Bourdieu’s theory of fields: towards understanding help-seeking practices in mental distress

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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, that may even drive to both over- and under-treatment resulting in inequities of access and poor use of resources. In order to 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

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INTRODUCTION

Social, economic and health costs of persistent mental distress that 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 et al, 2016; James et al, 2018). Besides changing population structures, remaining high levels of under-diagnosis or under-treatment 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, over-medicalisation of mild symptoms or psychiatrization of social problems fuelled by the pharmaceutical industry, changes within the biomedical paradigm or even public pressure is also common (Conrad, 2007; Rose, 2018).

This suggests that there are multiple factors that impact pathways to healthcare and social scientists 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, 2005 [1951], 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) to understanding help seeking in mental distress, i.e. 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 even drive to both over- and under-treatment resulting in inequities of access and poor use of resources.

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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 (2018), 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 pathway 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 it differently, how the logic of the field and its agents impact this pathway 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 (1998, p.7) summarises it, "the space of social positions is retranslated into a space of position-takings through the mediation of the space of dispositions".

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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, 1998, 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, 1998, p.32), and as *a field of struggles*, where social positions are "strategic emplacements, fortresses to be defended and captured" (Bourdieu, 1984, p.244). An unequal distribution of field-specific forms of capital (power), which vary across places and moments (Bourdieu, 1998), 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, 1998, 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, 1998) maintains relative stability of social fields.

The framework also accommodates the concept of figuration by Norbert Elias (2012) to define user-provider relations. Both Elias and Bourdieu are often viewed as sociologists of power that rely on a very similar set of concepts as well as employ them relationally (Paulle et al, 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 field of mental healthcare and conceptualise symbolic power as embedded in the logic of the field. Second, I approach a user as being between structures and agency and, finally, while 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 comparative study on help seeking in common mental disorders.

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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, the field 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 that 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 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 these agents share *illusio* or interest, as opposed to disinterestedness or indifference and being both the condition and the product of the field (Bourdieu, 1998; Wacquant, 1989), which functions as a driving force of action. That is to say, even agents, who occupy opposing and 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, 1998, p.78).

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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 institutionalized (academic qualifications) and embodied (scientific knowledge and skills) forms (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 an 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 these 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 – a distinctive value of different position-takings (theories and paradigms of approaching mental distress) may change.

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 hierarchization, i.e. principles of defining the structure and limits of the field. The more autonomous the field is, the less external principles of hierarchization dominant in the field of power (those of the economic and political fields) apply (Bourdieu, 1993; Hilgers and Mangez,

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2015). In his analysis of the field of mental health, Strand (2011), however, 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 of mental healthcare (Figure 1). 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.

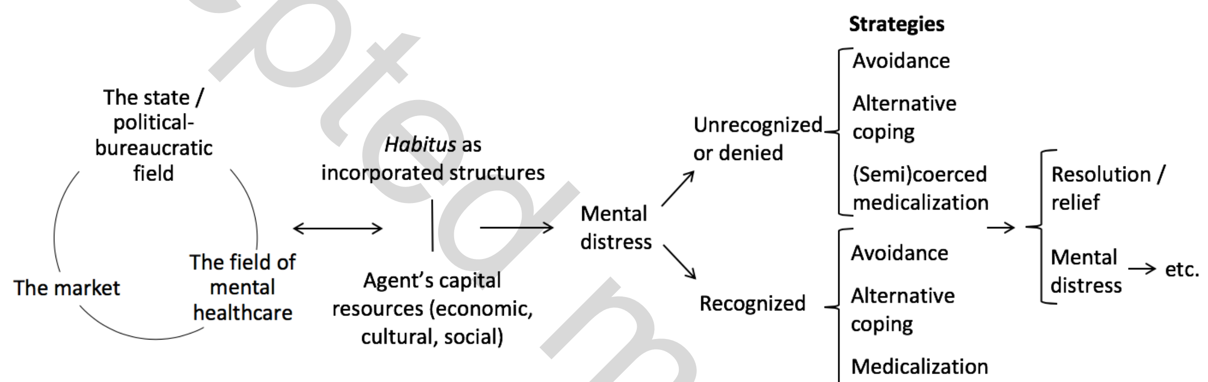

Figure 1. The theory of fields and help seeking in mental distress.

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

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However, their appropriation 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 that cultural 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 specialist 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 of mental healthcare, at the same time 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. Nonetheless, 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 effectiveness (Gøtzsche, 2013; Rose, 2018). Although few countries allow direct to consumer marketing of prescription pharmaceuticals which is particularly effective in expanding boundaries of diagnosis and increasing medicalization of problems of living (Conrad, 2007), their influence over providers and even political-bureaucratic field may encourage certain treatment strategies (Gøtzsche, 2013) and "blurring of the boundaries between normal distress and mental disorder, both of which

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receive medication as the preferred response" (Horwitz, 2007, p.218). Due to this vagueness and ease to manipulate the boundaries of mental disorders, Gøtzsche (2013, p.191) 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 to understand the rules of the game and how they are settled. Through analysis of the historical genesis of the medical field in France in the 19th century, Pinell (2011) reveals how treatment of mental illness was marginalized and devalued. Album and Westin (2008), Hindhede and Larsen (2018) or Stuart et al. (2015) show 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 et al, 2015), patient categorization or, in general, "setting priorities at all levels" (Album and Westin, 2008, p.188).

Symbolic power in the field

As a 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, it influences agent's practices. It is symbolic and "most completely misrecognized – and, thus, in fact, recognized" as legitimate (Bourdieu, 1991, p.163-164). The dominated groups not only accept forms of 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 that power.

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The assumption of healthcare seeking in the treatment system as an adequate and expected response to mental distress as well as thinking in diagnoses presuppose 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 alternative to biological psychiatry, has been professionalised fitting "perfectly with the rationalities and technologies of neoliberalism" (Rose, 2018, p.164). The specialized 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) limiting the paths of access to the dominant groups – by whom something can be said, what is meant by it and with what effects (Wacquant, 1989).

This specialized 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), who is authorized "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 minimize, eliminate, or normalize 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). Nonetheless, providers' cultural capital resources would allow this reflexivity, but given their

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powerful position as the dominant group in the social field as a whole and their *habitus*, they 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 medicalization 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). Particularly in the case of common mental disorders, whose symptoms are often "diffuse and transient" (Rose, 2018, 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, 2018, p.74) as well as provides 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, 2018) since the focus is shifted from social issues to individual troubles as symptoms of diseases allowing the dominant groups to protect the social order so that it remains in *doxa*.

As a result, on the one hand, given the interests of pharmaceutical companies and institutional design of healthcare systems which focus on treating symptoms rather than social causes, this encourages over-medicalization 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 bypass the treatment system for severe mental distress with subsequent social and health costs: for instance, medical collaboration with other institutions (medical professionals

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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 reveals 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 analysis 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 pathways towards and within the field of (potential) users of mental health services. Nonetheless, analysis of help-seeking practices in mental distress needs approaching "the relative positions and resources of the producers and consumers" (Hilgers and Mangez, 2015, p.21) – that is, the role of both agents and institutions in the field of mental healthcare as well as users as consumers of services.

ON USERS: BETWEEN STRUCTURES AND AGENCY

An agent can participate in the field of mental healthcare while "taking no direct part in the game that is played there" (Lahire, 2015, p.73). As consumers (not producers), users indeed enter the 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) and providers usually experience power surplus due to accumulation of

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the field-specific cultural capital as well as 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 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).

Nonetheless, instead of acting separately, 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 it differently, service user movements can struggle for domination or changes of the rules of the field rather than being excluded from it. While Gøtzsche (2013) unveils influences of 'big pharma' on patient organizations through financial support showing their dominated position in the field and incorporation of *doxa* as taken-for-granted order or rules of the field, Rose (2018), on the other hand, 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 organizations such as the World Network of Users and Survivors of Psychiatry or promotion of alternative forms of knowledge including the concepts of 'empowerment' or earlier-mentioned 'recovery framework', among others. Although such movements do challenge *doxa* moving it to the discourse, Rose (2018, p.170) recognizes that their role in "a transformation of the fundamental power relations in psychiatry" has been limited so far and they remain dominated in the field.

On capitals

Even without considering users as playing in a group, their capital resources accumulated individually and dependent on class origins, education, gender or even residence (Wacquant, 1989) differentiate them in terms of power and define their location in the social field as a

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whole determining access to information and, as a result, pathways of help seeking. Besides other strategies, this includes 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, depending on the institutional design of health systems. 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, since field-specific cultural capital as embodied knowledge about mental health and illness 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) synthesizes these field-specific capitals offering the concept of cultural health capital as "the particular repertoire of cultural skills, verbal and nonverbal competences, and interactional styles that can influence health care interactions at a given historical moment". Thus, cultural (mental) health capital can be a useful tool in the model of help seeking in mental distress. Not only do these resources facilitate clinical encounters, once help is sought, but also improve one's ability to acknowledge suffering as pathological, i.e. to perceive need for care, particularly in case of common mental disorders which often lack a clear physical basis, and to cope with them 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 an ability to accumulate it through past experiences of health practices in the field (Guldager et al, 2018; Shim, 2010).

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Social capital, being linked to "membership in a group" (Bourdieu, 1997, p.51), also appears an effective resource encouraging (or impeding) help-seeking practices. Other scholars have extensively analysed their 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 network of connections that can be effectively mobilized 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). Put it differently, the same overall number of connections can accumulate different volume of the social capital depending on cultural and economic capitals of those 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 'choice' of certain strategies in case of mental disorders. Nonetheless, 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 through a location in the social space only and, therefore, agents' *habitus* or incorporated dispositions (Figure 1) that are "*acquired through experience*, thus variable from place to place and time to time" (Bourdieu, 1990a, p.9) need to be analysed.

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 institutions as social structures – and objectification in bodies or

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incorporated collective history as *habitus,* which "reflects a shared cultural context" (Adams, 2006, p.514) while, at the same time, being individualized (individual history). Therefore, the importance of *habitus* in help seeking lies in its reflection of sociocultural context – incorporated 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 depending on one's capital resources, i.e. *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). Socialization in the family, the journalistic field and, particularly, the school system play important roles 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 among celebrities as "possessors of distinctive properties" (Bourdieu, 1984, p.251) may result in imitation of practices. The imitation, however, may also lead to over-medicalization of mild symptoms depending 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, dispositions are *structured* reflecting the social conditions where they are acquired (the social position of the family, prestige and social conditions of neighbourhood or school

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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). Nonetheless, the fact of unconscious functioning does not rule out that "the responses of the *habitus* may be accompanied by a strategic calculation" (Bourdieu, 1990b, p.53) although these 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 whilst 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).

To describe this implicit adherence between social structures and *habitus,* Bourdieu (1977) talks about *doxa* which is taken-for-granted understanding that people have about their social worlds, their (im)possibilities or their place in the field (Veenstra and Burnett, 2014). *Doxa* is produced and imposed "categories of thought that we spontaneously apply to all things of the social world" (Bourdieu, 1998, p.35) – for example, perceptions about the role of healthcare providers as authorizing withdrawal from regular social roles and responsibilities 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 although with the dominant groups intending

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to defend it (Bourdieu, 1977) – e.g. scientific crises with medical knowledge and its self-evidence being questioned.

Thus, help seeking in mental distress "has a logic which is not that of the logician" (Bourdieu, 1990b, p.86) and 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) given their past experience in different fields, which they have acquired over time as dispositions within *habitus* guiding their practices or, in other words, responses to symptoms of mental disorders.

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. However, it depends 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), i.e. it is very much structured and dependent on 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 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,* that 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 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;

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Williams, 1995). Nonetheless, as a response to this, Bourdieu emphasizes 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 pathway of actions). Instead, depending on the objective state of the field of mental healthcare, agent's capital resources and 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, but 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 that, 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) and where such harmony and knowledge of the limits of the field and one's possibilities (and accepting them) 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

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and limits initially set on its inventions" (Bourdieu, 1990b, p.55). Yet, 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 "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 "characterizes all minimally competent members of society" (Sewell, 1992, p.18). Specifically, 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). Although certain extent of agency is a given to all humans, its form depends, nonetheless, on these resources that are socially conditioned and enable a capacity to reinterpret and reapply schemas in a new context (e.g., to recognize and acknowledge symptoms in his/her own body).

As a result of these features of *habitus*, different strategies as individual responses to mental distress may emerge (Figure 1 summarises some of them) – from medicalization 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

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challenges in the treatment system and results “automatically from the conditions of existence” (such as avoidance or some strategies of 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).

Nonetheless, 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 of the limits between normality and abnormality, health and illness (technologies of domination though the medical *logos*). Nonetheless, such practices suggest an agent who, despite the limits of action, “is engaging in a reflexive evaluation of the situation and responding accordingly to maximise her or his life changes” (Lupton, 1997, p.105).

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 comparative qualitative study on help seeking in mental distress. Specifically, this ongoing study examines how institutional (the logic of the field of mental healthcare), cultural (*habitus*) and social (individual capital resources) contexts influence help seeking, in general, and healthcare seeking, in particular, in depression or anxiety disorders. Users of services and healthcare providers have been interviewed in two settings that contrast in under-/over-treatment rates in

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mental distress due to "the particularities of different *collective histories*" (Bourdieu, 1998, 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, although 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, although the psychopharmacotherapy is available and accessible, psychosocial interventions are often restricted to a limited number of psychological consultations per user only, revealing dominance of biological psychiatry in the field, which along with power differentials in the provider-state relations drives the logic of the field. This logic of action 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 in terms of employment in public sector (law, medicine, police, etc.), getting or renewing a driving license or owning a gun), which functions as an instrument of symbolic power. Therefore, analysis of the logic of the field unveils accessible but not necessarily acceptable or humane mental healthcare.

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Furthermore, s*tatus quo* of the field of mental healthcare is structuring and structured by beliefs towards mental illness dominant in the cultural context and 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 resulting in guilt and shame, which was present in the interviews of nearly all 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.

Agents with capital resources were 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) as well as social capital that provides push to care or can be converted into cultural health capital proved to be particularly crucial in agent's pathways of help seeking. By the same token, a lack of accumulated capitals delayed healthcare seeking and resulted in maladaptive or ineffective coping such as alcohol use and abuse, normalisation, self-isolation or somatisation. As a result, mental healthcare seeking was late (often coerced) with significant health and social outcomes resulting in reproduction of social structures.

Therefore, the proposed theoretical approach helps to reveal that there is homology between objective structures of the field of mental healthcare and mental structures of *habitus* that reinforce one another and reproduce social and health inequalities. Guilt and shame in both domains – social field as a whole and the field of mental healthcare, particularly through

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institutionalised stigmatisation – 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 potential of the theoretical framework.

CONCLUSION

The model earlier outlined in the figure 1 summarises the field approach proposed in this article, where the logic of the field of mental healthcare, its historical configurations and interplays with the state and the market as well as individual's 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 field of healthcare as a structure of interdependent positions or distribution of capitals impacts access to healthcare;

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how incorporated or mental 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.

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FIGURES

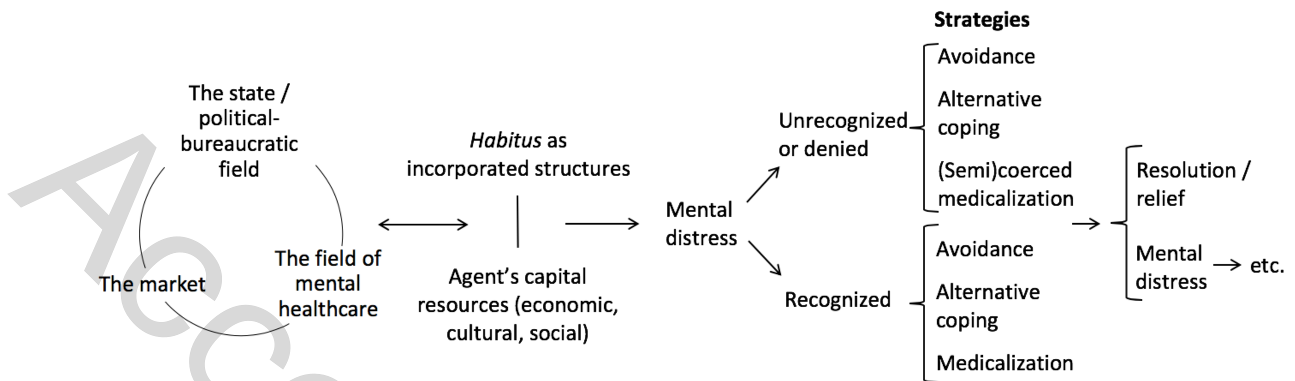

Figure 1. The theory of fields and help seeking in mental distress.

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