

## **Representing Mental Illness: A Case of Cognitive Polyphasias**

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Within social representations theory, the concept of cognitive polyphasia describes the co-existence of differing, even contradictory, forms of knowledge in the same individual or community. To go beyond this notion is to ask how these rationalities co-exist and what forms the co-existences take. This paper aims to contribute to such an understanding using a study of representations of mental illness among Tamil Singaporeans. While Tamil culture has its own rich history, Tamil Singaporeans find themselves part of a multicultural melting pot, in a country fully engaged in the processes of modernisation and globalisation. The paper reports on findings from semi-structured interviews and group discussions held with members of the lay Tamil community. Thematic analysis of the data identified several semantic ‘barriers’ and ‘promoters’ (Gillespie, 2008) that regulated dialogue between competing representations. The paper will discuss how these semantic mechanisms ultimately result in different types of cognitive polyphasia and their relationship to identity.

Cognitive polyphasia refers to a state in which different, even conflicting, forms of knowledge co-exist in the same group or individual (Jovchelovitch, 2002; Moscovici, 1976/2008). A classic illustration of the phenomenon is a study by Wagner and colleagues (1999; 2000) which revealed

that the Indians of Patna employed psychiatric models as well as more ‘traditional’ Indian ideas of mental illness. In addition, cognitive polyphasia has been demonstrated in a number of other contexts including representations of general health (Gervais & Jovchelovitch, 1998), homelessness (Renedo & Jovchelovitch, 2007), and intelligence (Mugny & Carugati, 1989). With the strength of such empirical evidence, there seems little to be gained in further questioning whether multifaceted thinking exists or not. Moscovici (1976/2008) himself argued that the “*coexistence* of cognitive systems should be the rule rather than the exception” (p.189). Marková (2008) further suggests that cognitive polyphasia should be seen “as a presupposition enabling the researcher to discover conditions which facilitate, hinder, provoke or lead to transformation of different ways of thinking and knowing” (p.479). To do this, we must first consider the mechanisms by which cognitive polyphasia materialises. There have been several notable approaches in this regard including Foster’s (2001) account of differentiation, Jovchelovitch’s (2007) articulation of knowledge encounters, and Provencher’s (2007) systematic operationalisation of polyphasia, as well as relevant theoretical discussions by Gillespie (2008), Marková (2008), and Kalampalikis and Haas (2008).

This paper aims to contribute to the literature in this area through a dialogical approach to polyphasia; specifically, Gillespie’s (2008) analysis of ‘alternative representations’ and ‘semantic barriers’ is the point of departure. Building upon Moscovici’s (1976/2008) research on the diffusion of psychoanalysis within different groups in French society, Gillespie (2008) addresses how social representations “enable individuals to negotiate the plurality of alternative and potentially competing representations which contemporary society confronts them with” (p.376). He proposes a sub-component of social representations, called alternative representations, which are representations of potentially competing representations; they are ideas attributed to real or imagined others. “They enable people subscribing to different representations to communicate with each other, even if only in a partial way” (Gillespie, 2008, p.382). Semantic barriers are structures that prevent dialogue between the main representation and the alternative representations. Examples of barriers include rigid ideological opposition, stigmatisation of particular representations or representors, and splitting of representations into separate categories; these strategies allow people to isolate the alternative representations such that dialogue is muted (Gillespie, 2008). Thus, while globalisation and the digital age are enabling different

representational fields to come into contact, “this does not mean that people become more open to alternative representations, more able to reflect upon their own representations, more tolerant, or more decentred in their thinking” (Gillespie, 2008, p.389). Following from this, we can also ask what might happen when ‘semantic promoters’ are present: what happens when individuals do become open to alternative representations?

Gillespie’s (2008) analysis concludes that there is a variety of polyphasias in terms of the degree of dialogue between the main and alternative representations, echoing Jovchelovitch’s (2007) proposal that different types of knowledge encounters (in terms of dialogicality) result in varying states of cognition. This paper aims to provide an empirical demonstration of such a typology, focusing specifically at the level of the individual. At this point, it is important to clarify the definition of polyphasia; though the construct is as old as the theory of social representations, it has been operationalised in a number of different ways. For instance, Gillespie (2008) articulates polyphasia as the co-existence of multiple representations while Jovchelovitch (2007) does so in terms of multiple rationalities. That is to say, the first compares representations about a target object whereas the second compares the logics employed. We might reconcile these two positions with the notion that different representations must necessarily be derived from different forms of knowing. This is the assumption underlying the present paper.

The remainder of the paper outlines a study of social representations of mental illness conducted in Singapore. The context of the study and the methods used are described first, followed by an application of the analysis set forth by Gillespie (2008). This is then extended into a discussion of the varieties of polyphasia found in the data and their relationship to identity.

## **METHOD**

### **Context**

Previously a British colony, Singapore gained independence less than 50 years ago. Often used by the West as a gateway into Asia and less developed Asian economies, Singapore has historically faced an influx of Western products, concepts, and ideologies. Yet, Singapore remains distinctly Asian, although hardly homogenous. Instead, most of the residents fall into one

of three distinct ethnic or cultural groups: Chinese, Malay and Indian<sup>1</sup>. This multicultural melting pot provides ample opportunities for different knowledges to make contact. It is in this context that the present study was located.

A specific ethnic community within Singapore, the Tamils, was chosen as the target population. The Tamils, who comprise the largest sub-group among the Indians in Singapore (60%), originate from the southern state of Tamil Nadu in India, as well as Sri Lanka. A majority of Tamils are of Hindu religion<sup>2</sup>. In focusing on one ethnic group and excluding others, the sacrifice in breadth is compensated by an increased depth of coverage. Further, as a member of the community, and literate in Tamil, the author had direct access to the target population as well as an intrinsic understanding of the community's culture and traditions. The study's aim was to investigate and document the ideas and beliefs that Tamil Singaporeans have about mental illness, including meanings, causal attributions and effects. In addition, there was an expectation of cognitive polyphasia as a result of Singapore's multiculturalism and the 'clash' between Western and Eastern knowledges (Wagner et al., 1999; 2000).

### **Materials and Procedure**

A qualitative study, consisting of semi-structured interviews and focus groups with members of the lay public, was conducted in Singapore in 2007-2008<sup>3</sup>. Tamil Singaporeans (citizens and permanent residents) were recruited for the study through a process of snowballing. Participants were informed that the purpose of the study was to understand the community's attitudes and beliefs about mental health and illness. In total, forty interviews and six focus groups were held. Interview participants ranged between 18 to 67 years of age, with 19 females and 21 males. The majority (34) were of Hindu religion and just over half (22) had completed or were completing university education. The focus groups had a total of 29 participants; all but one of the groups

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<sup>1</sup> The Chinese majority (76.8%) originates from China and Taiwan, while the next largest group, the Malays (14%), find their ancestors in Malaysia and Indonesia. The Indians comprise about 8% of the Singapore population (Department of Statistics, 2001).

<sup>2</sup> The majority of Indians (55%) in Singapore are Hindu (Department of Statistics, 2001); similar statistics are assumed for Tamils.

<sup>3</sup> This study was one component of a larger research project. Another component was an analysis of newspaper articles from the English and Tamil dailies which is not included here.

were ‘natural’ groups wherein the participants were members of existing social groups (Bauer & Gaskell, 1999).

All interviews and focus groups were conducted by the author. The language medium was English<sup>4</sup>, Tamil, or a mix of both, depending on the preference of individual participants or consensus among focus group members. The majority of the interviewees (63%) chose to speak English during the interview while the rest spoke Tamil or changed between the two. Four focus groups were conducted in English while the other two were mixed.

Interviews and group discussions began with the presentation of a vignette that was developed for this study; it described behaviour that could be interpreted as mental illness (see Appendix I). Participants were asked what they thought about the story and probed on the causes of such behaviour, possible treatments, their own personal experiences of such incidents and what they would do if a loved one were to behave in a similar way. Another stimulus, a free-sort (Bernard, 2000; Coxon, 1999), was used to stimulate conversation about mental illness in an indirect manner (see Appendix I for object domain).

As suggested in the literature on the social nature of the interview (Farr, 1982; Holstein & Gubrium, 1997) and in light of the author’s background and educational status, the interview scenario may have promoted the need, at least for some participants, to identify themselves as modern and well-educated. To mitigate this, the author projected herself as a young novice, open to learning about different ideas and experiences.

## **Analysis**

Transcripts and associated notes were analysed through a process of thematic coding (Boyatzis, 1998) with the assistance of ATLAS-ti. A combination of deductive and inductive processes was employed to build a coding scheme; initial codes were compiled from a review of the literature and modified, and added to through an iterative coding process. The final coding scheme comprised three macro coding categories, each with multiple sub-categories and codes: *model of*

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<sup>4</sup> It should be noted that Singlish or Singaporean-English is the local version of English commonly used in informal settings in Singapore. Based on British English but heavily influenced by Chinese and Malay, Singlish is an ideal example of the inter-mixing of the various cultures in Singapore.

*mental illness, society-mental illness relations, and structural*. Codes and their associated quotations were then examined in detail in order to identify common themes.

The focus of this paper is primarily on the macro coding category, *structural*, and specifically the sub-category of *dialogue*. Gillespie's (2008) analysis provided the initial codes of 'voices' (to capture alternative representations), and 'barriers' and 'promoters'. Through iterative coding, different barriers and promoters were eventually identified.

The transcription convention is provided in Appendix II. Translation was only carried out for the purpose of presentation; translated utterances are indicated by underlining.

## **KNOWLEDGES, POLYPHASIAS, AND IDENTITIES**

### **Multiple Knowledges**

As predicted, different systems of knowledge about mental illness were present; these could be termed 'Western psychiatric' and 'traditional Indian', similar to Wagner et al. (1999), although this disguises the heterogeneity within each of these categories. It is perhaps more accurate to say that participants employed a number of knowledge sources, including science, religion, supernatural, and personal experience (their own as well as those of others). The co-existence of these various knowledges was most apparent in the causal attributions and treatment notions of mental illness.

Causal attributions of mental illness were predominantly psychosocial, but biophysical and so-called traditional causes, including ghost possession and black magic, were also referenced. Participants were often cognizant of alternative causal models even if they did not express belief in them; traditional causes were rarely mentioned spontaneously by participants though acknowledged upon probing. The diversity of causal attributions was similarly reflected in ideas about treatments of mental illness. Participants' suggestions were varied, ranging from managing the illness at home to alternatives such as visiting temples or faith healers. Most importantly, there was evidence of pluralistic help-seeking behaviour. In the extract below, a participant recounts the experience of her acquaintance who sought a doctor, and subsequently a priest, for help with the 'voices inside his head':

Nithya: So yeah, he feels like somebody inside, always kept on telling him. So I think some people, they have this kind. He calls it a...hipsophonia or something like that.

Interviewer: Is it schizophrenia?

Nithya: Yeah. Yeah, so that one. So...(trails off)

Interviewer: Did he go to the doctor?

Nithya: Yes he did, he did. He went to the doctor, but the medicine didn't help or anything so he went to, he came across this priest, it was a Buddhist priest and he was able to help him to get rid of it and gave him a Ganesha, a small Ganesha [Hindu idol]. So he keeps it with him and...so yeah. (Nithya<sup>5</sup>, Female, 34)

As this anecdote shows, the decision to seek out particular treatments is not necessarily driven by belief in certain models of illness or medicine but by practical considerations such as finding a cure. The fact that Nithya's friend first approached a medical doctor speaks to the dominance of the medical system; it was the perceived lack of success within this system that led him to seek out alternative approaches. Other practical considerations that drive help-seeking behaviour include financial constraints and concerns of privacy.

## Dialogue

These findings suggest that different representational systems are being communicated and maintained within the community. The concept of semantic barriers and promoters (Gillespie, 2008) provides one way to understand how individuals of the community manage these competing systems. As described earlier, barriers inhibit dialogue between representations whereas promoters encourage dialogical engagement. In this section, analysis identifying these meaning complexes is presented. Three major semantic barriers to dialogue between competing representations (irrationality, stigmatisation and separation) and three promoters of dialogue (separation, openness, and credibility) are identified. Although these barriers and promoters are elaborated and evidenced separately here, they are, in practice, intertwined.

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<sup>5</sup> Pseudonyms are used for all participants, for the purposes of confidentiality.

*Barriers to dialogue*

The first barrier to dialogue, irrationality, refers to the strategy where traditional models were dismissed as irrational, even ‘crazy’. More generally, medical models were seen as scientific while traditional models were regarded as unscientific superstitions. Thus, scientific knowledge was privileged as the only way to the truth. Consider the extract below:

Or things like, even a lot of very educated people say things like...‘oh you know, actually, this person is supposed to die you know, but then ah, I went to this healer, so they kinda gave me like five more years to live.’ What rubbish. (laughs) ‘Really? Hello.’ (laughs) (Gayatri, Female, 33)

Gayatri acknowledged the existence of traditional ideas and beliefs but she chose to dismiss them as irrational - in her words, “rubbish”. We will return to this quote further on as it also shows evidence of the second barrier, stigmatisation. Some participants displayed a somewhat different version of the irrationality barrier. They provided what they considered more rational explanations for traditional ideas; thus, spirit possession and effective treatment by faith healers were *re*-presented as having psychological roots and basis. This is demonstrated in the following excerpt where members of a focus group discussed faith healers’ abilities and the mechanics of godly possession:

F1: Maybe...I don’t know...the magician person [faith healer] is probably also like a psychologist and, I mean he knows how to control like a person’s mind and sort of influence the person to act a certain way.

[...]

F2: You know in temples and stuff when, when...some...if the music is loud and you have like...some, some people, they just start dancing and, and they say God, Godly trance?

Moderator: Mmhmm?

F2: So...what I feel is, it's, it's actually not, as in, I don't think there is anything /spirit or some God./

F1: /Yeah, just you're so/ overwhelmed by the.

F2: Yeah you're just, the nervous system is just so overwhelmed by the new sounds and the...everything that you just, you...lose your consciousness. So it's what I feel. (Focus Group 5, female students)

These participants demonstrated a slightly higher level of engagement with the alternative representations, compared with Gayatri. Whereas Gayatri simply dismissed supernatural phenomena as implausible, these focus group members felt it necessary to rationalise them through scientific explanations<sup>6</sup>. That is to say, although they, like Gayatri, considered these supernatural ideas as irrational, they attempted to explain the perspective of believers. We could conclude that, in this case, the barrier to dialogue, while ultimately effective, was not impenetrable.

The second barrier, stigmatisation, is related to the dismissal of traditional models as irrational. The difference between the stigmatisation and irrationality barriers is that the former is focused on attributions of others – people who subscribed to these traditional models were held in contempt; they were seen as uneducated and backward. We can return to Gayatri's account presented earlier to illustrate. Her language (“Really?”) and laughter displayed her open contempt for subscribers, which included “even” the highly-educated. Her quote reflects a general assumption among participants that believers of traditional models are usually members of the older generation (hence why younger, highly educated believers were regarded with dismay). In the following excerpt, another participant made this explicit:

Uh, I think in, as far as Singapore is concerned ah, the older generation...a certain extent...has certain superstitions...In the sense that, we look at, you know, the Chinese pray to the gods and leave offerings right? They say if you step on it [the offerings] you'll be cursed, all that. But the younger generation, I don't think so.

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<sup>6</sup> That these preferred, scientific, accounts are not necessarily accurate – for instance, psychologists cannot control minds – is irrelevant.

It's, it's a dying...it's a dying, what shall I say...belief lah<sup>7</sup>. Even the Chinese don't believe in it these days you know. (Durai, Male, 48)

Durai used the example of the Chinese Hungry Ghost Festival, commonly celebrated in Singapore, to make his point that belief in traditional models of mental illness is part of a wider set of superstitions characteristic of ignorant, older generations. As with Gayatri's quote, there is evidence of the first barrier here as well. Durai's use of the term "superstitions" subtly, but clearly, advertised his dismissal of traditional models as irrational.

The final semantic barrier is separation, wherein the main representation is separated from alternatives (Gillespie, 2008). In his extended analysis of Moscovici's research on psychoanalysis, Gillespie (2008) illustrated how separation allowed Catholics to find out more about and engage in psychoanalysis without threatening their faith. In the present data, separation was manifested in the differentiation between spirit possession and mental illness as two disparate phenomena. This was particularly evident among Christian participants as demonic possession was part of their religious doctrine. As an example, consider the following excerpt from a focus group session with a church youth group. In this snippet, the moderator returned to something mentioned earlier in the session:

Moderator: Ok. Mmm, I think it was you who mentioned [F1], about possession as something [that could be inferred from the vignette]...do you, any of you think that that's possible?

F1: Yeah there's demonization. I mean, but definitely there's a fine line between demonization and mental illness lah.

Moderator: OK.

F1: Yeah.

Moderator: So you're saying there's a difference but it's very fine?

F1: They may display similar symptoms and signs and all that but the root cause is different, yeah.

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<sup>7</sup> Singlish manifests most prominently in the ubiquitous use of the particle 'lah'. Lah appears at the end of utterances; it has different intonations and thus conveys the mood of the speaker.

F2: One can be treated through medicating.

F1: One, one cannot. Yes. (Focus Group 2, Church youth group)

Although F1 was the main voice here, the lack of discussion reflected a high level of consensus within the group regarding this understanding of demonic possession. While separation was also present in the accounts of Hindu participants, it was less consistent and structured than for their Christian counterparts.

### *Promoters of dialogue*

Although separation can function as a semantic block, it also appeared to indirectly promote dialogue between the different knowledges. Returning to the extract from Focus Group 2, there is a clear understanding that possession and mental illness, whilst producing similar displays of behaviour, were fundamentally different in terms of their origins and consequently, their ‘cures’. Thus, we can say that separation actually resulted in two different objects being represented, thereby allowing each to be independently elaborated. At the same time, their similarity provided opportunities for dialogue. This explains why the focus group participants were able to pinpoint specific differences between the two phenomena rather than merely having knowledge of one or the other. This is further demonstrated in the following quote from a Hindu participant:

Of course, like these kind of black magic, people possessed or anything, it’s always in the night. [...] These kind of things, you can see lah, there’s difference at night especially, they behave differently. So you know something is wrong in them. But people with mental depression and stress, forever they’ll be like showing their...whatever, their attitude. As I said, their attitude will be different, that one is different from this. (Rani, Female, 35)

For Rani, mental illness and possession were differentiated by variances in temporality – she suggested that a possessed person would display bizarre behaviour only at night whereas a mentally ill person would always be behaving differently.

The second promoter of dialogue, openness, is the recognition that there might be more than one approach or solution. That is, any explanation or treatment that works, is acceptable and indeed, preferred. This is the basis of the pluralistic help-seeking behaviour described previously. Scientific or medical approaches do not necessarily satisfy those who are trying to make sense of illness. As we saw in the excerpt in the previous section, Nithya's friend sought an alternative route when he found that medical treatment could not quell the voices in his head. In the following extract, another participant articulated why openness is a reasonable response to the illness experience:

So I, I think I take a very functional aspect to this in the sense that I think an individual's reality is real to them, you know. [...] rituals that help a person cleanse and all that, sometimes work. If they work, then they're a bona fide solution...right? They may not be a scientific solution. But science has its limitations, you know. (Lawrence, Male, 46)

In noting that alternative treatments such as temple rituals "may not be...scientific", Lawrence suggested that science is the ideal that other models are compared against. However, he went on to state that science has limitations, suggesting that it does not always provide answers to the questions we have. In these situations, alternative models can address a need. The limitations of science are especially apparent when one considers the evolution of scientific knowledge over time. At a later point in the interview, Lawrence gave the example of Pluto which "used to be a planet, until we looked at it a little closer and then realised it's just a speck of dust floating in space".

Another promoter of dialogue arose from participants' unwillingness to dismiss the credibility of their family and social peers. This can be seen as the inverse of the stigmatisation barrier discussed earlier. Thus, subscribers of traditional models were considered credible parties rather than dismissed as irrational. In the quote below, a participant explained why her friend's experience of spirit possession is believable, thus contributing to her own belief in the phenomena:

She said, yeah she said 'I felt like I was sharing my body with somebody else'. (laughs) So I guess...But these are, these girls are, so-called, very normal girls and you, you have been with them, and they're your friends and you know how they are. So, you can't disregard it I feel, so (laughs) yeah, I guess these are the things I've heard. (Asha, Female, 29)

Asha's laughter, and her use of "very normal girls" to describe her friends, revealed her self-consciousness: she recognised that belief in possession and other traditional models is often seen as irrational and thus she was forced to defend her friends, and by extension, herself. While Asha's case was premised on the credibility of an intimate peer, the mass media and other authoritative sources of knowledge, such as religious figures or texts, could also be considered credible sources that can promote dialogue between representational systems. This is illustrated in the following quote from a Christian participant, who, having provided an account of a possessed individual taken to church for treatment, went on to say:

It's more like I have to believe because...I'm from a Christian background. But there's still no proof you see. Unless I become a priest and God passes some...powers to me, then I'll know [for sure]. So...still maybe [these things are possible]. (Isaac, Male, 20)

As Isaac's account shows, the presence of semantic promoters can generate ambivalence and tension. For Isaac, religion is an authoritative, even prescriptive, knowledge source ("I have to believe"). However, in a loose application of the scientific method, he noted that religion cannot take the place of direct evidence. Hence, he was left in an ambivalent, open state. This contrasts with the Christian participants quoted previously who successfully employed separation.

The analysis in this section has highlighted several barriers and promoters in the discourse of the participants that either blocked or promoted dialogue with alternative representations. As Gillespie (2008) noted, it is likely that there are many others yet to be identified. It is also important to note that while this analysis was concerned with the semantic level, there are

certainly other barriers and promoters at the structural level. Power differentials between knowledges have a significant impact; as Jovchelovitch (2007) has noted, “Asymmetries in the status and valuation of different forms of knowledge impinge directly on the ways knowledge is communicated, establishes its veracity and constructs its authority” (p.143). It should also be noted that the purpose of this analysis is not to advocate that dialogue is preferred, or that people who endorse particular knowledge forms (whether traditional or medical) should be open to others; the primary objective is to illustrate how polyphasia manifests itself at the level of the individual.

### **Forms of Cognitive Polyphasia**

Using the different levels of dialogue between co-existing representations due to the presence of various barriers and promoters, in this section, three different forms of polyphasia are identified: pluralism, separation and hybridisation. Broadly speaking, pluralism reflects a low dialogical engagement while hybridisation involves a high level of engagement. Separation is a special case in-between the two, wherein dialogue is indirect; it is characterised by the unique barrier/promoter of separation described earlier.

#### *Pluralism*

In this form of polyphasia, the individual does not actively engage with the multiplicity of representations circulating in the community. It should be stressed that although individuals might not ‘use’ alternative representations in the conventional sense, they are aware of these alternatives. In the present study, all of the participants knew about spirit possession and black magic though not all were open to these beliefs. Consider the extracts below:

...they have all those people who whenever they go to church or those religious ceremony, they seem to be possessed. I don’t think, you know, they’re possessed by anything else other than that occasion. (Chandran, Male, 48)

Interviewer: Do you think it [belief in possession and black magic] is common, prevalent?

Leela: A few, few news comes. They say, this like...because that kind of thing, some people say, but we do not know that. I do not know whether there is or is not but I am also not going to think about it. But there can be...they say can do that [black magic] to other people. (Leela, Female, 42)

Chandran and Leela both acknowledged the existence of traditional ideas and beliefs though they chose to dismiss them, albeit using slightly different strategies. Chandran blocked the alternatives by providing what he considered more rational explanations. Leela seemed to think it a waste of time entertaining these possibilities, perhaps because she had no first-hand knowledge and did not consider the second-hand sources credible.

It should be noted that this form of polyphasia also includes the rarer case where an individual rejects the medical model in favour of a traditional one.

### *Separation*

This second form of polyphasia is characterised by the unique semantic mechanism of separation<sup>8</sup>. Participants in the present study made a distinction between mental illness and spirit possession. Whilst this was most obvious among Christian participants, it also manifested among the Hindu participants. It is striking that the strategy of separation in both the current data and in Moscovici's data (Gillespie, 2008) allowed participants to hold onto their religious beliefs whilst also endorsing more scientific models (psychiatry and psychoanalysis respectively). One participant from Moscovici's data noted that "Faith is a different domain to science; there's no conflict" (as cited in Gillespie, 2008, p.386). Is separation a form of polyphasia resulting from the specific encounter of religion and science? It certainly appears so; within this type of polyphasia people combined their religious and scientific knowledges by allowing each its own domain. Thus, possession is neither a cause nor an effect of mental illness but rather, a separate phenomenon. Certainly, the two can manifest in superficially similar ways but there are crucial

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<sup>8</sup> The term separation in this paper is used to refer to the semantic mechanism as well as a form of polyphasia.

differences in aetiology such that the conditions can be distinguished and have appropriate treatments. The independent elaboration of possession and mental illness also allowed for the inclusion of divine or godly possession, at least in the case of the Hindu participants. For them, possession could be by good or bad spirits.

Separation (of the two conditions) might appear to be the result of a conscious effort, as evidenced in the discussion of Focus Group 2 presented earlier. Yet, separation was also implicit in the accounts of other participants. Most participants did not spontaneously mention possession either in relation to the vignette or mental illness generally, but once the subject was broached, they displayed their awareness and knowledge in the stories they shared. Whilst this could be due to the demand characteristics of the interview or focus group situation, it might also reflect that the representation of possession was simply not activated in the discussion of mental illness.

Strictly speaking, it could be argued that separation is not a case of cognitive polyphasia because the representations are not of the same object. There are instead two different objects being represented here. However, the representations of any one object are necessarily linked to those of other objects in a representational network. Thus, if we change our perspective to look at the object 'abnormal behaviour', there appears to be a hybrid representation constituted by the representations of mental illness and spirit possession, that is, elements from both science and religion. The next section explores hybridisation in more detail.

### *Hybridisation*

In this form of polyphasia, dialogue between representations is promoted. Whereas separation allows for the independent elaboration of two representations and knowledges, hybridisation combines them. Thus, instead of multiple representations, there is one hybrid representation. This hybrid is akin to what Gervais and Jovchelovitch (1998; Jovchelovitch & Gervais, 1999) referred to as a 'mixed representational field' to describe the representations of health and illness in a Chinese community in England. They noted that Chinese and Western knowledges were in co-existence; however, it is important to realise that the mixing occurred within a framework of the traditional Chinese concepts of harmony and balance. The authors argued that the Chinese way of thinking "accommodates opposites which, in the Western world, would appear as unresolvable

contradictions” (Jovchelovitch & Gervais, 1999, p.256). Thus, the incompatibility of representations or knowledges, which has been a central feature in the understanding of cognitive polyphasia, is a function of perspective. That is to say, the contradiction between psychiatric and traditional knowledges is only apparent in the frame of Western rationalities. Like the Chinese worldview, Indian spirituality, as epitomised in the systems of Ayurveda and Siddha, is a holistic system encompassing physical, mental and supernatural elements (Bhugra, 1992; Marutham, 2005). The Hindu religion itself is known for its inclusivity of a diverse set of ideas and traditions, having been described as “all things to all men” (Jawaharlal Nehru, cited in Flood, 1996, p.7). The wide variety is partly because “Hinduism does not have a single historical founder...it does not have a unified system of belief encoded in a creed or declaration of faith” (Flood, 1996, p.6).

Hybridisation, as manifested in the current study, is the case where Western scientific knowledge is not privileged. Thus, knowledge systems which are open, and which recognise that there might be more than one ‘solution’, are seen to be superior. It follows then, that there is no one fixed formula of hybridisation but several. The overarching theme is the integration of medical and spiritual approaches. In the hybrid representation of mental illness, prayer and meditation have healing powers not only for possession or sorcery but for any illness, whether mental or physical; however, participants varied in terms of how much potency they attributed to spirituality.

In the following excerpt, a participant described his own experience of the curative effects of meditation to show why he believes it is an effective cure (and indeed, preventive action) for illness:

Sivaram: (referring to vignette) This kind would not happen if [the person had been] sent for meditation.

[...]

Interviewer: Like you are saying, have you seen this type, [where they] went meditation and this illness was cured?

Sivaram: I myself, I myself have become cured.

Interviewer: Mmm?

Sivaram: In 1972, duodenal ulcer, supposed to be go for operation. That is when I went to translandal [sic] meditation [referring to transcendental meditation technique].

Interviewer: Mmm.

Sivaram: Did meditate, meditate, that energy [???] from here releases. That place through this way (gesturing with his hands). About two, three, in about two months, all fully gone. I went to see the doctor again, he asked what happened. I said nothing happened, I said. That is meditation, how powerful. (Sivaram, Male, 69)

Sivaram practiced meditation, even as he was seeing a medical doctor, as he had a strong belief system. This is one example of how medicine and spirituality are often combined in a hybrid representation. For other participants, greater faith in either one or the other system was not the driving force. Rather, the hybrid representation was a functional response to the illness experience. For yet other participants, the power of prayer and faith took the place of formal meditation.

Generally, spiritual health was considered relevant for overall well-being in, particularly as a preventive measure. One participant, a yoga teacher, explained that by regularly performing meditation, one surrounds oneself with positivity and thereby prevents negative elements from approaching:

When doing meditation all, when we ourselves have good mind, good...thoughts are there, that bad thought will not come in. That I believe. With good mind, good thoughts, constantly doing meditation...surrounding us, around us that bad ghost will not approach. But there is chance for good spirit to approach. Because we are being good, then why would the bad thing come into [us]? (Meenakshi, Female, 51)

Within the hybrid representation, possession is ultimately a symptom of weakness (psychological or spiritual). Mental and physical illnesses are also symptoms of such weakness.

## **Identities**

Thus far, the discussion has taken an individualistic slant; in this section, social context is considered through the concept of identity. To be precise, the relationship between polyphasia and identity, or rather, between the types of polyphasia and identities, is explored. It has been argued that cognitive polyphasia is linked to the multiple identities that we hold, the various social roles we play, and the groups that we are members of (Kalampalakis & Haas, 2008). In Duveen's (2001) words, "an identity is first of all a way of making sense of the world, a way of organising meanings" (p.264). More specifically, the demands of identification within a particular social context are motivations for such sense-making. Thus, by blocking or engaging with alternative representations in different ways, the individual is positioning him or herself in relation to those representations and fulfilling certain needs. Pigg (1996) makes a similar point in her study on Nepali beliefs, saying, "In Nepal, nowadays, your attitude toward shamans communicates who you are" (p.160).

In the present data, this was perhaps most apparent with individuals who utilised the barriers of irrationality and stigmatisation, that is, in the pluralistic form of polyphasia. The biopsychosocial model of mental illness was dominant and accepted as a reality by the majority of participants. Within the interview scenario, traditional models were typically not introduced by the participants, but once brought into the open, were a means of positioning. Participants clearly situated themselves in opposition to the believers of traditional models who were considered less-educated and backward. In the following extract, a participant explains that such beliefs were common before the arrival of scientific knowledge. He goes on to suggest that though these ideas might persist in under-developed areas, they would not survive in a modern country like Singapore:

All that went away a long time ago, went away a lot in villages. Before education was prevalent, a few, how do you say, a few approaches, few fears...like that. They'll say evil spirits possessed, they'll say ghost possessed. All this is SCIENCE, the story before science arrived [...] In villages there may be. In India.

In India, in China. May be in backward countries, cannot say no. But I doubt whether that [belief system] is present in Singapore. (Ashok, Male, 67)

Ashok is clearly presenting himself as a forward-thinking individual who has been 'enlightened' by scientific education. As mentioned earlier, the interview setting and the presence of an academic researcher is likely to have promoted the need to claim particular identities. This is less a limitation, and more a demonstration of a specific type of social encounter. Indeed, the interview scenario itself is not a fixed type; the encounter would naturally differ according to the participants involved. While some participants in this study may have wanted to 'please' the author and appear modern and scientific, others viewed the author as unschooled in spiritual matters and requiring education in that regard.

Another identification that was important among participants was religious identity. The quote by Isaac, presented earlier, clearly points to the role of religious identity in negotiating between various representational systems. Isaac believed in possession because of his Christianity, though he was disturbed by the lack of evidence. Other participants were less conflicted. Using their religious knowledge as a basis, they employed the strategy of separation to differentiate between possession and mental illness. This form of polyphasia may have allowed them to maintain their religious identity in the face of scientific knowledge; the confrontation heightened, as it were, by the presence of the author who was typically perceived as a medical/clinical professional.

Let us be reminded that representations are not fixed entities existing in the minds of individuals; rather they exist in the intersubjective space created in dialogue between individuals (Jovchelovitch, 1996). The social situation is thus critical. In the interview scenario, the pluralistic form of polyphasia was prevalent, but this does not mean that participants were polyphasic in this manner, all the time, with everyone. That is to say, the different forms of polyphasia are themselves linked to different social circumstances. To take this argument further, it is perhaps useful to conceptualise identity in the form of a representational project. Representational projects link the subjects, who are concerned with an object of representation, through "mutual interests, goals and activities" over time (Bauer & Gaskell, 1999, p.170). Thus, specific representational projects govern the representational efforts of the subjects involved.

People who have experience of mental health problems have different projects from those who have experience with mentally ill family members. In turn, these projects would differ from those of people who are further distanced from mental illness. Consider the specific project of the family members of a mentally distressed individual. Their representational work might incorporate seeking help from any and all avenues that offer viable solutions, particularly when financial constraints and the need to keep a low profile are taken into account. It is not uncommon for them to approach faith healers from a variety of faiths. This plurality of treatments might seem inconsistent and irrational to an outsider but not for the family members, who are likely to be concerned with representations of 'abnormal behaviour' as opposed to representations of mental illness. As discussed earlier, the former are more likely to be hybrid representations constructed from the integration of multiple representational systems. Hybridisation, then, is the form of polyphasia associated with this particular representational project.

## CONCLUSION

The concept of cognitive polyphasia was originally put forth by Moscovici (1976/2008) to describe how different modalities of knowledge, in relation to a specific object, could co-exist within the same group, and even the same individual.

In this paper, a study of social representations of mental illness was used to explore particular manifestations of polyphasia. A dialogical analysis, using the concept of semantic barriers and promoters, was applied. Some participants blocked alternative representations by trivialising them as unscientific and discrediting their proponents. Conversely, those who engaged with alternative representations felt that there was no one superior knowledge; they also considered the proponents of alternative models to be credible sources. Separation was both a barrier and promoter, as it facilitated independent elaboration of alternative representations. The relative presence or absence of these semantic structures reflected three different forms of polyphasia: pluralism, separation and hybridisation. Pluralism described the state wherein people did not engage with the multiplicity of representations whereas hybridisation described the integration of multiple representations into one system. Separation was a special case where the

multiple representations were reorganised into representations of different objects, namely mental illness and spirit possession. This typology is by no means exhaustive; the main objective was to show how we might go beyond simple statements about the diversity of representations or knowledges.

The varieties of polyphasia were, in turn, associated with different identity requirements. There is a clear demonstration that polyphasia is not a singular, fixed state of co-existing knowledges but rather a dynamic negotiation, dependant on the individuals and the social situation. Polyphasia, then, is a *process* by which people differentially draw upon a range of resources. The mechanics of this process are affected by identity. Identity here is more usefully conceptualised in the form of representational project as this allows for a more dynamic, relational notion of identity. Going forward, the concept of representational project appears to be a fitting tool to extend our understanding of polyphasia, in particular its functionalities and operationalisations.

In conclusion, this paper has attempted to further the concept of cognitive polyphasia through a focus on the mechanics of co-existence. Clearly, there are more avenues for future research, not least because of the limitations of the research study described here. There is a need for theoretical development of the concept (for instance, to reconcile the varying operationalisations) as well as more empirical work to explore how polyphasia manifests in different contexts and situations.

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## APPENDIX I

### Vignette

*Mathi is talking to a friend:*

*"It's not easy taking care of my brother/sister. He/she talks to himself/herself a lot and walks around without his/her clothes on. It's as if he/she doesn't know what he's/she's doing or he/she can't control himself. When we talk to him/her, he/she often makes funny faces or gestures and will even start singing loudly. Sometimes, he/she gets very anxious and fearful and says we are trying to harm him/her. At other times, he/she is very sad and won't eat or sleep for days. But his/her mood can change very suddenly, and he/she becomes bad-tempered and aggressive."*

The gender of the vignette character was varied such that half of the participants received the male version and half received the female version. The vignette was always presented at the beginning so as to take advantage of the minimal priming - of mental health or illness - at that time. This strategy, together with the lack of explicit labelling within the vignette allowed participants maximum flexibility in interpreting what they read.

### Free-sorting object domain

Alcoholism	Amnesia	Anorexia	Anxiety
Dementia	Depression	Drug addiction	Epilepsy
Gambling	Homosexuality	Insomnia	Leprosy
Mania	Mental retardation	Multiple/split personality	Obesity
Obsessive-compulsive	Pain	Phobia	Sadness
Schizophrenia	Shock/Trauma	Stress	Suicide

As one of the objectives was to look at participants' meanings of mental illness, the object domain was selected to include common mental illness terminology as well as other closely-related terms, including physical conditions and emotional states. Each card had both the English and Tamil terms displayed. The cards were presented in alphabetical order. Participants were told to sort the cards into groups based on whatever criteria they wished, with reassurances that there were no right or wrong answers. Focus group members were presented with the task in the form of a group activity, meaning they would collaborate in performing the sort. Once participants or groups had sorted the cards, they were asked to explain their grouping.

## APPENDIX II

### Transcription Symbols

Symbol	Meaning
<u>Underlined words</u>	Translated from Tamil
CAPITALS	Words said with emphasis
...	When between words, signifies a pause; at the end of a sentence indicates a trailing off
/words/	Words or phrases between slashes are overlapping talk
(actions)	Descriptions in parentheses are of actions or non-verbal expressions of participants
[???	Inaudible or incomprehensible section of recording
[...]	Omission of words or sentences after transcription for presentation purposes
[words]	Words or phrases in brackets are author's additions after transcription for ease of understanding