**The Informalization of Doctor-Patient Relations in a Finnish Setting: New Social Figurations and Emergent Possibilities.**

When first featured as a theorist with important insights into the culture and practice of modern medicine, Norbert Elias was identified as operating with a focus largely drawn to processes of affect regulation and self-control (Atkinson 2008; Malcolm 2011; Turner 1992: Waddington and Smith 2013). In this regard, his reflections on the role played by hygiene codes and sanitary practices in the advancement of civilizing processes, as notably featured in his study of *The Loneliness of the Dying* (1985)*,* were often taken as a guide to how we should approach the significance of his work for the study of health and medicine (Pinell 1996). Additionally, Elias’ analysis of how experiences of embarrassment and shame operate to inculcate social regulations inspired some to reflect on the extent to which he might be read as a sociological complement to a Foucauldian analysis of the regulation of bodies and care of the self (Smith 1999). In this respect, it may be that in some minds Elias is situated as a segue to Foucault (Turner 1992; Greco 2002). More recently, however, attention has turned to the ‘radically relational’ approach of his figurational sociology and his concern to attend to processes in which individual lives are woven into interdependencies and shared attachments; and how in turn, these are manifested in people’s habitual behaviours, expressions of emotion and terms of mutual recognition (Elias 1978 ; Dopson 2005; Gibson and Malcolm 2020). In this context, the value of Elias’ work is perceived to lie in its capacity to explain changes in social practices of health and medical care in relation to the reconfiguration of social bonds and concomitant reformulations of codes of manners and self-restraint.

One of the more complicated matters that is raised for analysis and debate in this setting concerns the co-existence and ‘spiraling’ movements of both civilizing *and decivilizing* trends (Elias 1994 [1939] 1: 307 n; De Swaan 1997; Mennell 1990; 2007; Powell and Flint 2009; Law and Mooney 2012; Wouters and Mennell 2015). Arguably, this aspect of Elias’ work has been most extensively developed by Cas Wouters under the umbrella heading of ‘informalization’ (Wouters 1986; 2007; 2011). This pays heed to the ‘collective emancipation of emotions’ that accompanies a relaxation of ‘formalized’ manners and codes of self-restraint (Wouters 2007: 202). It attends to the new demands that are set for emotion management as individuals are made to negotiate with social situations where rules of etiquette are rendered more flexible, codes of behavior made more varied and emotional states become more subject to conflicts of interpretation.

More recently this theoretical perspective has been adopted by Patrick Brown and colleagues as a means to chart shifts in power relationships between general practitioners working within the British National Health Service and their patients (Brown, Elston and Gabe 2015). Their work illustrates the conceptual value of an Eliasian approach for analyzing relational dynamics in which patients appear to be losing their respect for the authority of doctors. By drawing a focus to the ways doctors struggle to manage increasingly fractious interactions with ever more demanding and less deferential patients, Brown et al argue that the net effect of more democratized doctor-patient relations is a ‘social distance’ that ‘can lapse into mutual misunderstanding and fear which is experienced by both parties as rudeness and confrontation’ as a welter of (de)civilizing and (in)formalizing processes continually push up against one another (Brown et al 2015:171).

In what follows we analyse similar processes that are taking place in the Finnish occupational health care system where doctors also report themselves to be dealing with patients that increasingly relate to them without the levels of formality and deferential respect accorded to older generations. However, in contrast to the study of Brown et al, our data suggest that this does not so much serve to advance positions of mutual distrust and hostility, but rather, to more concerted attempts to renegotiate social roles, cultural meanings and individual responsibilities. According to Elias’s figurational approach, these trends challenge earlier asymmetries and reflect the increasing informalization of doctor-patient interactions (McKinlay and Marceau, 2002). We document forms of social and cultural reflexivity that appear to be implicated in what Cas Wouters refers to as a ‘spiral process’ in which informalization is accompanied by revitalized currents of formalization and new syntheses of moral codes and conduct (Wouters 2007: 167-96).

These relate to both the practice of medicine and the use of diagnostic language. Indeed, when framed in these terms, one of the more interesting findings from our study concerns how we might venture to interpret and explain the social prevalence of mental health problems connected to problems of anxiety and depression; for we argue that from the perspective of ‘informalization’ these may be construed as *both* the genuine result of the social turmoil aroused by distressing experiences of social change and a greater willingness among populations to vent such feelings and give voice to their experience in clinical settings.

In this regard, it appears that as these doctors seek to better accommodate and manage the problems that patients submit to them for diagnosis, they are being moved towards a greater recognition of the determining influence of wider social conditions over occupational health problems and upon their role and identity as health professionals. Here the practice of medicine under conditions of informalization is operating to advance a greater sociological reflexivity among practitioners that entails a heightening consciousness of the social forces shaping both the symptoms of disease and favoured languages of diagnosis. It might be argued that this amounts to an instance where a process of medicalization operates with an ever more elevated sociological awareness of the socio-economic and cultural forces shaping conditions set for medical treatment and the terms under which this is set into practice.

We begin by outlining the context of our study and the methods used to gather our data. We then reflect upon our findings within the frame of an Eliasian perspective that relates transformations in the doctor-patient relationship and in the negotiation of mental health problems to a ‘spiral process’ of informalization and reformalization. Here we further elaborate on our analytical approach before moving to explain how this has directed the interpretation of our interviews. We conclude by issuing an invitation to further dialogue and debate over the ways that we have applied Elias’ figurational sociology to the interpretation of our data. In this, moreover, we emphasise that, insofar as Elias’ sociology is committed to analyzing an open and ongoing process in which formalizing and informalizing currents are always being washed together, then it commits us to an inherently conjectural domain of analysis. While this approach may be valued as a way of making sociological sense of the increasing incidence of a society’s mental health problems, it also invites us to speculate over the extent to which symptoms are the result of a reconfiguration of the relationships between doctors and their patients. Insofar as these are made more subject to processes of informalization, then we might also expect the expression and documentation of experiences social distress to become more culturally elaborated and widespread.

**The Study**

This study was part of *The Rise of Mental Vulnerability in Work Life* project led by the Finnish Institute of Occupational Health. Doctors with careers running from the early 1970s through to the mid-2010s were our primary target group. In countries with exclusive occupational health care for the employed, such as Finland, occupational health physicians play a vital institutional role in caring and managing employees’ mental health problems (Martimo and Mäkitalo 2014). They draw lines between work ability and disability, and evaluate the underlying reasons for employees’ sicknesses (OECD 2012). Their observations and interpretations therefore form a noteworthy, although underexplored, corpus of data for analysing the advent of mental health problems and their temporal and contextual specificity.

The article does not conduct historical analysis per se, rather, it explores occupational health professionals’ notions and perceptions of their past work experience (Beard 2017). It also documents some of their “biographical work” from today’s perspective (Mathieson 1999). Data collection ceased when the research group reached the consensus that no new information on the topic was being acquired (Little et al., 2016). Although most interview questions and themes were predefined and based on reading the existing literature, the interviews were designed so that the interviewees also had the opportunity to describe their views, experiences, and how their work changed in a free manner so as to provide a space for them to introduce new topics to the discussion (Wilhelmy et al. 2016).

Forty-one in-depth semi-structured expert interviews were conducted in 2015. Most participants (78%) were recruited via network contacts and the rest via the Finnish Association of Occupational Health Physicians. Altogether 41 health professionals participated in the study. Thirty-three of these were occupational health physicians, five psychiatrists, three occupational health nurses and one occupational health psychologist. At the time of the interviews, the age of the participants ranged from 38 to 78 years with the mean age being 62 (63% men). The average job tenure was 33 years (range 13‒46). One third of the participants had retired. Most of them had worked in the 1970s, 1980s, 1990s and 2000s as occupational health professionals and with patients from various sectors of industry (industrial work, finance, public administration, media etc.). They had worked through wide-scale social and economic changes which they readily identified as operating to transform the lives of their patients, the institutional organisation of the health care sector and their occupational practices. The average duration of the interview was 84 minutes.

Each interviewer used the same background set of questions, which was composed of ten sub-topics. These gathered information on the occupational life stories of medical and health care experts along with their views on changes in the patient characteristics in relation to transitions in the experience of work. They further documented doctors’ views on how these transitions were involved in transforming health risks at work, changes in treatment and diagnostics, cultural shifts in mental health attitudes and norms and the terms of professional address to these matters at the level of occupational discourse. Topics were formulated and interviews schedules were devised with the aim of establishing a shared and consistent approach to gathering the data (Patton 2002). In each instance the first interview was conducted with two interviewers present so one could observe the other with the aim of monitoring the consistency of the approach to questioning. Subsequent interviews were conducted use one interviewer.

All interviews were audio-recorded and transcribed verbatim. Data analysis consisted of four stages. The second author (PI of the study) of this manuscript was involved in all these stages and led the analytical process. First, in the descriptive stage, the PI and two interviewers (Jussi Turtiainen, Anna Kuokkanen) read though all the interview transcripts and identified the key aspects of knowledge work and its nature. They detected 19 themes frequently mentioned in the interviews (e.g., changes of working life, social stigma related to mental illness, transitions in the professional role of doctor, diagnostic criteria, relationships between doctor and patient etc.).

In the second stage, the texts were classified according to analytical categories using theoretical ideas from previous research. At this stage, the three main coders reorganized the materials from all 41 interviews into more focused categories. The aim was to detect the key long-term tendencies among health professionals that influenced criteria of working life, standards of health, norms of health behavior and other issues related to mental health issues and psycho-emotional symptoms treated in the medical encounter. For instance, it was discovered that for most interviewees, doctors’ work had included a growing tension between medical expertise and a more critically reflexive clientele. To guarantee the homogeneity and consensus of the classifications between the researchers, the coders met in joint coding meetings to compare individual codings and discuss discrepancies (Wilhelmy et al. 2016). The coders were attentive to how the classifications (e.g., key tensions) were related to existing research and how previous research could be used to identify new categories (Locke 2001).

The third stage of the data analysis was crucial for the analytical framework of this article. The interview material showed that various transitions in professionals’ work related to mental health problems that corresponded with the informalization thesis developed by Cas Wouters (2007). This finding helped us interpret the data in a more sociologically meaningful manner that attended to the role of functional informalization, and the concomitant development of more permissive culture, within the social development and expression of people’s mental health problems. It also provided us with an analytical frame in which to reflect on how the co-existence of civilization and decivilization processes is experienced and displayed within the practice of health care.

Finally, in stage four, to expand the contribution of the study to sociological research and the medical sociology in particular, the authors assessed and reflected on how traditional arguments concerning medicalization, medical dominance, and civilization process fit the analysis of recent processes associated with the crisis of mental health and the rise of psycho-emotional health concerns (Catanzaro 1988; Payne and Williams 2005). In addition, they evaluated how such conceptual and analytical contstructs may contribute both to the development of figurational theory and the current analysis of subjectivity and mental health as incisively influenced by people’s habitual dispositions towards self-regulation and emotional self-expression.

**The Finnish Context**

The Finnish economy was heavily based on agriculture and forests until the 1950s. In the early 1950s, it was about 50 years behind the industrial development of the Swedish economy (Hannikainen and Heikkinen 2006). Over the past 60 years, Finland has rapidly transformed from an agricultural society into an industrial society, and then into a late modern knowledge-intensive society. A dramatic decline of low-skill jobs in agriculture and heavy industry took place between the 1960s and 1990s and there was a sharp increase in more knowledge based work between the 1980s and 2010s (Hannikainen and Heikkinen;2006; Pyöriä 2006; Väänänen, Koskinen and Toivanen 2016). From the 1960s onwards, major demographic changes took place as working age people started to move from rural settings to cities in bids to find employment in the new industrial and service sectors.

This drastic structural shift, accompanied throughout by changes in the level of education is reflected in overall conditions of work and standards of living (Fellman 2008; Sutela and Lehto 2013). In the 1970s most employees received only a basic level of education and were still rooted in the countryside. According to the one of the oldest nationally representative working life surveys in Europe, in 1977 about 10% of the Finnish employees had a university degree, while by 2018 their share was 46% (Sutela, Pärnänen and Keyriläinen 2019). The transition pointed to considerable changes in people’s work practices and cultural outlooks. For instance, in 1984, 17% of the Finnish employees used information technologies in their work whereas in 2018 the corresponding rate was 91. In 1984, 26% of the Finnish employees reported that they had a female supervisor. In 2018, more than 42% had women as their supervisor. During the same time, the possibilities to develop oneself at work increased considerably. In 1984, 28% of the employees reported that they had good opportunities to develop oneself while in 2018 the percentage was 45.

These changes were accompanied by considerable transitions in occupational health. The prevalence of chemical and physical hazards declined while various psychosocial exposures and needs for work stress management were identified (Kauppinen et al. 2013; Kinnunen-Amoroso and Liira 2014). Finnish employees, working life and occupational health concerns changed drastically. During the course of modernization, the proportion of cardiovascular diseases and injuries declined at the same time as there was an increase in mental health concerns. Later, between the early 1990s and the late 2000s, the number of sickness absence spells due to mental disorders more than doubled and the use of antidepressant drugs grew fivefold (Järvisalo et al. 2005). Currently, the majority of disability pensions are granted for mental disorders (Nyman and Kiviniemi 2018).

The whole occupational health care system was built since the 1970s as part of the Finnish welfare state. Occupational health doctors have been operating in the context of a highly ‘compressed’ experience of modernization (Beck and Grande 2010). In this regard, we contend that by focusing our attention on transformations within the working knowledge and experience of Finnish occupational health care practitioners that we are provided with a unique opportunity to study interconnections between processes of formalisation and informalization. In what follows we are particularly concerned to highlight some of the ways in which the broadening area of mental health and psychological work ability was accompanied by the reconfiguration of the doctor-patient relationship. The doctors in our study testify to the rebuilding of behavioral codes as well as a need for new health care practices that are better suited to support people who increasingly look to them for help when faced with new work-related psychological distresses and demands.

**The Data**

The doctors we interviewed agreed that they were both witness to, and experiencing significant changes in, the doctor-patient relationship. Insofar as these involved them in more frequent encounters with less deferential and opinionated patients, their overall significance was often identified in the extent to which they operated to erode the authority of doctors. As one comments:

*The biggest change is that when I started as a physician in the 60s and 70s the medical doctor was an important figure. The patient didn’t come to the consultancy with a completed diagnosis but he/she came to ask advice and with certain symptoms. Then it was easy to give instructions and people believed and accordingly. But now people come in with a google diagnosis…[Earlier] it was more about the trust and using the methods you had in hand….Perhaps it was easier for both parties involved I think.* [ID13. Male born in 1941. Started practicing in 1960s]

The above quote refers to the involvement of the internet in advancing a ‘democratizing’, or rather, a social levelling process, that was modifying the relationship between doctors and patients. This recognition was widespread. For example, another comments:

*[In the late 1970s and 1980s] patients were ‘virginal’ so that no one had tried to give it [the medical problem] some sort of name. The patient did not have some preliminary appraisal of what was bothering him/her. The nomenclature was that the patient comes to see the doctor and the doctor defines what the situation is, and what next steps are. And then the patient leaves. Today patients have unspecific symptoms [and] big demands..[such as] One should be allowed to see an occupational psychologist, this means this and that according to Google, those tests should be performed….When problems are complex in their nature they should lead to various types of consultancies, discussions with occupational psychologists and control visits, and the opinion ought to be mutually constructed. But second opinions are being sought all the time…..* [ID07. Male born in 1951. Started practicing in 1970s]

In these respects, our findings are similar to those documented by Brown and colleagues (Brown et al 2015: 167-9). Like them, moreover we also encountered doctors who admitted to feelings of estrangement and resentment as a result of their interactions with patients. For example, with the implication that their patients are now displaying new psychological weaknesses that are being granted excessive levels of formal recognition, one declares

*[For the] the new working life generation… it is more allowable and easier to be sick for psychological reasons, you don’t have to be so strong [as you used to be]* [ID37, male born in 1953, started practicing in 1970s]

In a similar vein, while admitting to the suspicion that younger generations may be having an easier passage through their working lives than older generations, another holds that:

*Children who have been brought into medical care with the support of private insurance they have adopted new standards of behaviour whereby it is now acceptable when you have something (wrong) you start seeking help without questioning whether it should be common sense response. In this regard, the threshold by which people are set to cope with these sorts of problems has lowered considerably.*[ID35, male born in 1957, started practicing in 1980s]

 In contrast to Brown and colleagues, however, we found that while doctors reported themselves now to be involved in noticeably less hierarchical relationships with ‘internet-informed patients’, that these did not appear to operate as a spur to outbursts of rudeness and aggression. Brown and colleagues found that the doctors and patients in their study often appeared to be left somewhat confused and frustrated by the more democratized terms of their interactions with one another, and further, that this seemed to be implicated in the breakdown of cordiality and mutual respect. We found evidence to suggest, however, that in the context of Finnish occupational health care, that both doctors and patients appeared to be considerably better at adapting to the fact that their professional skills and identity are now more likely to be questioned and contested by their patients[[1]](#endnote-1). Indeed, some went so far as to welcome this as presenting opportunities to explore health problems that hitherto tended to be sidelined as a consequence of due deference and formality. For example, in recognition of the extent to which it is now more socially acceptable for a patient to declare themselves to be experiencing mental health problems, one notes that as far as the 1970s were concerned:

*They were hidden issues and people didn’t want to bring them out. And I didn’t start… If the problem had been labelled with some physical disease diagnosis and I noticed that it (a mental health problem) was difficult for the patient, as a doctor I didn’t want to dig it out with force because it seemed to be managed and that was enough. Sometimes I thought by myself that there is something else here, not just neck or back pain*… [ID12, male born in 1951, stared practicing in 1970s]

Similarly, when reflecting on the differences between the 1970s and the present day in relation to the professional acknowledgement of, and on patients’ responsiveness to, the medical address to mental health problems, another comments:

 *[Currently] mental health is discussed more easily. Doctors are ready to start to speak about these issues. There are various supportive tools such as checklists that can be used in the case of mood issues and so on. And people’s behavior has changed. They come to see a doctor more easily. People accept it [mental health challenge] and are willing to receive treatment and help* [ID15, male born in 1948, started practicing in 1970s]*.*

In part it appeared these differences between the British and Finnish context may be due to the fact that Finnish doctors are working under cultural and organizational conditions that are better designed to facilitate their negotiation with patient problems and demands. As compared to institutional arrangements within the British health care system, it seems that more concerted attempts have been made to set organizational structures and practices in place to enable Finnish doctors to adapt to new duties of care2. For example, one notes:

*At the corporation we have a workplace programme with an associated ‘wellness at work’ web site. And we have also written a job satisfaction guide in which there are sections on recover, stress, and the work community issues……Then there is the ‘let’s talk about work’ model that is our early support preventative models according to which the foremen are trained and there is support for them with respect to supporting of their subordinates, and also support of the foremen’s own coping is included*. [ID17. Female born in 1954. Started practicing in 1970s]

Indeed, in many instances, when reflecting on the overall direction of recent social and economic changes in Finnish society and their impacts upon their professional identity and practice, for the most part we found that doctors were able to regard these in positive terms. For example, when commenting on the fact that younger generations of Finnish people appear to be more prone to experience problems of anxiety and to readily treat these as a justification to pay a visit to the doctor, one declares:

*The younger the population, the more they come to talk about mood disorders and the milder causes for visiting a doctor……Perhaps this is an exaggeration, but you can now come to visit a doctor if you feel down because your pet has died and a short-term girlfriend has left you. These were not reasons to visit a doctor in the 1970s and 1980s. Perhaps it is good for a person’s coping…Perhaps it is good that one can talk… People come to the appointment when they have need. You treat the issue like he/she experiences it. You can start to value whether there is an intention to overly use social benefits. And rarely is this the case. It is mostly that the patient doesn’t feel that he/she is able to cope with the thing and comes to talk about it more easily. I suppose this is good.* [ID15. Male born in 1948. Started practicing in 1970s]

The above quotation exemplifies one of the most common findings from our study, which is that, in this Finnish context, a greater informalization of the culture of manners and of norms regulating terms of emotional expression appears to operate as the prompt for doctors to operate with a sociological reflexivity as part of their practice. Those we interviewed were readily prepared to engage in a discussion of how their working conditions and patients’ health problems were determined by wider economic and social arrangements. In this regard, the doctors understood many of their patients to be experiencing mental health problems as a result of being made subject to intensive work pressures and to the threat of unemployment as well as drastic organizational changes. For example, one comments:

*[With] the transition of work, the arrival of computers and loss of traditional occupations the sources of distress changed. [In the 1980s] autonomous workgroups and ITC entered. Employees were told that booking systems and many other functions were being automatized but hardly any training was given. It was at that time that people started to regularly cry in their appointments. Then the recession of the 1990s arrived and this came with more widespread anxiety: …“how I will survive”, “how will I deal with my debts”, “what is going to happen to my family”… At that time, mental health diagnostics started to be revised.* [ ID03, female born in 1950, started practicing in 1970s

Another observes:

*It was those big mergers (in the 1980s and early 90s) in the sectors where people had a belief that once you get in and start there you can stay until you retire… Suddenly, the firms started to fall and merger. Those were quite shocking situations. I remember a social event when a bank employee told me that it was like spouse’s death when her bank went bankrupt. People had a strong workplace identity and all of a sudden they were told that this is was closed and did not exist anymore. That was a time when I realized that I had to take care of communities and not just of people as individuals, [and that this includes both] their worries and their despair. After that profit-making objectives were introduced, and the employees of the banks became ‘salespersons’. Once, a long time ago, employees had been recruited because of good handwriting skills and with an interest in how they could advance to higher grade positions […] The demands became intolerable for the psyche. Of course, some persons took it and managed to float above it all somehow… but some experienced it most harshly* [ID36, female born in 1961, started practicing in 1980s (banking sector)]

Many were consciously adapting their clinical practice and adapting their diagnostic vocabulary in bid to better manage a new range of mental health problems. For example, ehen reflecting on how increasing levels of work stress first came to their attention in the 1980s, one recalls:

*All the time when you moved forward in the categories (ICD), more and more descriptive diagnoses appeared. The concept of disease changed. People started to have multiple unspecific symptoms…. And there started to be a social pressure that this should be formally classified somehow as a disease*. [ID42. Male born in 1945. Started practicing in 1970s]

Here we see a recognition that at the same time as they were responding to new patient demands for doctors to treat mental health problems, the medical profession was actively and consciously involved in creating a conceptual language to render these more subject to terms of medical diagnosis and treatment. Moreover, some of our respondents welcomed the new opportunities they had to create a new range of cultural codes and social spaces for their patients to vent their frustrations on the understanding that this represented a new advance in rendering them formally recognizable as illness. For example, one confides:

*We started to have problems in the domain of mental health. We decided to conduct a Bergen Burnout Inventory for all employees. This was in the mid-2000s. Clear cases of burnout were indicated. Some were previously unknown. I interviewed them all. Typical symptoms were a lowered sense of professional efficacy and cynicism. Earlier they had not dated to come to a doctor’s appointment. It was quite exciting that after we started to perform the burnout inventory they started to come to the appointments - it somehow turned on the tap.* [ID12. Male born in 1951. Started practicing in the 1970s]

In this respect, we suggest that in our interviews we have found further evidence to support Cas Wouter’s contention that processes of informalization and their accompanying ‘emancipation of emotions’ tend to increase new demands for more formal emotion management (Wouters 2007). We can identify outcomes similar to those Wouters documents when charting recent transformations in rituals of mourning and terms of sexual etiquette, that is, new movements to create behavioural standards and institute social practices that *reformalize* relationships, albeit to more *flexible* strictures of self-regulation. Indeed, in this context, it also seems that our Finnish doctors are undergoing what Wouters has referred to as a ‘sensitizing’ process that is animated not so much by a self-regulating conscience, but more by a heightened consciousness of the need to demonstrate a greater tactfulness and willingness to compromise when managing the emotional demands of their patients (Wouters 2011). On their accounts, there is no doubt that they are experiencing a change in the ‘power balance’ between themselves and their patients, but this is a matter that, albeit through some difficult professional adjustments and adaptations, most are prepared to accept on the grounds that the overall gains in terms of their capacity to offer meaningful help and support for their patients is perceived to outweigh any costs borne in relation to a loss of hierarchical esteem.

**For Dialogue and Debate**

In this article we have argued that the new social proximities and interdependencies of the clinical encounters between Finnish occupational health care doctors and their patients signal a process of ‘functional democratisation’ (Elias 1978; Wouters 2016). Here doctors are experiencing what Elias at one point refers to as a diminishing ‘power gradient’ between themselves and their patients that commits them to revise the meaning of their social roles and the terms under which they conduct their clinical practice (Elias 1978: 34). A process of informalization is taking place. While this certainly involves the doctors we interviewed in some frustrations and difficulties in connection with the task of managing their relationships with less deferential patients, in contrast to the study of Brown and colleagues, we did not find that this resulted in a ‘social distance’ that led to more ‘rudeness and confrontation’, but rather, to new forms of social integration, collaboration and adaptation (Brown et al 2015:171). In this regard, we hold that we have recorded an example of a ‘spiral process’ in which informalization is accompanied by new departures in processes of formalization that are advancing new syntheses of moral codes and conduct (Wouters 2007: 167-96).

This raises some wider questions about how sociologists might venture to document and analyse the mental health crises of advanced industrialised nations (OECD 2018). On the one hand, the reconfiguration of the social relationships between the doctors and patients in our study served to create social opportunities and spaces for doctors to be more attentive to patients’ experiences of emotional distress, anxiety and burnout. The doctors were sensitized to the social and economic dimensions of work conditions that were implicated in escalating problems of mental health. On the other hand, they were also involved in the construction of new languages and forms of exchange that served to amplify these problems. The ‘democratization’ of the clinical encounter facilitated a more open and fulsome expression of emotional discontent that gathered diagnostic legitimacy through a sociologically recalibrated discourse of medicalization. Accordingly, a heightened recognition of the harms being done to people through their conditions of work and difficult life situations was accompanied by a reconfiguration of institutional arrangements and cultural activities by which they were set to be magnified. While work-related mental health problems were increasing, it appears that both doctors and patients were in the process of forging social relationships and forms of cultural exchange with one another through which such problems were likely to appear more visible and disquieting. On this evidence it might be argued that at the same time as increases in mental health problems among Finnish workers were the result of increased pressures of work, it was also the case that such problems were now far more likely to be recognized and represented as legitimate issues for medical concern as a result of the recalibrated social exchanges between occupational health care doctors and their patients.

A further matter for debate here concerns the analytical value of an Eliasian approach to interpreting the social substance and sociological meaning of the relationships between doctors and their patients. It may be due to the fact that figurational sociology has tended to be introduced to the study of health and medicine in a context where Foucauldian concerns hold sway that a greater emphasis has been brought to formalizing rather than informalizing processes in the analysis of human conduct and conditions. It is certainly the case, moreover, that there has been a tendency in some quarters to read Elias as a sociological augmentation of Foucault, and in this context, as an aid to understanding the potential for medicalization to operate as a regulatory regime over our bodies and feelings (Turner 1992; Greco 2020). By contrast, in this study we have sought to emphasize the extent to which an Eliasian approach to studying the disciplinary mechanisms within processes of civilization should also be committed to understanding how these always *coexist* in tension with decivilizing potentialities and tendencies. Moreover, when it comes to determining the overall direction and consequences of spiraling movements of formalization and informalization, then all judgements are set to be partial and open to review. We are dealing with processes that are ongoing and open-ended. We are drawn, moreover, into some of the deeper complexities, that might also be cast as the ‘ambiguities’ and ‘ambivalences’ of the Eliasian position (Burkitt 1996). While formal constraints may dominate one period or place, they are always set to be held in tension with countervailing tendencies that are pushing towards alternative moral, and possibly far more informal, arrangements. On this view, Eliasian sociology is inherently conjectural and always leaves the door open to many conflicts of interpretation. It may help us to make sociological sense of ambiguities of our moral condition, but us also cautions us with the knowledge that these are matters that cannot be adequately resolved. The sociological significance and human consequences of these processes will always be open for review.

**Notes**

 For a fuller report on this matter see Väänänen et al (2019).

**2** These doctors were notably “reformist” in their approach. There remained some “traditionalists” who adopted a more sceptical response to the changes they experienced, and were not so eager to learn and use new “interactive approaches”.

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1. [↑](#endnote-ref-1)