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Encounters Between Forms of Knowledge

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INTRODUCTION

On the occasion of the fiftieth anniversary of the publication of Moscovici's seminal book *La psychanalyse, son image et son public*, I mentioned (Jodelet 2011a, 2012) how, despite their original and coherent input to the theory of social representations, the different research programmes resulting from this work have somehow neglected Moscovici's contribution to the theory of knowledge, a theory whose character is fundamental for the production and circulation of social representations and to their use in the promotion of social change.

The objective of this paper is to revive this research programme by examining the evolution of the models that govern the transmission and development of different forms of knowledge. The study of social representations as a form of knowledge whose practical aim is to interpret our life world, orient our behaviours and our communication should benefit from the questions we are asking today concerning the diversity of forms of knowledge and the emergence of a new category: the experiential knowledge. I will concentrate on education and health,

domains where these questions are especially acute and relevant, with a particular focus on a new and growing trend: the therapeutic education of patients.

SOCIAL REPRESENTATIONS, EDUCATION AND FORMS OF KNOWLEDGE¹

As soon as education became a topic of interest to scientific thinking, the link between the former and social representations has been obvious. During the inauguration of the first chair dedicated to the science of education at the Sorbonne in 1902, Durkheim defined this discipline in the following way: “something between art and science.” Education is not an art “made up of habits, practices and organised ability” but rather a “system of ideas relative to a practice, a set of theories.” Neither is education a science since its goal is “to guide behaviour. It is a practical theory.” This conception calls to mind social representations that are also practical theories. This similarity has been highlighted by Maurice Halbwachs in his preface to Durkheim’s book *The pedagogical evolution in France* (1938). He was comparing education systems to “the other institutions of the social body, with its customs and beliefs, to the major currents of ideas.”

Moscovici also mentioned this similarity when he introduced the concept of social representations by studying how a scientific theory, here psychoanalysis, was received by the French post-war society. His interest focused on the question of the transmission, diffusion and transformation of scientific knowledge. The aim was to examine the relations that exist between common sense and scientific thinking, the impact that the introduction of science within the social sphere may have on the formation and transformation of common sense and, conversely, on the transformation of scientific knowledge following its assimilation within a society. This perspective gave rise to a significant body of literature concerning the diffusion of knowledge, scientific popularization and the didactics of science, a literature which has influenced the

¹ The expression ‘forms of knowledge’ has been used here in order to highlight the distinction that exists in French, but does not in English, between ‘savoirs’ and ‘connaissance’. ‘Savoirs’ refer to forms of knowledge that differ both in terms of how they are produced or validated and how they are used and communicated (daily life, work, education, research, etc.) as well as in the relation they entertain vis-à-vis the object with which they are dealing. Thus, ‘savoirs’ can be lay, traditional, experiential, practical, technical, disciplinary, scientific, etc. ‘Savoirs’ can either be enunciative, thus depicting the ‘reel’, or operative, thus transforming the ‘reel’. They bring together the competencies and identities of subjects who appropriate, build or apply them. This distinction will be discussed in greater detail later. Please note that, at times and for the sake of elegance, knowledge in plural has sometimes been used as an alternative to forms of knowledge.

procedures of knowledge transmission used in schools, in professional training and in adult education.

The progress made in the reflection concerning these different domains has allowed for a better understanding of the link between scientific theory, scholarly knowledge, expert knowledge and common sense knowledge. In the same way, Moscovici (2011) has enlarged the relevance of the concept of social representations by including within the range of phenomena covered by this concept those that belong to forms expressive of human sensitivity such as art, literature and ethics in their relation with action. He thus echoes Merleau Ponty who said in his book *The visible and the invisible*: “Literature, music, the passions, but also the experience of the visible world are – no less than is the science of Lavoisier and Ampère - the exploration of an invisible and the disclosure of universe of ideas” (1964, p. 193)².

One of the consequences of this enlargement has led to the drawing of a new analytical frame of the genesis and sharing of social representations. Indeed, on one hand, new dimensions of representations, including subjectivity and experience, have appeared. On the other hand, the research has had to take account of a wider diversity of contexts and to be applied to social fields that call for a collective form of intervention based on the new perspective of ‘care’. These developments prompt us to study in greater detail the relations between different forms of knowledge and their encounter.

DIVERSITY OF FORMS OF KNOWLEDGE, DIVERSITY OF CONTEXTS

Traditionally, studies on common sense take into account the individual within his/her context, but the contexts thus considered are usually divided between those that result from a direct interaction and those that result from a more global character. In the latter case, we may refer to modern societies, recently marked by globalisation processes and the influence of the media; of public spheres; of cultural fields and of the resources they offer for the interpretation of the everyday life; or of social fields and of these structures of social relationships that determine feelings of social belongingness and mental structures. Here, common sense is perceived as a

² Unless specifically stated, the translations of quotes from non-English sources come from well-established English editions.

homogenous reality whose distinct characteristics are related to the management of everyday life and to group identity.

In contrast with other forms of mental constructions (science, religion, ideology, etc.), common sense comes across as having properties and functions linked to its mode of production and its role within social interactions and communication. In particular, in the case of the relations between common sense and science, and in spite of Moscovici's masterful demonstration of the dynamic of their interaction at the level of social groups, research has mainly focused on two types of phenomena. On one hand, the impact on the modalities and content of representations or their communication, be it in the shape of exchange, diffusion, disclosure, propaganda, of popularisation or transmission of scientific knowledge. On the other hand, the ways by which common sense knowledge may represent an obstacle to, mediate or facilitate the reception of scientific knowledge or act as a source of inspiration for it. In all cases, the attention has focused on the institutional or media-related frameworks and on the social representations characteristic of specific social groups or expressive of specific social identities.

Today, the rise of an interest in experiential knowledge transforms the way we deal with singular subjectivities and different concrete contexts. This change of direction echoes Merleau Ponty who affirmed that:

“... we are experiences, that is, thoughts that feel behind themselves the weight of the space, the time, the very Being they think, and which therefore do not hold under their gaze a serial space and time nor the pure idea of series, but have about themselves a time and a space that exist by piling up, by proliferation, by encroachment, by promiscuity – a perpetual pregnancy, perpetual parturition, generativity and generality, brute essence and brute existence, which are the nodes and antinodes of the same ontological vibration (1964, p. 115).

The question thus becomes, how, within a specific context, are created representations that incorporate the subjects' history, social belonging and practices while being, at the same time, influenced by larger social systems.

To illustrate this point, I will turn to the domain of school education. This domain represents a perfect setting within which to observe the interplay of social representations held at different levels within the education system: the political level where are defined the objectives and the organisational arrangements of teacher training; the level of the institutional hierarchy whose agents are responsible for the implementation of these policies; and the level of users, pupils and parents, of the school system. These representations can be observed, within concrete institutional contexts and practices, through the discourses of these different actors. They can be historically apprehended by looking at the evolution of the educational policies and of the populations targeted; an evolution resulting from the democratisation of school and the mass recruitment of pupils and from the positioning and identities that these phenomena induce in the partners of the educational relation. Such a perspective focused on the different contextual levels enables us to highlight the problems associated with the transmission of different forms of knowledge in diverse teaching and learning contexts.

I have proposed elsewhere (Jodelet, 2008) to picture these situations as an example of what Schaff (1969) called 'semioses situations'. That is, a system of sense production according to which the institutional and social context where the representations are construed affects the elaboration of a 'representational system' within which the representations of the situation, of the task and of the partner are linked, as proposed by Codol (1969). In this interactionist perspective, the different partners in the pedagogical relation define the situation taking into account the constraints that it lays upon them and the resources, expectations and desires invested by everyone working towards a shared social action. In a similar vein, N. Lautier (2001) discussed the dimensions which are involved in the construction of the school situation and that have an impact on the representations held by pupils about their success or failure and their relationship with school learning.

It is possible to consider other contexts besides those implied by the school system. We are thinking here of those concerned with everyday life, with work, with training and with care. Their specificities will have an impact on the way subjects position themselves vis-à-vis the discourses that take place in their social space and how they appropriate them. I am proposing to examine them through the conceptualisation proposed by Schütz in his book *Le Chercheur et le*

Quotidien (1987)³ regarding ‘finite provinces of meaning’, a concept inspired by William James’s theory on beliefs, which distinguishes sub-universes that give rise to different modalities of reality, each with its own particular style of existence. Schütz uses the notion of “finite province of meaning (...) for it is the meaning of our experiences and not the ontological structure of its objects that constitutes reality”⁴. These provinces refer to a diversity of intersubjective worlds and are characterized by specific properties: cognitive style, types of consciousness, of spontaneity, of experience of the self, of sociality, of temporal perspective. Later, Berger and Luckman in their book on *The social construction of reality* (1963) described common sense as ‘province of savoir’ whose study is as legitimate as the one of other provinces, notably science.

The trend that is currently taking shape should lead us back to Schütz with the recognition, within common sense itself, of sub-universes, of provinces of meaning and knowledge, that are influenced by the types of experience and the social relationships specific to different intersubjective contexts. In the following pages, I will examine in greater detail the health sector, which allows a more detailed examination of the relations between lay and expert forms of knowledge in the context of the therapeutic relationship.

THE HEALTH SECTOR: A PRIVILEGED EXEMPLAR OF ENCOUNTERS BETWEEN DIFFERENT FORMS OF KNOWLEDGE

Moscovici’s contribution has inspired several pieces of research interested by scientific popularization and the teaching of sciences by highlighting the way social representations represented a break from a linear and hierarchical transmission of knowledge model which leads to the establishment of an equivalence between knowledge and power. In this model, the receiver of information was perceived as a blank slate, a virgin wax on which was carved the information transmitted in a vertical relationship between the communicator who owns the knowledge and a receiver, ignorant and passive. This model also held true for the relationship between a doctor and a patient and, indeed, was used as the interpretation framework for this relationship for a long

³ and ⁴ Translation from texts chosen in A. Schütz, *Collected Papers*, Volume 1, pp. 287–356. The Hague: Martinus Nijhoff.

time. However, the framework has now been turned upside down thanks to a number of factors that have marked the development of the health sector over the last thirty years. Some of these factors are ideological, while others are related to a change in the positioning of patients and their closed ones or correspond to a more community-based conception of public health.

As noted by Le Breton (2005), one of the first changes occurred when people started to react against the purely biomedical model in which the health professional was more concerned by the illness than by the patient and in which the care provided focused more on the body than on the person. Indeed, until the end of the 20th century, the development of medical science and techniques resulted in a reification of the body which became a collection of organs to be treated. At a social level, 'hygienism' was there to protect the social body thus conveying to the State the role of care provider and establishing what Foucault calls the 'biopower' by which he refers to "the entry of phenomena peculiar to the life of the human species into the order of knowledge and power, into the sphere of political techniques" (Foucault, 1976, p.186). The movement of humanization which began in the 1970s has offset the deficiencies of the biomedical model with listening and accompaniment techniques. The involvement and education of patients proved beneficial by increasing patient compliance to treatments and a more informed consent. However, it is the apparition of AIDS and the mobilization of people suffering from this illness, which most markedly contributed to the establishment of a new type of patient, active and keen to change, able to identify the changes required of the health system so that it can deal with new problems, a patient willing to get involved in the organizational and decision-making processes related to public health and thus providing patients' association with a role in the care and medication policies, and willing and able to appeal to public opinion.

These grass-roots organizations have enabled patients to speak out and to occupy a legitimate place within the health system. They have contributed to the establishment of a 'health democracy'. This health democracy in turn provided patients with a number of rights (information, informed consent, participation in the health system) and a clear role for the associations and patient representatives, and introduced the principles of a health education. This resulted in far-reaching changes in the health sector, approved by the authorities, as well as a deeper recognition of patients' representations and forms of knowledge.

REPRESENTATIONS AND EXPERIENTIAL KNOWLEDGES

On one hand, in psychiatry, the concept of social representation is becoming more frequently used. In addition to the references made in studies aiming to delineate and modify the images of people suffering from mental illness and their stigmatisation (Giordana, 2011; Jodelet, 2012), social representations have been adopted in this field and defined as a “a psychic process which, based on the perceptions, the investment of the family, the social and cultural environment, and the interactive situation, constructs an interpretation and a figuration of the object which will structure our relation to the world” (Bonnet et al., 2007)⁵. This orientation highlights the importance of analysing the lay conceptions of mental illness. It gives a key role to the patient’s subjectivity and enables health professionals who are in a situation of power to learn something new from these patients. From now on, one speaks of an ‘expertise of experience’ of patients suffering from mental illness and the emphasis is being put on the processes of recovery, putting forward a phenomenological approach of the lived experience (Davidson, 2003; Greacen & Jouet, 2012).

On the other hand, in the field of medicine, the World Health Organisation introduced the concept of health education and therapeutic education in the continuous care of patients as early as 1986. In France, the law concerning “Hospitals, Patients, Health and Territory”, adopted in 2009, advocates programmes to do with education, accompaniment and formation and that aim to improve the observance and the quality of life of patients. Until now, therapeutic education has been mostly defined in terms of prevention, a definition which becomes quickly inappropriate when dealing with people who are already ill, suffering of chronic disease or in need of palliative care. This perspective took for granted the validity of an approach based on a pure transmission of information, aiming to regulate health spending and to make people responsible for their own health. However, its validity proved to be totally unfounded following the recent development of a trend inspired by a number of models that make clear that forms of knowledge depend on the positions taken by the different actors, their interests and their objectives (feminist studies, gender studies, subaltern studies, ethics of care, community psychology).

⁵ Translation by Claudine Provencher.

THE KNOWLEDGE OF PATIENTS

This perspective, which imposes itself and becomes more common (Jouet & Flora, 2010), diminishes the amount of attention usually granted to the application of medical knowledge and the conformity to their recommendations. Instead of focusing on the producers of science who validate their knowledge amongst themselves, the attention now focuses on the users who appropriate this knowledge as thinking and embodied human beings and transform it in forms of knowledge, beliefs, opinions, and representations which allow them to put together an optimal approach towards the care that they need. On the patients' side, the emphasis is put on experiential forms of knowledge built from how one lives his/her illness and the resources mobilised to ensure one's survival (Tourette-Turgis, 2000). This form of knowledge can be transmitted by those who own it to other patients so as to help them to face their illness.

Until recently, patients' knowledges were perceived as being inferior to those of health professionals – the patient being in a hierarchical relation of dependence – there only to facilitate therapeutic education. Today these forms of knowledge are perceived as playing a key role in the elaboration of survival strategies and as useful for both society and other patients. Being ill is no longer considered as a state but as a phase through which the patient develops new skills, acquires new competences, the communication of which will, in turn, enrich the knowledge practice of, and dialogue with, health professionals, while, at the same time, making a positive impact on other patients. From this evolves the notion of 'expert-patient' whose forms of knowledge resulting from the meeting between experiential knowledge and scientific knowledge transform his/her status of 'ill subject' and may thus contribute to a transformation of the practices adopted by health professionals. Indeed, amongst those health professionals who take care of the sick or weak people (medical and paramedical personnel, psychologists, teachers and trainers, etc.), the work on others, traditionally based on theories of care, is no longer conceived as an unequal relationship between someone who has the knowledge and the power and someone who is in a position of weakness. This work has stopped being prescriptive and judgemental and rather aims to increase the capability of patients, to understand better their concerns, their desire to survive as well as to acknowledge their competences.

However, this reversal of perspectives is not always welcome and has resulted in some opposition within the health sector. Thus, according to Faizang (2010), the official recognition of patients' rights has had a real impact on the relationship between doctors and patients. It replaced a paternalistic approach with a contractual one that grants to patients the power to decide, discuss, negotiate, accept or refuse treatments. But this relation still assumes an inequality between the person asking for help and the one who owns the knowledge enabling him/her to provide this help. Thus the acceptance of patients' power does not necessarily correspond amongst medical doctors with an acknowledgement of patients' competence, of their ownership of a real knowledge, nor of their legitimate right to receive information. As a result, the changes introduced in health policies have exacerbated the fight between power and knowledge, leading the author to conclude that: "Knowledge is more than ever a fundamental challenge of the relationship between doctors and patients."

MEDICAL KNOWLEDGE, LAY KNOWLEDGE

Furthermore, this transformation is still in a phase where the protagonists of therapeutic education are far from mastering the processes involved in the elaboration of this domain of practice. As a result, several avenues of research are now opening up for which the social representations approach can be beneficial inasmuch as it is interested in the dynamic relation between expert knowledge and lay knowledge and in the role of experience in the development of forms of knowledge. To make this happen, we will need to focus on local forms of knowledge, finite provinces of meaning, structured around concrete contexts in which take place the health worker-patient relationships as well as the activities by which patients take care of their bodies and try to preserve a balance between their condition and their daily life. The relationships refer to interpersonal exchanges with individual caretakers or with teams of health-workers and to relations with care institutions. The activities refer to the world of daily lives, to relationships with families and loved ones and, at times, to the world of work and social benefits. In these cases, the ways of accessing or producing forms of knowledge, their relevance and their encounters will adopt different shapes. There lays potentially a new field of study for the theory of social representations.

Staying in the health sector, I will now try to examine a number of questions resulting from the study of the encounter between expert knowledge and lay knowledge. However, before doing so, it would be useful to highlight the idea that, independently of this domain, the relations between science and common sense seem to have taken a renewed significance thanks to a number of factors: the scientific and technical advances and their consequences, sometimes catastrophic; the social impact of globalisation and of the creation of social communication networks; changes in the way our institutions operate, particularly in the education sector; the emergence of new social demands, etc. This theme has modified the shape of the problems associated with the diffusion of the academic and scientific knowledge, thus revealing a new interest for the private knowledge of social actors, called experiential knowledge, which I will discuss after having clarified the two following points: the possibilities for an equivalence between knowledge and social representations and the universe of senses encompassed by the concept of knowledge.

SCIENTIFIC KNOWLEDGE AND REPRESENTATION

I would say that the equivalence between knowledge and social representation is largely justified. On one hand, scientific knowledge is to a large extent rooted in our day-to-day knowledge, as noted by Schütz building on one of Husserl's arguments:

Furthermore, the basis of meaning (Sinnfundament) in every science is the pre-scientific life-world (Lebenswelt) which is the one and unitary life-world of myself, of you, and of us all. The insight into this foundational nexus can become lost in the course of the development of a science through the centuries. It must, however, be capable in principle of being brought back into clarity, through making evident the transformation of meaning which this life-world itself has undergone during the constant process of idealization and formalization which comprises the essence of scientific achievement. (Schütz, 1967, *Collected Papers*, Volume 1, p. 120)

This is the space where the encounter between common sense and science proposed by Moscovici takes place.

On the other hand, works in anthropology and the sociology of knowledge (Knorr Cetina, 1981) have shown that scientific knowledge is a social construction largely built on the exchanges between researchers, thus producing representations of the world. For that matter, the representational status of scientific knowledge is acknowledged by scientists themselves, as noted by the astrophysicist Evry Schatzman (1993, p.18):

In my view, the essential thing is that science or sciences represent a system of representation, a representation of the real, an operative representation, which enables us to do things that we would not do without this knowledge.⁶

On their side, social psychologists willingly agree that their models are inspired by common sense reasoning, even when they criticize the latter for its cognitive biases or its irrational character. Thus Kelley (1992, p.22) maintains that:

Discarding our common-sense psychology "baggage" would require us needlessly to separate ourselves from the vast sources of knowledge gained in the course of human history. (...) Common-sense psychology constitutes both a bondage and a heritage for scientific psychology. And like other inheritances, at the same time that it constrains and creates problems for us, it provides a useful and potentially rich foundation for development and growth.

This affinity between representation and science thus established, we have to examine the extent to which representation and knowledge correspond to each other. As both terms are polysemous, we have to identify the precise points where they overlap. When not used to designate those phenomena that can be observed in the flow of communication, social representations refer, on one hand, to a cognitive or semantic activity, that is, an activity of construction and of expressive sense-making; on the other side, to the products of these activities

⁶ Translation by Claudine Provencher.

which can be a knowledge or a meaning. Representation theorists make the related distinction between a 'declarative knowledge' (a proposition about the world), the 'knowledge that' and a 'procedural knowledge', which refers to processes of knowledge, the 'knowledge how'. This brings social representations in line with conceptualisations of knowledge.

THEORETICAL KNOWLEDGES AND KNOWLEDGES OF ACTION

Focusing on the notion of knowledge, we can see how it encompasses a diversity of meanings. There are theoretical forms of knowledge, abstract or empirical ones and, finally, experiential ones. In order to assess to which extent they include characteristics typical of representations, we must pay attention to their intricate specifications. For example, the idea of education was closely linked to the idea of an apprenticeship of a theoretical and practical knowledge, echoing Durkheim's ideas and highlighting the complexity of the relationship to knowledge, which brings together a multiplicity of meanings. On the other hand, existential forms of knowledge, referring to singular sensitivities and representation of the self, are closely related to theoretical and practical forms of knowledge.

To develop my analysis further, I will go back to the literature concerned with training where we find the most elaborate ideas concerning the notion of knowledge ('savoir'). This literature makes a fundamental distinction between two types of knowledge: the 'theoretical knowledge' and the 'knowledge of action'. This distinction goes back to the opposition between theory and practice. The knowledges of action have traditionally been associated to practical competencies, abilities acquired by and through action. Related to activities that transform a state of the world, these forms of knowledge appear often as tacit, hidden and not conscious. In order to disclose the knowledge of action, it must be examined through an investigation based on the clarification of its meaning by those subjects who carry out the activity. This procedure echoes the way by which researchers elicit the social representations underlying conducts. Thanks to the changes in organisations, in the training and research in the work place, the knowledges of action are being formalised thus acquiring a status similar to the one granted to theoretical forms of knowledge. Such an approach brings us closer to the way we isolate, in the field study of social

representations, those representations that orientate our behaviour, our relations to objects and to others.

We see a parallel development concerning theoretical forms of knowledge. They traditionally refer to disciplinary forms of knowledge. These disciplines can belong to the scientific universe, with corresponding forms of knowledge being made available through education, social transmission or through the media or else through research conducted in professional areas. Recently, other concerns have appeared. They refer to the theoretical dimensions underlying the practical domains. This is another similarity with representations, thus bringing theoretical forms of knowledge nearer to actions and their intelligibility.

This has led to a reconceptualization of the difference between theoretical knowledges and knowledges of action. The notion of theoretical knowledge refers to two types of referents (Barbier, 2004). On one hand, the terms and statements that enable us to name, designate, and rule on a reality external to the individual. These are referred as 'objectified knowledges' and are said to formalise a representation of the real and to be transmissible. The overlap with the concept of social representation here is obvious. On the other hand, the notion of theoretical knowledge refer to 'owned knowledges', that is, the capital of information, forms of knowledge, abilities, aptitudes and competencies of individual or collective agents. We are dealing with a reality that cannot be dissociated from acting subjects and which shapes a part of their identity. Those forms of knowledge are inferred from the behaviour of these agents. Here again the similarity with social representations is obvious. Depending on how we define theoretical forms of knowledge, the knowledges of action will acquire a different meaning. When dealing with 'objectified knowledges', the knowledges of action refer to an activity of management or transformation of the real. When dealing with 'owned knowledges', the knowledges of action refer to the identity component of the actor who, together with his/her competences, enables the management and the transformation of the real.

THE EXPERIENTIAL KNOWLEDGE

The evolution of epistemological models that underline the intricate links between theoretical forms of knowledge and knowledges of action sheds a light on the relation between scientific

knowledge and common sense knowledge. The former provides a representation of reality and common sense knowledge adds to this representation the characteristics of the action on reality that closely depend on subjects' identity. This identity is affected by subjective, positional and cultural factors. We have here a conceptualisation that enables us to approach social representations as a type of knowledge and to take into account the significance of experiential knowledge in our reflection about knowledge encounters.

As I highlighted a few years ago in a text about experience (Jodelet, 2006a), the attention given to the notion of experience results from diverse factors. Firstly, the orientation of human sciences towards real-life experiences and the phenomenology of the life-world (Husserl, 1931; Schütz & Luckman 1974). Secondly, the transformations of sociological perspectives which give a preponderant role to active and reflective subjectivity (Jodelet, 2008). Thirdly, in the fields of social intervention such as education, health, and work, the change in the paradigms and expectations of collectives leads to consider, beside the constraints imposed by institutional systems, the experience of actors.

For instance, the sociologist of education, Dubet (1994), has shown that the notion of experience has become an essential course of action in order to understand how teachers assume their pedagogical function and their tasks vis-à-vis their pupils. At least in the French context, our era is characterised by different phenomena that affect the practice of teachers: the breakdown of the education system; the change in families' attitudes who now consider school as a consumer product, a space where people's expectations count more than the respect of the values promoted by teaching and education; the manifestation on parents' part of a desire to control or, on the contrary, of a total drop-out or absenteeism; finally, the transformation of the school population resulting from the massive enlargement of participation in education and the emergence of a 'youth culture'. Confronted by this situation, teachers cannot rely anymore on past codes nor can they define their action by referring to statuses and roles which made sense in a stable institution but which have now become obsolete. They can only base themselves on their personal experience and use it to define their work and their behaviours towards pupils. This experience reveals to the same degree the remnants of practices that have succeeded or failed, the ordeals they have been through or the successes obtained in their relationships with their pupils.

In a similar vein, the changes observed in the health sector totally modify the relation between patients and the workers of the care system, conferring a privileged place to the experience of patients in how they deal with their illness and their treatment. It is in this area that the notion of experiential knowledge has developed the most. This example demonstrates the conditions for the elaboration and transformation of different forms of knowledge and their encounter. Indeed, anthropologists, sociologists or social psychologists have for a long time acknowledged the role and significance of social representations in the health sector (Jodelet, 2006a).

THERAPEUTIC EDUCATION AND EXPERIENTIAL EXPERTISE

Considering the new situation discussed above, how will the relative competencies of the carers and the patients merge from now on? Of which knowledge are we talking about? At the time of its introduction, therapeutic education highlighted the need to “take in account the way patients live their treatments, even their illnesses; this consideration was identified by nurses, doctors, and other health and social professionals as a way to improve the therapeutic care“ (Jouet & Flora, 2010, p.31)⁷. It is thus the improvement of the treatment adherence that was targeted at the time, obviously influenced by the economic concerns of political authorities. However, the possibility of allowing patients to take a more active role in their health was also an objective. This has resulted in the implementation of psycho-pedagogical strategies focused on the motivations and the coping mechanisms aimed at improving patients’ self-management and encouraging the appropriation for themselves of therapeutic competencies.

The validity and usefulness of patient education now acknowledged in developed countries are articulated around three principal axes: i) the patient is the subject of the care being delivered; ii) the objective is to promote health and not to combat illness; iii) an approach based on education is better than one based on prescription. This gives rise to a new category of patients: the ‘expert patient’ who is able to share his/her knowledge with other actors in the health sector, to transmit it during the training of carers and to become a ‘training patient’, a ‘helping peer’ whose experience can benefit other patients. According to specialists, “the

⁷ Translation by Claudine Provencher.

recognition of patient expertise within healthcare institutions is one of the most significant characteristics of the changes currently taking place in the representations of health” (Jouet & Flora, 2010, p.41)⁸.

The expertise is based on the patient’s lived experience of both the illness and of the treatments and different activities provided to maintain his/her health. The training provided in therapeutic education in order to build this expertise raises a number of issues. Based on a support and counselling approach, they are also in line with the sharing of scientific and medical forms of knowledge. To which extent can the access to these forms of knowledge be useful to patients and enable them to take a better control over their illness and treatment? How is medical knowledge assimilated and used by patients? On the patients’ side, care management implies an assessment of the treatments being proposed, based on their own reaction, thus introducing the subjective aspect of one’s relationship to illness. On the side of carers, who are no longer the only ‘experts’, one finds the fear that this transmission of scientific information could encourage patients to express new, illegitimate and unrealistic prerogatives. This is a new domain of research that could be explored by looking, on patients’ side, at the processes of transmission and assimilation of medical forms of knowledge by patients; on carers’ side, the conditions needed to encourage a sharing of lived experiences and of the different activities developed to manage one’s illness and treatment. On the other side, as noticed by Taylor and Bury in a review of the literature (2007), the encouragement of self-care management can be perceived as integrating an element of magical thinking, of inequality and of social normalisation with the call for a medicalised knowledge likely to trigger a lack of respect for patients’ beliefs, their ethnic, cultural and religious differences as well as for the individual decisions they take in order to take into account other social and economic factors. It is here that we go back to the importance of the specific contexts of the production of knowledge and of representations.

Concerning the experiential knowledge of patients, it would be possible to go back to the questions initially proposed by Moscovici about the relations between science and common sense. We would examine how, in the different contexts of people’s lives and activities, experiential knowledge incorporates scientific knowledge and practical advice or is influenced by them. How will knowledge and advice be affected by the lived experience of pathological

⁸ Translation by Claudine Provencher.

episodes and of their treatment, according to the specific contexts of a patient's life? Another interesting problem to study deals with the role played by emotions and the uncertainty as for the efficiency and success of treatments as well as for the internalisation of medical knowledge and the positive or negative tone of the lived experience. How to adopt a positive attitude and self-care practices when a cure is impossible? There is also a moral dimension at stake here. Patients can, in the context of certain illnesses, feel a responsibility towards their pathological state and could well feel even more guilty when being asked to be responsible for their survival when they do not feel as competent as the carer. Knowledges and meanings are not always compatible.

CONCLUSION

The innovating area of social activity that I have just discussed presents two main advantages. On one hand, thanks to the intricate role played by cognitive, semantic, emotional and moral dimensions in the construction of experiences and practices, the medical context represents a fertile area of research for the theory of social representations and the study of the production of forms of knowledge. On the other hand, this sector has the advantage of encompassing two fields that are generally studied independently: education and health. Each of them is a privileged place for the study of social representations despite a lack of a common approach towards them until now. We thus have a unique opportunity to apply and enrich the social representations approach in a multidisciplinary perspective and to combine together for the first time the findings in terms of research and intervention that have been obtained in the health and education sectors. The potential of such a situation deserves to be explored further.

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