, which provides push to care or can be converted into cultural health capital, prove to be particularly influential in defining agent's trajectories of help seeking. By the same token, a lack of accumulated capital resources delays healthcare seeking and results in maladaptive or ineffective coping such as alcohol use and abuse, normalisation, self-isolation, or somatisation. As a result, mental healthcare seeking is late (often coerced) with significant health and social outcomes, resulting in reproduction of social structures.

The proposed theoretical approach, therefore, helps to reveal that the homology between objective structures of the mental healthcare field and incorporated structures of *habitus* reinforces one another and reproduces social and health inequalities. Guilt and shame in both domains – social field as a whole and the mental healthcare field through institutionalised stigmatisation, in particular – are deeply embedded in both objectified and embodied structures. The findings, however, could be supported by a broader historical perspective and reconstruction of policy-making trajectories, which suggest directions for future research to fully reveal the potentiality of the theoretical framework.

5. CONCLUSIONS

The model outlined in the figure 3 summarises the field approach proposed in this article, where the logic of the mental healthcare field, its historical configurations, and interplays with the state and the market, as well as individuals' capital resources and embodied history as *habitus,* structure how and what symptoms are recognised as pathological (need for care is perceived) and what strategies are employed to deal with them. The framework intends to move beyond individualistic belief-centred models (mis)predicting health behaviours or the relationship between health-related knowledge and action (Williams 1995) by rather focusing on "revealing the complexities of the relations between mental structures (categories of perception and appreciation, systems of preference, perceived limits) and objective structures (fields)" (Veenstra and Burnett 2014, p. 194).

As demonstrated in the empirical example, the model should be used as a method or a set of interrelated concepts to guide an empirical investigation rather than to be considered as a theory *per se* (Hilgers and Mangez 2015). Bourdieu's sociology is relational and, therefore, meanings of practices or capitals vary with varying power configurations across settings and from one time to another. Elias (2012, p. 91) – an earlier-generation relational scholar – stresses that agents' actions "need to be understood and explained within the framework of the game". That is to say, in order to understand help-seeking practices in mental distress, researchers should relationally analyse and account for how the structure of the healthcare field as a structure of interdependent positions and the distribution of capital impacts access to healthcare; how incorporated structures that mirror cultural context and social conditions where they have been acquired influence perceptions of the access and, therefore, help seeking; and what historical genesis of both mental and objective structures is.

II. 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 delays. 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 analysed. 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

1. INTRODUCTION

Common mental disorders, depression and anxiety, in particular, are 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, Thornicroft, and Atun 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 hospitalisation, restrictions, and dispanserisation as tools of social control (Daubaras 2004; Van Voren 2013).

Today, provision of mental health services is ample (Pūras et al. 2013) – 22.7 psychiatrists per 100,000 inhabitants practiced in the country in 2016, which was substantially more than in other states in Central and Eastern Europe (source: Eurostat). 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 centres that are organised at the primary care level and spread across the country. While this organisation of outpatient specialised 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 centres (Šumskienė and Pūras 2014).

If treatments in mental health centres prove to be ineffective, patients can be sent to outpatient day centres, or hospitalised. Like in other post-socialist societies (Raikhel and Bemme 2016), the number of psychiatric care beds has decreased significantly over the past decades (source: Eurostat), but hospitalisations 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 (Order on the Approval of the List of Reimbursable Medicines 2000).

Despite the organisation 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; Flensborg-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 (source: Eurostat). 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 (source: Eurostat). 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 (source: Eurostat). Less than 5 per cent of the population reported depression in 2014 being among 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 2020a; 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, p. 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).

2. 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, p. 7), which, due to the lack of perceivability of generative mechanisms, must "be detected by their effects" (p. 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 about 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, p. 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 1990b). The mental healthcare field is both *a field of forces,* whose rules of the game are "imposed on agents" (Bourdieu 1998b, p. 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 1998b, p. 32). Bourdieu attempts to transcend the subjectivism/objectivism dualism with his concept of *habitus* that introduces vertical relations to the theory (Vandenberghe 1999, p. 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, p. 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, p. 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, p. 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 1998b, p. 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 towards 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 misrecognised – and thus, in fact, recognised" (Bourdieu 1991, p. 163). In other words, it is recognised as legitimate, but "misrecognised as arbitrary" (Bourdieu 1991, p. 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.

3. 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, p. 92). This understanding can be produced hermeneutically (Bhaskar 2016, p. 58) through "a logic of question and answer" (Schwandt 2000, p. 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 analysed in this article form part of a broader research project on medicalisation 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 May 2, 2017.

For the recruitment of the participants, three mental health centres, two health centres, 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 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 (seven women and four 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 centres. Four users had also been hospitalised for mental health problems and another four participants had additionally received treatments at day centres.

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 analysed 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 has been 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, p. 186). After the familiarisation with the data and development of an initial code list, the interviews have been coded and potential themes have been 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, p. 91). Although presented as a linear process, the analysis was recursive moving back and forth between the phases.

4. 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. (HCP01, 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 centre 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, institutionalised stigmatisation as bureaucratised symbolic power.

4.1. 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, p. 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 utilisation 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. (P09, 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. (P02, 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. (P11, 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 hierarchise, 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 hospitalised 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. (P02, female user, 18-35)

Such experiences of domination and even demoralisation, 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. (P04, 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 2008a, p. 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, Jakab, and Shishkin 2010), but also to the strong domination of, and dependence upon, 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, p. 587) and to evolve into a form of coercion rather than voluntary gratitude (Gaál, Jakab, and Shishkin 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*]. (P04, male user, 51-65)

Yet, only users amongst the 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 does not take bribes. (P03, 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 democratisation (reduced asymmetry or informalisation of clinical encounters) and de-democratisation 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 hospitalisations, 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.

4.2. 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, p. 1459) including the regulation of clinical practice or the structure of decision-making. In this sense, the meanings that emerged in the interviews centre around being dominated or disempowered. The healthcare providers spoke about power being concentrated in the hands of agents interested in maintaining the *status quo* of the mental health system. The narratives were marked by feelings of disillusionment and disappointment induced by power asymmetries and the dominance of the 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. (HCP01, 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. (HCP02, 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, Petružytė, and Klimaitė 2018, p. 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. (HCP10, 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. (HCP05, 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. (P09, 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, p. 204). Friedman (2016, p. 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*", that is, 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 (centre vs. periphery) and organisation from above:

> The figures [*suicide rates*] in Vilnius are great, but the project focuses on the city of Vilnius and they teach everyone here. [*It's an*] unsensible amount, a waste of time. And what do we need it for? There are so many services here (…) And in the regions, 80-90 per 100,000 commit suicide and one psychiatrist works there, who doesn't have time for anything, doesn't see anything and can't help. (HCP04, psychiatrist)

Nonetheless, policies oriented to health promotion (rather than one-time initiatives) 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 hospitalisations 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 hospitalised. If only someone would have approached me then. (P02, 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. This, in turn, preserves stigmatic attitudes and low mental health literacy and, therefore, a high treatment gap and delay. “The longer it is delayed, the more hospitalisation is needed” (HCP08, clinical psychologist), which consequently proves the need for traditional but expensive mental health services leaving insufficient financing for health promotion and prevention. Therefore, with few exceptions and some modernisation, the system appears to remain dependent on “Soviet-style mental health care provision” (Tomov et al. 2007, p. 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. (HCP04, psychiatrist)

Providers’ antagonism with the political-bureaucratic field was also present when they 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 15-20 minutes maximum. (HCP04, 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 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 the medical records, (…) and now they don't 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. (HCP04, 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, p. 78). In other worlds, 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, p. 50). So far, nonetheless, the state appears to secure these power differentials with surveillance from above downwards, which immerses 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. (HCP04, psychiatrist)

Trust between them and policy-makers or regulators, nevertheless, 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, p. 1460).

4.3. Institutionalised stigmatisation

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 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. (HCP01, psychiatrist)
>
> (…) but the 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. (HCP04, psychiatrist)

It is a form of institutionalised stigmatisation 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, p. 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 acquiring or 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, midwifes… (*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. (HCP04, 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 practice), others – at the time of writing – continue to be in force. Order No. 404/96, for instance, which 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 three or more years) and recurrent depression. Similarly, the legislation that establishes health requirements to obtain a lawyer license (Order No. 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, that is, 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. (HCP01, psychiatrist)

In Bourdieu's words (1991, p. 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, the *status quo.* If help is sought, such instruments of bureaucratised symbolic power by the state towards its citizens "help to ensure that one class dominates another" (Bourdieu 1991, p. 167). Nonetheless, the better-off can escape this in the private sector and avoid the morass 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. (HCP02, general practitioner)

In other words, it reproduces the social order by impeding the life chances for those who depend on the public healthcare system (Šumskienė, Petružytė and Klimaitė 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 are restricted. 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 you're invalid, you are not able to support your family. Everything is connected. (P07, 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 it. I worried so much that I finally suffered a stroke. I wasn't able to speak at all, even now I sometimes get stuck. (P07, 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, the 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 (for example, 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 1998b, p. 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).

5. CONCLUSION

This 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 organisation 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 the 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, institutionalised stigmatisation or work and other restrictions upon diagnosis of mental disorders inherited from the Soviet Union function 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 bureaucratised 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 1998b, 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-centred 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, p. 166).

The study, however, has several limitations. The retrospective nature of patient interviewing is likely to result in recall bias, that is, 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, p. 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, p. 38). This assumption, however, hides social determinants of distress by individualizing and medicalizing it. Nevertheless, users’ stories and context of their mental health problems are 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 behaviours 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 analysing longer-term processes such as historical policy trajectories and the extent of continuity of practices, that is, 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.

In sum, objective structures of the mental healthcare field – such as organisation of care leading to overreliance on certain treatments – and mental structures in *habitus* – such as stigmatic attitudes towards mental illness (Doblytė 2020a) or a lack of trust in state-provider-user interdependences – seem to fuel each other enforcing the *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 1990b, p. 58) and this appears to remain the case in contemporary Lithuania.

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

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Abstract: After the regime collapse, the former socialist societies in Central and Eastern Europe experienced rapid social and economic transformations. Consequently, mental health deterioration coupled with ambitions to break with the past triggered reforms of mental health systems. Yet, 30 years later, mental health in the region remains poor. Stigma of mental illness may be one of the factors that delays help seeking and, therefore, maintains status quo. Thus, the aim of the article is to better understand the roots of stigma and the process of stigmatisation in one of these countries – Lithuania. Drawing on Norbert Elias's model of established-outsider relations, the article presents the analysis of 23 in-depth interviews with healthcare providers and users of services diagnosed with depression or anxiety disorders. Said analysis reveals how stigma of mental illness might result in damaged self-image and shame of feeling different. Mental illness and healthcare seeking are perceived as a threat to culturally and historically determined self-values, at the core of which seems to be intolerance of difference. The article contributes not only to research concerning mental health in a relatively understudied region of Central and Eastern Europe, but also to existing literature on stigma as embedded in a local context.

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

1. INTRODUCTION

After the regime collapse, the former socialist societies in Central and Eastern Europe experienced rapid social and economic transformations. The adverse effects of said transformations on mental health, along with ambitions to break with the past, triggered reforms of mental health systems (Pūras et al. 2013; Raikhel and Bemme 2016; Skultans 2003; Tomov et al. 2007). As a result, the number of psychiatric hospital beds has substantially decreased, and a range of accessible outpatient mental health services has been developed in many countries of the region. Nonetheless, high rates of alcohol consumption, suicide mortality or assault-related deaths (source: Eurostat Statistics, WHO GISAH Data) signal that, 30 years later, mental health in the region remains depleted. Researchers have shown positive associations between these forms of violence towards oneself or others and levels of mental distress in the population, which often manifests in forms of depression or anxiety disorders (Bellos et al. 2016; Pūras et al. 2013; Rihmer 2007).

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

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

At the same time, scholars (Kleinman and Hall-Clifford 2009; Manago, Pescosolido, and Olafsdottir 2019; Yang et al. 2007) stress the importance of culture in the social construction of stigma. What matters is not only the magnitude and consequences of stigma, which seem to transcend geographical borders, but also its roots, which are embedded in a local context. To explore this, Yang et al. (2007, p. 1528) use the concept of moral experience that "defines what matters most for ordinary men and women". Individuals intend to maintain this moral standing, that is, to meet culturally defined norms and expectations. A label of mental illness might mean "the loss or diminution" of such moral experience (Yang et al. 2007, p. 1530) and, therefore, influence behaviour of both the stigmatised and observers. In other words, a fear of social contact with people with mental health problems or low self-worth of those with mental illness arise from context-specific moral experiences, whose integrity is endangered by a label of mental illness. It has been found to threaten such values and expectations as safety and individual initiative in the USA (Manago, Pescosolido, and Olafsdottir 2019; Yang et al. 2007), work in Germany (Angermeyer et al. 2016), family and fulfilling family-related obligations in China (Yang et al., 2007), Tunisia (Angermeyer et al. 2016) and India (Weiss et al. 2001) or community in Iceland (Manago, Pescosolido, and Olafsdottir 2019).

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

The highest or second-highest rates of suicide mortality, assault-related deaths or alcohol consumption (source: Eurostat Statistics, WHO GISAH Data) seem to indicate poorer mental health in Lithuanian population than in other European countries. Likewise, greater proportion of the population that would find it challenging talking to people with mental health problems in Lithuania (52 per cent) than in any other country in Europe (Eurobarometer 2010) signals very strong public stigma of mental illness that might lead to high self-stigma at the individual level (Evans-Lacko et al. 2012). Lithuania, therefore, can be considered as an ‘extreme’ or ‘critical’ case where structures and generative mechanisms “appear in an almost pure form” (Danermark et al. 2002, p. 104), which facilitates their exploration. The article contributes to the literature about mental health and stigma of mental illness in the former socialist countries that remain understudied (Raikhel and Bemme 2016; Winkler et al. 2016), as well as to the literature on how stigma of mental illness is shaped by local contexts and values (Angermeyer et al. 2016; Kleinman and Hall-Clifford 2009).

2. THEORETICAL LENS

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

In short, one of the main regularities within the figuration is that the established see themselves as superior or ‘better’ individuals with group charisma whereas they attribute inferiority, disgrace and blame to the outsiders and, as such, exclude them “from chances of power and status” (Elias 2008c, p. 224). Unequal power ratio between the groups, which emerges “due purely to differences in the degree of organisation of the human beings concerned” (Elias 2008a, p. 4), is a fundamental explanatory factor in these processes. To maintain their superiority and status, the established employ stigmatising stereotypes, degrading names and blame gossip about the entire outsider group, which are "modelled on observations of its worst section" (Loyal 2011, p. 198) or "its anomic minority" (Elias 2008a, p. 5). Gossip can be a particularly effective weapon to praise the established and to blame the outsiders (Elias and Scotson 2008) used within communities and at other social levels, for example, in media or state discourses (Elias 2009d; Loyal 2011).

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

3. MATERIALS AND METHODS

To understand the nature of stigma as lived experience and how it might impede help-seeking processes in mental distress, the data have been collected employing semi-structured in-depth interviews with relevant healthcare providers and individuals who suffer from depression or anxiety disorders and have subsequently sought healthcare. The participants have been recruited from three mental health centres, two health centres/polyclinics and a psychiatric hospital that provides both inpatient and outpatient services (max. three providers or users per facility). Several additional participants (mostly, users of services) have been identified through author's professional or personal networks and using a snowballing or chain referral, which has been very helpful due to the stigmatising nature of the topic (Robinson 2014). The study information sheet has been used as a recruitment aid and sent via e-mail, explained over the telephone or handed in person. Prior to the interview, the participants have provided informed consent which, along with other documents and procedures, was approved by the author's regional research ethics committee. Given the sensitivity of the topic and possible anonymity concerns, as well as for logistic reasons, telephone and face-to-face interviews have been used although prioritising face-to-face encounters when possible.

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

The interviews were transcribed and analysed in Lithuanian with a support of MaxQDA software and using the method of reflexive thematic analysis (Braun and Clarke, 2006; Nowell et al. 2017). After familiarisation with the data, I have developed a codebook guided by the transcripts, the theoretical framework, and literature review. It has then been used to code the interviews, while allowing new codes to emerge. This has been followed by clustering the codes into potential subthemes and themes, and then reviewing, defining and revising the themes. The process, however, has been iterative (rather than lineal) moving back and forth between the phases of analysis and initiated while still sampling and collecting data, which has allowed for assessment of saturation. Code saturation has been reached with the completion of approximately half of the interviews, with very few new codes being developed after that. Yet, Hennink, Kaiser, and Marconi (2017, p. 594) argue that code saturation might be insufficient to "fully understand issues" and suggest also considering meaning saturation "when no further dimensions, nuances, or insights of issues can be found". Few new dimensions of codes have been emerging towards the final informants, which signals that relatively high levels of meaning exhaustion have been also achieved, albeit new data could have provided new meanings.

4. FINDINGS

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

4.1. Stigma of mental illness in a post-Soviet context

4.1.1. Stigma

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

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

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

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

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

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

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

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

4.1.2. Historical context

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

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

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

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

Thus, stigma of mental illness and psychiatry seems to be embedded in past practices. They took place relatively recently and resulted in "longstanding and profound" delegitimisation of psychiatry in the region (Raikhel and Bemme 2016, p. 159) to the degree that, even today, mental health services are often perceived as a last resort, and avoided by both users of services and other healthcare providers.

4.2. Gossip and labels as means of stigmatisation

4.2.1. Gossip

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

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

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

In other words, stigmatisation is experienced and reproduced through means such as blame-gossip, whose vehicle can be face-to-face encounters between people as well as media channels, with the difference being "more one of degree than one of kind" (Elias 2009d, p. 75). Gossip can also drive towards "the emotional barrier against closer contact with the outsiders" (Elias 2008a, p. 8) due to a fear of being associated with them:

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

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

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

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

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

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

4.2.2. Labels

Stigmatising names and labels attached to an outsider group is another weapon of stigmatisation. One of the labels that constantly replays in nearly all of the interviews is the word ‘*durnas*’ (dumb, stupid, out of one’s mind) and other words derived from it, for example, ‘*durnynas*’ (used pejoratively for a psychiatric hospital). Its meaning differs substantially from ‘being crazy’ in the English language, where one can be out of one’s mind but also crazily in love with someone or very enthusiastic about something, both of which imply positive meanings. ‘*Durnas’* can be used with diminutive suffixes to show some degree of compassion towards the disgraced, but there are always pejorative connotations that imply exclusion and uneven power ratios.

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

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

4.3. Shame and self-values

4.3.1. Shame and shaming

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

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

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

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

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

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

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

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

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

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

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

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

4.3.2. Self-values

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

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

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

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

Mental illness and mental healthcare seeking, therefore, are a direct threat to the sameness and even "markers of social failure" (Skultans 2007, p. 29), which "become inseparable from feelings of overwhelming shame, humiliation and despair" (Yang et al. 2007, p. 1532). These feelings of failure, inadequacy or a fear of rejection can be observed in nearly all the interviews with the users. Shame is one of the most powerful emotions of social control, "because people will monitor and sanction self in interactions" (Turner 2010, p. 182). Anticipation of shame also functions as a mechanism of social control and impedes or delays healthcare seeking, leading to various (and often destructive) strategies of coping with mental distress and, as such, avoiding stigma.

4.4. Avoiding stigma

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

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

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

4.4.1. Somatisation, self-medicalisation and alcohol abuse

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

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

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

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

4.4.2. The role of gender

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

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

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

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

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

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

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

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

Yet, all of them substantially delayed help seeking and reported access to mental healthcare through emergency departments and even suicide attempts. For men, help seeking in the treatment system usually becomes the final and often coerced rather than voluntary step, once the suffering threshold has been met (Doblytė and Jiménez-Mejías 2017) and alternative often self-destructive but perceived as masculine coping strategies (Tereškinas 2010) have been proved to be ineffective. Therefore, men, and particularly middle-aged men, whose practices of help seeking seem to remain guided by stigmatic attitudes incorporated under the Soviet rule, might find themselves in unique social situations marked by shame, guilt, and powerlessness due to their age, gender and often class (Tereškinas 2010). A decline of opportunities promised by regained independence for many men meant a loss in power as well as “discrepancy between the actual and the imagined position”, which pushes them “in pursuit of a fantasy image of one’s own greatness” (Elias 2008a, p. 28) that may result in violence towards oneself or others. In other words, hidden shame might be expressed as anger (Goudsblom 2016):

> I had a car accident, I was in a hospital for a long time […] and then, that fall, there was a suicide attempt. (P04, male user, 51-65)
>
> I will tell you frankly, I used violence against my pregnant girlfriend, yes, there was violence. (P10, male user, 35-50)

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

5. DISCUSSION

In this article, mental healthcare seeking is situated within an established-outsider figuration to better understand how it might be shaped (i.e., delayed) by stigma of mental illness. The established (non-users), who “think of themselves in human terms as *better* than the others” (Elias 2008a, p. 1), secure their status, power and behavioural standards using the tools of gossip, stigmatising beliefs or degrading code words (e.g., *durnas*) (Elias 2008a). As a result, a shift to the outsider groups (users) leads to damaged self-image and shame that were present in the interviews with nearly all the users and notwithstanding their power resources or reported beliefs about mental illness. Likewise, they might inculcate and feel this inferiority without actual stigmatisation taking place, for “though innocent of the accusations or reproaches, they cannot discard, not even in their own mind, the identification with the stigmatised group” (Elias and Scotson 2008, p. 133). Anticipation of shame may push individuals to employ coping behaviours that avoid stigma but that are often destructive and ineffective in the long term.

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

The article, therefore, contributes not only to research concerning mental health in the region of Central and Eastern Europe, which continues to be limited, but also to existing literature on stigma as embedded in a local context. It adds an empirical case from non-Western countries, which remain underrepresented (Angermeyer et al. 2016). Furthermore, the article provides a possible explanation as to why, despite numerous and internationally evidenced health education campaigns, stigma of mental illness and healthcare remains steadfast, even after 30 years of the regime collapse. Effective programmes that reduce stigma should focus on "the cultural underpinnings of stigma" (Weiss et al. 2001, p. 85) or, to put it differently, on its generative mechanism. It, therefore, must address general intolerance of difference, which might be seen as the heritage of the Soviet rule when difference was punished and "self-control and self-reliance" (Skultans 2003, p. 2422) endorsed, and which seems to have been reinforced under capitalism.

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

While qualitative interviewing has been chosen due to its capacity to explore subjective interpretations or experiences and, consequently, to better understand healthcare seeking in mental distress, it has several limitations. First, recall bias due to the retrospective nature of patient interviewing – that is, their discourses might be influenced by how they remember and legitimate their pathways to care – should be taken into consideration. Second, self-selection bias is inevitable due to voluntary participation in interview-based research (Robinson 2014). The interviewed users are likely to embody less self-stigma or stigmatic attitudes towards mental illness than ones who were not willing to participate. Third, a substantially larger number of the participants has been located in big cities than in villages and towns, which may have resulted in not capturing certain nuances of stigmatisation. Yet, these limitations suggest underestimation of stigma and its effects on healthcare seeking rather than the reverse.

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

Despite the discussed limitations, it could be concluded that change and stability interact in a post-socialist society. Although laws and regulations reformed after regaining independence guarantee access to specialists and modern outpatient treatments, stigmatic attitudes towards mental illness, which remain prevalent even after 30 years of the regime collapse and which are shaped by the images of Soviet psychiatry, delay healthcare seeking in mental distress. While stigma of mental illness may transcend geographical borders, its generative mechanism – in particular, self-values focused on behavioural and normative similarity to others, which is threatened by the process of healthcare seeking – seems to be an outcome of civilising processes that are culturally or historically embedded in the analysed region “in conjunction with the peculiarities of their social fates” (Elias 2008b, p. 5).

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

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

Keywords: healthcare seeking, common mental disorders, medicalisation, health system, Pierre Bourdieu, qualitative methods, interviews, thematic analysis, Spain, Europe

1. INTRODUCTION

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

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

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

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

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

2. THEORETICAL CONCEPTS

The concept of medicalisation of society has been in the academic discourse since at least the early 1970s – the time at which scholars started discussing concepts such as healthism (Crawford 1980), medicalisation of deviance (Conrad 1975) and how “medicine and the labels ‘healthy’ and ‘ill’” were becoming “relevant to an ever-increasing part of human existence" (Zola 1972, p. 487). In mental health, it might be understood as a process by which behaviours and feelings "that are expectable responses to stressful circumstances" (Horwitz 2007, p. 214) are managed with medical interventions or "become defined and treated as medical problems" (Conrad 2007, p. 4). Medicalisation, therefore, refers to the expansion of medical power or jurisdiction in a society (Williams and Calnan 1996). Although the dangers of medicalisation are considered more frequently than its benefits, it should be treated as a value-neutral term that "may include both gains and losses to society" (Williams, Martin, and Gabe 2011, p. 711).

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

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

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

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

3. METHODS AND MATERIALS

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

3.1. Procedure

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

3.2. Participants

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

3.3. Analysis

The transcribed interviews were analysed in Spanish with the support of software for management of qualitative data – MaxQDA. The method of reflexive thematic analysis was used (Braun and Clarke 2006; Nowell et al. 2017). After familiarisation with the data by means of transcribing, reading and re-reading the transcripts, the system of tentative codes guided by the theoretical framework, research-relevant literature and the data themselves was produced and then used to code the interviews whilst allowing for the emergence of new codes. In other words, thematic analysis was both researcher (theoretical) and data (inductive) driven (Braun and Clarke 2006). The subsequent phases included clustering codes into potential sub-themes and broader themes (patterns of meaning) as well as, finally, reviewing, defining and further refining themes. The process, nonetheless, was recursive moving back and forth between the phases rather than lineal.

4. FINDINGS

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

> I believe that it would be difficult to make it [*access*] easier. (…). I just do not think that we need to improve this. (HCP09, clinical psychologist)

While this is in line with a low proportion of unmet medical needs in Spain (Doblytė and Guillén 2020; OECD/EU 2018; Petmesidou, Guillén, and Pavolini 2019), the analysis of qualitative data reveals the logic of the field and the role of other fields that go beyond accessibility *per se* and that could explain certain logic of practice and outcomes for individuals and society, all of which are presented in the following sections. It is argued that being able to meet with a healthcare provider of any type without major barriers may not necessarily mean that individuals receive appropriate care or that those in need access it. The findings are organised in five main themes: first, the logic of the field of mental healthcare; second, the perceived role of other fields in maintaining the logic of the mental healthcare field; third, healthcare-seeking practices and differences between mild and severe mental distress; fourth, possible consequences of medicalisation for the field and individuals; and, finally, points of resistance and how agency might be enacted.

4.1. The logic of the field

4.1.1. Adequacy of care

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

> It is so comfortable for so many people that we end up overusing an instrument, which undoubtedly has enormous utility in a lot of situations, but often we are left only with it, we are left only with medications. (HCP05, psychiatrist)

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

> The problem we have with the recommendation of psychological treatments is that there are very few psychologists and a lot of people in need. (HCP04, general practitioner)

> I would say that the effectiveness of seeing people every two months is very little or none. (HCP11, clinical psychologist)

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

> The only care I have received has been medications, I have never had a consultation with a psychologist. (P01, male user, 36-50)
>
> The doctor always approached it with the medical treatment as if it was the flu – medicines and nothing else. (P04, female user, 36-50)

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

4.1.2. The dominance of biomedical discourse

Many of healthcare providers explain the limited access to and adequacy of psychological therapies as an issue of cost or resource control, because of which "there is no other option as to have either one or the other treatment" (HCP01, psychiatrist). Yet, certain treatments become the first choice more often than others. This might suggest the role of certain medical hierarchy or the structure of dominant and dominated positions where biomedical rules of the game prevail:

> The general practitioners have a medicalised vision. Then, I am working with someone from a psychological point of view and, if not in agreement with my work, the doctor convinces the patient that it is better to make an appointment with a psychiatrist. That happens a lot. (HCP11, clinical psychologist)

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

> Since SSRIs, [*the issues*] we have at this level we have been solving practically everything with them. (HCP07, general practitioner)

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

> [*My general practitioner*] prescribed anxiolytics and antidepressants. I said to her that, look, at the moment if I see that I am feeling well with these, I don't see any need to go to a psychiatrist or others. (P03, male user, 18-35)

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

To sum up, the analysis suggests that healthcare can be generally accessed without significant structural barriers. Some treatments, however, are less accessible and adequate than others. Available care appears to be highly dependent on psychopharmacotherapies, which seems to be the case both in Spain (Martín García-Sancho et al. 2018) and other countries (Rose 2019). Although clinical trials evidence superiority of psychopharmacotherapy over placebo in treatment of common mental disorders (Arroll et al. 2009; Bighelli et al. 2018), there are growing indications of its limited therapeutic capacities, particularly when its long-term risks and withdrawal effects are considered (Gøtzsche 2013; Kirsch 2014; Rose 2019). Effective non-pharmaceutical therapies (Abbass et al. 2014; Hunot et al. 2007) could supplement or even replace medications. Yet, while *de jure* available, psychological services in the public treatment system are not necessarily accessible or adequate, due to lesser amenability to the logic of the field (Horwitz 2007). Several healthcare providers explain it as an issue of cost control. Increasing antidepressant consumption and reliance on these therapies, however, suggest the dominance of biomedical model and psychiatric capital.

4.2. The role of other fields

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

4.2.1. The market

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

> I think that [*mental distress*] is medicalised so much because there is an industry that puts on a lot of pressure. (HCP05, psychiatrist)

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

> Every single day pharmaceutical company representatives come to this mental health centre and spend the entire morning waiting to talk to all the psychiatrists (…). And then we have what is called the phenomenon of variable prescription. (HCP09, clinical psychologist)

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

4.2.2. The state

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

> Psychotherapy is much more expensive than the medication and we, the majority of us, try to be co-responsible for the resources we have. (HCP07, general practitioner)

Their *habitus* that is attuned to the logic of the field of mental healthcare, therefore, is "what enables the institution to attain full realisation" and reproduction (Bourdieu 1990b, p. 57). At the same time, it guarantees that their accumulated cultural capital (i.e., biomedical) remains dominant in the field. Some of the clinical psychologists, on the other hand, experience more conflictual relations that may result from their dominated position in the field due to the limited biomedical cultural capital:

> It is a lost battle (…) as much as the clinical psychologists of the national health system have requested an improvement of their conditions, their request has never been considered. (…) My feeling is that those who are in power are not interested that psychotherapeutic services would be provided in reasonable conditions. (HCP11, clinical psychologist)

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

> [A]ll this process [*of workplace adaptation*] that I had with the inspector of social security. (…) The inspector said that if the psychologist did the report, they would not give me the workplace adaptation. (P05, female user, 36-50)

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

4.2.3. The journalistic field

Finally, media might also reproduce the logic of the mental healthcare field through messages that help individuals accumulate certain types of cultural capital in objectified (goods such as medical technologies) and embodied forms (information and knowledge). On the one hand, the mass media channels might retranslate the taken-for-granted vision of dominant biomedical principles of mental healthcare (Williams, Martin, and Gabe 2011) and even reinforce them:

> One of the things that led us to this [*overreliance on psychopharmaceuticals*] is television, TV health shows, health promotion – everything that initially seemed to be something positive. (HCP05, psychiatrist)

> It is also a clear ideological question where the medical model is maintained through practices of doctors, pharmaceutical industry and the mass media that insists non-stop. (HCP09, clinical psychologist)

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

> I think that there is much more [*information*]. They talk much more, they write much more. (P04, female user, 36-50)
>
> It is very accepted, because look (…) they talk so much about depression and anxiety on TV. They talk that they are very common problems. (HCP06, general practitioner)

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

> It should be really seen as an epidemic. (P03, male user, 18-35)
>
> Stress is a new epidemic or pandemic. (P06, female user, 18-35)

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

4.3. Medicalisation of mental distress

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

> The one who is depressed – but who actually is not – because he lost his job, because his wife left him or because he had a car accident, this one will come and will talk about it (…). The one who initially has a good relational and

> socioeconomic situation and who suddenly has a depressive disorder, of course, feels guilty. (HCP07, general practitioner)

In other words, mild mental distress is normalised and even standardised. Yet, not all emotions and behaviours seem to be equally destigmatised. External factors behind distress imply its temporality, treatability, and guiltlessness as compared to a genetic, personality, or brain defect or disorder (Horwitz 2007). It is likely to produce differences not only in stigma but also in healthcare-seeking practices, which has been stressed by all the healthcare providers in the study:

> Some people come a week after losing a job and not finding a new one, or after three days in mourning. (…) then, although there are very few cases of severe depression, those indeed tend to come late. (HCP07, general practitioner)

Thus, while severe mental illness remains undertreated, these processes may lead to medicalisation of social problems as an unplanned consequence. Through dramatisation and failure to consider over-diagnosis, "media involvement, witting or unwitting, facilitates processes of pharmaceuticalisation" (Williams, Martin, and Gabe 2011, p. 715) and, more generally, of medicalisation (Halfmann 2012).

4.3.1. The role of healthcare providers

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

> I recognise that I finally end up treating those who I do not refer [*to specialised care*] but who should not have come here at all. You end up treating them with SSRIs because it improves compliance and helps them cope better with the problem. (HCP07, general practitioner)

General practitioners are the principal gatekeepers of medicalisation in the Spanish National Health System. The narratives of the participants as well as findings by other scholars (Ortiz-Lobo et al. 2011) suggest high levels of pharmaceuticalisation in the primary care and high referral rates of these patients to the specialised care, resulting from objective (time constraints) and inculcated structures (pharmaceuticals as an adequate response to health problems):

> It would be adequate and normal that they do not refer to a psychiatrist because of grief. It is not that you need to medicalise all the human suffering. (HCP02, psychiatrist)

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

4.3.2. The users as consumers

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

> Since for this – feeling depressed, a bit unwell, having a discomfort in one’s life – it is easy to take anxiolytics and to feel relieved, there are a lot of people who want it (…). People demand it. (HCP04, general practitioner)

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

> As soon as a problem comes up that causes stress at work or out of work, they demand medications (…) for example, my parents… My mother, my sister – all of them – are taking medications. It's more common to see a box of *Tranquimazin* than a box of *Aspirine* at home. (P10, male user, 36-50)

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

> Since I decided to quit my job, I am better, I feel much better. I think that work influenced a lot. At least, stress, tachycardia and sleeplessness were because of work. (P09, female user, 18-35)

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

To sum up, while severe mental disorders remain stigmatised and undertreated, the healthcare field expands its jurisdiction to life situations and emotions that "are unpleasant but normal" (Horwitz 2007, p. 217) such as losing a job, experiencing a divorce or grief. Given the taken-for-granted or doxa that dominates in the field, biological solutions to these social problems are usually offered and, paradoxically, "more and more people are taking drugs whose mode of action is unclear and whose efficacy is debatable" (Rose 2019, p. 129). Such medicalisation of mild and common mental distress results in certain consequences and impacts the functioning of the institution. At the same time, as any other process, it is bidirectional (Conrad 2007) and space for resistance or negotiation can be found.

4.4. Consequences of medicalisation

4.4.1. Individualisation of the social and chronification

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

> We have three or four supermarket checkers from (name) on sick leave (…), perhaps it should be better analysed in what work conditions they work and it would save a lot of suffering and a lot of consultations that are probably not useful. (HCP09, clinical psychologist)

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

> In the end, chronification is the only thing we are left with, because we don't solve the problem and, even worse, we are going to generate the problem of having someone with dependence on medications. (…) So, it is a malpractice and, in the end, we make people chronic and sick that were not sick initially. (HCP05, psychiatrist)

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

> [*My general practitioner*] simply prescribes medications. (…) She doesn't look at my medical history to see how long I have been on medications and

> perhaps I should try another type of treatment, change the medication (…). No, nothing. (P04, female user, 36-50)

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

4.4.2. Consequences for the field of mental healthcare

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

> People enter in a vicious circle where they can no longer stop taking their medications (…) and, from the point of view of the system, that is disastrous. (HCP09, clinical psychologist)

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

> Every time we have more demand for treatment. (…) Our schedules have multiplied, although the population is the same. What happens is that there are lots of problems that were unthinkable to intend to solve through the health system a few years ago. (HCP05, psychiatrist)

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

> I think that people mostly worry about empathy, whether they are going to treat me well. (…) If not, they will delay seeking help. (HCP09, clinical psychologist)

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

> If I go to a doctor, I do what they say; to the letter, because they are professionals and I do not doubt it. (P05, female user, 36-50)

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

> I see it as a system of (…) 'yes, the next one'. In other words, I arrive, explain and am told – yes, the next one. And it has been like this during the years. (…) They try with this or that medication, but they do not care about your problem. (P10, male user, 36-50)

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

> We are not numbers, I don’t see that they treat us as humans (…) more humane, they should be more humane. (P08, female user, 51-65)

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

> My experience is not to trust them. So yes, you are afraid to go to the doctor and to say that you feel sorrow. (P02, female user, 51-65)
>
> Many times, when feeling unwell, I would go to the emergency room in order not to go to her [*general practitioner*]. (P08, female user, 51-65)

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

4.5. Points of resistance

Both healthcare providers and users of services, however, do not necessarily accept medicalisation and its consequences passively and uncritically. Ballard and Elston (2005), Conrad (2007) or Williams and Calnan (1996) suggest possibilities of de-medicalisation processes and scepticism towards the healthcare field. There is always some space for resistance or agency through *habitus* and its "infinite yet strictly limited generative capacity" (Bourdieu 1990b, p. 55). Notwithstanding their mental structures or dispositions being *a priori* adjusted to the objective structures of the field, healthcare providers might intend to avoid medicalisation, in general, and pharmaceuticalisation, in particular:

> I try to normalise but never take away the importance. I always say that it is very important what has happened to you (...) but that it is not necessary to medicalise something that is normal. (HCP10, general practitioner)

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

> I don't agree with those psychological interventions like when your father dies and that same day a psychologist sees you. I think that first you have to find your own personal resources. (HCP02, psychiatrist)

This doubt and scepticism towards medicalisation and medical doxa are further developed by the users of services that are not necessarily "passive consumers who are duped by medical ideology" (Williams and Calnan 1996, p. 1613). Their negotiations with providers not to be medicalised with psychopharmaceuticals in a clinical encounter illustrate such agency:

> I told them that I don't want medications, first I want to be treated by a specialist. (P10, male user, 36-50)

Others resist medicalisation by not adhering or abandoning treatments:

> I stopped [*antidepressants*] on my own, I looked at the information pamphlet and knew what I had to do. (P02, female user, 51-65)

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

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

5. CONCLUSIONS

The findings of this study go beyond accessibility of healthcare, which proves to be relatively high, and reveal how the logic of the field of mental healthcare with its dominant and dominated positions results in increasing reliance on biological therapies and a lack of access to adequate non-pharmaceutical ones. The analysis also explores how the interplay between the pharmaceutical industry, which accumulates economic capital and dominant scientific expertise, the political-bureaucratic field as “organisational structure and regulator of practices” (Bourdieu 1998b, p. 54) and the journalistic field with accumulated informational capital might help to preserve the logic or doxa of the field.

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

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

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

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

To conclude, the aim of this study has been to better understand help-seeking practices in mental distress and how the institutional context of the health system might shape such practices. It outlines one of possible generative mechanisms, as well as evidencing possible outcomes and resistance pathways. The findings could go beyond the Spanish context and are likely to indicate more general trends of medicalisation of emotionality that is driven by multiple agents and fields as well as the role of agency in it. Yet, there might be other explanations, agents, consequences, or points of resistance that the analysis has not captured. The self-selection bias should also be taken into consideration. The healthcare providers and users of services who were willing to participate in the study might have been more reflective and critical towards the mental health system and/or have had more negative experiences within it. Voluntary participation in qualitative interviews, nonetheless, is "central to ethical good practice" (Robinson 2014, p. 36) and to the reliability of information provided by the participants.

Finally, the question of how and which factors of the social field as a whole drive to everyday life "being colonised by pharmaceutical solutions" (Williams, Martin, and Gabe

2011, p. 722), in general, and to the analysed help-seeking practices, in particular, falls beyond the scope of this article. This suggests, nevertheless, future research directions that engage with the analysis of “how the populace has internalised medical and therapeutic perspectives as a taken-for-granted subjectivity” (Conrad 2007, p. 14) and that could include an in-depth analysis of media discourse or of narratives of other agents in the game, for example, policy-makers. Research in other countries or with larger samples could also complement the findings of this study.

V. “Women are tired and men are in pain”: Gendered *habitus* and mental healthcare utilisation in Spain

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

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

1. INTRODUCTION

It is frequently concluded that women have poorer health, in general, and more often suffer mental health problems, in particular. They report suffering from chronic depression, as well as consulting medical professionals and mental health specialists, substantially more often than men (source: Eurostat). At the same time, however, not only do men live shorter lives, but they also die by suicide nearly four times more often than women, lose their lives in transport accidents three times more often than women do (source: Eurostat). This later feature might result, at least partially, from reckless driving as a means of stress release (Dolan 2011). Men also engage in other risk behaviours such as heavy alcohol consumption and they do this more frequently than women do (source: Eurostat). All of this may signal that, like women, men suffer from mental distress, but that they are less likely or willing to recognise it and consequently to seek healthcare (Addis and Mahalik 2003; Doblytė and Jiménez-Mejías 2017; Galdas, Cheater, and Marshall 2005; Pattyn, Verhaeghe, and Bracke 2015). In other words, there is not necessarily a difference in need but rather a difference in help-seeking practices between genders.

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

This article, therefore, contributes to the literature addressing the interplay between gender and health behaviours. The aim of the article is to examine how gender might be enacted in the field of mental healthcare, and facilitate or constrain healthcare seeking and utilisation where a person suffers mental distress. To achieve this, I analyse in-depth interviews with healthcare providers and users of services with depression or anxiety in Spain. The weight of traditional gender and family values in Southern Europe is often stressed, particularly in light of familistic public policies, such as limited care services that, in turn, may reproduce the roles of women as carers and men as breadwinners (Moreno Mínguez 2010), as well as considering the gender care gap, which is found to be large in this region (Da Roit, Hoogenboom, and Weicht 2015). Likewise, the stereotypes such as women being more vulnerable and men being 'tough', risk-loving and athletic remain prevalent in the culture (García-Calvente et al. 2012).

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

2. THEORETICAL LENS

This research is informed by critical realism (Bhaskar 2016; Danermark et al. 2002; Fletcher 2017) that emerges as an alternative to both positivism and strong constructivism. Reality, whose part the social phenomenon under research forms, is viewed as an open, emergent, stratified and differentiated system, "in which events are determined by a multiplicity of mechanisms" (Bhaskar 2016, p. 80). Social research is interested in uncovering some of these deep generative mechanisms based on collected evidence and available theoretical knowledge that is always fallible. In other words, reality exists independently from human knowledge, theories and concepts (it is not exhausted or determined by them), but it is known and explored through them (it is theory-laden). Theories and theoretical concepts provide us with an interpretive framework to go from observable events or experiences within the empirical domain to the possible mechanisms that produce those events.

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

The relational dimension of gender can be further explored through Pierre Bourdieu's sociology (1990b, 2001) and his conceptual triad of field, capital, and *habitus*. Although Bourdieu focused more on social class and its reproduction, he also devoted substantial attention to gender and, particularly, to masculine domination (Bourdieu 2001). Cockerham (2018), Dixon-Woods et al. (2006) or Robinson and Robertson (2014) demonstrate the potentiality of his theoretical approach in the analysis of gender and health behaviours, specifically. The interplay between the field as a dynamic structure of power positions, where agents with differential capital resources (economic, cultural or social) aim to maintain or transform their positions, and *habitus* as personality structures or "systems of durable, transposable dispositions" (Bourdieu 1990b, p. 53) that organise one's practices allows for "conceptualisation of differentiation within the construction of gender identity" (McNay 1999, p. 96).

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

Thus, healthcare-seeking delay may be understood not as the result of masculinity norms themselves, but as the result of these oppositions in social and mental structures and, consequently, men's pre-reflexive self-protection from potential user-provider relations and their position in them, that is, being dominated in the healthcare field, which is feminine *per se,* but which is further organised according to the male/female oppositions (Bourdieu 2001). The aim of the article, therefore, is to explain how the dominant-dominated relations and the fundamental male/female opposition in the social field as a whole (as embedded in social and mental structures) might be enacted in the healthcare field.

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

3. MATERIALS AND METHODS

3.1. Procedure

The article focuses on understanding individual experiences or perceptions and interpreting how gendered *habitus* as one of the possible generative mechanisms might shape them. In other words, the "primary focus is on *structures* and *mechanisms*, not regularities or patterns of *events*" (Bhaskar, 2016, p. 79; emphasis original). To achieve this, the intensive or qualitative approach – specifically, semi-structured in-depth interviews – is employed. The study protocol has been approved by the Research Ethics Committee in a medium-sized region in the North of Spain. Prior to interviewing, the interview procedures and ethical matters were explained to the participants, who then provided informed consent. The overall focus of the empirical study was not gender, in particular, but rather healthcare seeking, in general, and how it is embedded in social, cultural, and institutional contexts. The participants, therefore, were not asked to think about gender and health beforehand, but were prompted spontaneously or it emerged when discussing other topics.

3.2. Participants

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

In addition, interviews were conducted with 10 working-age adults with depression or anxiety disorders. These varied in ages (four participants younger than 36, four between 36 and 50, and two older than 50) and in educational levels (two participants with secondary education or below, four with vocational training, and four with university degree or postgraduate). It was substantially easier to identify and recruit women than men, which is in accord with expectations – particularly, given the high gender gap in treatment for common mental disorders in Spain (Van de Velde et al. 2019). As a result, seven women and three men took part in this component of the study. While it was a relatively small sample from each group, Robinson (2014, p. 29) has argued that this is sufficient for research with an idiographic aim and recommended precisely three to 16 individuals “for an intensive analysis of each case to be conducted”.

3.3. Analysis

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

4. RESULTS

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

4.1. The male/female oppositions

4.1.1. Provider vs. carer

Despite increasing female participation in the labour market, the participants – particularly, healthcare providers – explain the gender gap in mental health fundamentally as the result of distinct drivers of distress that are objectified in social structures as an opposition between the social roles or as the gendered division of labour. Women are perceived as carers – including caring for family health and well-being – and, therefore, as being more burdened by care responsibilities along with their work commitments, if any. This results in a negative impact on health and in women’s overrepresentation in common mental disorders. The female users of services spoke about their carer role as a factor explaining their distress or non-adherence to a medication regime:

> I think that, since we [‘*nosotras’ – we feminine*] take on more responsibilities in life, we are always going to have more problems or more chances to have depression than they [*‘ellos’ – they masculine*]. (P04, female user, 36-50)

> The medications were very strong, I couldn't take care of my daughter. (P02, female user, 51-65)

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

> If men come, they mostly come not because of the problems with children or family, but because of work problems, always. (HCP08, general practitioner)

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

> Showing negative feelings and vulnerability is more acceptable for women. There are many men who do not tolerate it. (…) It is harder for them to accept that someone knows more and put themselves in a position where they are helped, weak or however you want to name it. (HCP09, clinical psychologist)

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

> There are some stereotypes of masculinity that everyone wants to meet, they are compulsory if you want to be respected by the rest. (…) Even so, of course, if something has saved me from my anxiety decaying into a depressive state all this time, it is this pride and self-esteem. (P01, male user, 36-50)

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

4.1.2. Physical vs. mental healthcare

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

> In common mental disorders, men are very often referred here with osteoarticular pains and problems. (HCP01, psychiatrist)
>
> My first reaction was denial. I cannot have this, it must be another disease that they didn’t detect and that makes me feel accelerated. (P01, male user, 36-50)

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

4.1.3. Psychiatry vs. psychology

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

> For me, it is not frightening to put something into the body and even less so if it is scientifically tested. (P03, male user, 18-35)
>
> I don't trust psychology, I think it is a science on the grounds of statistics only. (P01, male user, 36-50)

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

> It was a psychologist, not a psychiatrist, because I don't like to take medications (…). I think that you can find other solutions for depression. You might need medications, but first you better try other options. (P07, female user, 18-35)

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

> They [*ellos – they masculine*] don't feel unwell, they come with a pain – that is, I need this because it hurts. I need an X-ray because my knee hurts. (…) We can say that women are tired and men are in pain – pain of whatever you want but it's pain. (HCP08, general practitioner)

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

> What you have is a physical pain, which does not let you think, does not let you act rationally. (P03, male user, 18-35)

> I hardly ever went out because I was so tired that all I wanted was to get home and sleep and it's over. (P06, female user, 18-35)

To sum up, Bourdieu (2001, p. 104-105) argues that the logic of fields and practices are organised according to different oppositions, which "always stand in a relation of homology with the fundamental distinction between male and female" and which are "accompanied by the inscription in the body of a series of sexually characterised oppositions", that is, they are embedded in gendered *habitus*. Table 5 summarises the oppositions that emerge in this research.

Table 5. The male/female oppositions in social and mental structures.

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

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

4.2. Gendered habitus and health practices

4.2.1. The gap in help seeking

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

> Although it has improved a lot – but not as much as people think – men turn to alcohol to escape from anxiety and depression. (HCP07, general practitioner)

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

> [I]t is a matter of intimacy: I don't want to share this problem, its origin and consequences with others, neither strangers nor acquaintances. (P01, male user, 36-50)
>
> My brother consulted a psychologist for a while, but not until I said at home 'I'm not feeling well, I want to see a psychologist' did he tell me he had done it, you know. My brother hid it from the family. (P07, female user, 18-35)

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

> [S]aying ‘my husband is depressed’ – that doesn’t happen. Evidently, even a wife herself would not want to say that her husband is depressed. (…) Men do not classify themselves, they can be stressed, have anxiety, be sad, but they never talk about it or say that they are depressed. (P02, female user, 51-65)

Being dominated in the structures of different fields and with dominated dispositions inculcated in their *habitus*, women, on the other hand, do not experience these conflicts either in the social field as a whole or in the healthcare field. Their *habitus* might be seen as pre-adapted to asking for help, which, therefore, does not endanger their femininity:

> For example, my son – he might need help himself, but no, ‘I solve it myself’. (…) A mum yes, but I am fine, I am solving it myself. I think that men do not dare to go to a psychologist or a psychiatrist. These are women's things. (P08, female user, 51-65)

> There are lots of us [*feminine*] and we open up. There is a sort of market, I would say, it’s natural and you can have conversations in any place. (P02, female user, 51-65)

4.2.2. The legitimate vs. trivial help seeking

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

> I think that a male is more reluctant to seek help. Above all, when things are not serious (...) At milder levels, a female expresses more complaints and demands more. (HCP01, psychiatrist)

> [*My mother and sister*] take medications, but they don't take them because they are sick, they take them because it calms them (…) because they are stressed (…) But I have an illness and I accept my illness. (P10, male user, 36-50)

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

> The studies show that men are referred [*to specialised mental healthcare services*] earlier than women, because women are complainers (*laughs*). So, when a man expresses emotional discomfort, he must feel awful and it is true that they are referred sooner and arrive less serious, at least in common mental disorders. (HCP03, clinical psychologist)

Since psychopharmacotherapy "takes considerably less practitioner time than alternatives such as psychotherapy" (Horwitz 2007, p. 218), these inclinations to retain women longer than men in primary care may lead to women's higher pharmaceuticalisation and, consequently, chronification and dependence on the healthcare field and its services:

> Women are overburdened and it has often been solved with medications: tranquilisers, anxiolytics. They are very effective because we feel much better right away (…). But it is very easy to turn to them again and again, and it becomes chronic (…) Lots of women take anxiolytics and they are prescribed by doctors, by ourselves, in specialised or primary care. (HCP05, psychiatrist)

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

4.2.3. Agency

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

> (*Interviewer: have you ever asked for a referral to a psychiatrist or a psychologist?*) No, to be honest, never. (P04, female user, 36-50)
>
> I think I needed more than what they gave me. I felt that I left empty, with a medication and an appointment within 6 months. That was not my intention, I really wanted help. (P08, female user, 51-65)

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

> I went [*to a general practitioner*] and he told me that it was a stress problem and gave me medication (…) and referred me to a psychologist. But I told him that I didn't need a psychologist, that the problem I had was an anxiety disorder, and that I needed a psychiatrist and another type of medications. He rejected that and referred me to a psychologist. I did not go, I directly refused and then, yes, he sent me to a psychiatrist. (P10, male user, 36-50)

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

> [*My general practitioner*] prescribed me anxiolytics and antidepressants. I told her that, look, at the moment if I see that I am feeling well with these, I don’t see any need to go to a psychiatrist and so on. (P03, male user, 18-35)

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

> When I realised that I was unwell, I did not seek help in the public health centre because of my past experiences. I mean, I didn't even consider it. (…) So, I tried one [*psychologist in the private sector*], but it didn’t work. (…) Then, I kept searching and found another one. (P07, female user, 18-35)

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

5. CONCLUSIONS

There is a variety of masculinities and femininities that results in a variety of health practices. In this article, nonetheless, I interpret the male/female oppositions in social and mental structures as shaping health practices that are generally more common either to men or to women. In other words, the analysed practices and differences in them do not necessarily apply to all men or to all women, since agents' *habitus* are singular due to "the singularity of their social trajectories" (Bourdieu 1990b, p. 60). Yet, such singular *habitus* of agents from the same group "are united in a relationship of homology, that is, of diversity within homogeneity" (Bourdieu 1990b, p. 60). Thus, certain practices and perceptions "are more likely to be common" to one gender or another (Cockerham 2018, p. 143), for they are likely to have experienced similar situations and socialisation processes.

Gendered health practices in Spain are analysed as power relations embedded in the oppositions homologous to the one between the male (dominant) and the female (dominated) (Bourdieu 2001). Such oppositions in social structures – provider/carer, physical/mental and psychiatry/psychology – mirror the male/female oppositions built into mental structures or *habitus*: strong/vulnerable, body/mind and, finally, in pain/tired (see Table 5). Therefore, men more than women delay and avoid healthcare seeking, for their dominant position in the social field as a whole may be threatened in the healthcare field. Healthcare seeking might mean surrendering oneself to the domination in the user-provider relationship, that is, losing power and control. Once men seek care, nonetheless, this is often validated by themselves and by healthcare providers as a legitimate action (as opposed to women characterised as frequent or trivial users) and, most importantly, narrated as active and independent decision-making. Despite the discourse of 'mental illness as a disease like any other' in their own narratives, they aim to show their help-seeking as deserved and to preserve their masculinities, albeit if only in front of the interviewer. *Habitus* functions pre-reflexively and changes more slowly than some of the conditions that structured it (Bourdieu 2001; McNay 1999).

Women's *habitus*, on the other hand, does not encounter such contradictions to the same extent. They are likely to be the dominated in the social field as a whole, which is also confirmed and accepted (with the exception of younger women) in the healthcare field. They engage in mental help seeking more easily, since this does not challenge their mental structures and their dominated position in social structures. Yet, this same position of the dominated results in many of them being treated as trivial users and, at the same time, frequently overmedicalised with psychopharmaceuticals (notwithstanding their distrust of them) that not only leads to chronification but also reproduces power relations rather than challenging the social conditions that cause distress. The findings of this study contribute to the literature on the medicalisation of women's emotions, behaviours, and bodies (e.g., Blum and Stracuzzi 2004; Smirnova and Gatewood Owens 2019; Ussher 2010). Medicalisation as a gendered practice is produced in the interplay between social and mental structures with the embedded male/female oppositions within them, as well as becoming itself a means of reproducing power relations.

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

By interpreting the empirical evidence in light of Bourdieu's sociology, the article contributes to the literature that shows the potentiality of this theoretical approach for studying how gender shapes practices. Instead of focusing either on men or on women, it is argued that gender is a relational phenomenon and should be studied relationally in order to better understand gendered regularities and tendencies. While the findings suggest that the gender roles (provider vs. carer) and stereotypes (strong and active vs. vulnerable and passive) remain relatively strong in Spain, the article reveals that younger women could be transforming such gender hierarchies (Connell and Messerschmidt 2005). Future research, therefore, could engage with further analysis of such changes in gender relations in Spain. Focusing on the role of different capital resources (in particular, social class or social networks), which falls beyond the scope of this article, might also unveil more diverse functionings of gendered *habitus*. Finally, research in other settings could confirm to what extent the findings may go beyond the Spanish context.

VI. "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.

Keywords: Medicalisation, mental health, emotional distress, help seeking, civilising process, Norbert Elias, Spain

1. 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, Martin, and Gabe 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, Martin, and Gabe 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 2020b).

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, Bendelow, and Philip 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[2] 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, Martin, and Gabe 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 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 2020b) 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

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[2] 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.

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.

2. 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 2020a), 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, van Heerikhuizen, and Emirbayer 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 2009c, p. 32), that is, 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 2009c; 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, van Heerikhuizen, and Emirbayer 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 2009c) 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, that is, 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, that is, "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.

3. 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), that is, 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 (seven women and three men), and educational levels (two participants with secondary education or below, four – vocational training, four – 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, that is, 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.

4. 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.

4.1. 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), that is, 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 2020b). 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.

4.2. 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, 2009c). 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.

4.3. 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 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) 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 wonderful, beautiful, tall, thin, happy, and have a good job and much of everything. And, of course, as you cannot achieve this, you are not satisfied. Then, drinking alcohol or taking pills is a way to put up with this unhappiness. (HCP04, general 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).

4.4. 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.

5. CONCLUSIONS

In this article, employing Elias's process sociology (2000, 2009c), 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 '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, Martin, and Gabe 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 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 2020b).

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, that is, “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.

CHAPTER 3.
CONCLUSIONS

1. SCHOLARLY CONTRIBUTION

In this thesis by publication, my point of departure stems from the debate between two positions. On the one hand, epidemiological research demonstrates that treatment gap and delay in common mental health issues – that is, depression or anxiety disorders – remain substantial (Alonso et al. 2007; Wang et al. 2007). On the other hand, other scholars stress overestimation of unmet needs for mental healthcare and in turn medicalisation of non-disordered mental distress (Horwitz 2007; Horwitz and Wakefield 2007; Pilgrim 2015; Rose 2019). In light of this, the aim of the thesis is to better understand such processes of under- and/or overtreatment by examining how institutional and cultural contexts influence help-seeking practices in mental distress.

The publications of the thesis draw upon 44 in-depth interviews with healthcare providers – general practitioners, psychiatrists, and clinical psychologists – and users of services with self-reported diagnoses of depression or anxiety disorders. The interviews were conducted in Lithuania and Spain, countries which diverge with regard to direct and indirect indicators of treatment gap in common mental disorders. The two settings, therefore, should feature differential help-seeking practices. Guided by critical realism, which positions itself between psychiatric positivism and cultural relativism (Pilgrim 2015), and building upon the works of Pierre Bourdieu and Norbert Elias, I unpack some of the possible generative mechanisms of such practices and demonstrate the inherent complexities of medicalisation. The following sections outline the thematic and theoretical contributions of the thesis.

1.1. Thematic conclusions and contribution

The boundary between depression and circumstantial sadness, between anxiety disorders and everyday fear, or more broadly, between disordered and non-disordered distress, is thin yet present. While the manifestations of both states may be similar, Horwitz and Wakefield (2007) separate disorder and normality by making the distinction between sadness 'without cause' and 'with cause'. They argue that the contextualisation of distress – that is, considering its contextual appropriateness, proportionality, and temporality – is what enables such distinction. Employing the Habermasian approach, Crossley (2000) establishes a similar separation between, on the one hand, rational or reasonable emotions and, on the other hand, irrational feelings that "transcend the boundaries of communicative rationality to a socially intolerable extent" (p. 281). In current medical, epidemiological, economic, or media practice, however, the two states are frequently conflated. This results in overtreatment of normal yet intense emotions, which may co-exist with undertreatment of disordered distress (Horwitz and Wakefield 2007; Rose 2019).

In the collection of articles presented in this thesis, I in turn argue that which of the sides becomes salient is shaped by a range of institutional and cultural processes. In particular, the interplay between such factors influences individual health behaviour, in general, and help-seeking practices, in particular. This results in diverging demi-regularities in the analysed countries. In Spain, undertreatment of severe mental illness appears to co-exist with overtreatment or medicalisation of non-disordered distress. Yet, the latter tendency was not present in the interviews with the participants in Lithuania, specifically so with the healthcare providers, who stressed that the individuals they treat experience emotions that are well beyond 'normal' angst. This, nevertheless, does not necessarily mean that their distress was not initially caused by life adversities. Rather, it is help-seeking delay and, therefore, chronicity of said adversities that may lead to mental illness. The critical issue in Lithuania, therefore, seems to be unwillingness to seek help sooner. In the following paragraphs, I summarise how such practices are shaped by the institutional and cultural contexts in both countries.

First, the participants in the two countries perceive mental healthcare as relatively accessible with few financial and non-financial barriers. Yet, accessibility may mask ideologically-laden gaps or unbalances of power in the treatment system. That is, although being able to meet with a healthcare provider of any type is rather easy in both countries, this does not mean that appropriate or acceptable care is received. On the one hand, the dominance of biomedical responses to mental distress has been highlighted in both settings. In Lithuania, such psychopharmacotherapies are *de facto* nearly exclusively provided at the specialised care level due to unrestricted access to it. The first contact with mental healthcare in Spain, nevertheless, is usually at the primary care level, which may destigmatise and make care potentially more acceptable to individuals. Yet, biomedical training of general practitioners and time constraints at this care level can facilitate pharmaceuticalisation of both disordered and non-disordered distress. In addition to overreliance on psychopharmaceutical remedies, the appropriateness and effectiveness of available psychological therapies appear to be limited in both countries, which may be explained by psychologists' dominated position and lesser amenability of their therapies to the biomedical logic of practice in the field.

On the other hand, mental healthcare is relational. Acceptability of services may in turn be diminished by distrust in the user-provider relationship. While such issues have been stressed by the users in both Lithuania and Spain, the perceptions of trust and distrust differ. Two dimensions of the relationship emerge in the interviews: technical competence, on the one hand, and concern, respect, or interpersonal skills, on the other hand (Gilson 2003; Stasiulis et al. 2020). Distrust in Spain is mainly related to interpersonal communication that lacks concern or empathy and that frequently emerges due to time constraints in a clinical encounter, whereas the interviewed users in Lithuania express their distrust in healthcare providers in terms of both technical competence, as well as fairness, concern and, in particular, respect. Work and non-work restrictions that can be enacted after the diagnosis of any mental disorder – that is, the state's bureaucratised symbolic power (Bourdieu 1994) – deepen such distrust and the disempowerment experienced by the users in Lithuania.

Put differently, individuals' distrust in the institution or the state can aggravate their relations with the provider, for the institution supplies "the foundation of trust as a property of the overall social system" (Gilson 2003, p. 1457). The user-provider relationship is also underpinned by trust or distrust in the relationship between the state/institution and the providers themselves (Brown and Calnan 2016; Gilson 2003). To a great extent, the former mirrors the latter. In Spain, healthcare providers perceive trust in the institution and, more broadly, the state, albeit with some exceptions. They tend to view themselves as part of the state or public/administrative milieu. In Lithuania, however, power asymmetries in the user-provider relationship replay in relations between the provider and the state by means of from-above monitoring, disciplining, and pressure. The providers in turn perceive status quo inertia and the feelings of disappointment or disillusion. Put differently, the logic of the field seems to be driven by chains of distrust (Brown and Calnan 2016), which influences healthcare seeking and utilisation.

The institutional differences between the countries, therefore, can be viewed as differences in configurations of power. In Lithuania, power disparities between agents in the state-provider-user figuration are inelastic and disproportionately "in favour of the upper tier" (Elias 1978, p. 88). Resistance or agency in terms of the user resisting the provider, the provider resisting the state, or the user resisting the state, in turn, appears to be rather weak. It is frequently limited to completely avoiding healthcare or to abandoning the field altogether by means of purchasing or practising healthcare in the private sector. The logic of the field, therefore, resembles an apparatus or oligarchic multi-tier model (Elias 1978; Wacquant 1989). In Spain, nevertheless, the balance of power is more flexible, that is, more characteristic of an increasingly democratic type (Elias 1978). While power differentials remain, agents at all levels feature "various degrees of strength and therefore diverse probabilities of success" (Wacquant 1989, p. 40), which allows for more opportunities to enact agency.

Such institutional effects are embedded in cultural context, where individuals are socialised and acquire shared dispositions to perceive and think about mental health and help seeking. In Lithuania, the stigma of mental illness and mental healthcare is shaped by the unique historical experience of the region, the result of which is long-lasting delegitimisation of psychiatry (Raikhel and Bemme 2016). Stigma, therefore, is still deeply inculcated not only by the members of the society as a whole, but also within the medical field itself. Blame-gossip and labels associated with mental illness and healthcare result in feelings of rejection, failure, or inadequacy, that is, shame of being different. The roots of stigma, therefore, are in this intolerance of difference in terms of behavioural or normative standards. Anticipation of such shame as embedded in *habitus* and functioning unconsciously may impede help seeking and push individuals to employ coping behaviours that avoid stigma, but that lead to negative social and health outcomes.

In Spain, nevertheless, the diminishing stigma of common mental disorders, as well as trust in medical competence and science, facilitates healthcare seeking. At the same time, individualisation processes lead to waning emotional support provided by individuals' informal social networks, although instrumental support remains strong. Such processes, coupled with demands for emotional self-restraint, seem to result in medicalisation of non-disordered distress. In the meantime, the effects of stigma in Lithuania seem to weaken not only emotional but also instrumental support, which could aid in the push towards care. This, along with distrust towards the mental healthcare field, constrains treatment seeking for both disordered and non-disordered distress.

Structured by the cultural context, *habitus* is also gendered. In Spain, the medicalisation of non-disordered distress that is caused by social circumstances seems to disproportionately affect women. Men delay healthcare seeking, which is shaped by their learned masculinity ideals. Yet, they are also able to enact agency more actively once in the field. The gender gap in Lithuania is likewise marked by men's greater delays. Given the interplay between the cultural and institutional contexts, such delays, nevertheless, often extend over several decades and result in (semi)coerced entry to the treatment system through hospital emergency departments and/or after suicide attempts. The interviews in both countries evidence the potential intersection of gender, age, cultural and economic capital resources, as well as place of residence. Their combinations may lead to various degrees of the propensity to seek care or to actively express one's agency and resistance to stigmatisation in Lithuania or pharmaceuticalisation in Spain.

To conclude, the thesis demonstrates how the interplay of the institutional and the cultural may influence the logic of practice and in turn the direction of the medicalisation process. This contributes to the research concerning health behaviours and help seeking for mental distress in different institutional and cultural contexts, for most of the empirical evidence comes from English-speaking countries, and in particular, from North America (Doblytė and Jiménez-Mejías 2017; Van den Bogaert, Ayala and Bracke 2017). It also adds to the literature addressing stigma and medicalisation of society. Both of the notions continue to identify relevant societal processes and to offer valuable conceptual tools for sociological research (Busfield 2017; Pescosolido 2013).

1.2. Theoretical conclusions and contribution

The thesis also contributes to the standing theoretical body of medical sociology. The first article of the collection (Doblytė 2019), in particular, adds to the literature by presenting the theoretical analysis of help seeking for mental distress that is built upon the work of Pierre Bourdieu (1977, 1990b, 1991, 1998b, among others). It is theorised that help-seeking practices, which may result in undertreatment, overtreatment, or both, can be better understood through the analysis (1) of the logic of the mental healthcare field as the structure of dominant and dominated positions defined by their accumulated power/capital and in relation to the economic and political fields, (2) of social *habitus,* which is a system of durable, structured, and culturally-laden, but also generative and dynamic dispositions that lead an individual towards perceiving, acting, and thinking in determinate ways (Paulle, van Heerikhuizen and Emirbayer 2012; Wacquant 2016), and (3) of their historical genesis. Put differently, the article outlines a research programme or tool to analyse help seeking for mental distress that considers the interplay between structure and agency, as well as between the institutional arrangements, sociocultural context, and their historical trajectories.

The presentation of an empirical example in the article demonstrates the utility of the framework, which is further established in other publications of the thesis (Doblytė 2020b, 2020c, 2021a) that employ the Bourdieusian concepts as their theoretical lens. First, the notion of gendered *habitus* (Doblytė 2020c) is used to analyse how gendered health practices are enacted and reproduced in the healthcare field, as well as how they structure and are structured by the fundamental opposition between the male (dominant) and the female (dominated) (Bourdieu 2001). This contributes to the theory by showing the potentiality of Bourdieu's sociology to examine how gender as a relational phenomenon shapes practice. Second, the study of the logic of the Spanish healthcare field (Doblytė 2020b) demonstrates how the work of Bourdieu (1990b, 1998b) may guide the analysis of medicalisation as a process that is not only bidirectional and dynamic, but also, and above all, relational. Finally, the analysis of the Lithuanian mental health system (Doblytė 2021a) heavily relies on the concept of symbolic power (Bourdieu 1991) that enables the understanding of interdependences between agents and their practices, which are marked by profound inequalities in power.

In addition, the latter (Doblytė 2021a) draws on the process sociology of Norbert Elias (1978, 2000) and, in particular, his notion of figurations as dynamic functional interdependences. Eliasian sociology also guides the analysis in the remaining publications (Doblytė 2020a, 2021b). The former (Doblytė 2020a) builds upon Elias's model of an established-outsider figuration (Elias 2008a, 2008c; Elias and Scotson 2008) to better understand the roots of stigmatisation in mental health, which is viewed as a relational and historical process that emerges within human figurations characterised by fluctuating power ratios. In the meantime, the latter (Doblytė 2021b) employs Elias's tension balances or trends (Elias 2000, 2009a, 2009c; Wouters 2019) that define the direction of processes in order to examine societal developments – that is, transformations in social structures/figurations and in personality structures – that facilitate medicalisation in mental distress. The articles, therefore, show the potential use of Elias's perspective in stigma or medicalisation research.

To sum up, while the thesis focuses on a single (yet open) reality, social research can propose multiple interpretations regarding generative mechanisms of such reality by means of engaging with a range of existing theories. On the one hand, my point of departure is the Bourdieusian perspective as a guiding or organising 'carcass' of the thesis. On the other hand, the publications build not only upon Bourdieu's, but also upon Elias's work. Both Elias and Bourdieu theorise about the interplay between objectified and embodied social structures, and draw on the same set or triad of concepts as the cornerstone of their theories: the field/figuration, capital/power ratios and *habitus* (sometimes translated as 'personality structure' in the work of Elias). Both may be considered as sociologists of power and its dynamics.

The questions they address, however, are slightly different. Bourdieu mainly focuses on the dominant and oppressed groups – that is, who is in control, how, and with what consequences – or, put differently, "on the multi-dimensional space of inequalities" (Sik 2019, p. 480). In the meantime, Elias centres around how specific figurational developments produce transformations in social and mental structures (such as diminishing social controls and increasing emotional self-control). In this thesis, therefore, I demonstrate how each of their perspectives can be integrated in order to analyse different aspects of the same process and, as a result, to achieve a better understanding of health behaviours, which enables to "yield a vision more far-reaching and powerful than either considered separately" (Paulle, van Heerikhuizen and Emirbayer 2012, p. 70). For this reason, the thesis adds to both sociological theory and medical sociology.

2. REFLECTIONS ON LIMITATIONS

Qualitative researchers frequently argue that the concept of validity is too tightly related to quantitative assumptions and, therefore, suggest using alternative concepts such as trustworthiness, authenticity, and quality (Maxwell 2013) or "rigour, breadth, complexity, richness, and depth" (Denzin and Lincoln 2000, p. 5). Others, nevertheless, continue to use the notion of validity "to refer to the correctness and credibility of a description, conclusion, explanation, interpretation, or other sort of account" (Maxwell 2013, p. 122), which also covers the aforementioned concepts. In this thesis, therefore, I employ such broad an understanding of validity. In the stages of data collection and analysis, it has been enhanced through consistent and transparent sampling process (Robinson 2014); through triangulation by data source, that is, the inclusion of different social groups – users of services and healthcare providers – as well as a diverse sample of individuals within groups (Mabry 2008); through the use of software for rigorous qualitative data management; or through rich empirical support for emerging results.

While the power of qualitative methods, in general, and in-depth interviews, in particular, lies in their capacity to explore subjective interpretations or experiences and, consequently, to better understand how certain processes might be embedded in the institutional and cultural context, there are, nevertheless, several potential limitations. First, recall bias can be viewed as a study-specific threat, which results due to the retrospective nature of user interviewing. In other words, I have only accessed "the verbalized, retrospective stories of what happened" that might have been "influenced by the way they recall and legitimate their decision to seek care" (Andersen et al. 2010, p. 380, 383), that is, how they remember their decision-making or trajectories to care.

Second, self-selection bias or intrinsic problems of voluntary participation is inevitable in interview-based research, for "voluntary participation is central to ethical good practice" (Robinson 2014, p. 36). It is likely that the participants, who have agreed to be interviewed, have certain experiences and dispositions stored in their *habitus*. In particular, 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. Similarly, they might have embodied less self-stigma or stigmatic attitudes towards mental disorders and mental healthcare. This may have resulted in underestimation of stigma and its effects in both countries. Nevertheless, reflexivity concerning these issues and triangulation by data source should have enabled to soften said biases.

Third, "the subjectivity of the researcher" (Maxwell 2013, p. 124) during both the interviewing and the analysis phase may also contribute to biased results. That is, reactivity or researcher's influence on the participants is always present and cannot be fully eliminated in interview-based research – particularly, if differences in power are marked. Likewise, researcher's bias might lead to the selective choice of data in analysis and reporting. Elias's concepts of involvement and detachment (Elias 2008a; Perry et al. 2004) in turn appear to be an effective tool in reflecting on the researcher's position in this study. Rather than aiming for Weber's value-free objectivity (Weber in Runciman (ed.) 1978), I pursue the balance between involvement and detachment by means of self-reflexivity or constant cognitive self-evaluation.

In other words, since the collection and development of sociological knowledge take place within figurations of interdependent individuals, including the researcher her/himself, complete detachment may not be achievable (Lever and Powell 2017). Yet, excessive involvement is not something desirable in scientific research either. On the one hand, an interest in studying an emotionally charged topic has inevitably meant researcher's involvement. On the other hand, commitment to scientific standards, as well as being 'distanced' from the local context as a non-local academic in Spain and as an academic located abroad from the Lithuanian view, may have resulted in a certain level of detachment.

Regarding the users of services, such balance between involvement and detachment might have helped them to feel listened to due to "a heightened sensitivity" towards their perceptions (Perry et al. 2004, p. 138), yet simultaneously safe and anonymous. The latter could also have been enhanced by a relatively low power position of the researcher due to age and socioeconomic background. By the same token, the healthcare providers have not only felt like experts in a power position, but several of them have also expressed their interest in interpretations from a 'distance' or 'outside', which encouraged their participation in the research. During the stages of analysis and reporting, said balance has been further strengthened through rigorous and transparent sampling and analysis procedures, as well as by means of regular discussions on emerging themes with the supervisor and presentations of the results in conferences, workshops, or other academic meetings.

3. POLICY IMPLICATIONS

Despite the aforementioned limitations, the findings of the thesis signal several directions for policy interventions. They focus on the generative mechanisms of help-seeking practices that drive to under- or overtreatment in mental distress. First, trust is central in mental healthcare that is marked by a great extent of uncertainty and vulnerability (Brown and Calnan 2016; Stasiulis et al. 2020). Trusting relations between the state and the provider or between the provider and the user could be built through their more active involvement in decision making at policy or clinical levels. Trust in state-provider relations that is based on cooperation and dialogue may bring bottom-up changes in service provision, which could lead to more appropriate care. In the meantime, the trusting provider-user relationship may result in higher acceptability of healthcare for the user and more possibilities for the enactment of agency in said relationship. The trusting relationship can empower and satisfy the need for self-esteem (Gilson 2003), which may itself be therapeutic.

Second, more trusting or user-centred communication also entails shared and informed decision-making. While taking medicines for non-disordered yet intense mental distress should remain a matter of choice (Horwitz and Wakefield 2007), such a decision must be made not only by the clinician but also by the individual who seeks care. This being said, the choice should be as informed as possible within the time and human resource limits that structure medical consultations. To put it differently, although being durable and deeply inculcated, *habitus* “may be accompanied by a strategic calculation”, which nevertheless is performed “in relation to objective potentialities” (Bourdieu 1990b, p. 53). In order to enable such calculations in a clinical encounter, the potential practices or alternatives should be acknowledged and identified, including the difference between non-disordered and disordered distress, as well as the benefits and risks of treatments. Not only could this promote the understanding that intense emotions are normal reactions to a social situation or event, but it could also enable individuals to weigh medical treatments with their potential risks and side effects against alternative non-medical coping strategies.

Third, intolerance of difference is embedded in the Lithuanian cultural context and underpins the widespread stigma of mental illness and healthcare. Effective stigma-reducing programmes should, therefore, focus on the roots of such stigma. Given the intersections between sex, class, age, and residence, certain groups are particularly vulnerable to this: men, lower social classes, older generations, or people residing in smaller towns and villages. In addition, distrust that the state expresses towards its citizens by means of work-related restrictions enacted through the health system – that is, institutionalised stigmatisation towards the groups that are devalued – is structured by and structures said intolerance of difference at the societal level. Healthcare seeking should not be punished. Besides, building trust "within social and political structures, such as health systems" may gradually develop greater generalised trust between fellow citizens (Gilson 2003, p. 1458) and, in turn, higher levels of tolerance in a society.

Finally, diminishing emotional support by one's informal networks could be partially replaced through alternative networks such as civic associations (e.g., social clubs or voluntary organisations). They could strengthen we-feelings and, as a result, provide an alternative to medicalisation in Spain or to stigmatised mental healthcare in Lithuania. Such formal social capital or participation in civic society is weak in both countries (Pichler and Wallace 2007). Therefore, resources allocated to mental health should be directed not only, and often exclusively, towards the specialised and psychiatric services, but also towards alternative community-based services (Rose 2019) such as the development of stronger associative ties. To sum up, the thesis provides qualitative evidence for policy interventions both at the health system and societal levels. All of such implications involve relational aspects between interdependent individuals and/or institutions, and in turn, evidence the importance of focusing on human figurations both in research and practice.

4. FUTURE RESEARCH DIRECTIONS

Based on the interpretation of collected evidence and by engaging with several sociological theories, the thesis uncovers some of the possible generative mechanisms that shape the logic of help-seeking practices in mental distress. Future research could deepen such understanding through the analysis of aspects that fell beyond the scope of the thesis (see Figure 2 in the introduction, p. 60). On the one hand, the role of other relevant fields in structuring the logic of the healthcare field was not analysed thoroughly. First, approaching policy-making process or, in other words, the forces and struggles within the political-bureaucratic field could enable the exploration of how the political elites and regulators define the logic of practice in the healthcare field and, as such, influence help-seeking. Second, the market, and in particular, the pharmaceutical field is one of the most influential agents in promoting the process of pharmaceuticalisation. The development, functioning, and influence of its promotional apparatus, for example, provide a relevant case for sociological research. Third, the media or the journalistic field also patterns individual propensities to think or act, thus shaping the help seeking process.

On the other hand, the depth of knowledge may be further achieved through the historical inquiry of the identified generative mechanisms. Both Bourdieu and Elias stress the importance to study long-term processes or historical genesis of objectified and embodied structures (Bourdieu 1990b; Elias 1978, 2000; Wouters 2019). In this thesis, nevertheless, the analysis of historical influences and trajectories was limited. Likewise, the role of the three aforementioned fields – the political-bureaucratic, the pharmaceutical, and the journalistic – was considered solely through the views or experiences of the interviewed healthcare providers and users of services (i.e., the agents that usually do not practice and struggle for domination in said fields). All of these, therefore, signal directions for future inquiries.

Finally, research may also focus on the breadth of knowledge by employing the theoretical framing and providing further evidence on the identified generative mechanisms. This could include larger samples or other research settings. Investigating different mental or physical health states in Lithuania and Spain may also contribute to the literature, for much of the evidence comes from other European regions or English-speaking countries. Once undertreated, bipolar or attention deficit hyperactivity disorders, for example, have become increasingly prevalent, raising concerns regarding their overdiagnosis (Conrad and Bergey 2014; Moncrieff 2014). Pharmaceuticalisation for cognitive or physical performance enhancement (Williams, Martin and Gabe 2011) – for instance, off-label or non-medical use of smart drugs such as stimulants, physical enhancers such as steroids, or human growth hormone (Conrad 2007; De Bruyn et al. 2020) – may also indicate an area for future research.

CHAPTER 4.

CONCLUSIONES EN ESPAÑOL

1. CONTRIBUCIÓN AL CONOCIMIENTO

El punto de partida en esta tesis surge del debate entre dos posiciones en el estudio de la búsqueda de atención sanitaria en afecciones mentales comunes. Por un lado, la investigación epidemiológica demuestra que la brecha de acceso y el retraso en el tratamiento de los problemas comunes de salud mental, es decir, depresión o trastornos de ansiedad, siguen siendo considerables (Alonso et al. 2007; Wang et al. 2007). Por otro lado, otros académicos enfatizan la sobreestimación de las necesidades insatisfechas de atención de la salud mental y, a su vez, la medicalización de la tristeza y la ansiedad proporcionadas o dentro de la normalidad (Horwitz 2007; Horwitz y Wakefield 2007; Pilgrim 2015; Rose 2019). Por lo tanto, el objetivo de la tesis, estructurada como compendio de publicaciones, es explorar estos procesos de infra- o sobre- medicalización analizando cómo los contextos institucionales y culturales influyen en las prácticas de búsqueda de atención sanitaria en afecciones mentales comunes.

Las publicaciones de la tesis se basan en 44 entrevistas en profundidad con profesionales sanitarios (médicos de familia, psiquiatras y psicólogos clínicos) y usuarios de los servicios de salud mental con historial de depresión o trastornos de ansiedad. Las entrevistas se realizaron en Lituania y España, en dos contextos que parecen divergir en la extensión de la brecha de tratamiento en dichos trastornos mentales y, por lo tanto, podrían presentar prácticas de búsqueda de ayuda distintas. Partiendo del realismo crítico, que se sitúa entre el positivismo psiquiátrico y el relativismo cultural (Pilgrim 2015), y basándose en las perspectivas teóricas de Pierre Bourdieu y Norbert Elias, se analizan algunos de los posibles mecanismos generativos de tales prácticas y se demuestra la complejidad de la medicalización. En las siguientes secciones, se describen las contribuciones empíricas y teóricas de la tesis.

1.1. Conclusiones y contribución al conocimiento temático

El límite entre la depresión y la tristeza circunstancial, entre los trastornos de ansiedad y el miedo cotidiano, o más ampliamente, entre trastorno y no-trastorno, es fino. Si bien las manifestaciones de ambos estados pueden ser similares, Horwitz y Wakefield (2007) separan el trastorno y la normalidad al hacer la distinción entre la tristeza "sin causa" y "con causa". Los autores argumentan que la contextualización de la angustia, es decir, considerando su adecuación contextual, proporcionalidad y temporalidad, es lo que permite tal distinción. Empleando el enfoque habermasiano, Crossley (2000) establece una separación similar entre, por un lado, emociones racionales o razonables y, por otro lado, sentimientos irracionales que "trascienden los límites de la racionalidad comunicativa hasta un grado socialmente intolerable" (p. 281). Sin embargo, en la práctica médica, epidemiológica, económica o mediática actual, se mezclan frecuentemente los dos estados. Esto da como resultado un sobre-tratamiento del sufrimiento mental intenso, pero proporcionado y adecuado dentro de su contexto, que puede coexistir con el infra-tratamiento del trastorno mental (Horwitz y Wakefield 2007; Rose 2019).

En la colección de artículos presentados en esta tesis, se argumenta que cuál de los dos lados se vuelve más prominente depende de varios procesos institucionales y culturales. En particular, la interacción entre estos procesos influye en el comportamiento de cuidado de la salud individual, en general, y en las prácticas de búsqueda de ayuda, en particular. Esto se traduce en unas semi-regularidades divergentes en los países analizados. En España, el infra-tratamiento de las enfermedades mentales graves parece coexistir con el sobre-tratamiento o la medicalización de las afecciones mentales comunes. Sin embargo, esta última tendencia no estuvo presente en las entrevistas con los participantes en Lituania, específicamente en las desarrolladas con los profesionales sanitarios. Los profesionales lituanos enfatizaron que las personas que tratan experimentan emociones que van mucho más allá de la angustia ‘normal’. Sin embargo, esto no significa que su tristeza o ansiedad no fueron inicialmente causadas por eventos y circunstancias sociales. Más bien, el retraso en la búsqueda de atención sanitaria y, por tanto, la cronicidad de dichas adversidades son las causas que pueden llevar a un trastorno mental. El problema crítico en Lituania, por lo tanto, parece ser la poca disposición de las personas a buscar atención sanitaria. En los siguientes párrafos, se resume cómo estas prácticas son moldeadas por los contextos institucionales y culturales en ambos países.

Primero, los participantes de los dos países perciben el sistema sanitario como relativamente accesible con pocas barreras económicas y no económicas. Sin embargo, la accesibilidad puede enmascarar desequilibrios de poder o brechas ideológicas en el sistema de salud mental. Es decir, aunque acudir a un profesional sanitario de cualquier tipo es bastante fácil en ambos países, esto no significa que se reciba una atención adecuada o aceptable. Por un lado, el predominio de las respuestas biomédicas se ha destacado en ambos entornos. En Lituania, estos tratamientos con psicofármacos se proporcionan casi exclusivamente en el nivel de atención especializada debido al acceso libre a la misma. El primer contacto con la atención sanitaria a la salud mental en España, no obstante, suele ser a nivel de atención primaria, lo que puede des-estigmatizar y hacer que los servicios sanitarios sean potencialmente más aceptables para las personas. Sin embargo, la formación biomédica de los médicos de familia y las limitaciones de tiempo en este nivel de atención pueden facilitar la farmacoterapia de las afecciones mentales comunes. A parte de la prevalencia alta de los tratamientos con psicofármacos, la idoneidad y la efectividad de las terapias psicológicas disponibles parecen ser limitadas en ambos países, lo que puede explicarse por la posición subordinada de los psicólogos y la menor adecuación de sus terapias a la lógica biomédica de la práctica que domina en el campo.

Por otro lado, el sistema sanitario es intrínsecamente relacional. Por la tanto, el grado de aceptabilidad de los servicios puede reducirse por la desconfianza en la relación médico-paciente. Si bien estos problemas han sido enfatizados por los usuarios tanto en Lituania como en España, las percepciones de confianza y desconfianza difieren. En las entrevistas surgen dos dimensiones de la relación: competencia técnica, por un lado, y preocupación, respeto o habilidades interpersonales, por otro lado (Gilson 2003; Stasiulis et al. 2020). La desconfianza en España se relaciona principalmente con la comunicación interpersonal que carece de preocupación o empatía y que surge frecuentemente por la falta de tiempo en el encuentro clínico, mientras que los usuarios entrevistados en Lituania expresan su desconfianza en los profesionales sanitarios tanto en términos de competencia técnica como de equidad, preocupación y, en particular, respeto. Las restricciones laborales y no laborales que pueden imponerse con el diagnóstico de cualquier trastorno mental – es decir, la violencia simbólica burocratizada y promulgada por el Estado (Bourdieu 1994) – profundizan esa desconfianza y el sentimiento de impotencia experimentados por los usuarios en Lituania.

Dicho de otra manera, la desconfianza de los individuos hacia la institución o hacia el Estado puede agravar sus relaciones con el profesional sanitario, ya que la institución proporciona "la base de la confianza como propiedad del sistema social en general"

(Gilson 2003, p. 1457). La relación médico-paciente también se sustenta en la confianza o desconfianza en la relación entre el Estado/la institución y los propios profesionales sanitarios (Brown y Calnan 2016; Gilson 2003). En gran medida, la primera refleja la del segunda. En España, los profesionales sanitarios muestran confianza en la institución y, más ampliamente, en el Estado, aunque con algunas excepciones. Tienden a verse a sí mismos como parte del Estado o del sistema público/administrativo. En Lituania, sin embargo, las desigualdades de poder en la relación médico-paciente se repiten en las relaciones entre el profesional y el Estado por medio de la supervisión, la disciplina y la presión desde arriba. Los profesionales sanitarios, a su vez, perciben la inercia del *status quo* y los sentimientos de decepción y desilusión. Dicho de otra manera, la lógica del campo parece estar impulsada por cadenas de desconfianza o *chains of distrust* (Brown y Calnan 2016), lo que influye en la búsqueda y utilización de la atención sanitaria.

En resumen, las diferencias institucionales entre los países pueden verse como diferencias en las configuraciones de poder. En Lituania, las disparidades de poder entre los agentes en la configuración de la relación Estado–médico–paciente son inelásticas y desproporcionadamente "a favor del nivel superior" (Elias 1978, p. 88). La capacidad de agencia en términos de resistencia del usuario frente al profesional sanitario, del profesional sanitario frente al Estado o del usuario ante el Estado, a su vez, parece ser bastante débil. Con frecuencia se limita a evitar por completo la asistencia sanitaria o al abandono del campo mediante la búsqueda de atención sanitaria privada o mediante la práctica médica en el sector privado. La lógica del campo, por tanto, se parece a un aparato o modelo oligárquico de múltiples niveles (Elias 1978; Wacquant 1989). En España, sin embargo, el equilibrio de poder es más flexible, es decir, más característico de un modelo democrático (Elias 1978). Si bien persisten las diferencias de poder, los agentes en todos los niveles presentan "varios grados de fuerza y, por lo tanto, diversas probabilidades de éxito" (Wacquant 1989, p. 40), lo que permite más oportunidades para ejercer la capacidad de agencia.

Estos efectos institucionales están integrados en el contexto cultural, donde los individuos están socializados y adquieren disposiciones culturales que llevan a percibir y pensar la salud mental y la búsqueda de ayuda de formas determinadas. En Lituania, el estigma de las enfermedades mentales y de la atención sanitaria de salud mental está influido por el contexto histórico de la región, cuyo resultado es la deslegitimación duradera de la psiquiatría (Raikhel y Bemme 2016). El estigma todavía está profundamente arraigado no solo en la sociedad en general, sino también dentro del propio campo médico. Los cotilleos de culpa (*blame-gossip*) y las etiquetas asociadas con las enfermedades mentales y su atención médica dan como resultado sentimientos de rechazo, fracaso o insuficiencia, es decir, vergüenza de ser diferente. El origen del estigma, por lo tanto, está en esta intolerancia a la diferencia respecto a los estándares normativos o de comportamiento. La anticipación de tal vergüenza incorporada en el *habitus* y funcionando inconscientemente puede impedir la búsqueda de atención sanitaria y empujar a las personas a emplear conductas de afrontamiento que eviten el estigma, pero que conduzcan a efectos sociales y de salud negativos.

En España, sin embargo, la disminución del estigma de los trastornos mentales comunes, así como la confianza en la competencia médica y en la ciencia, facilitan la búsqueda de atención sanitaria. Al mismo tiempo, los procesos de individualización llevan a la disminución del apoyo emocional proporcionado por las redes sociales informales de las personas, aunque el apoyo instrumental sigue siendo fuerte. Estos procesos, junto con las demandas de autocontrol emocional, resultan en la medicalización de las afecciones mentales comunes que son intensas pero esperadas o proporcionadas dentro de su contexto. Mientras tanto, los efectos del estigma en Lituania parecen debilitar no solo el apoyo emocional, sino también instrumental, que podría empujar hacia el sistema sanitario. Esto, junto con la desconfianza hacia el campo de la salud mental, limita la búsqueda de tratamiento para los trastornos psicológicos.

No solo el contexto cultural, sino también el género influye en las disposiciones adquiridas e incorporadas en el *habitus*. En España, la medicalización del sufrimiento emocional causado por circunstancias sociales parece afectar de forma desproporcionada a las mujeres. Los hombres retrasan la búsqueda de atención sanitaria, lo que está determinado por sus ideales de masculinidad. Sin embargo, también pueden ejercer la capacidad de agencia de manera más activa una vez en el campo. La brecha de género en Lituania también está marcada por los mayores retrasos de los hombres en la búsqueda de tratamiento. Dada la interacción entre los contextos culturales e institucionales, tales retrasos, sin embargo, a menudo se prolongan durante varias décadas y dan como resultado un ingreso en el sistema sanitario (semi)forzado a través de las unidades de urgencias hospitalarias y/o después de intentos de suicidio. Las entrevistas en ambos países evidencian la posible intersección entre género, edad, recursos de capital cultural y económico, así como el lugar de residencia. Sus combinaciones pueden llevar a diversos grados de propensión a buscar atención sanitaria o a expresar activamente la capacidad de agencia y la resistencia a la estigmatización en Lituania o a la farmacoterapia en España.

Por lo tanto, la tesis demuestra cómo la interacción entre lo institucional y lo cultural puede influir en la lógica práctica (*the logic of practice*) y, a su vez, en la dirección del proceso de medicalización. Esto contribuye a la investigación sobre conductas de salud y búsqueda de ayuda para el tratamiento de afecciones mentales en distintos contextos institucionales y culturales, ya que la mayor parte de la evidencia empírica proviene de las regiones angloparlantes, y en particular de América del Norte (Doblyte y Jiménez-Mejías 2017; Van den Bogaert, Ayala y Bracke 2017). También se suma a la literatura que aborda el estigma y la medicalización en la sociedad. Ambos conceptos identifican procesos sociales relevantes y ofrecen valiosas herramientas teóricas para la investigación sociológica (Busfield 2017; Pescosolido 2013).

1.2. Conclusiones y contribución al conocimiento teórico

La tesis también contribuye al cuerpo teórico de la sociología médica. El primer artículo del compendio (Doblytė 2019), particularmente, se suma a la literatura al presentar el análisis teórico de la búsqueda de ayuda para el tratamiento de las afecciones mentales que se basa en la obra de Pierre Bourdieu (1977, 1990b, 1991, 1998b, entre otros). Se teoriza que las prácticas de búsqueda de ayuda, que pueden resultar en infra-tratamiento, sobre-tratamiento o ambos, se pueden analizar a través de la investigación (1) de la lógica del campo de la salud mental como una estructura de posiciones dominantes y dominadas, el cual se define por el capital acumulado y en relación con los campos económico y político, (2) del *habitus* social, que es un sistema de disposiciones duraderas, estructuradas y definidas por el contexto cultural, pero también generativas y dinámicas, que llevan al individuo a percibir, actuar y pensar de manera determinada (Paulle, van Heerikhuizen y Emirbayer 2012; Wacquant 2016), y (3) de la génesis histórica de ambos. Dicho de otra manera, el artículo propone una herramienta de investigación para analizar la búsqueda de ayuda para las afecciones mentales, que considera la interacción entre la estructura y la (capacidad de) agencia, así como entre los procesos institucionales, el contexto sociocultural y sus trayectorias históricas.

La presentación de un ejemplo empírico en el artículo demuestra la utilidad del marco teórico, lo que también se establece en otras publicaciones de la tesis (Doblytė 2020b, 2020c, 2021a), las cuales emplean los conceptos bourdieusianos. En primer lugar, la noción del *habitus* de género (Doblytė 2020c) se utiliza para analizar cómo se producen y se reproducen las prácticas de salud diferenciadas por el género y cómo la oposición entre el hombre (dominante) y la mujer (dominada) estructuran y están estructuradas por dichas prácticas (Bourdieu 2001). El artículo contribuye a la teoría al mostrar la potencialidad de la sociología de Bourdieu para examinar cómo el género, como fenómeno relacional, da forma a las prácticas sociales. En segundo lugar, el estudio de la lógica del campo sanitario español (Doblytė 2020b) demuestra cómo la obra de Bourdieu (1990b, 1998b) puede orientar el análisis de la medicalización como un proceso no solo bidireccional y dinámico, sino también (y, sobre todo) relacional. Finalmente, el análisis del sistema de salud mental lituano (Doblytė 2021a) se basa en gran medida en el concepto de la violencia simbólica (Bourdieu 1991) que permite comprender las interdependencias entre los agentes y sus prácticas, que están marcadas por profundas desigualdades de poder.

Este último (Doblytė 2021a) también se basa en la sociología de Norbert Elias (1978, 2000) y, en particular, en su noción de figuraciones como interdependencias funcionales dinámicas. La obra de Elias también guía el análisis en las publicaciones restantes (Doblytė 2020a, 2021b). La primera (Doblytė 2020a) se basa en el modelo de la figuración de establecidos y marginados (Elias 2008a, 2008c; Elias y Scotson 2008) para analizar los orígenes de la estigmatización en la salud mental. La estigmatización se considera como un proceso relacional e histórico que emerge dentro de las figuraciones humanas caracterizadas por las relaciones de poder fluctuantes. Mientras tanto, el último artículo (Doblytė 2021b) emplea los conceptos de equilibrios o tendencias que definen la dirección de los procesos (Elias 2000, 2009a, 2009c; Wouters 2019) para examinar los cambios sociales, es decir, las transformaciones en las estructuras/figuraciones sociales y en las estructuras de la personalidad, que facilitan la medicalización de afecciones mentales comunes. Los artículos, por lo tanto, muestran el potencial de la perspectiva de Elias en la investigación del estigma y de la medicalización.

En resumen, si bien la tesis se centra en una realidad única (aunque abierta), la investigación social puede proponer múltiples interpretaciones sobre los mecanismos generativos de dicha realidad mediante una serie de teorías existentes. Por un lado, la perspectiva bourdieusiana funciona como una ‘carcasa’ o guía organizadora de la tesis. Por otro lado, las publicaciones se basan no solo en la obra de Bourdieu, sino también en la de Elias. Tanto Elias como Bourdieu teorizan sobre la interacción entre las estructuras sociales objetivas y subjetivas/incorporadas, y se basan en el mismo conjunto o tríada de conceptos como piedra angular de sus teorías: el campo/figuración, el capital o desigualdades de poder y el *habitus* (a veces traducido como 'estructura de personalidad' en la obra de Elías). Ambos autores pueden ser considerados sociólogos del poder y de su dinámica.

Sin embargo, las preguntas que abordan son ligeramente diferentes. Bourdieu se centra principalmente en los grupos dominantes y oprimidos, es decir, quién tiene el control, cómo y con qué consecuencias – o, dicho de otra manera, “en el espacio multidimensional de las desigualdades” (Sik 2019, p. 480). Mientras tanto, el enfoque de Elias se centra en cómo las figuraciones y sus cambios producen transformaciones en las estructuras sociales y mentales (tales como la disminución de los controles sociales y el aumento del autocontrol emocional). En esta tesis, por tanto, se demuestra cómo se puede integrar ambas perspectivas para analizar diferentes aspectos de un mismo proceso y, como resultado, lograr una mejor comprensión de los comportamientos de cuidado de la salud, lo que permite tener “una visión más trascendental y poderosa que cualquiera de los dos considerado por separado” (Paulle, van Heerikhuizen y Emirbayer 2012, p. 70). Por esta razón, la tesis contribuye tanto a la teoría sociológica como a la sociología médica.

2. LIMITACIONES DEL ESTUDIO

Los investigadores del enfoque cualitativo suelen argumentar que el concepto de validez está demasiado estrechamente relacionado con los supuestos cuantitativos y, por lo tanto, sugieren utilizar conceptos alternativos como confiabilidad, autenticidad y calidad (Maxwell 2013) o “rigor, amplitud, complejidad, riqueza y profundidad” (Denzin y Lincoln 2000, p. 5). Sin embargo, hay quienes continúan usando la noción de validez “para referirse a la exactitud y credibilidad de una descripción, conclusión, explicación, interpretación u otro tipo de relato” (Maxwell 2013, p. 122), lo que también incluye los conceptos mencionados antes. En esta tesis, por lo tanto, empleo esta última comprensión amplia de la validez. En las etapas de recopilación y análisis de datos, la validez se ha aumentado mediante un proceso de muestreo consistente y transparente (Robinson 2014); a través de la triangulación por fuente de datos, es decir, la inclusión de diferentes grupos sociales – los profesionales y usuarios sanitarios – así como una muestra diversa de individuos dentro de los grupos (Mabry 2008); mediante el uso de software para un manejo riguroso de datos cualitativos; y, a través de una evidencia empírica fuerte para los resultados emergentes.

El potencial de los métodos cualitativos, en general, y de las entrevistas en profundidad, en particular, está en su capacidad de explorar interpretaciones o experiencias subjetivas y, en consecuencia, comprender mejor cómo ciertos procesos pueden ser influidos por el contexto institucional y cultural. Sin embargo, hay una serie de limitaciones potenciales. En primer lugar, el sesgo de recuerdo puede verse como un sesgo específico del estudio y se debe a la naturaleza retrospectiva de las entrevistas con los usuarios. En otras palabras, solo se ha podido acceder a "las historias retrospectivas verbalizadas de lo que sucedió" que podrían haber sido "influenciadas por la forma en que recuerdan y legitiman su decisión de buscar atención sanitaria" (Andersen et al. 2010, p. 380, 383), es decir, cómo recuerdan sus decisiones o trayectorias hacia el sistema sanitario.

En segundo lugar, el sesgo de autoselección o los problemas intrínsecos de la participación voluntaria son inevitables en la investigación basada en entrevistas, ya que "la participación voluntaria es fundamental para las buenas prácticas éticas" (Robinson 2014, p. 36). Es probable que los participantes, que han aceptado ser entrevistados, tengan determinadas experiencias y disposiciones incorporadas en su *habitus*. En particular, los usuarios de los servicios sanitarios con experiencias negativas en el sistema de salud mental podrían haber estado más motivados a participar en la investigación que los usuarios sin tales experiencias. De manera similar, podrían haber incorporado menos autoestigma o actitudes estigmáticas hacia los trastornos mentales y la atención sanitaria de salud mental. Esto puede haber resultado en una subestimación del estigma y sus efectos en ambos países. Sin embargo, la reflexividad sobre estos asuntos y la triangulación por fuente de datos deberían haber permitido disminuir dichos sesgos.

En tercer lugar, "la subjetividad del investigador" (Maxwell 2013, p. 124) durante las fases de recopilación y análisis de datos también puede contribuir a unos resultados sesgados. Es decir, la reactividad o la influencia del investigador sobre los participantes siempre está presente y no puede eliminarse por completo en la investigación basada en entrevistas, especialmente si las diferencias de poder son marcadas. Asimismo, el sesgo del investigador puede llevar a la elección selectiva de datos en el análisis y las publicaciones. En este contexto, los conceptos de implicación (*involvement*) y distanciamiento (*detachment*) de Elias (Elias 2008a; Perry et al. 2004) parecen ser una herramienta eficaz para reflexionar sobre la posición del investigador en este estudio. En lugar de aspirar a la objetividad libre de valores de Weber (Weber en Runciman (ed.) 1978), se busca un equilibrio entre la implicación y el distanciamiento mediante la autorreflexión o la autoevaluación cognitiva constante.

En otras palabras, dado que la recopilación y el desarrollo del conocimiento sociológico tienen lugar dentro de las figuraciones de individuos interdependientes, incluido el investigador mismo, es posible que no se pueda lograr el distanciamiento completo (Lever y Powell 2017). Sin embargo, la implicación excesiva tampoco sería algo deseable en la investigación científica. Por un lado, el interés por estudiar un tema emocionalmente cargado ha significado cierta implicación del investigador. Por otro lado, el compromiso con los estándares científicos, además de estar 'distanciado' del contexto local como una académica no local en España y como una académica ubicada en el extranjero desde el punto de vista lituano, puede haber dado lugar a un cierto nivel de distanciamiento.

Respecto a los usuarios de los servicios sanitarios, este equilibrio entre implicación y distanciamiento les podría haber ayudado a sentirse escuchados debido a una "mayor sensibilidad" hacia sus percepciones (Perry et al. 2004, p. 138), pero a la vez seguros y anónimos. Esto último también podría haberse visto reforzado por una posición de poder relativamente baja del investigador debido a la edad y el estatus socioeconómico. Del mismo modo, los profesionales sanitarios no solo se han sentido expertos en una posición de poder, sino que varios de ellos también han expresado su interés en interpretaciones desde la 'distancia' o desde 'fuera', lo que motivó su participación en la investigación. Durante las etapas de análisis y reporte, dicho equilibrio se ha fortalecido aún más a través de procedimientos de muestreo y análisis rigurosos y transparentes, así como mediante discusiones regulares sobre los temas emergentes con la directora de tesis y las presentaciones de resultados en conferencias, talleres y otras reuniones académicas.

3. IMPLICACIONES

A pesar de las limitaciones analizadas en el apartado anterior, los hallazgos de la tesis señalan varias direcciones para las intervenciones políticas. Se centran en los mecanismos generativos de las prácticas de búsqueda de atención sanitaria que llevan a un infra- o sobre- tratamiento en las afecciones mentales comunes. En primer lugar, la confianza es fundamental en la atención sanitaria de la salud mental, que está marcada por un alto grado de incertidumbre y vulnerabilidad (Brown y Calnan 2016; Stasiulis et al. 2020). Las relaciones de confianza entre el Estado y el profesional sanitario o entre el profesional y el usuario podrían construirse a través de su participación más activa en la toma de decisiones a nivel político o clínico. La confianza en las relaciones entre el Estado y los profesionales sanitarios, que se basa en la cooperación y el diálogo, puede generar cambios de abajo hacia arriba en la prestación de servicios, lo que podría llevar a una atención más adecuada. Mientras tanto, la relación de confianza entre el profesional y el usuario puede resultar en una mayor aceptabilidad de la atención médica por parte del usuario y más posibilidades para la agencia en dicha relación. La relación de confianza potencia y satisface la necesidad de autoestima (Gilson 2003), que en sí misma puede ser terapéutica.

En segundo lugar, una comunicación más confiable o centrada en el usuario también implica una toma de decisiones informada y compartida. Si bien tomar psicofármacos para las emociones intensas, pero proporcionadas o dentro de normalidad, debe seguir siendo una cuestión de elección (Horwitz y Wakefield 2007), esta decisión la tendría que tomar no solo el médico, sino también la persona que busca atención sanitaria. Dicho esto, la elección debe ser informada lo más posible dentro de los límites de tiempo y de los recursos humanos que estructuran las consultas médicas. En otras palabras, aunque sea duradero e incorporado profundamente, el *habitus* “puede ir acompañado de un cálculo estratégico”, que no obstante se realiza “en relación con las potencialidades objetivas” (Bourdieu 1990b, p. 53). Para permitir tales cálculos en una consulta médica, se deben reconocer e identificar las prácticas o alternativas potenciales, incluida la diferencia entre el trastorno y no-trastorno, así como los beneficios y riesgos de los tratamientos. Esto no solo podría promover la comprensión de que las emociones intensas son reacciones normales a una situación o evento social, sino que también podría permitir a las personas sopesar los tratamientos médicos con sus posibles riesgos y efectos secundarios frente a estrategias alternativas no-médicas de afrontamiento.

En tercer lugar, la intolerancia a la diferencia está arraigada en el contexto cultural lituano y lleva al estigma de las enfermedades mentales y de la atención a la salud mental de forma muy extendida. Por tanto, los programas de des-estigmatización eficaces deben centrarse en las raíces de dicho estigma. Dadas las intersecciones entre sexo, clase, edad y residencia, ciertos grupos son particularmente vulnerables a ello: hombres, clases sociales más bajas, generaciones mayores o personas que residen en pueblos y ciudades más pequeñas. Además, la desconfianza que el Estado expresa hacia sus ciudadanos a través de las restricciones impuestas por el sistema de salud, es decir, la estigmatización institucionalizada hacia los grupos que resultan devaluados, refuerza y está reforzado por dicha intolerancia a la diferencia a nivel social. La búsqueda de atención sanitaria no debe ser castigada. Además, generar confianza "dentro de las estructuras sociales y políticas, como el sistema sanitario" puede generar gradualmente una mayor confianza entre los ciudadanos (Gilson 2003, p. 1458) y, a su vez, niveles más altos de tolerancia en una sociedad.

Por último, la disminución del apoyo emocional por parte de las redes informales de las personas podría reemplazarse parcialmente por redes alternativas como asociaciones cívicas (por ejemplo, clubes sociales u organizaciones voluntarias). Estas redes podrían fortalecer el sentimiento 'nosotros' o solidaridad colectiva y, como resultado, proporcionar una alternativa a la medicalización en España o al estigmatizado sistema de salud mental en Lituania. Dicho capital social formal o participación en la sociedad civil es débil en ambos países (Pichler y Wallace 2007). Por lo tanto, los recursos asignados a la salud mental deben dirigirse no solo, y a menudo exclusivamente, hacia los servicios sanitarios especializados o psiquiátricos, sino también hacia servicios comunitarios (Rose 2019), tales como el desarrollo de vínculos asociativos más fuertes. En resumen, la tesis proporciona evidencia cualitativa para las intervenciones políticas tanto en el sistema de salud como en la sociedad general. Todas estas implicaciones involucran aspectos relacionales entre individuos y/o instituciones y, a su vez, evidencian la importancia de centrarse en las figuraciones humanas tanto en la investigación como en la práctica.

4. LÍNEAS DE INVESTIGACIÓN FUTURA

A través de la interpretación de la evidencia recopilada y de varias teorías sociológicas, la tesis propone algunos de los posibles mecanismos generativos que dan forma a la lógica de las prácticas de búsqueda de ayuda en afecciones mentales comunes. La investigación futura podría profundizar en dicha comprensión mediante el análisis de aspectos que quedan fuera del alcance de la tesis (ver Figura 2 en la introducción, p. 60). Por un lado, no se ha analizado en profundidad el papel de otros campos relevantes en la estructuración de la lógica del campo de la salud. Primero, abordar el proceso de formulación de políticas o, en otras palabras, estudiar las fuerzas y luchas dentro del campo político-burocrático podría permitir conocer cómo las élites políticas y los reguladores definen la lógica (institucional) de las prácticas en el campo sanitario y, por lo tanto, influyen en la búsqueda de ayuda. En segundo lugar, el mercado y, en particular, el campo farmacéutico es uno de los agentes más influyentes en el proceso de la medicalización a través de los psicofármacos. El desarrollo, el funcionamiento y la influencia de su aparato promocional, por ejemplo, proporcionan un caso relevante para la investigación sociológica. En tercer lugar, los medios o el campo periodístico también influyen en las disposiciones individuales a pensar o actuar, dando forma al proceso de búsqueda de ayuda.

Por otro lado, la profundización del conocimiento puede también lograrse a través de la investigación histórica de los mecanismos generativos identificados. Tanto Bourdieu como Elias enfatizan la importancia de estudiar los procesos a largo plazo o la génesis histórica de estructuras objetivas e incorporadas (Bourdieu 1990b; Elias 1978, 2000; Wouters 2019). En esta tesis, sin embargo, el análisis de las influencias y trayectorias históricas ha sido limitado. Asimismo, el rol de los tres campos mencionados antes, el político-burocrático, el farmacéutico y el periodístico, se ha considerado únicamente a través de las percepciones y experiencias de los profesionales y usuarios de los servicios sanitarios (es decir, agentes que generalmente no actúan o luchan por la dominación en dichos campos). Todo esto, por lo tanto, señala direcciones para la investigación futura.

Finalmente, la investigación también puede enfocarse en la ampliación del conocimiento empleando el marco teórico y proporcionando más evidencia sobre los mecanismos generativos identificados. Esto podría incluir muestras más grandes u otros entornos de investigación. La investigación de diferentes estados de salud mental o física en Lituania y España también puede contribuir a la literatura, ya que gran parte de la evidencia proviene de otras regiones europeas o países de habla inglesa. Una vez infra-diagnosticados, los trastornos bipolares o por déficit de atención con hiperactividad, por ejemplo, se han vuelto cada vez más frecuentes, lo que genera preocupaciones con respecto a su sobre-diagnóstico (Conrad y Bergey 2014; Moncrieff 2014). El uso de psicofármacos para mejorar el rendimiento físico o cognitivo (Williams, Martin y Gabe 2011), entre otros, el uso no autorizado o no médico de los *Smart drugs* tales como estimulantes, potenciadores físicos, como, por ejemplo, esteroides u hormona del crecimiento humano (Conrad 2007; De Bruyn et al.2020), también puede indicar un área de estudio para futuras investigaciones.

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APPENDIX 1. STUDY INFORMATION SHEET AND INFORMED CONSENT DOCUMENT

STUDY APPROVED BY THE RESEARCH ETHICS COMMITTEE OF THE PRINCIPALITY OF ASTURIAS: 2 MAY 2017 (nº 74/17)

Study Information Sheet

Sigita Doblytė
Departamento de sociología
Facultad de Economía y Empresa
Avda. del Cristo, s/n, 33006, Oviedo, España

Dear Participant,

I am a Ph.D. researcher within the research group PROMEBI (Promoviendo el Empleo y el Bienestar en Europa/Promoting Employment and Welfare in Europe) at the University of Oviedo, working under the guidance of Prof. Ana Marta Guillén-Rodríguez. You are being invited to take part in this research study, which forms part of my doctoral thesis.

The overall goal of the study is to better understand experiences of people with common mental health issues such as anxiety or depression in Lithuania and Spain with a specific focus on trajectories to care and factors that hinder or facilitate it.

Your contribution as a healthcare provider or an individual that has experienced common mental health problems and sought treatment is highly valuable for our research. Participation is voluntary, and you are free to choose whether or not you would like to participate. If you agree to participate, we will schedule a time convenient for you to participate in a one-on-one interview.

The interview will last approximately 45-60 minutes. It will be audio-recorded and transcribed which will be reviewed by the researchers involved in the study. The interview records will be kept confidential. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

If you agree to participate or have any questions or concerns at any time about the study, contact Sigita Doblytė at

Prof. Ana Marta Guillén-Rodríguez	Sigita Doblytė, Ph.D. Candidate
Department of Sociology	Department of Sociology
University of Oviedo	University of Oviedo

APPENDICES

STUDY APPROVED BY THE RESEARCH ETHICS COMMITTEE OF THE PRINCIPALITY OF ASTURIAS: 2 MAY 2017 (nº 74/17)

An agreement to be in a research study

Informed consent document: study information

Research title: Access to care and healthcare seeking in common mental disorders: a comparative study of Lithuania and Spain.

Principal investigators: Sigita Doblytė (predoctoral researcher and PhD candidate) and Prof. Ana M. Guillén Rodríguez (thesis supervisor), Department of Sociology, University of Oviedo.

Contact information: Sigita Doblytė, tel.: xxx-xxxxxx, e-mail: uo259758@uniovi.es

Purpose of the study:

You are being invited to take part in a research study, which is part of the doctoral thesis of the principal investigator. Its overall goal is to better understand experiences of people with common mental health problems such as anxiety or depression in Lithuania and Spain with a specific focus on how the local or national context impacts access to a healthcare system and pathways to healthcare as well as on factors that hinder or facilitate access to care. Therefore, your contribution as a healthcare provider or an individual that has experienced common mental health problems and sought treatment is highly valuable for our research. It is precisely to help people suffering from symptoms of anxiety or depression find support and timely help.

What will happen during the study:

Once you have agreed to participate and signed this informed consent document, we will schedule a time convenient for you to participate in an individual interview, which will last approximately 45-60 minutes and will be recorded. After the completion of the interview, you will be asked to complete a brief socio-demographic and/or clinical history form. These questions will give us some basic information about you and your clinical history (for example, age, education, etc.), all of which will remain strictly confidential.

Possible risks and benefits:

There are no known risks to participating in this study. There is no direct benefit to you either but information learned from the study may advance our knowledge about barriers and facilitators to access to care and, therefore, may help other people in the future.

Confidentiality:

Your study records will be kept private. According to Spanish Law 15/1999 on personal data protection, your name and other personal information that may result in your identification will not be used in any of the reports or publications that derive from this investigation.

Costs and payment for being in the study:

There will be no costs to you for participation in this study. There will be no economic compensation for the participation either.

Alternatives to participation:

Your participation in this study is voluntary. You can choose not to participate in this study.

Leaving the study:

You have the right to leave this study at any time without any penalty to you.

Informed consent document: consent

Research title: Access to care and healthcare seeking in common mental disorders: a comparative study of Lithuania and Spain.

Principal investigators: Sigita Doblytė (predoctoral researcher and PhD candidate) and Prof. Ana M. Guillén Rodríguez (thesis supervisor), Department of Sociology, University of Oviedo.

Contact information: Sigita Doblytė, tel.: xxx xxxxxx, e-mail: uo259758@uniovi.es

____ I have read and understood the informed consent document.

____ The information of the informed consent documents has been explained to me.

____ I understand that I can leave the study at any time.

Name of adult participant:	Name of investigator:
______________________________	__________________________________
Signature of adult participant:	Signature of investigator:

Date: ________________________

APPENDIX 2: INTERVIEW GUIDE AND SOCIODEMOGRAPHIC FORM (USERS OF HEALTHCARE SERVICES)

Interview guide

Thank you for agreeing to participate in our study and for taking the time to speak with me today. The purpose of this study is to learn about your experiences and trajectory to healthcare for mental health problems.

All of the information you provide today will be used for the purpose of this research study only. You do not have to answer any questions you don't want to answer. We are interested in your thoughts, experiences and opinions and, therefore, there are no right or wrong answers.

With your permission, I will audio-record this interview and the recording will be transcribed to allow us to review your responses. To protect your confidentiality, we will not associate your name with the audio-recording, the interview transcript or any reports.

Do you have any questions before we begin? Do I have your permission to audio record this interview? [Turn on the recorder]

Problem recognition and social networks

1. First of all, I would like to ask when this all started. When did you first recognize that you do not feel well and might need help?
2. How did you first manage the symptoms?
    a. [PROBE]: What did you do to make yourself feel better?
    b. [PROBE]: Did you try different types of help or self-help before going to a family doctor, psychologist or psychiatrist?
3. Social networks:
    a. Did you discuss your emotional problems with your family or other people in your life with who you normally discuss important matters? ([PROBE]: Did they notice themselves that something was happening?)
    b. If so, at what point? What were the outcomes?
    c. If not, why didn't you do so?

Healthcare system and cultural context

I would like now to talk a little bit more about the process you went through in making decision to seek healthcare and your opinions about healthcare system.

4. Did you delay the contact with treatment system? If so, what were the reasons not to seek help?
    a. [PROBE]: Did you know where to seek help?
5. What prompted you to get help? (How did you get to treatment?)
    a. [PROBE]: Who made the decision to seek treatment?
    b. [PROBE]: What was the reaction of your family or people important to you?
6. When you first went to a doctor for your emotional problems, what type of clinician was he/she?
    a. How did you bring up the subject?
    b. What symptoms did you mention?
7. Did you have any fears or concerns when you sought treatment? What were they?
8. [MEN ONLY]: In what ways did being a man impact your decision to seek healthcare?
9. How do you think being a man or woman influence experience and decision-making to seek help?
10. Can you tell me about your experiences and relation with doctors involved in your treatment?
    a. [PROBE] Service provider(s) involved in your treatment for mental health problems.
11. What kind of things can make it difficult or easy to decide to seek healthcare, when you do not feel well emotionally?
    a. [PROBE] Society / cultural factors (e.g.: stigma; others' opinions; perceived effectiveness of treatments)
    b. [PROBE] Healthcare system (e.g.: co-payments for medications, access to psychotherapies, waiting times, distance to services, appropriateness of mental health problems in primary care, healthcare provider's expertise)
12. What are your views about mental health treatment?
    a. Has treatment met your expectations?

   b. What are your thoughts about medications for treatment of common mental health problems? Did you receive them?
   c. And about psychotherapy? Did you receive it?
13. What are your views about mental health policy and system?
   a. Do you belong to any patient association or support group?
14. Finally, is there anything else about your experience with mental health problems and treatment seeking that you think would be important for me to know?

To end the interview, I would like to ask some questions about your socio-demographic and clinical history. These questions give us some basic information about you in addition to obtaining more specific information about your clinical history. [Give a socio-demographic form to complete]

User’s socio-demographic and clinical history form

Date of the interview: _________
Participant ID: _________

1. Has your doctor diagnosed you with any of the common mental health problems below? (Check all that apply)
   a. Depression
   b. Generalized anxiety disorder (GAD)
   c. Social anxiety disorder or social phobia
   d. Post-traumatic stress disorder (PTSD)
   e. Panic disorder
   f. Other mood (affective) disorder (please specify): _________________
   g. Other anxiety disorder (please specify): ___________________
   h. Don’t know

2. When were you diagnosed with the condition above? (if more than one, please indicate the year of diagnosis of the earliest one) ____________

3. What treatments have you received for common mental health problems that you have been diagnosed with? (Check all that apply)
   a. Medications (antidepressants and other)
   b. Psychotherapy (cognitive-behavioral, interpersonal, psychodynamic therapies and other)
   c. Self-help or support groups
   d. Dietary and lifestyle changes
   e. Other (please specify): __________________________

4. Who do you normally see (or have seen) for your mental health problems?
   a. A family doctor or general practitioner
   b. A psychiatrist
   c. A psychologist
   d. Other (Please specify): ________________
   e. Don’t know

5. Are you currently:
   a. Single
   b. Married or living with a partner

   c. Widowed
   d. Divorced or separated

6. What is the highest level of education you have completed?
   a. Primary school
   b. Secondary school
   c. Vocational training
   d. University degree and postgraduate

7. How would you describe your current employment status? Please select the answer which best applies.
   a. Employed, full-time
   b. Employed, part-time
   c. Student
   d. Stay-at-home parent
   e. Unemployed
   f. Retired
   g. Not working due to ill health
   h. Other (please specify): ___________________________

8. How would you define your profession? __________________________

9. Please indicate your age: _______ years old

10. Your gender: a. Male b. Female

11. Please indicate the city or town you live in: _______________

Thank you very much for your time!

APPENDIX 3: INTERVIEW GUIDE AND SOCIODEMOGRAPHIC FORM (HEALTHCARE PROVIDERS)

Interview guide

Thank you for agreeing to participate in our study and for taking the time to speak with me today. The overall goal of this study is to better understand experiences of patients with mood or anxiety disorders, with a specific focus on pathways to care and factors that hinder or facilitate it.

All of the information you provide today will be used for the purpose of this research study only. We are interested in your thoughts and opinions and, therefore, there are no right or wrong answers.

With your permission, I will audio-record this interview and the recording will be transcribed to allow us to review your responses. To protect your confidentiality, we will not associate your name with the audio-recording, the interview transcript or any reports.

Do you have any questions before we begin? Do I have your permission to audio record this interview? [Turn on the recorder]

General characteristics and symptom recognition

1. First of all, can you briefly describe your current job and role?
    a. [PROBE]: What type of patient population do you typically see? How many patients do you have in an average day?
2. Speaking about mental health problems, what are the typical symptoms people present for conditions that are later diagnosed as common mental disorders?
    a. [PROBE]: Do they present physical symptoms rather than emotional problems? If so, what groups of patients (in terms of gender, age or socioeconomic status) tend to do so?
3. At what stage do people seek help for common mental health problems?

    a. [PROBE]: Are there alternative sources of help or self-help they tend to use? If so, what are they?

4. Do patients have any concerns or fears when telling you their symptoms? If so, what are they?
5. Are there any typical concerns when talking about diagnosis and treatment options? What sort of treatment do you normally use for these patients?
6. Do organizational or institutional characteristics impact your communication with patients? If so, how?
    a. [PROBE] Time constraints (the length of appointment); need to contain costs (limiting treatment options)
7. [GPs ONLY]: As a general practitioner, do you feel that you have relevant skills to recognize and treat mental disorders?
    a. [PROBE]: If not, what do you think would help to gain them?
    b. [PROBE]: Did you receive any special training in mental health?
    c. [PROBE]: Are there any other barriers you face as a healthcare provider when working with people with common mental health problems?
8. [HCPs IN SPECIALISED CARE ONLY]: It is often argued that common mental disorders can and should be managed in primary care by general practitioners. What do you think about that? Do you think that they have relevant skills to recognize and treat such disorders?

Social networks and gender

9. I would like now to talk about relatives and friends of people who are seeking care. What is the level of involvement of family or friends in healthcare seeking and decisions about treatments?
10. In terms of gender, could you describe typical differences between male and female patients in terms of their healthcare seeking?

   a. [PROBE]: In what ways do you think being a man impacts seeking care for emotional problems?

Healthcare system and cultural context

11. Talking in general, do people tend to delay seeking care for common mental disorders or the reverse?

12. In your opinion, what are the obstacles or, on the contrary, facilitators to seeking healthcare?

    a. [PROBE]: Society / cultural factors (e.g.: stigma; others' opinion; effectiveness of treatment: do you think that it is important or necessary to seek medical care for common mental health problems? etc.)

    b. [PROBE]: Healthcare system: what are the organizational or institutional factors that impede or facilitate treatment-seeking?

        i. [PROBE]: co-payments (What types of treatments are NOT covered by the state? What user charges do patients have to pay?)

        ii. [PROBE]: waiting times and distance to services

        iii. [PROBE]: access to medications (Do you think that they are used appropriately for common mental health problems?)

        iv. [PROBE]: access to psychotherapies (Is it adequate?)

        v. [PROBE]: any gaps in service delivery?

13. What would you like to change in management of common mental disorders in terms of access to care and healthcare utilisation?

14. Do you feel that you can participate in mental health policy-making at local, regional or national levels?

    a. [PROBE]: If so, do you participate? How exactly?

b. [PROBE]: If not, do you trust in policy makers to make appropriate decisions?

To end the interview, I would like to ask some questions about your socio-demographic background. These questions give us some basic information about you and your professional background. [Give a socio-demographic form]

Healthcare provider's socio-demographic form

Date of the interview: _________
Participant ID: _________

1. Type of your main facility:
   a. Health centre
   b. Mental health centre
   c. General hospital
   d. Psychiatric hospital
   e. Private medical practice
   f. Other (please specify): ___________________

2. How would you describe your occupation at this facility?
   a. A family doctor or general practitioner
   b. A psychiatrist
   c. A psychologist
   d. A nurse
   e. Other (Please specify): ________________

3. How long have you worked as a healthcare provider? __________ (years)

4. How long have you worked at this facility? __________ (years)

5. In an average week, how frequently do you see patients seeking help for symptoms of mood and anxiety disorders? ___________ per week

6. Please indicate your age: _______ years old

7. Your gender: a. Male b. Female

8. Please indicate the city or town you live in: _______________

Thank you very much for your time!

APPENDIX 5. REVIEWS BY INTERNATIONAL EXPERTS

Since one of the requirements for opting for the International Doctoral Mention is the dissertation assessments by two expert PhDs from a non-Spanish higher education institution or research institute, the doctoral thesis is accompanied by the following:

1. Thesis review by Dr Artūras Tereškinas, Full Professor of Sociology, Vytautas Magnus University (Lithuania)
2. Thesis review by Dr Guido Giarelli, Full Professor of Sociology, University “Magna Graecia” – Catanzaro (Italy)

VYTAUTO DIDŽIOJO UNIVERSITETAS
SOCIALINIŲ MOKSLŲ FAKULTETAS
SOCIOLOGIJOS KATEDRA

VYTAUTAS MAGNUS UNIVERSITY
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF SOCIOLOGY

May 19, 2021

Review of Sigita Doblytė's doctoral thesis "A matter of context: Cultural and institutional influences on healthcare seeking for mental distress in Lithuania and Spain"

Sigita Doblytė's doctoral thesis is an interesting and long-awaited study on the impact of the cultural and institutional contexts on mental distress in Lithuania and Spain. In her thesis, she describes specific mechanisms that drive people to specific help-seeking practices in mental distress. Her thesis and articles on which it is based are indeed an invaluable addition to both the empirical and theoretical development of medical sociology.

The structure of the thesis conforms to the principles and the structure of a scholarly thesis. Doblytė's thesis consists of six articles intended to illustrate how health system design and functioning as well as the cultural contexts shape the process of help seeking for mental distress in Lithuania and Spain. The author presents, with a great analytical skill and insight, her theoretical approach and framing, power dynamics of the healthcare field, the production of shame in a post-socialist Lithuanian society, the dynamic of under- and overtreatment of mental distress in Spain, gendered habitus and mental healthcare utilisation in Spain, and medicalisation of mental distress from an Eliasian perspective. It should be emphasized that Doblytė's theoretical and empirical analysis presented in the chapters based on the articles is comprehensive and multi-faceted.

The thesis is a well-constructed and well-structured piece of research. Bourdieu and Norbert Elias's ideas are a point of departure that guides the empirical investigation of the thesis. Her presentation of theoretical framework evidences Doblytė's good knowledge of main theoretical discussions and issues relevant to her research. The author clearly defines her approach of critical realism and consistently uses it throughout the thesis. The author undeniably demonstrates the utility of the theoretical approach in the analysis of in-depth interviews with 44 healthcare providers and users of services with self-reported diagnoses of depression or anxiety disorders.

Doblytė should be commended for her self-reflexivity regarding both her theoretical and empirical choices. The dissertation captures a diversity of mental healthcare systems and differences in the organisation of care in Lithuania and Spain and contributes to qualitative research on healthcare seeking in different cultural and institutional contexts in Europe. Doblytė also presents a well-argued discussion on the merits and limitations of her thesis. The author's self-reflexive use of theoretical concepts, research methods, empirical data and categories throughout her dissertation is also admirable.

Doblytė's thesis contributes to the global knowledge on mental health, medicalisation, health policies, stigmatisation, and power relations, particularly within the context of the little-researched post-socialist Lithuania. It could be argued that her research results will help both to further a research programme for the analysis of help seeking for mental distress and to develop policies in the field of mental healthcare in Lithuania and Spain.

The thesis by Sigita Doblytė fulfils all the conditions and is acceptable for the doctoral degree in sociology.

Artūras Tereškinas
Professor of Sociology
Vytautas Magnus University

Università “Magna Græcia” - Catanzaro

To whom it may concern

Catanzaro, May 31, 2021

I reviewed the thesis of Sigita Doblyte on “A matter of context: cultural and institutional influences on healthcare seeking for mental distress in Lithuania and Spain” with great pleasure since the text is formally well written, grammatically correct and lexically rich, and the style adopted appears smooth and attractive to read.

In particular, in the Introduction, the social and economic burden of mental disorders for societies is properly delineated and the problems they represent for healthcare services specifically outlined in terms of delayed presentation, over- and/or undertreatment, overestimation due to inadequate definition, increasing medicalisation and bio-reductionist and positivistic psychiatric approach. The central concept of healthcare seeking behaviour as part of a wider help seeking is then correctly discussed according to the literature as micro-sociological process embedded within both institutional and cultural macro-sociological contexts influencing it. The two research questions are consequently well defined in their complexity and the review of the international literature on the dominant theoretical models about healthcare seeking appears exhaustive and updated. The identification of their gaps is properly argumented and well substantiates the proposed theoretical framework based on critical realism, Elias’ process sociology and Bourdieu’s generative structuralism. Moreover, the justification for the two cases selection (Lithuania and Spain) as extreme or critical cases in the European context along with the articulated discussion of the methodologies adopted sound appropriate and relevant for the chosen research topic.

The following six articles included in chapter two represent interesting insights into the issues discussed in the Introduction. The first article, published in *Social Theory and Health*, is an in-depth examination of Bourdieu’s key concepts of field, capital and habitus aimed at proposing a model that can be employed to study help seeking in mental distress, and appears convincing and well structured to ground the research questions of the thesis. The following two articles, published in the *Journal of the Baltic Studies* and in the *Sociology of Health and*

Illness, constitute empirical studies examining the case of Lithuania by applying Bourdieu's concept of field to mental healthcare and Elias' model of established-outsider relations to the process of stigmatisation of mental illness with interesting outcomes in both cases. The fourth article, published in *Qualitative Health Research*, examines how the process of help seeking for mental distress is shaped by the health system design and functioning through medicalisation of non-disordered mental distress, instead leaving undertreated severe mental illness. The fifth article, published in the *Journal of Gender Studies*, applies the concept of habitus to gender influences on healthcare seeking and utilisation for common mental health issues in Spain, highlighting their consequences in terms of different behaviours and conditions of men and women. Finally, the last article still under review, show how the cultural context might drive to increasing medicalisation of nondisordered distress by the processes of individualisation and scientisation, coupled with demands for emotional self-control, adopting an Eliasian perspective.

In the Conclusions, the findings of the thesis as a whole are well synthesized, emphasizing the scholarly contribution offered at both thematic and theoretical levels, and its empirical grounding on 44 in-depth interviews with healthcare providers and users of mental healthcare services conducted in Lithuania and Spain. The articulated series of reflections about the limitations of the work, and the examination of its policy implications along with suggestions for future researches concluding the thesis represent a further precious added value to its scholarly contribution.

According to an overall evaluation, I argue that the thesis of Sigita Doblyte certainly deserve a special mention for its capacity of dialogue with the international literature on the chosen topic, the consistency and the appropriateness of the proposed methodological framework and of the research design, the relevance of its implications for policymaking in mental healthcare, and the originality of its theoretical contribution.

In faith,

Prof. Guido Giarelli, Ph.D.
Full Professor of Sociology
Department of Health Sciences
University 'Magna Græcia' – CZ (Italy)