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Exploring the potential of the theory of social representations in community-based health research - and vice versa?

Journal of Health Psychology

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This paper seeks to demonstrate the importance of developing a dialogue between social representations theory and community approaches to researching issues of health. We begin this project by demonstrating how we have used the theory within our own research to ground our findings at the level of community. The paper is divided into three sections, each dealing with a central aspect of social representations theory. These are the recognition of competing systems of knowledge, the role of representations in maintaining stigmatising practices and the impact of representations on identities. Each section is illustrated with material drawn from Foster's research on mental illness and Dorrer's research on women's representations of healthy eating. We conclude by arguing that, while social representations theory is a valuable tool for community-based health research, the theory would benefit from developing a more participatory methodology.

Key words:

Community, knowledge systems, stigmatising practices, identity, participatory methods.

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Please note:

All authors have had equal responsibility in the development of the ideas presented here and in the writing of this paper.

Exploring the potential of the theory of social representations in community-based health research - and vice versa?

This paper seeks to demonstrate the importance of developing a dialogue between social representations theory and community approaches to researching issues of health. Although recent academic work has highlighted this link (e.g., Campbell and Jovchelovitch, 2000), the potential of the theory within community-oriented health research is in need of clarification, elaboration and development. This is an ambitious task, and not something easily achieved within one paper. However, in this article we hope to begin such an endeavour by introducing the specific tenets of social representations theory that have guided our own research in health-related fields. We make particular reference to work on mental health service clients' representations of mental health problems (Foster, 2001, in press) and women's representations of healthy eating (Dorrer, 2002).

We shall concentrate on three aspects of the theory of social representations: firstly, its recognition of, and perspective on, competing systems of knowledge, particularly across lay and professional spheres; secondly, the role of representations in defending and maintaining stigmatising practices, in conjunction with wider social, economic and political factors; thirdly, the impact of representations on identity and well-being. Our discussion demonstrates what value social representations theory has for health research, particularly for grounding research findings at the level of community. By 'community', it is necessary to explain, we mean the socially-constructed spaces within which people develop common codes for understanding, confronting and identifying with one another. These codes, or representations, permeate social relationships, cultural practices and power relations¹.

We do not argue that the theory of social representations is the only theoretical perspective available to health researchers exploring the significance of community knowledge, beliefs and practices. Clearly there are other perspectives that emphasise the

¹ For more detail on a social representations approach to community see Howarth (2001).

inter-subjective, cultural and ideological levels to knowledge about health and health-related practices. Narrative approaches in health psychology, for example, offer similar tools with which to explore community views on health (e.g. Bury, 2001; Murray, 2000; Riessman, 1990). The sociology of health has also highlighted the importance of researching lay knowledge in parallel with studying structured inequalities in access to treatment (e.g., Popay, Williams, Thomas and Gatrell, 1998). While making a similar contribution focused on the reflexivity and subjectivity of health professionals and lay people, Stam (2000) has highlighted the need for community health studies to develop rigorous theoretical approaches. By way of a contribution to this growing field we would like to demonstrate how the theory of social representations can be used to explore health from a community perspective.

To compare and contrast this approach with others within the community health field is somewhat premature. What we hope to do here is simply offer our insights into how the theory has anchored our own research at the level of community, and to suggest some ways in which the relationship between the theory of social representations and community health research might develop. Health has long been a focus for social representations research (e.g. Herzlich, 1973; Jodelet, 1991; Campbell, 1997; Gervais and Jovchelovitch, 1998). Research questions in these studies have focused on the importance of lay knowledge, community, cultural practices and social identities for the study of health and illness.

What such studies share is a focus on the intersubjectively negotiated nature of knowledge, beliefs and practices and a concern for the social and psychological consequences of representations of health for identity and for community. These concerns are also central to our own research, as we reveal below. Before we move on to illustrate how we have used social representations theory, however, in the interests of transparency, some more detail on these studies is necessary.

Foster's (2001; in press) work focuses on the understandings that clients of the mental health services have of mental health problems. Clients are holders of what Foucault

(1980) termed a 'subjugated' knowledge, and as such their views have been considered less than those of professionals or the general public. The study focuses both on client knowledge in its everyday context, and on how it might affect clients' interaction with the mental health services; it comprised ethnographic work and narrative-style interviewing, carried out for periods of between six and eight weeks at three different mental health services - two day centres and one acute ward. Additionally, in an attempt to gain access to the more 'sociogenetic' level of representation (Duveen & Lloyd, 1990), material produced by clients or former clients of the mental health services in four mental health service user newsletters was collected over the period of a year. The aim of this design was to access as wide a range of different kinds of mental health service users as was possible within the timeframe. All data were analysed with the aid of the Atlas-ti computer programme (Muh, 1997): initial coding was performed using a partially deductive, partially inductive coding frame, after which themes were drawn out of the data. Communicative validation was employed, and participants' insights incorporated into the analysis. Efforts were made to maintain self-reflexivity throughout the study, and the principles of consistency and coherence (Duveen & Lloyd, 1993) guided the research.

Dorrer's (2002) study focuses on women's understandings of body, diet and eating in relation to dominant representations of health and femininity. The study aims to explore the interrelationship of socially shared knowledge and women's often problematic engagement with dieting and weight control behaviours. Central questions of this study were a) how dominant representations of the body and eating impact on women's everyday interactions with self and others and b) how women position themselves in culturally specific knowledge contexts. The research was carried out in two countries (Scotland and Tobago) in order to focus on the cultural embeddedness of health-related behaviours. In the UK, where eating disorders and dieting are far more common, the concerns and practices directed at the body, eating and health differ significantly from those in Tobago. Hence the focus here will be on the UK sample, where body dissatisfaction and dieting are associated with a high prevalence of eating disorders and other health problems. The extracts come from narrative interviews with British women

aged 16-26 from a variety of occupational backgrounds. The analysis of the material was aided by the software package QSR NUD*IST Vivo (QSR International, 2000), and is based on the deduction of representational themes and underlying themata (Marková, 2000) through the coding and comparison of interview as well as observational data.

Quotations from both studies are used throughout this paper: these have been chosen to represent underlying themes and representations that were common throughout the remainder of the data. Hence the process of carrying out this research, and the results that have emerged from it have informed the tentative claims that will be made in this paper regarding the potential of the theory of social representations in the field of community health. We also suggest that the principles of community-based health research have an important potential contribution to make to the theory of social representations. This would both aid theoretical development and enable researchers using the theory to develop more participatory research practices. However considering such developments, we first lay out how we have used social representations theory within our own research. These three sections establish what is distinctive about research within a social representations perspective.

1. Competing systems of knowledge about health and illness

There are clear parallels between the perspectives of the theory of social representations and community health psychology on the relationship between ‘lay’ and ‘expert’ forms of knowledge. Both approaches to health stand in stark contrast to dominant approaches within psychology that presume an individualistic, cognitivist and rationalistic approach to how people make sense of health and illness (Joffe, 1996).² Despite claims to the contrary, health psychology has often been closely aligned with mainstream biomedical approaches (Murray & Chamberlain, 1999). Such medicalisation can limit the focus, findings and reception of health research. As Kleinman (1988) points out, there is little

² One could argue that the dominant ideology of our culture, individualism, has pervaded our cultural and *scientific* understandings of health and illness in Western societies, just as it has influenced our attributions of success and failure (Ichheiser, 1949), educational achievement and dissatisfaction (Bourne, Bridges, and Searle, 1994) and the discipline of psychology as a whole (Farr, 1996).

room for patient narratives within biomedicine: they might be regarded by professionals at best as harmless irrelevancies, at worst as barriers to effective treatment.

By its very nature, social representations theory acknowledges multiple and dynamic knowledge systems about any socially significant object. Hence different groups are likely to hold different social representations. It was precisely because of the multiplicity of social groups and communities that Moscovici modernised Durkheim's (1898) concept of collective representations (Farr, 1998). Moscovici, the founder of social representations theory, demonstrated that as societies have become more diverse and more fragmented so too have representations become less stable and less uniform. However, where the theory differs from some other approaches to lay understanding of health, but parallels the community health psychology approach, is that it does not privilege one form of knowledge over another. Differences between knowledge systems are not seen as deficiencies, nor as the product of biased thought or error (Moscovici, 1984), as they are in some other studies – such as Furnham and Rees (1988) on schizophrenia or Nicholl (1993) on HIV/AIDS. Instead social representations theory demands that different knowledge systems are examined on their own terms, in their own contexts: differences are seen as consequences of the value and purpose of knowledge systems for different social groups.

In our research we have maintained a focus on the knowledge and experiences of our research participants and highlighted the differences between these and dominant, professional discourses. In Foster's (2001; in press) work, for example, the recognition of competing knowledge systems was crucial. Mental health is an area in which a strict hierarchy of knowledge exists. Although the dominance of psychiatric forms of knowledge is now questioned in more multi-disciplinary mental health teams (e.g., Miller, 1986; Sampson, 1995), certain forms of knowledge are still likely to be viewed as inferior or even damaging to both the holder and to wider society. Many of these forms of knowledge are those that exist at a more community-based level: for example, non-Western understandings of mental health experiences (Littlewood & Lipsedge, 1989; Wagner, Duveen, Verman, and Themel, 2000), or the understandings held by people seen

as 'mentally ill' by the medical profession (Foster, 2001). This latter group in particular struggle to convince both mental health professionals and wider society of the legitimacy of their claims. Indeed, the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994), used by psychiatrists around the world, maintains that an integral component of many mental health problems is that clients do not understand their own experiences and lack insight into their own problems (Rogers & Pilgrim, 2001). Certainly, as we detail below, some clients diagnosed with schizophrenia might not accept their diagnosis. To a busy professional, such resistance might constitute a lack of insight, and be a further demonstration of the validity of their assessment. Taking an approach driven by social representations theory, however, invites the researcher to probe further into what health professionals would see as denial or lack of understanding.

Interviewer: When you went to hospital did they, sort of, did the doctors and people tell you what... did they give you a diagnosis?

Chris: They said it was schizophrenia, erm... but when I went to the doctor's, he said to me, 'I'll have to put down on here that schizophrenia', and I said 'But I'm not' and he said, 'I know, but I'll have to put something down.'

Interviewer: Oh, OK

Chris: So he had to put a name to an illness, so they said schizophrenia. Now I don't agree with that.

Interviewer: Don't you?

Chris: I don't think I have had that.

Interviewer: Right. OK.

Chris: I've heard voices, but not.... I've never hurt anybody, or anything like that.

Interviewer: So do you think that being... schizophrenia is something different?

...

Chris: Erm... I've forgotten the question.

Interviewer: No, it was just that you don't think that your experiences are schizophrenia, so I was just wondering what you thought schizophrenia might be?

Chris: What I think it might be? I think it's, erm... sort of lose your temper very quickly..

Interviewer: Right, OK

Chris: If somebody says something you don't like, you sort of jump, and erm....

Interviewer: OK

Chris: I think that's what it is, I'm not sure.

This conveys competing knowledge systems between professional and client. For a professional, a diagnosis of schizophrenia need not rest upon violent behaviour. By contrast this particular client, Chris, believes that it should do, demonstrating an understanding of mental illness that is close to representations found amongst the general public (Jodelet, 1991; Nunnally, 1961). Taking a social representations approach, the Interviewer moves beyond the simple 'denial' of schizophrenia and encourages Chris to reflect on what a person with schizophrenia might be like. Rather than exhibiting a lack of understanding around the concept of schizophrenia, Chris shows that she does hold representations of it, and that these do not resonate with her own experiences and identity. Given the power structures within the mental health system, the professional's definition of schizophrenia is likely to be seen as 'correct' and lay representations disregarded. Such differences in definition and detection can have damaging consequences for the professional-client relationship, particularly with regard to relations of trust, disclosure, effective communication and treatment.

The example of Chris and her doctor described above shows the consequences of competing knowledge systems on an interpersonal level. However, such problems can also arise in wider health education campaigns, such as in public health programmes focused on the promotion of healthy eating behaviours. Here, as in the example of mental illness presented above, we can find a bias towards the medicalised model and a dominant individualistic ethos (Germov and Williams, 1996). As a consequence many health promotion projects prioritise knowledge that conceptualises healthy eating as rational lifestyle choice. Much research on primary prevention thus carries a focus on individual risk factors such as body dissatisfaction or lack of adequate information. Approaches of this kind can have certain negative social and psychological consequences. Besides reinforcing a culture of 'victim blaming' and neglecting socio-structural determinants of eating behaviours, individuals identified as 'at risk' are often positioned as passive recipients of expert knowledge. Their own representations are then ignored or rejected. Positioned in this way women are given few opportunities to present and discuss their own knowledge about the social influences on their experiences and behaviours. Consequently they may feel restricted in the degree to which they can

become active participants in the promotion of women's health (Moulding and Hepworth, 2001).

A social representational view of the following extract illustrates these points. The extract has been taken from an interview with Emma, who has been talking about a time in her life when she was “not eating anything” as “smoking and drinking juice” was her diet. The Interviewer probes her on the issue of (self)control³ – something often associated with self-esteem in eating disorder research (Polivy and Herman, 2002).

Interviewer Do you think it has anything to do with control? Like you being in control if you...of your life, if you look a certain way?

Emma Uhm in control...uhm I think, I'm uch I don't know, I don't know (interruption)

Interviewer In control, like say when we manage our weight to be uhm at a certain level and our looks to be a certain way you feel in control...like in control and if we don't do that we feel like we've lost control over ourselves, our lives, and we're just kind of a failure.

Emma Yea uhm I don't think it's a control thing. When when I was, I hate saying overweight because I wasn't overweight, but when I had a wee (little) bit of weight uhm it wasn't, I couldn't, I never considered like uhm not in control of myself, it was just like a more men...not in control of your mental state, do you know what I mean, I felt really...not being able to control yourself (?)

Interviewer Maybe, you felt really vulnerable?

Emma Vulnerable to other people not myself. I just felt uhm other people were judging me all the time and cause I know the kind of person I am, and people were judging me straight away, and I wasn't, I didn't have the control like saying this is the kind of person I am, and other people were just making assumptions straight away and I never had that control, just like kind of express the kind of person I was and these people were just jumping to the conclusion that I was a fat loser when I wasn't.

³ The interview style is informed by the recognition that interview accounts are always socially situated (Farr, 1984). Thus, it is not assumed that minimal interviewer presence will produce authentic 'facts' or give access to the 'true' experiences of the interviewee. The interviewer aims to understand what meanings or interpretations are produced in response to particular positions in dialogue, how they relate to the wider context, and what their implications are for self-other interactions. In the extract discussed here the Interviewer consciously introduces a thematisation of control drawing on dominant representations of eating behaviours. This invites the interviewee to engage with this representation and to position herself in relation to it.

Emma's understanding of the problem is not focused on body dissatisfaction and self-esteem. Her experiences of being seen as 'overweight' bring to the foreground the judgments of others and the importance of social recognition. Her representations of eating behaviours are thus dialogically produced; that is the meaning of unhealthy eating is jointly constructed in response to a dominant representation of weight as failure and bodily regulation as success. Not recognising that women have an understanding of body dissatisfaction as socially constituted may distort and further marginalise lay representations. If health promotions are to be effective then the socially and dialogically constituted nature of competing knowledge systems needs to be recognised.

As Farr (1993, p.31) has argued "health professionals ought to take into account people's conceptions of health and illness *before* devising their campaigns" (p. 31, italics in original). Failing to explore and understand lay representations of health and illness, we have stressed, can present insurmountable obstacles to developing effective community health programmes. A clear example of this is given in Wagner *et al's* (2000) study of cultural change and diverse health-related beliefs in local communities in North India. They describe how a non-government organisation was unsuccessful in developing an AIDS awareness programme as they had not researched local representations of sex and sexual health. Unaware of the local community's attitudes to sexual practices and, in particular, what were seen as acceptable terms of reference, the organisation ended up producing health promotion material that was wholly inappropriate in that context – containing images and vocabulary that were deemed offensive and disrespectful. As Wagner and his colleagues (2000) highlight a more participatory approach to community health programmes that sought to uncover and integrate local meanings and competing knowledge systems would have more chance of success. This study, together with our research discussed in this section, demonstrates the vital importance of recognising and respecting lay systems of knowledge and representations of health and illness.

Taking a social representations approach does not mean, however, that the wider social, political and economic factors involved in society are not taken into consideration: social

representations theory works from the basis that the researcher must focus on intrapersonal, interpersonal, positional and ideological levels in any analysis of meaning-making (Doise, 1986). Indeed, the way in which representations are employed within the wider power structures of society must be a central feature of any representational study (Jovchelovitch, 1997) and it is to this point that we will now turn.

2. The role of representations of health in maintaining stigmatising practices

Inequalities in health experiences, access to treatment and prevention schemes need to be theorised in relation to social, economic and political realities, as community psychologists have recognised (e.g., Orford, 1992). And yet what we have argued in the previous section demonstrates that the way health and illness are actually understood and experienced can help maintain, defend or challenge such inequalities. While poverty and social exclusion obviously cannot be simply reduced to psychological levels of explanation, an analysis of inequalities in health must include critical understanding of how representations of health and illness can actually marginalise and stigmatise people labelled as 'ill'. In this way, representations can play a role in sustaining social exclusion (Howarth, 2001).

Moscovici (1984) was keen to highlight that, while there is always the space and possibility for individuals and groups to take on, resist and transform representations, social representations also have something of an 'irresistible force'. Representations develop through generations, relying on ancient themata, and can therefore take on the status of the taken-for-granted or ontological reality (Marková, 1996). We see this in the fabric and practices of society, even in architecture. In the case of mental ill health, the large-scale Victorian asylums built in the countryside served to actualise and reinforce representations of the 'mad' as threatening and frightening 'Others' who must be kept locked away from normal, sane society. The roots of such representations may be historically distant, but continue to influence our modern-day practices. Jodelet (1991) found that the villagers in her study, while overtly denying that mental illness could be contagious, organised their daily lives around rituals of separation. These practices ensured that their own bodily fluids did not mix with those of their mentally ill lodgers:

for example, they kept separate crockery for their lodgers and did not wash this up with their own. What this example illustrates so vividly is that social representations become part of social practices which may serve to maintain boundaries between ‘us’ and ‘them’, ‘the mad’ and ‘the sane’, illness and health.

Even when structural changes are made in our society, representational distinctions can remain. We may, for example, have seen the closure of the distant out-of-town asylums, but have we fully integrated their former inmates into our communities, or maintained them at a psychological and representational distance? Foster’s research (2001; in press) would suggest that many structural and psychological barriers remain, and illustrates the interconnections between representation, practice and stigma. Almost all the participants in her study spoke of experiences of being discriminated against, being marginalised and disempowered in social encounters. Being labelled ‘mentally ill’ involves becoming a target for a whole host of negative representations that can serve to distance the client from mainstream society in very tangible ways, for example, in employment and educational opportunities, social activities and political participation. With regard to health-related practices, representations of the ‘mentally ill’ make it difficult for clients to discuss and question treatment with health professionals, to demand respect and recognition and to negotiate a voice in public debate. The stigmatising representations of clients as violent, unpredictable and frightening are particularly evident in the media (Philo, 1996; Nunnally, 1961). Such media representations may lead the general public into strategies of avoidance and discrimination, often with very concrete consequences for those labelled, as Martin describes below:

Martin: Yeah, I’d like to have another job, you know. It’s just getting people to accept me for what, after what I’ve been through.

Interviewer: Right, is that difficult?

Martin: Yeah... most [job interviews] I’ve been for... I went to [factory], erm... at the [], and he read my form, and that, and he said, ‘We don’t employ people like you’. I just walked out.

Interviewer: Really?

Martin: I thought, you nasty, miserable, little git.

Here we see how social representations permeate the lived experiences and social realities of the 'ill'. These are far more than simply cognitive structures, or ways of thinking about health, illness and other significant social issues. They inform, legitimise and/or challenge particular, beliefs and practices (Gervais and Jovchelovitch, 1998). As such social representations may work to maintain and legitimise structured inequalities in society in general as well as in health services. Social representations, therefore, are not merely abstract ideas or concepts, but are embedded in strategies and practices, both conscious and non-conscious, and guide action, interaction and the maintenance of unequal inter-group relations.

Bauer and Gaskell (1999) have highlighted the centrality of representation as practice in their discussion of the representational project: representations are elaborated and developed in the context of particular projects in which social groups actively engage, collaborate or compete. These projects do not simply operate at a conceptual level of sense-making: they provide practical strategies for living and interacting with others.

In view of this, mental health service clients are not alone in engaging in such projects with regards to mental health problems: many groups and organisations in society have an interest in clients' lives and projects. Health professionals, for example, hold very definite ideas about what is and is not appropriate for their clients, as we have discussed in the previous section. Given the structure of the health services, with its emphasis on the lack of insight of the patient (Rogers and Pilgrim, 2001), control of a project is often removed from the client (Foster, in press): decisions regarding medication, hospitalisation, housing and service use, for example, are often taken in such a way that a client feels that they are marginalised, with little or no opportunity for negotiation. The representations that professionals have about ill health therefore play an important part in maintaining such structured inequalities (Morant, 1998).

Similarly, health discourses and 'expert' representations of the body play a significant role in sustaining stigmatised images of the 'ill', the 'obese' or the 'underweight'. The over-reliance of health practitioners on a weight-centred model of health, for example,

has been criticised for actively reinforcing the high prevalence of weight loss concerns amongst the general public⁴ (Berg, 1999). A ‘thinness bias’ apparent in society as a whole is therefore reproduced within expert discourses re-enforcing the stigmatisation of the ‘overweight’ and contributing to the legitimisation of harmful dieting practices (Cogan and Ernsberger, 1999). At the same time health education programmes often pathologise body dissatisfaction in attempts to reduce dieting in women. These are the contradictory positions between which individuals have to mediate. As we have argued above, social representations can have a pervading influence on the practices and judgements of social groups despite socio-structural changes. It is therefore not surprising that, although women’s role in society has changed considerably over the past century, ‘who I am’ as a woman continues to be significantly determined by ‘how I look’ (Giddens, 1991; Malson, 2000). An unregulated female body, in a western consumerist context, continues to imply abnormality, evokes a loss of self-control and so threatens marginalisation and exclusion.

Again we can clearly see how the consequences of social representations go far beyond the cognitive. This reiterates our point that stigmatising representations infringe on people’s daily practices, their interactions with others and their perceptions of self. In Dorrer’s research women’s everyday experiences of eating, gaining and losing weight were marked by feelings of guilt, disgust and inferiority. For the majority of women in this research this meant a retreat to self-damaging behaviours, such as unhealthy dieting and social withdrawal. The following extract, in which Fiona talks about the consequences of failing to adhere to her own dieting rules, illustrates this finding.

Fiona: First you can feel it in your body, you feel fat and you feel bloated and you feel more lethargic that automatically makes you feel extremely low and not worthy to be seen. So I stay in, stay in not go out and you feel, even if it is not true, but then you feel like you (?) although even if you don’t go on you just feel lousy about yourself, don’t you think, that’s the worst scenario.

Interviewer: So you feel kind of disgusted with yourself you feel like -

⁴ Increasingly men's health is also affected by harmful eating and weight control behaviours such as the use of anabolic steroids in bodybuilding, over-exercising, under-eating, over-eating, and purging (Connell, 1990; Sparkes, 2002).

Fiona: - yeah angry with yourself because I can't stick to it. Not just sticking to it but then doing something to make it worse, do you know what I mean [...] in the end you feel more lousy about yourself and then you start questioning yourself more, you start comparing yourself more to other people.

Interviewer: Hmm yeah, how do you feel in relation to other people when you don't manage to control your eating in a way that you wanted to control it?

Fiona: Everyone then looks a lot slimmer and and nice, everyone looks superfit, and like I said, you don't feel like you are as good as them in a way -

Interviewer: - not worthy

Fiona: yeah, not worthy to be to be seen, you feel like (?). So I am sure it's all in the head.

The idea that "it's all in the head" draws on two stigmatising representations - of women as passive adherents of manipulative media discourses, which distort their self perception, and also a representation of the (mentally) ill as unable to properly understand their health-related practices, as in Foster's research on mental illness. Both these representations serve to marginalise the experiences of the 'ill' and make it difficult for women engaged in unhealthy eating behaviours to seek social support. When embedded in expert knowledge systems of this kind social representations of health can perpetuate the exclusion of participants or clients from discussions about their health problems and appropriate treatment.

Hence representations can have significant social and psychological consequences for those seen as 'ill'. Social, in that they may experience barriers to employment, education, social participation, access to treatment and the realm of public sphere networks in general. Psychological, in that these representations may inform how they experience health and illness, how they are 'seen' by others and so how they develop a sense of identity and well-being in relation to health. In this section we have discussed how representations can present very real barriers to social inclusion. We now turn to the more social psychological level: how do representations of health and illness impact on identity?

3. The impact of representations of health on identities

In the previous section we have examined the stigmatising nature of social representations with particular reference to how representations permeate social practices. We now examine how representations impact on identities in both constructive and destructive ways. In particular we consider how representations can be transformed by social groups in order to maintain a more affirmative identity. Once again, we argue that this is of particular interest for community health psychology approaches.

Identity is a central aspect of social representations theory: without an understanding of identity we could not explain why and how different people use representations of health and illness to different ends. The world around us is permeated with representations that we use to communicate with others, develop social ties and assert differences with ‘other’ social groups and communities. But most crucially we use these representations to position ourselves, to claim common identities and to make sense of our experiences and relationships (Howarth, 2002a). When others’ representations of us are negative – perhaps positioning us as mad, deviant and frightening as we saw above, we find strategies to protect our sense of self and defend our esteem.

What is significant for our discussion is that the theory demands that agency and resistance be explored in relation to how people think about, and act towards, themselves and others. Social representations theory draws on this tension between individual agency, society and history (Moscovici, 1984): we can, and do, change our representations, but always within the possibilities and constraints of past and present. In presenting, reflecting and enacting how we think about health and illness within the context of the everyday, for example, we may become self-conscious of our own social representations. Consequently the act of re-presenting the social world carries with it the possibility for critique and transformation. As Joffe (1998) has pointed out, within a social representations framework “lay people are not seen as ‘victims’ of dominant ideas, but as active agents” (p. 29), who may collaborate, associate and develop the social and cultural capital to challenge dominant representations of health and illness.

Duveen (2001) claims that resistance to dominant representations can be articulated both at the level of a particular group and at a wider level in the form of social movements and community participation. This was clear in Foster's research with clients of mental health services. Clients found ways to resist stigmatising representations of mental ill health and collectively negotiate alternative representations about what it is to be a mental health service user. Such resistance provides strategies to assert and defend positive identities. For instance, clients would often differentiate between types of mental ill health, suggesting that the general public was not sufficiently aware of different psychological conditions and their consequences. In doing this, they could more successfully distance themselves from negative representations of mental ill health.

Steve: ... and there's a lot of people who survive, who've gone through it themselves without even realising it. I think it depends how severe the mental illness gets.

Interviewer: Right, so would you say there are different sorts of severity?

Steve: Oh, very much so, yes.

Interviewer: So what would be, like, less severe?

Steve: I think possibly something like having a personality disorder. Or anxiety, or panic attacks. The sort of thing that you can control, that doesn't get out of control. But with these things, like somebody who's manic depressive, or schizophrenic, it can be controlled with the right medication, but it's long term.

Interviewer: OK.

Steve: And severe. That's what I'd say. As a patient.

Here Steve draws on his personal experience of mental health services and encounters with other clients to define mental ill health and to differentiate between types and 'severity'. It is significant that the conclusions he reaches run counter to many ideas in mainstream media regarding the severity and seriousness of personality disorders (Castillo, 2000). To represent certain conditions as less serious or 'different' from others might allow a client to maintain a more positive identity for him or herself than the one that public representations might seek to confer upon him or her. Hence social representations offer people strategies with which to subvert stigma and present affirmative versions of self.

As has been illustrated with the interview extracts discussed in the previous sections, stigma and identity also emerged as dominant themes in the interviews conducted with women in Dorrer's study. For the majority of these women stigmatising representations of the 'overweight' in association with dominant representations of femininity could have serious social psychological consequences: in a quest to protect their identities some of these women would engage in health damaging behaviours such as dieting, purging, exercising or surgery. What is crucial, however, from a social representational view, is that we are not merely positioned by given representations. The women negotiating the tensions between (re)gaining a positive sense of self and staying healthy actively sought ways to collaborate alternative representations, that is, to re-present themselves. For instance they would assert themselves through the rejection of feminine representations that portray them as "little and sparkly and delicate" and the transformation of these into notions of "a strong woman" (Christine). Similarly, the extract below shows how Naomi develops a means of negotiating the demands of control and rejecting representations of idealised thinness:

Naomi: I have got a sense of perspective but I have still got a body image ideal, I have still got these things that I make myself do because I feel that if, you know, I need to have this control over myself. But I think it's it's more achievable to say, you know, well I I know I know I've got big thighs but that's because I am meant to be a dancer and I am meant to be a skier and I need big thighs, so you know great.

Challenging the content of representations linked to female identity in this way enabled women such as Christine and Naomi to shift the emphasis from health damaging behaviours to practices of body management focused on strength and physical health. Representing the self in this way may still be marked by individualistic notions of control and responsibility but none-the-less constitutes a critical engagement with dominant representations. Such engagement is potentially empowering. Hence lay representations may play a transformative role, challenging and possibly even changing dominant discourses, as Joffe (1998) has already shown in relation to social representations of HIV/AIDS. Transformation can happen on both an individual and a collective level, as people develop strategies of protecting their identities against stigmatising representations and claim a version of health that enables positive social identities.

An excellent example of this is given by Krause (2002). In this study, researchers worked with a small group of individuals affected by Crohn's Disease and Ulcerative Colitis. Having examined representations of the diseases, the group and researchers embarked upon a wide-ranging programme of strategies from expanding information and social support in the group to sensitising the mass media to the conditions and promoting the public image of the group. After a year, not only was the self-help group larger and more active, but participants' representations of inflammatory bowel disease were less stigmatising: as such, they were more tolerant of the disease, and more able to cope with it on a daily basis, with the support of others, as it posed less of a threat to their identities. Hence, through the process of social re-presentation, they had transformed stigmatising representations of their illness into a more affirmative version of self.

Collective resistance to stigmatising representations is an important part of the articulation of identities. The 'Mad Pride' movement, for example, which models itself on civil liberties groups of the past, engages in efforts to reclaim 'mad' identities and rearticulate them in a more empowering way. It is a truly collective attempt on the part of disenfranchised and stigmatised communities of mental health service users to actively resist negative representations and their consequences, and to renegotiate more affirming representations and identities. Social representations can therefore be transformed to empower groups and individuals and to oppose dominant discourses that would otherwise threaten their identities (Howarth, 2001).

In this section we have seen how individuals who experience ill health may have to confront representations that disrupt their own notions of health, illness and self. These representations can have profound and stigmatising consequences for the individuals concerned, as our identities are developed and contested through others' representations of our claimed social groups and communities. This is particularly true with the arena of health and illness. Being labelled 'ill' can have serious consequences for individuals in a society in which medicine, like law and religion, often defines the normal, the proper and the desirable (Illich, 1995). Hence, social representations impact on how people perceive,

experience and treat health and illness. Because of this, we have argued, health researchers need to engage with community levels of understanding, explore the significance of social practices relating to health and illness and recognise the impact of representations of health and illness on identities. One possible route into such proactive research, we have suggested, is the theory of social representations.

By way of a conclusion – challenges for social representations theory

Thus far in this paper we have discussed three central tenets of social representations theory that have guided our own research. We have argued that this theory recognises that there are different knowledge systems at play within any research context, that certain representations of health and illness may stigmatise and exclude those labelled the ‘ill’, and that certain representations have the power to inform our identities. Our aim has not been to provide a comprehensive review of the theory of social representations but simply to discuss how it has enabled us to develop our research with an explicit focus on community. A conclusive review of SR research would not be appropriate at this point as it is a theory still in development: there are several challenges yet to be overcome.

One challenge is that research within this perspective needs to be culturally sensitive and self-consciously reflective. As researchers, we need to engage with the researched community, develop relations of trust, openness and rapport, and begin to negotiate an inter-subjective understanding of health from the perspective of those ‘researched’. This means becoming conscious of our own knowledge systems and representations of health and illness, and attempting to recognise the differences between these and those of the researched community (Howarth, 2002b). This must be a crucial part of any research that employs the theory of social representations: we need to position ourselves as *learners* in a new cultural environment, and so seek to understand the life-world of participants from their culturally-embedded perspectives. More than simply recognise the competing knowledge systems within any social domain, as we have discussed in section one, we have to highlight how the representations that emerge from a piece of research differ from those of the researcher.

This is precisely where social representations theorists could learn from other community approaches to research practice and ethics. In doing research with community members the social representations researcher invites participants to reveal and share their representations: this may expose not only their health-related experiences and practices, but also feelings of anger, resentment, pain and shame. Many critical psychologists in working in the area of community health and elsewhere question the rights that researchers have to 'parachute' into a group, treat people as the objects of research, from an omnipotent, omniscient position, and then leave to analyse the data. Such an approach has rightly been criticised as imperialist and exploitative (e.g., Humphries, Mertens, and Truman, 2000; Hollway and Jefferson, 2000).

However, it is also important to recognise that as researchers we do bring our own skills to any situation (Condor, 1997), and that accepting what is expressed by participants unquestioningly and without deeper analysis may be just as problematic as accepting the views of the researcher, in a kind of 'empiricism by proxy' (Bauer, Gaskell and Allum, 2000, p.18). What is needed, then, is an open discussion and foregrounding of representations, involving both researcher and researched. Such collaboration would allow the taken-for-granted, the assumed and the hidden on both sides to be considered. This would go some way in addressing the criticism that social representations researchers are likely to be affected by their own representations, and therefore 'biased' in any research situation (Potter and Edwards, 1999).

Adopting such a community approach would encourage social representations researchers is to use more participatory and empowering practices in engaging service users and practitioners in developing and managing action research projects. The theory has clear potential to promote social participation and community development in the research process, as Campbell and Jovchelovitch (2000) have already suggested. The practice of seeking out participants' representations, analysing them and asking participants to consider them, may encourage collaborative critical reflection, social debate and 'conscientisation'. This is the process whereby social participants take on an appreciation of reality which was not there before (Freire, 1973; Campbell and

Jovchelovitch, 2000). To speak of different knowledge systems, meanings as changeable, challenges to truths and insights into underlying notions can raise the visibility of alternative and oppositional representations. Through the offering of alternative readings the researcher can play a role in the facilitation of participants' agency, as marginalised groups can gain new power over dominant representations of their own position and experiences. To use the potential of "coming to speak one's own life", discussed by Drewery and Winslade (1997, p.43), has long been made a central objective in feminist theorising, community activism, and narrative therapy (e.g., Harding, 1991; Nelson and Prilleltensky, forthcoming). It may also open an opportunity of "practical engagement" within the research context (Moscovici and Marková, 1998, p.405).

Yet studies of the social representations of health have often been more reactive than proactive in their approach to knowledge, for example, Farr's (1995) analysis of advertising campaigns conducted by various disability charities and Stockdale's (1995) analysis of HIV/AIDS campaigns. These studies focused on representations that are implicit within or might arise from particular health promotion campaigns after the event. An alternative would be to employ representations in a more proactive fashion from the very beginning of a project.

To date, only a few social representation studies have adopted this approach. One clear example is that of Krause (2002), discussed above, on the transformation of representations of members of a self-help group, their community development and strategies for empowerment. This study demonstrates how social representations can operate as the "vectors of change" (Philogene, 2001, p. 113) by promoting conscientisation and so provides a model for social representation researchers focussed on listening to and empowering research participants. The success of this approach would lead us to claim, very tentatively, that social representations theory could indeed play a wider role within more participatory projects in community health, grounded as it is in the exploration of common sense and the public sphere. Research projects formulated in this way are more likely to be received and accepted with the support of the local community and hence have more chance of developing genuine partnerships between

academic researchers and others. Until social representations researchers develop more explicitly participatory approaches to doing research, however, these tentative claims will remain within the realm of academic debate.

Failure to recognise and incorporate the transformative potential of community perspectives on health into the theory of social representations may be seen to legitimise the status quo in the name of disinterested science. This is both a challenge and an invitation for social representations researchers. Reluctance to take up this invitation and find ways of taking the theory into practice will simply leave the health inequalities we research uncontested and intact. Social representations theory, we have found in our research, provides the health researcher with many valuable tools with which to anchor analysis in the community. However, as it stands, questions of the purpose and value of this research for researched communities are in urgent need of discussion. Hence, we cannot conclude this discussion, but hope it will provoke interest, debate and no doubt critique.

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