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ARTICLES

Objectification in Common Sense Thinking

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In epistemologies of both scientific and common sense thinking “objectification” characterizes the formation of knowledge and concepts, yet in each case its meaning is different. In the former, objectification in acquiring knowledge refers to the individual’s rationalistic reification of an object or of another person and to disengagement or alienation. Formation of concepts refers to the attainment of common features of persons, objects, or events. In the latter case, objectification is a dialogical process that takes place in daily activities and in communication. It rarely, if ever, pursues dispassionate ways but is judgmental and ethical. In this process, old myths, collective images, and historical narratives as well as habits of the mind, consciously and unconsciously present, refer to previous forms of knowledge and generate new ones.

In this article, objectification in common sense thinking is discussed using an example of haemophilia in relation to HIV/AIDS. Haemophilia is a genetically transmitted disorder of blood clotting that has already been known as a family disease in Talmudic rulings in the second century. It seems that social representations of this disorder, which in its most common form affects male individuals because they inherit the defective gene from their mothers, evoke beliefs prevalent in various religions and mythologies. These beliefs and the lack of scientific knowledge about haemophilia have led, throughout history, to a wide spectrum of psychological and behavioural challenges with respect to patients, carriers, their relatives, and the general public. The nature of these challenges is not stable: They undergo alterations with technological advances in diagnosis and treatment as well as with changes in the understanding of medical complications including HIV/AIDS.

SCIENCE VERSUS THINKING IN THE WILD

The *Zeitgeist* of the European thinking in the 16th and 17th centuries was characterized by diversification of ideas about knowledge and the nature of concepts. Although the idea of “right” and

“false” knowledge still dominated the emerging sciences and rational objectification, contrasting points of view came from the rising studies of nature, from arts, and from technological developments.

The terminology of newly developing natural sciences in the 17th century created a univocal language and methods that became universally communicable in the scientific community (Campbell, 1920/2007, p. 10). However, the fact that social sciences have often adopted the terminology of natural sciences when referring to human phenomena has become a serious obstacle to the communication of ideas and concepts. The misuse of terminology has often arisen through the attempt of social sciences to imitate natural sciences in believing that the term has the power to alter the nature of the concept to which it refers. Conversely, such attempts might be due to overlooking the fact that the terms in natural and social sciences are underlain by different epistemologies and that, therefore, they carry different meanings.

Take as an example the term “representation.” “Social representations,” “cognitive representations,” “collective representations,” “mental representations,” “Kantian representations,” among many other kinds of representations, are often used *as if* belonging to the same concept. For instance, Moscovici’s “social representation” has been continuously confounded with Durkheim’s “collective representation,” or with a “mental representation” in cognitive psychology, although these “representations” refer to vastly different phenomena (Marková, 2003/2005). Other examples could be terms like “epistemology,” “communication,” “dialogue,” and so on. To avoid terminological confusion, researchers may coin their own terms—although inventing new notions has its own problems.

Alternatively, researchers may be using different terms to refer to phenomena that are underlain by the same or similar concepts. This is an issue that the Norwegian philosopher Arne Naess (1953) brought to attention in his discussion of the depth of intentionality. For instance, researchers, in discussing the meaning of “democracy,” may agree that democracy means the freedom of speech. However, when probing further, they may find that they disagree about the meaning of “freedom of speech.” On the other hand, they may think that they have diverse views about the meaning of democracy, each defining it differently; one may define democracy in terms of decisions of the majority, whereas for the other it may mean the freedom in market economy and privatization. However, researchers’ subsequent clarification may reveal that their differences in definitions of democracy are underlain by the same values attached to the freedom of speech and opportunities.

This terminological problem refers to the concept of objectification that is the subject matter of this article. In scientific and rationalistic thinking, “objectification” refers to the concept of universal, real or true knowledge, and to neutral and factual ways of attaining it. Indeed, the aim of science is often stated in terms of making objectified generalizations. Concept formation in psychology exemplifies this approach. Margolis and Laurence (1999), in their seminal volume on *Concepts: Core Readings*, stated that concepts are the most fundamental constructs in theories of the mind, ranging from bundles of features to abstract entities. Numerous theories of concept formation that have been proposed treat concepts as reified categories pertaining to essentialism. Even prototype theory conceives concepts as complex mental representations “whose structure encodes a statistical analysis of the properties their members tend to have” (p. 27).

In standard accounts, to acquire a concept means to “correctly” classify or categorize people, objects, or events on the basis of their common features. Concept formation in psychology is associated with a single mental representation and was originally derived from or closely

related to behaviorism (Bruner, Goodnow, & Austin, 1956). In this approach, Rubin (2009) noted, “Generalization and the search for commonality take the form of abstract principles or objectified accounts” (p. 305).

However, objectification is also one of the main concepts in the theory of social representations and in common sense knowledge, where it refers to knowing obtained in and through experience, communication, and daily activities underlain by traditions, customs, folk-knowledge, and historical narratives. In this approach, the notion of concept formation is not used. This approach assumes that concepts are not acquired as single entities from strictly discernible attributes but instead they are generated in and through social experience and communication from semiotic networks of signs and symbols in their socio-cultural and historical contexts. Rather than referring to attainment or formation of concepts, this approach refers to social representing.

In other words, objectification in scientific knowledge and in common sense knowledge is based on different epistemologies. Because this is rarely acknowledged, the resulting terminological confusion carries the main problem for human and social sciences not only with respect to their theories but also, above all, with respect to practical and professional issues in which generalization or objectification does not take the form of abstract principles but instead evokes caring relationships, clinical wisdom, and ethical concerns.

In view of these matters, in the remainder of this article I focus first on objectification in scientific and in common sense thinking and concept formation; second, I discuss objectification in one practical example: in the genetic disorder of blood clotting, in haemophilia in relation to HIV/AIDS.

OBJECTIVITY AND OBJECTIFICATION AS FORMAL AND SCIENTIFIC DEVICES

Although the terms “objectivity” and “objectification” attain numerous meanings in philosophy and science, I briefly refer only to objectivity/objectification in relation to subjectivity/subjectification, which I consider relevant to my argument.

Objectification and objectivity in the Cartesian science was intimately related to the Cartesian disengaged reasoning of the self (Taylor, 1989). Analyzing the concept of inwardness in the Cartesian science, Taylor (1989) showed that it aimed to achieve objective and universal knowledge through disengagement and rational control: “Disengagement is always correlative of an ‘objectification’” (p. 160). “Objectifying” something means taking a neutral, that is, a disengaged stance toward a domain in question. “Objectification of human nature” (Taylor, 1975, p. 13) leads to decomposing the human mind into individual faculties, to a mechanistic separation of cognition from emotions and will—and so devising a new concept of objectivity that was linked with a new notion of subjectivity (p. 10). In this new notion of subjectivity, the human subject takes a disengaged stance with respect to the self, including emotions, will, and compulsions. It involves distancing oneself from one’s subjectivity in order to act rationally. Once the subject disengages himself or herself from living experience, he or she moves into an objectified and impersonal mode and assumes control over the world by standing back from it. The world is viewed as a big mechanism that the subject can objectively reconstruct and draw conclusions from that reconstruction. As Taylor (1989) explained, we can see connections “between disengagement and objectification, on one hand, and a kind of power or control, on the other; . . . assembling

or constructing our thoughts, which defines rationality; and lastly between rationality and the attaining of knowledge” (p. 163).

In other words, objectification is derived from the individual rationality based on indubitable knowledge. This follows from Descartes’s (1628/1955) claim that “science in its entirety is true and evident cognition” (p. 3). He made it a rule to trust only what is completely known and incapable of being doubted. Therefore if two individuals hold opposite views about the same thing, at least one of them must be wrong.

Disengagement of the subject is even more profound in the ideas of John Locke, Taylor (1989) argued, because Locke’s idea of disengagement penetrates the whole theory of mind. Locke’s mind as such is reified because it conceives objects as decomposed into simple ideas. Conceiving such elementary simple ideas, the mind constructs them into objects; again, this construction proceeds in a neutral and objectified manner.

Descartes’s and Locke’s impersonalized objectification has influenced the epistemology of scientific thought for the following three centuries, strictly separating the subjectivity from the objectivity of knowledge. Subjectivity was seen not only as a threat to rationality but also as inculcation of relativism and scepticism.

Objectification as an epistemological device has rarely been questioned until the 19th century, and in many respects it still prevails as a dominant epistemology in psychology. Discussing the theory of knowledge and of the mind, Dewey (1929) contrasted the methods of traditional and new experimental sciences. In the traditional scientific quest for certainty “knowledge in its full and valid sense is possible only of the immutable, the fixed; that alone answers the quest for certainty” (Dewey, 1929, p. 83). It ignores any changes and turns itself only to the unchanging state of affairs. In contrast, the new experimental science moves in an opposite way. Not only does it assume changes, but it deliberately introduces them into its inquiries “in order to see what other change ensues” (p. 84). Dewey gives an example of the latter in astronomy where, although researchers cannot introduce changes into the remote heavenly bodies, they can deliberately alter the conditions under which they observe these bodies: “Observations are taken from widely different points in space and at successive times. By such means interconnected variations are observed” (Dewey, 1929, p. 84).

We can observe in these examples that scientific and rational objectification have taken different forms. They range from strictly formalistic meanings, to efforts that include change while preserving an individualistic and rational approach to science; and to social scientific Marxist positions, aiming at transformation of alienation into scientific objectification.

OBJECTIFICATION IN SOCIAL REPRESENTATIONS AND COMMON SENSE KNOWLEDGE

From Language as an Expression to Dialogicality

We have seen that objectification in scientific approaches refers to the individual’s rationalistic reification of the object (e.g., Descartes, Enlightenment) through disengagement or alienation. Scholars who revolted against these kinds of scientific objectification emphasized, instead, that the essence of humanity consists in the expression of freedom, will and emotions of the individual, and in representative functions of language (e.g., Vico, Herder, Hamann, and Humboldt,

among others). This is why Berlin (1965) and Taylor (1975) coined this revolt as expressivism (see also Marková, 1982). Language as an *expression* of freedom and of the will of the self surely formed an opposition to mechanistic rationalism of the Enlightenment—and we need to understand it as a rebellion against that.

However, having acknowledged its historical role as an anti-Enlightenment movement, it is my view that what epitomizes the innovative ideas of these 18th-century scholars is the perspective of language as communication and as a communal action; we must see in it the seeds of dialogicality. These scholars emphasized that the origin of language is social; they drew attention to heterogeneity of languages, and to language as the work of nations (Marková, 1982, 2003/2005). In this sense their ideas anticipated *dialogical ontology* and *dialogical epistemology*. “Dialogical” refers here not simply to a dialogue but to the broad conception of dialogism or dialogicality (Bakhtin, 1981, 1984, 1986). Let us explain. For dialogical perspectives, interdependence among minds, rather than their isolation, is deeply rooted in the human nature, and it permeates all fundamental faculties like cognizing, acquiring knowledge and believing, imagining, feeling, and acting. Sociality is so basic that it defines the human existence: We can call it *dialogical ontology*. Only if we adopt this perspective does it become meaningful to raise questions about *dialogical epistemology*, that is, about the nature of knowledge, beliefs, and myths. Speaking, thinking, knowing, and believing are interactive processes embedded in the social environment, history, and culture. This epistemology or theory of knowledge conceives of knowledge as mutually coconstituted by individuals and others, whatever “others” may include in a particular case, that is, communities, traditions, languages, institutions, and so on (Marková, 2003/2005).

Transforming an Idea into Reality

It was not that Giambattista Vico, who placed so much emphasis on common sense thinking and knowledge, rejected science. Rather, he argued for a new science, different from the narrow conception of the dominant Cartesian science, against its rigid concept of truth, and the lack of guidance for dealing with human concerns. Neither did Hegel reject the notion of objectivity of nature; rather, his concept of the objectification of nature and its harmony with human affairs remained at an abstract and metaphysical level.

The genuine conceptual turn with respect to objectification as a form of humanistic, rather than formal, scientific investigation became prominent in more recent philosophical approaches, for example, Neo-Kantian (Cassirer), phenomenological (Husserl, Heidegger, Ricoeur), and hermeneutic (Gadamer).

Although these approaches treated objectification in vastly idiosyncratic manners—for example, some were subjectively and others objectively orientated, some emphasized distancing (Ricoeur) and others dialogicality (Gadamer) between self and others—these approaches nevertheless changed the direction of the conceptualization of objectification in the following sense: They focused attention on language, communication, experience, and communal activities.

Ernst Cassirer, who started as a Neo-Kantian philosopher and became in his later work a philosopher of culture, described objectification in terms of language and practical activity. He derived his ideas on language from Herder, Humboldt, Lotze, and Noiré, among others, who all viewed language as a social activity designating objects and their properties and thus stabilizing the world and fixing social reality.

Among those whose views Cassirer endorsed is the German philosopher Ludwig Noiré, who emphasizes that language is *sensorium commune* (Cassirer, 1953, p. 286f.) and that it was from the communal activity that language sprang and designated objects. In and through language objects enter into the scope of human vision, that is, they become things only in so far as they *undergo* human activity, and it is then that they obtain their designation, their names. In other words, humans choose aspects of things that are relevant for them whether emotionally, cognitively, or otherwise.

These dialogical and activity-based ideas have become prominent in some of the most innovative developments in contemporary social psychology and anthropology and show ways in which objectification through language changes an idea into social reality. From the very beginning Moscovici (1961/2008) insisted that social representations are formed by anchoring and objectification. For example, in his analysis of psychoanalysis as a social representation he showed that Freud's "Oedipus complex," when used in common sense language, designates the way in which relations between parents and children are organized, and it helps to interpret certain tensions in such relations as well as pathological symptoms. Elements of scientific terminology turn into marks that correspond to a particular reality and become fixed within that reality. In other words, what was an intellectual activity and was perceived is now real; it is conceived and therefore reified. For example, words that could describe someone as stubborn or quarrelsome are now seen in terms of psychoanalysis as aggressive or repressed or having a complex. In other words, naming something or someone means to objectify, to make something real through speech and subsequently, turning it into habitual social practices.

The anthropologists Massoud and Kuipers (2008), too, characterized objectification as a language-based process and as an activity manifesting itself in everyday interaction. More specifically, the authors view objectification as an interrelational semiotic practice that has significant social and epistemological consequences. Cognition is "a public and collaborative event among participants" and objectification means "participation and practice within culturally defined activity systems" (Massoud & Kuipers, 2008, p. 213). It manifests itself in the discursive and ethnographic record of interaction, like linguistic objectification, entextualization, objectification of sensory experience, and identity formation. Just like in Moscovici's work, these authors focus on linguistic objectification through the analysis of names and sentences. Names "thingify" or "objectify," but nominalization is not solely a grammatical process; the meanings of the words affect and are affected by the very process in which nominalization takes place.

Graphic objectification is another form of transforming ideas into object-like entities. Writing, posters, pictures, all turn an idea into a real graphic object. Visual images in the press, advertisements, and campaigns are used to influence or change social representations of political or health issues (Joffe, 2008). Visual images in the press have been particularly influential in staged photographs capturing public images about genetic engineering as injecting tomatoes with genes that make them grow bigger (Wagner, Kronberger, & Seifert, 2002). Wagner and Hayes (2005, p. 181) commented that images of tomatoes injected with genes resemble inoculation and injecting foreign materials into bodies known from medicine and chemistry. There is also an associated belief of infection that passes from one organism to another.

In all these examples semiotic signs and symbols are means of fixing knowledge and making objects and social representations, and their transformation, centers of reality. This takes place in and through actions in social networks and institutions and through dialogical processes of communication. Open-ended epistemic social phenomena and objects are part of all aspects of

life (Engeström & Blackler, 2005), be it mundane activities, technologies, creating of artifacts, or pathologies and diseases. Engeström and Blacker, in their analysis of the life of objects, focus specifically on diabetes as an object. We find that naming, diagnosis, testing the patient, and various pragmatic and semiotic activities—all make the disease an “object as an identifiable entity” (p. 318).

A disease is not just an expression of medical condition and scientific objectification. It is both a cheerless feature of human life incurring physical and mental suffering and threat to life, and it is also associated with different kinds of social representations, fantasies, and myths. These social representations and myths are related to a variety of factors like the medical management of the disease, severity, chronicity, and pain, on one hand, and social and institutional aspects like the stigmatizing effects of the disease, traditions in the particular locality, and socio-historically established beliefs, on the other. Sometimes illnesses are associated with dull, colourless, and tedious images, like a chronic migraine, a severe toothache, or a stomach pain. The sufferer calls for no more than efficient medical advice and advanced technologies to alleviate his or her discomfort. On other occasions, in addition to physical and mental discomfort, diseases may invoke powerful fantasies and social representations. Among such illnesses are some mental diseases, haemophilia, and recently HIV/AIDS.

OBJECTIFICATION IN HAEMOPHILIA

Living With Haemophilia

“Haemophilia” is a generic term for several kinds of genetic disorders of blood clotting. Its most common forms, known as haemophilias A and B, are recessive sex-linked disorders. This means that the mother carries a defective gene on one of her X chromosomes and that there is a 50% chance that any of her sons will be affected by the disease and a 50% chance that any of her daughters will be a carrier of the disorder. None of the sons of a male with haemophilia will suffer from the disorder, but all his daughters will be obligatory carriers by inheriting the defective gene from their father. The disease manifests itself by external or internal bleedings that are due to physical injuries or to emotional traumas and so appear to be spontaneous bleedings. The most life-threatening are intracranial bleedings; bleedings into muscles and joints are extremely painful and in the long run they lead to degenerative lesions, deformities, and loss of movement. Depending on the level of the clotting factor in the blood, there is a broad spectrum of severity of haemophilia. Mild haemophilia may not be diagnosed for years, whereas severe haemophilia could be diagnosed at birth or very soon after (Marková, 2007).

Although in the majority of families the genetic pattern of the disease can be established, in 15 to 20% of families there is no such evidence. This could mean that either haemophilia was for a generation transmitted through female carriers (who did not suffer the disease) or it could be due to a spontaneous mutation. The latter was the case of Queen Victoria, who gave birth to a male with haemophilia, Prince Leopold. In addition, two of her daughters were carriers of the defective gene. Through them haemophilia passed into European royal families. The most publicized case was that of the Russian royalty. Princess Alexandra, the carrier of haemophilia, married the Russian Tsar Nicolas II, and their long-awaited son Alexis was severely affected by haemophilia. The Tzarina turned in her desperation to the monk Rasputin, who claimed that he

could help Alexis, and indeed he was able to relieve his pain from bleedings. Alexis, at the age of 14 years; his parents; and his four sisters were murdered during the Russian Revolution.

The fact that haemophilia runs in families has been known for a very long time. In their extensive review of haemophilia throughout history, Bulloch and Fildes (1912) referred to Rothschild's (1882) attempt to show that the disease was already known to the ancient Jews. Rothschild describes certain dispensations in the Talmud regarding circumcision. In the 2nd century, rules were introduced stating that if two boys died following circumcision, the third was not to be circumcised. Bulloch and Fildes also mentioned mediaeval writings of Albucasis, the greatest surgical writer of the Moorish period. Albucasis described a disease that resembled to what, today, is known as haemophilia. Bulloch and Fildes presented masses of cases of haemophilia and their family pedigrees giving 911 references to the works published in different languages throughout the 19th century.

During the 20th century a number of important scientific and technological advances have contributed to better management of haemophilia. Until the late 1960s the main therapeutic material used in the treatment of haemophilia was blood plasma, which the patient received in hospital and, if necessary, stayed there over a period of time. In the late 1960s various kinds of safe and stable clotting factors were developed that could be kept in home freezers, enabling self-infusion. Because this treatment can be administered either prophylactically or immediately after the bleeding occurs, the patient does not lose time by going to the hospital, can reduce long-lasting crippling of joints and painful bleeding, and can live a relatively normal life.

These successful developments were quashed in 1981 when reports came out that some patients with haemophilia had developed AIDS; in 1982 HIV had been found in the factor concentrates used for their treatment.

Although Bulloch and Flindes (1912) presented extensive and detailed descriptions of cases of families with haemophilia, it is interesting that they are concerned only with medical issues, saying nothing about the possible social and psychological aspects of the disease. Indeed, attention to social and psychological problems surrounding haemophilia started approximately during the 1960s and it coincided with the medical advances in treatment previously mentioned. Our own research into the social and psychological problems of haemophilia started in 1973, and it was concerned above all with social representations of haemophilia with respect to the self and others (e.g., Forbes & Marková, 1979; Forbes, Marková, Stuart, & Jones, 1982; Marková, 1979; Marková, Wilkie, Naji, & Forbes et al., 1980). When in the 1980s HIV/AIDS became an epidemic and affected people with haemophilia and their families, we carried out research into coping strategies of people with haemophilia and implications for counselling (e.g., Marková & Forbes, 1985; Marková, Forbes, & Inwood, 1984).

Common sense knowledge of this disorder has a number of specific features that influence social representations of haemophilia of patients, their families, and the general public. First, the disorder is transmitted by female individuals to male, and it has been well documented that this fact has created particular problems for mothers' "guilt feelings"; overprotection of their sons with haemophilia; anxiety of their sisters and daughters that they, too, could have a boy with haemophilia; and in general, affected the whole family dynamics. Second, anthropological observations, religions, and political ideologies have always attributed specific meanings to blood as a symbol of life or sacrifice, to implicit fears of blood impurity or, in contrast, to blood purity and blood mysticism. Popular myths that people with haemophilia may bleed to death from a needle prick have often created barriers between young patients and their schoolmates as well

as between adults and their potential employers contributing to the belief that haemophiliacs are untouchable. Remembering his experiences as a child, Robert Massie (1985) described his isolation due to misunderstanding of his condition by others, including his schoolmaster, who prohibited schoolmates to touch Robert under the threat of punishment. Massie felt humiliated and powerless having been turned suddenly into an untouchable person.

The lack of knowledge about haemophilia and social representations based on old myths have led, throughout history, to a wide spectrum of psychological and behavioural challenges in relation to patients, carriers, their relatives, and the general public. The nature of these challenges is not stable: It undergoes alterations with technological advances in diagnosis and treatment as well as with changes in the understanding of medical complications including HIV/AIDS.

Objectifying Haemophilia

Haemophilia and its relation to HIV/AIDS refers to a different kind of object with respect to different categories of people. Being a different kind of object for different categories of people, it is objectified in different ways. It takes one form in patients and their families, and their representations of others' objectification; it takes other forms in medical and paramedical staff, and in governmental institutions providing rules of guidance for HIV/AIDS and genetic diseases; yet other forms of objectifying are to be found in the general public. Above all that, there are some overarching forms of common sense objectifying that might relate to haemophilia and HIV/AIDS. Although sex, semen, and blood were representational symbols of sacrifice, fertility, life, and death since ancient Greece (e.g., Newtown, 1989), the emergence of HIV/AIDS has contributed yet other dimensions to these symbols—social deviance and moral judgement. Although during the HIV/AIDS epidemic it has been considered politically correct to emphasize that everybody is at risk, both statistics and daily experience show that in specific groups, like in men having sex with other men, drug users, and to a smaller degree in people who required treatment by blood or blood products, HIV/AIDS is much more common than in the general public. People with haemophilia were infected by concentrates of clotting factors used for the treatment of their bleeds. Tragically, by 1985, when these concentrates became heat-treated to destroy HIV, in some parts of the world as many as 90% of patients with severe haemophilia had been infected by HIV. The media described people with haemophilia at the time as “innocent victims,” thus separating them from those who got AIDS through sex and drug use. Despite that, for some of our patients it was difficult to understand the relations between semen and blood; they wondered how the HIV infection could pass from blood to semen. Needless to say, these different forms of objectification do not live their independent lives but are intermingled with one another, leading to problems of understanding and miscommunication. Let us consider some examples of problems that are involved in mixing different kinds of knowing.

Disengaged and common sense knowledge of haemophilia and HIV/AIDS. Like in other forms of knowing, to know haemophilia and its relation to HIV/AIDS means to objectify it. But what kinds of knowing, and what is it that is objectified? The well-meant efforts to stop the spread of HIV/AIDS during the 1980s emphasized the public education, and the British government ran educational campaigns under the slogan “Don’t die of ignorance.” It was the priority that the public should be well informed about scientific knowledge in order to stop spreading

HIV/AIDS and protect oneself against infection. But although personally disengaged and neutral knowledge is surely important for the general public, it is a different matter for those who need blood products, who are already HIV antibody positive, who live with haemophilia, and so on. Rational and personally detached models of reasoning ignore the fact that for those who are in one way or other involved with haemophilia and HIV infection, there is no such thing as neutral and objective knowledge or information. Indeed, both for those who are personally engaged with the object of that knowledge (i.e., with haemophilia and HIV/AIDS) and for members of the general public, scientific knowledge is in competition with common sense knowledge, with people's emotions and their social representations of these conditions.

Our research during the AIDS epidemic has shown that patients with haemophilia, and in particular those who were severely affected, had good knowledge of HIV/AIDS. By good knowledge we meant knowledge about the cause of HIV infection, spread of HIV, self- and other-protection and other medical issues that were known at the time (Marková, 1991). However, it appeared that their "objective" knowledge was combined and fused with their implicit fears of infection connected with blood and semen, affective meanings, and commonsense knowledge of cleanliness and dirt.

The image of dirt and uncleanness translated itself into daily practices, in particular into the use of disinfectants. Although patients and their families were well aware that HIV/AIDS cannot be transmitted through nonsexual household contacts, our patients commented that their mothers were constantly cleaning and that their house stank of disinfectants. One mother had "spent a small fortune on bleach," and another poured disinfectant down the toilet after her son had been there (Marková et al., 1990). In some households and hospitals, HIV antibody positive patients were given different crockery, and their laundry was washed separately from that of others. This happened despite the fact that the guidelines from the Scottish governmental bodies recommended that it was not necessary for the resident with HIV to be known to the staff (Marková, Wilkie, Naji, & Forbes, 1987, p. 18). Thus we see that at one level, family and carers knew that HIV was not contagious through household contacts, but at another level they believed in some unspecified ways of contamination. These findings were similar to those reported by Jodelet (1989/1991) in her study of social representations of mental illness. In her study, too, implicit beliefs about contagion were difficult to articulate and took the form of folk-fantasies, superstition, and beliefs in a magic power; these, one may guess, have been unconsciously transmitted for generations.

But it appears that caring staff, too, merged together different kinds of knowing. Patients reported changes in their treatment by hospital staff and were aware of changes in the attitudes of staff toward them. During the HIV/AIDS epidemic a local dentist appeared in a "space suit" to treat a patient with the comment, "These clothes are for folks like you." A new resident doctor carefully donned gloves and buttoned up his white coat to take blood from an HIV antibody positive patient, then removed the gloves before taking blood from another, "normal," patient. HIV antibody positive patients were naturally extremely sensitive to differentiation in their treatment by staff (Marková, Wilkie, & Forbes, 1988, p. 13).

In some cases, where scientific and common sense objectification intermingled, double messages were emitted by the staff, creating confusion in patients. For example, the advice coming from the medical profession was that all people with haemophilia, whether mildly or severely affected by haemophilia and whether HIV antibody positive or negative, should be treated in the same way. Specifically, they all were advised to practice safe sex and not have children. This

created a particular problem for HIV antibody negative patients. They were told, on one hand, that blood products were safe and at the same time they were given the advice to practice safe sex and not to have children. Because there was practically no likelihood to be infected by blood, the advice not to have children and to wear condom was meaningless for these patients and confused them. Medical staff found it difficult to explain the ambiguity, and for patients their double messages lacked authenticity. Did the staff believe both messages or did they privately believe one and publicly defend the other one? (Marková et al., 1988).

In a recent Penrose inquiry in Scotland concerning haemophilia and HIV infection in the 1980s, Patricia Wilkie, who had been a member of our research team at the time, said,

A young man with HIV had a surgical treatment. The members of the team were very apprehensive about treating him and nobody wanted to touch him. When he came back from theatre, he was left lying on his tummy on a flat stretcher with a drain. His bed-side table was out of reach and he was given only a plastic cup with a dribble of water. I helped him to drink the water. I pulled the table to be near him but when I came back the next morning to see him, the table had been pushed away. He hadn't been given any breakfast as the staff didn't know which crockery to give him. The young man asked me to bring the telephone to him so he could make a call. I asked the Sister if he could have the telephone but she said he couldn't as he might pass the infection on to other patients through the portable telephone. (Wilkie, 2011)

Creating myth and imagining how others create myth about haemophilia. Jodelet (1989/1991) noted that objectification explains social representations in terms of three processes, that is, selective construction, structuring schematization, and naturalization. With respect to selective construction, she emphasized that it is not that all elements that are part of lay psychology would be selected in representing the clinical state of the mentally ill patients in her study. For example, she found that sexuality, affectivity, and willpower were missing in villagers' representations of mentally ill patients. This is a general anthropological finding. She noted that, for example,

the attribution of dangerous nervousness to degeneracy of the blood leads the population to consider Africans less dangerous than those from the Magreb because the skin of the former is black and their blood thus purer than that of the second, whose skin colour gives rise to the idea of a mixing of blood. (p. 291)

With respect to Jodelet's own study, it was traits of the close personal contact, which in daily interaction of people with and without mental illness were forbidden by the prohibitions and fears of the group, that became part of villagers' representations.

Objectification in common sense thinking is not only creating myth but also imagining how others create myth about haemophilia and HIV/AIDS. Our studies of objectification in haemophilia showed that selective construction had specific characteristics depending on at whom the objectification was directed. For example, many of our patients were very reluctant to tell others (e.g., their employers or insurance companies) about their haemophilia for fear of being discriminated with respect to getting employment or social benefits (Forbes et al., 1982). Concerning strangers, they would not reveal facts about haemophilia and HIV antibody status for fear of being stigmatized: They thought that others would think that they were either homosexuals or drug addicts. Twenty percent of our patients said that they would not reveal their HIV antibody status even to their sexual partners. The respondents pointed out that as well as the information

they had received, the attitudes of other people, the respondents' own emotions, and the publicity of the mass media increased their feelings of being at risk (Marková et al., 1990). One patient became so conscious of other people's fear of infection that he found it difficult to kiss his own grandchildren; he commented that love had disappeared from his life.

Failure to apply safe sex practices was not due to not knowing the risk to partners but to fear of being rejected by them. Different kinds of patients used different kinds of explanation. For those in stable relations, the use of condom was a constant reminder of AIDS—it was dirty. For young ones this was a different problem: They imagined responses from young girls who had their own protection; therefore they tended not to form long-term relationships because that would commit them to explain (Marková et al., 1990).

These examples show that it is the specific aspects of haemophilia and HIV that enter into interaction with others that become objectified, often in patients' imagination, whereas other aspects may be ignored. Interactive aspects of imaginary objectification are those that could deny the individual's social recognition, fear of being denigrated and stigmatized and not seen as a worthy human being. These imaginary aspects about others' representations were selective with respect to how the other was represented. For example, objectification around the sexual partner was constructed along the object of social nonrecognition; objectification about the possible employer or insurance company was constructed around the object of illness and physical incapacity. Objectification of pregnant women was related to the fear that they would be responsible for birth of an affected child (Marková, 1995). The mother who poured disinfectant into the toilet did this not only to protect health but to make sure that people would not think that she did not keep a clean household.

Objectification and language. In her books *Illness as Metaphor* and *AIDS and Its Metaphors*, Sontag (1978, 1989) described the perspective according to which, in daily life, literature, and political discourse illness is often treated as a metaphor in order to enliven charges that a society was corrupt or unjust. In contrast, she argued that illness should not be treated as metaphor and that the healthiest way of being ill is to resist and to liberate oneself from metaphorical thinking. Why did she consider metaphorical thinking dangerous? Sontag (1989) explained that her purpose was to deprive illness of meaning because metaphoric trapping deforms the experience of being ill by not seeking treatment early enough or by not insisting on getting competent treatment. Shortly, "The metaphors and myths, I was convinced, kill" (Sontag, 1989, p. 14).

However, I argue that in common sense thinking illness is not reduced to metaphor, that is, to giving the thing a name that belongs to something else, a definition that Sontag (1989) adopted from Aristotle. Although she treats metaphor in terms of the substitution of names of different objects or social phenomena, we need to treat the issue differently. Rather than talking about metaphors as substituting one item for another one, we are concerned with the epistemology of common sense thinking. Words—and more specifically, names—are not metaphors. They are ways of objectifying ideas and turning them to reality.

Using examples of tuberculosis and cancer and later of HIV/AIDS, Sontag argued that with better treatment and understanding the images of disease will disappear and the metaphor of illness will lose its powerful influence. This is the same argument as the one discussed at the beginning of this article, following the route from mythos to logos. Although such a perspective sounds rational and understandable, one might nevertheless hesitate to accept it as a general rule. True, when the disease no longer exists, its social representation subsides. However,

themata and ideas that generated the representation in question do not disappear, but they may generate new representations of newly emerged phenomena, whether illness or other kinds of threat. Understanding the disease and its causes and familiarity with treatment do not necessarily mean that its social representation vanishes. Our own research on haemophilia and HIV/AIDS discussed in this article has shown that understanding and knowledge of the disease do not imply the disappearance of images, myths, and social representations associated with that disorder.

Returning to Cassirer's (2005) views on language, we should remind that in expressing ourselves in language we also express our own nature. The aim of language is to objectify, to generalize. It means building a common world in which people live together, express emotions, affects, and these sentiments lead to metamorphosis in meaning. The process of objectification is largely dependent on language: "The utterance of an affection always contains a will to objectification and a power to objectification" (Cassirer, 2005, p. 336). When we name something, we impose limits and properties, and in a sense play a part in structuration of the object or phenomenon. In other words, objectification in common sense knowledge is dialogical. I have already pointed out that people with haemophilia and their families are aware not only of their stigma and even of myths they create but, equally important, of language, beliefs, and myths of others. Interaction between beliefs surrounding the self and others fixes these beliefs even more.

CONCLUSION

Attempts to turn human thinking into machinelike algorithms, using knowledge only in a narrow manner and turning it into formalistic and rational reasoning, are likely to continue. If we take psychological studies on concept formation, they maintain formalistic objectification. We could concur with Palmer's (2002, p. 606) assessment of the Margolis and Laurence (1999) grand volume on concepts that "the book is a triumph of psychological essentialism." Concepts are researchers' constructs that have little to do with thinking in the wild because they are detached from daily experience of humans. In contrast, in common sense thinking and in generating social representations, objectification is a communicative process: the self makes something known to the other(s), or it makes something an object for the attention of the other(s). It never pursues dispassionate ways but is evaluative and ethical; old myths, collective images, historical narratives, as well as habits of the mind, consciously and unconsciously present, refer to previous forms of knowledge and generate new ones. History of humankind has provided evidence that a great deal of innovations in science and nonscience arise from imagination and myths. It has not shown that scientific knowledge brings to an end images and social representations. Instead, it has shown that scientific knowledge transforms itself into common sense knowledge and vice versa. Today, despite technological advances and progress in scientific knowledge, common sense thinking remains guided by deep-seated beliefs, myths, and moral judgement. Is it illogical thinking or is it just human? Lévi-Strauss (1970) was a great scientist who claimed that "myths operate in men's minds without their being aware of the fact" (p. 12). This applies both to the general public and to great myth-makers in science and social science. Lévi-Strauss explained why he turned away from Marx's beliefs concerning society and rationalistic explanation of history. One cannot start scientific work by postulating a social system. Instead, Lévi-Strauss pointed out that he came

to understand that “no real or even possible society can ever achieve the rational transparency” (p. 35). Societies have their past, habits, and custom. These are formed by irrational factors, whereas theoretical ideas, which claim to be rational, will remain challenged and contested by these.

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