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# ‘A Diagnosis in Flux’: Social Influence Redux?

# Commentary on Roberts (2017)

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In ‘Parents, clinicians and the genesis of a contested diagnosis: The development of knowledge surrounding paediatric bipolar disorder in the United States’, Roberts (2017) carefully outlines the development of representations of a novel social object (in her case, paediatric bipolar disorder) that have emerged as a result of the interacting knowledges and experiences of two distinct groups (in her case, practitioners and parents). The article is an excellent example of the use of the theory of social representations, insofar as it takes as its point of departure a phenomenon that is currently in communication and in tension (Marková, 2003). It is through the study of paediatric bipolar disorder that Roberts (2017) is able to consider several important aspects of the theory, some of which have to date received limited scholarly attention. It is therefore my pleasure to comment upon the article, and to discuss these aspects in greater depth. In this commentary, I focus on two related strands of Roberts’ (2017) work: (i) the relationship between social representations and social influence, and (ii) the relationship between social representations and social recognition. In so doing, I shall draw attention to the triadic relationship between the self, social other, and social objects (Moscovici, 1972), elsewhere called the dialogical triad (Marková, 2003), and suggest that Roberts’ (2017) article invites us to reflect upon new ways of conceptualising – and visualising – this triadic relationship.

## SOCIAL REPRESENTATIONS AND SOCIAL INFLUENCE

One of the central tenets of Roberts' (2017) article is that there is a relationship between the processes of social representation and the processes of social influence. Drawing upon Sammut and Bauer's (2011) 'cycle of normativity', Roberts (2017) maintains that polyphasic thinking must be understood within its context: that is, with attention to the interaction between different, and often competing, knowledges, and with related consideration of the fact that some modes of thinking may dominate over others. On the one hand, this argument seems to be well accounted for within the theoretical literature, for example in the work of Gillespie (2008), Jovchelovitch (2007), and others. On the other hand, Roberts' (2017) insights invite reconsideration of the curious historical development and trajectory of the theory of social representations, which has, for the most part, been independent of Moscovici's other major contribution to the social psychological discipline: his work on social influence.

In *Social Influence and Social Change,* Moscovici (1976) offered a critique of functionalist models of social influence that he argued had tended to conceptualise influence as a social process that produced unilateral conformity effects, *from* target *to* source. In Moscovici's view, and in his genetic model, interaction partners are rather mutually interdependent, and influencing of one another. From this point of departure, he described the psychology of social influence, properly conceived, as a theory "*of conflict and difference, both in terms of their production and their management*" (Moscovici, 1976, p.221). More specifically, he argued that *"conflict* [between social actors] *produces uncertainty, and…is a prerequisite of influence"* (ibid., p.102), insofar as it produces a *"new context of interpretation for the subject, and a new meaning for the object"* (ibid., p.107). Moscovici's (1976) account accounted, then, for the idea that social influence leads to social change, rather than conformity (an insight that no doubt underscored his later emphasis on 'innovation', rather than 'influence' (Moscovici & Marková, 1998)), and upheld the idea that such change arises through conflict and its negotiation, rather than its avoidance.

Conflict and its negotiation are equally important to the theory of social representations. It is now generally acknowledged within the theoretical literature that the relationship between the self and social others is a relationship characterised by tension (Marková, 2003), and that the social world, although comprised of consensual realities, is not characterised by complete consensus (Rose et al., 1995). Indeed, in his earliest study of social representations, Moscovici (1961) highlighted that different representations of the same objects could be held by different groups, who could also adopt distinct styles of communicating about them. In his definition of polemical representations (Moscovici, 1988), he described representations that are the result of social conflict, controversy, and the struggle over meaning between groups. In conversation with Marková, he explicitly acknowledged that a "*social representation is not a quiet thing…Usually there is kind of ideological battle, a battle of ideas*" (Moscovici & Marková, 1998, p.275), and it has since been forcefully argued by his interlocutor that it is precisely when taken-for-granted knowledges become contested that social representations are generated (Marková, 2003). Thus in both Moscovici's theory of innovation and his theory of social representations, one can identify a central concern with the role of conflict between social (inter)actors who reciprocally influence one another in the generation and transformation of social knowledge.

In her article, Roberts (2017) traces the development of paediatric bipolar disorder (hereafter PBD) as a 'diagnosis in flux' in the USA. Using evidence from interviews she conducted with American child psychiatrists and parents of children with PBD, the author describes how practitioners and parents have 'collaborated' and 'negotiated' with one another to develop "*a diagnostic home for children who no one knew how to label*" (Roberts, 2017, p.11). In particular, Roberts outlines that in the context of such uncertainty, professional and experiential knowledge come to influence one another in the genesis of the representation of PBD: practitioners (at least in part) depending upon parental experience to guide their knowledge, and justify their practices; and parents (at least in part) depending upon clinical knowledge as a means to legitimate their (often challenging) parenting experiences. As a result of these knowledge encounters, the representation of PBD, based upon self-knowledge and other-knowledge, is polyphasic in nature. PBD is, then, "*a socially elaborated product of different spheres of expertise*" (Roberts, 2017, p.6).

In making this point, Roberts (2017) draws upon some of the more recent scholarship on cognitive polyphasia to suggest that the development of PBD as a diagnosis is a specific example of the 'hybridisation of knowledge', described as the fusion of previously held knowledges that produces a single mixed representational field (Arthi, 2012; Jovchelovitch & Priego-Hernández, 2015). What is perhaps most interesting here is that Roberts (2017) emphasises that such polyphasic thinking serves a specific function: it is a strategy in which social actors accommodate and assimilate aspects of others' knowledge to understand a phenomenon of which it has proved difficult to make independent sense, and to justify their sense-making to others in the social sphere.

To my mind, this proposition invites several further questions, the first of which concerns the issue of time, not least because Roberts (2017, p.17) defines cognitive polyphasia in relation to her case as "*the internalised consideration of new norms still in the process of developing*". Will practitioners' and parents' talk about PBD be the same in five, ten, or twenty years' time, or is the hybridised knowledge that results from the different experiences of different actors specific to the immediate need for sense-making that exists for these two groups? I have raised this argument in my own research on single women using donor sperm (Zadeh et al., 2013): that polyphasic thinking (and talking) may be specific to, or at least accentuated during, particular points in a representational project. While this question cannot be answered by Roberts' (2017) initial study, it will be interesting to see whether PBD remains an object in a single mixed representational field, as in other phenomena relating to health (Jovchelovitch & Gervais, 1999; Moloney et al., 2012), or whether changes will be identified in the life of the representation as the object becomes increasingly 'common'. Roberts' (2017) research thus raises an important question: although thinking is polyphasic in nature (Moscovici, 1961), could a class of phenomena about which polyphasic thinking is *continually pronounced* be identified, and if so, what are the implications of this?

A second and indeed more complex issue raised by Roberts' (2017) research relates to the possibility that the hybridisation of knowledge may serve additional functions, beyond that of sense-making, which relate to the relationship between social actors. In what is perhaps one of the less often discussed, but most innovative contributions to the theory of social representations, Duveen (2008) suggested that there is a relationship between distinct communicative styles and specific forms of affiliation, and consequently, different representations of in-group members (amongst whom a representation of a given social object is shared), and their out-group(s). In relation to Moscovici's (1961) study of psychoanalysis, Duveen (2008) outlined how diffusion may relate to affiliative bonds of *sympathy*; propagation to affiliative bonds of *communion*; and propaganda to affiliative bonds of *solidarity*. I note Duveen's contribution here not only because the notion of affiliation is an important one for social representations scholars who acknowledge that social representations are *always held by someone* (Duveen & Lloyd, 1990), but because Roberts' (2017) particular empirical case invites the theoretical possibility that hybridised knowledges may be a function of particular bonds of affiliation, and/or may function to foster particular affiliative bonds. Put differently, it seems that insofar as it is concluded by Roberts (2017) that professional and experiential knowledge depend upon one another in the genesis of the representation of PBD, the question of whether the actors who hold such different knowledges also come to *regard one another as sharing a representation* of PBD comes to the fore. Indeed, it is particularly striking that several of the practitioners Roberts (2017) interviewed described parents as their point of reference for understanding PBD against a professional, 'sceptical' backdrop. It is similarly interesting that the majority of parents do not refer to specific clinicians as facilitating their sense-making, but rather emphasise the role of alternative – non-human – resources, such as the book, *The Bipolar Child*. From Roberts' (2017) research, then, a more general question arises: Do polyphasic representations relate to, or foster, affiliative bonds between social actors who ostensibly belong to distinct social groups, and if so, with what effects?

## SOCIAL REPRESENTATIONS AND SOCIAL RECOGNITION

Roberts' (2017) conclusion that sense-making around PBD evidences the role of psychosocial processes of social influence and polyphasic thinking therefore invites reflection upon the relationship between these two processes, and their effects, not only in terms of the generation of knowledge, but also in terms of their relationship to intergroup relations. Given that Roberts (2017) in her introduction draws attention to the fact that the concept of cognitive polyphasia brings to the fore the question of which forms of knowledge become privileged over others in sense-making, it is noteworthy that she concludes that "*social consensus is central to the development of PBD as a diagnostic category*" (p.17, emphasis added). Indeed, elsewhere in the paper, Roberts (2017) describes the genesis of the representation of PBD as "*very much a collaboration*" (p.2) between different social actors.

In a recent study of the relationship between religion and science in common sense knowledge (Falade & Bauer, 2017), it was argued that hybrid knowledges are characterised by different types of complementarity, such that knowledges may be perceived to be complementary and parallel, complementary but hierarchical, or empowering of each other. The latter case was identified in participants' positive descriptions of scientific and technological innovations that were perceived to enable the propagation of religious ideas.

The notion of ‘empowerment’ has also been considered by Jovchelovitch and Priego-Hernández (2015), who rather suggested that,

> “*Cognitive polyphasia allows specialized sets of representations to coexist in human thought, thereby empowering individuals and communities to make sense and cope with plurality and make full use of the diversity of the human symbolic landscape*” (Jovchelovitch and Priego-Hernández, 2015, p.170).

I want to now turn to the question of who or what may be empowered by the polyphasic thinking that Roberts (2017) has identified in her empirical case. In one sense, representations of PBD may be described as empowering of different experiences, both clinical and parental. Equally, such empowerment could be said to extend to the actors themselves, insofar as the hybridised knowledge that results from the knowledge encounter between practitioners and parents seems to rely upon social recognition of the other: that which Jovchelovitch and Priego-Hernández (2015) described as the ‘fundamental criterion’ that determines the outcomes of a specific knowledge encounter, and the nature of polyphasic thinking that may or may not result. In an earlier text, Jovchelovitch (2007) seemingly described a similar phenomenon when she referred to dialogical (and non-dialogical) knowledge encounters, the former being that which involves listening to the other, and leads to “*readjustment, change and hopefully enlarging the boundaries of all knowledges involved*” (Jovchelovitch, 2007, p.150).

There is something uncomfortable, however, in viewing the empirical case presented by Roberts (2017) as an example of a dialogical knowledge encounter, not least because dialogical relations between the self and others are also understood to be ethical relations that are characterised by self- and other-recognition (Marková, 2016). While it may indeed be the case that the representation of PBD is based upon recognition of parents’ perspectives on the part of practitioners, and clinical perspectives on the part of parents, Roberts (2017, p.11) herself stresses “*the position of clinicians in a dyad with the parent…with the child at the center of it all rendered almost peripheral in discussion*”. Simply put, the distinct lack of recognition of the child’s perspective that may be said to characterise this particular knowledge encounter between practitioners and parents (the latter of whom Roberts (2017, p.6) describes as ‘patients-by-proxy’) seems to bring with it a number of theoretical and ethical issues.

In my theoretical work, I have highlighted the difficulty of faithfully conveying the perspective of the other (Zadeh, 2017), and in my empirical work, I have been motivated to study the perspectives of children who are conceived through the relatively uncommon method of assisted reproduction with donor gametes (Zadeh et al., 2017). In this area, there exists a widespread acknowledgement that children's thoughts and feelings are important, but very few attempts are made – by researchers or indeed policy-makers – to ask for their views. Similarly, in Roberts' (2017) research, it is adults (and specifically parents), rather than children, who are perceived to be in possession of expert knowledge about PBD and its symptoms. The idea that certain social actors may act as a 'placeholder' for others seems to complicate the relationship between self and other in the generation of social representations.

In the existing literature, the triadic relationship between self, social others, and a social object is well established, and most often visually depicted as an equilateral triangle (Figure 1). Yet, in Roberts' (2017) case, parents' experiential knowledge is used by practitioners to make sense of PBD. In other words, the proximity of parent to child is relevant. As 'patients-by-proxy', parents may be said to mediate the relationship between children and practitioners, and act as the 'placeholder' interlocutor in the genesis of representations of PBD. If this is the case, it seems that the equilateral triangle is insufficient as a visual display of the relationships between the self, the social other, and the object of representation, insofar as it fails to account for the relevance of parents' knowledge of, and proximity to, the object (for an attempt at this, see Figure 2).

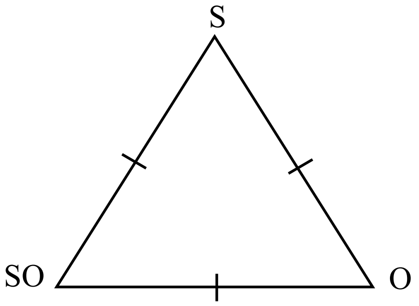

Figure 1: Common depiction of the dialogical triad of sense-making, as an *equilateral triangle*

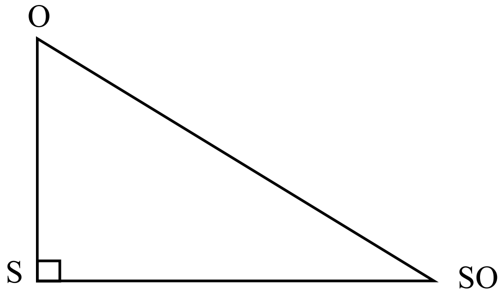

Figure 2: Dialogical triad of sense-making, depicted as a *right-angled triangle*, in which parents' (S) knowledge of (and proximity to) the object (O) is relevant to the genesis of a representation

Moreover, from a theoretical point of view, it is noteworthy that the genesis of the representation of PBD seems, at least in a partial sense, to be based upon parents' (and indeed other adults') representations of their children's behaviour, yet the representation identified by Roberts (2017) is of a diagnostic set of criteria, not a collective of children. If it is accepted that it is rather the children who are the object of representation, then it must be acknowledged that these social actors are not, as far as Roberts' (2017) findings would suggest, engaged in dialogical communication.

What, then, are the implications of Roberts' (2017), and other, cases – in which *social actors are the object of representation* – for thinking about dialogical communication? Is the relationship between actors (parents, practitioners, and children) in the case of PBD a dialogical – ethical – relation, based on self- and other-recognition between parents and practitioners, or is the non-recognition of children as interlocutors problematic? In her most recent book, *The Dialogical Mind*, Marková (2016) described the nature of self-other communication in bureaucratic systems as I-It, as opposed to I-You, communication. Relatedly, it is perhaps worth emphasising Roberts' (2017) acknowledgement that the healthcare system in which representations of PBD are generated is one in which the majority of people receive medical treatment through private insurance. As such, parallels may be drawn here between Roberts' (2017) case and cases of bureaucratisation (of the health service, and higher education) identified by Marková (2016) as resting on I-It, rather than I-You, relations. If the genesis of a social representation is characterised by *both* dialogical (parent-practitioner) and non-dialogical (parent-child, and/or practitioner-child) communication, what does this mean for theorising the relationship between social actors in the social construction of knowledge? And could this problem be addressed, at least in part, by attention to Moscovici's (1976) theory of social influence?

I do not claim to have the answers to these difficult questions. I can only emphasise that Roberts' (2017) contributions to the scholarship on social representations, specifically her insights on polyphasic thinking, seen in terms of the relationship between social influence and social representations on the one hand, and social representations and social recognition on the other, offer many new and challenging questions for the field.

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