



HAL
open science

**From one new law to (many) new practices?
Multidisciplinary teams re-constructing the meaning of
a new disability law**

Sabine Caillaud, Valérie Haas, Paula Castro

► **To cite this version:**

Sabine Caillaud, Valérie Haas, Paula Castro. From one new law to (many) new practices? Multidisciplinary teams re-constructing the meaning of a new disability law. *British Journal of Social Psychology*, 2021, 60 (3), pp.966-987. 10.1111/bjso.12428 . hal-04075070

HAL Id: hal-04075070

<https://hal.science/hal-04075070>

Submitted on 23 Apr 2023

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

From one New Law to (many) New Practices? Multidisciplinary Teams Re-constructing the Meaning of a New Disability Law

Running head: One (new) law, many practices?

Sabine Caillaud¹, Valérie Haas¹, Paula Castro²

¹ *Groupe de Recherche en Psychologie Sociale (GRePS EA4163), Université Lumière Lyon2*

² *Instituto Universitário de Lisboa (ISCTE-IUL), Cis-IUL, Lisboa, Portugal*

Request should be addressed to Sabine Caillaud 5 avenue Pierre Mendès France 69676 – Bron (France), s.caillaud@univ-lyon2.fr

Abstract

This paper explores how a new French law incorporating a new conceptualization of disability formulated at the international level by the WHO is appropriated at the local level by multi-disciplinary teams of professionals in charge of the assessment of disability. Drawing on social representations theory, its concept of cognitive polyphasia and its conceptualization of legal innovation, the paper specifically examines how the teams deal with the tensions between the old and the new models of disability and how the group dynamic is associated with how they do this: by hybridization of old and new models, by selective prevalence according to context, or by displacement of one model. Focus groups with the teams (n=65 from 10 groups), analysed with indicators of interaction, bring evidence of the three forms. They show how different groups, by drawing differently, depending on their relational dynamics, from a variety of meaning-systems circulating at the cultural level, reach different decisions that may lead to different practices in the local implementation of the same laws. We finish by discussing how social representations theory, linking the

cultural/global and the interactional/local levels, can enhance our understanding of how socio-psychological processes intervening in the appropriation of legal innovations may produce different practical implementations of the same new laws.

Key words: cognitive polyphasia, group dynamic, legal innovation, disability, focus groups.

Word count (without abstract/figures/tables/references): 7855

Data availability statement: The data that support the findings of this study are available from the corresponding author upon reasonable request.

Acknowledgements: This study was supported by l'Association de Psychologie et Psychopathologie de l'enfant et de l'Adolescent and by Caisse Nationale pour la Solidarité et l'Autonomie.

From one New Law to (many) New Practices? Multidisciplinary Teams Re-constructing the
Meaning of a New Disability Law

Abstract

This paper explores how a new French law incorporating a new conceptualization of disability formulated at the international level by the WHO is appropriated at the local level by multi-disciplinary teams of professionals in charge of the assessment of disability. Drawing on social representations theory, its concept of cognitive polyphasia and its conceptualization of legal innovation, the paper specifically examines how the teams deal with the tensions between the old and the new models of disability and how the group dynamic is associated with how they do this: by hybridization of old and new models, by selective prevalence according to context, or by displacement of one model. Focus groups with the teams (n=65 from 10 groups), analysed with indicators of interaction, bring evidence of the three forms. They show how different groups, by drawing differently, depending on their relational dynamics, from a variety of meaning-systems circulating at the cultural level, reach different decisions that may lead to different practices in the local implementation of the same laws. We finish by discussing how social representations theory, linking the cultural/global and the interactional/local levels, can enhance our understanding of how socio-psychological processes intervening in the appropriation of legal innovations may produce different practical implementations of the same new laws.

Key words: cognitive polyphasia, group dynamic, legal innovation, disability, focus groups

From one New Law to (many) New Practices? Multidisciplinary Teams Re-constructing the
Meaning of a New Disability Law

When a new idea gains some consensus in a society it is sometimes institutionalised as a new law, a form of prioritizing and seeking to stabilize some meaning-categories (e.g. principles, values) and rules over others (Castro, 2012; Castro & Santos, 2020; Elcheroth, Doise, & Reicher, 2011). Then, when the new law enters into force, the translation of these principles, values and rules to specific contexts and concrete practices mobilizes complex psycho-social processes of meaning-making, some of which may transform it: e.g., selection and adaptation to context, re-signification, resistance to rules despite acceptance of principles (Castro & Batel, 2008; Castro, 2012; Brondi *et al.*, 2012; Sarrica, *et al.* 2016). This complexity receives an added layer when the new laws are based on international treaties, as so often happens today in health or climate change governance, since in this case the laws have already undergone translation processes for passing from the international to the national level (De Burca, *et al.*, 2013; Castro & Mouro, 2011; Bertoldo & Castro, 2018). All these processes challenge social psychology to refine theoretical and methodological tools for better understanding sense-making about laws at several levels: how the meaning-categories created in global/international forums are brought to the national and the local and interactional levels, and whether – and how – this may result in somehow different practical implementations of the same laws (Castro, 2012).

This paper addresses this topic, analysing how multidisciplinary teams of healthcare professionals make sense of a new French disability law¹ they are in charge of implementing, a law passed in 2005 and inspired by the latest WHO (World Health Organisation) directives for viewing disability with a socio-psycho-biomedical model. The paper specifically examines how the teams deal with the tensions between the new model of disability of this novel law and the older, pre-existing ideas incorporated in French laws previously in force, and how this is linked to the relational dynamics of the group. To answer these questions, focus groups with teams were conducted.

The paper draws on social representations theory (Moscovici, 1961), a psycho-social approach theorizing how meaning-making as both a cultural and a relational achievement is brought about through discourse and communication (Batel & Castro, 2018; Castro & Santos, 2020; Markova et al., 2007; Jovchelovitch, 2019). For understanding meaning-making about laws and their practical implementation, the approach focuses on relations and collective practices (Elcheroth et al., 2011), as well as on the tensions between old and new ideas (Castro, 2012). The paper specifically uses the notion of cognitive polyphasia as developed by social representations theory (Moscovici, 1961; Jovchelovitch, 2008) for exploring the relational dynamics of these professional teams and how they express the tensions between the old and the new models of disability: whether they use only one model, or mix them, and how (Jovchelovitch & Priego-Hernandez, 2015). Thus, the study links the international and national levels of legal innovation with the local level of implementation, contributing to a better understanding of how new laws impact everyday practices and contribute to the practical and diverse everyday (re-)creation of categories of meaning, such as “disability”.

¹ “law on the equal rights and opportunities, the participation and the citizenship of disabled persons” of February 11, 2005 (loi n° 2005-102 du 11 février 2005 pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées)

In what follows, a brief history of the French approach to disability is presented, making salient the old and new models of disability debated when the new law was prepared. Afterwards, through the literature on cognitive polyphasia, we theorize how old and new meaning systems may compete or mix during legal innovation, depending on the dynamics of relations. Finally, we analyse these processes in focus groups conducted with the French teams in charge of the assessment of disabilities in children.

The legal innovation process for disability in France

Until 2005, two disability laws dating from 1975 were in force in France. They incorporated two main assumptions: for people with disabilities assistance is a social right (Stiker, 2000) and should take the form of compensation for rehabilitation in order to make them able to work (Winance, Ville & Ravaud, 2007). In the assessment of disability, the level of deficiency was estimated, and if greater than 50% the person had a *right* to compensation (Esnard, 1998; Bogalska, 2003). Hence, in these laws the idea of a difference from a norm, a measurable gap or deficit that causes inferiority – a *handicap* – which should be compensated in order to make people economically productive again, played a central role (Stiker, 2003, 2014; Winance *et al.* 2007). This made the term “handicap” quite operational in France (Calvez, 2007), where it is still used (Giami, Korpes & Lavigne, 2007), although it has become offensive in the international context².

In the 2000s, a change in the WHO’s definition of disability led France, among other countries, to adapt its new approach. Figure 1 illustrates the process, outlining the different definitions at stake in each step. Until 2001, for the WHO, disability described the social consequences of what was initially caused by a health problem (Gzil, *et al.*, 2007; Johnston,

² see <https://www.apa.org/pi/disability/resources/choosing-words.aspx>. Here we will employ the term when translating directly from the French documents where it is used.

1997). This was a *category-based* approach, separating those who have and those who do not have a deficiency, and suggesting a unidirectional causal chain (disease → deficiency → disability). This model was criticized for relying only on personal attributes and failing to take into account the impediments brought about by the environment (architectural, cultural, or institutional), and as therefore naturalizing social inequalities (Gzil, *et al.*, 2007). Thus, scientists and organizations proposed innovative approaches (Barral, 2003) that placed the focus on environmental factors (e.g., the absence of ramps can create a disability for someone in a wheelchair; Rioux, 1997). The focus on the environment constructs a *universalist* approach: “we are all potentially disabled” when the environment is not adapted (Winance, *et al.* 2007).

In the sequence of this contestation, in 2001 the WHO adopted the *International Classification of Functioning, Disability and Health* where disability is defined as a “restriction of social participation resulting from an *interaction* between the limitations of activity caused by the health condition and the environmental obstacles” (see Figure 1). This new model integrates the (old) *category-based* and the (new) *universalist* approaches (Gzil, *et al.*, 2007): the person should not be categorized only through the lens of medical information, instead the situation should be also evaluated as a person-environment interaction.

Following the WHO guidelines, in 2005 a new French law replaced the 1975 ones. However, the *category-based* approach was not simply abandoned. An approach termed the *global approach* was developed, with some paradoxes (Winance *et al.* 2007). In line with the WHO, the *global approach* considers disability as a restriction to participation in life in society, and no longer a deficiency (Winance *et al.* 2007). However, the idea of *interaction* between individuals and their environment, present in the WHO guidelines, disappeared and

the notion of environment was reduced to the specific context in which the person *with* disability lives.³

The *global* approach of the 2005 law also stipulated that the assessment of disability for compensations should no longer rely on biomedical elements only, but on a socio-psycho-biomedical model. Thus, new institutions were created – the Departmental Houses for Handicapped Persons, one in each of the 10 French regions – where disabilities are today assessed by multi-disciplinary teams of professionals (physicians, psychologists, teachers, etc.). These meet to construct a tailored compensation program (e.g. benefits, care, special education, etc.) by analysing the external experts' reports they receive (i. e. without meeting the person). However, a hybrid approach can be detected in these new institutions, which are called the *Departmental Houses for Handicapped Persons* rather than for *persons in a situation of handicap* (Boudaoud, 2008). Old assessment tools were also reused, such as the *Guide Barème*⁴ which offers a framework for calculating a level of disability and the “limitations encountered by the person in life for fulfilling his/her social *normal* role” (p. 2). Moreover, the staff working in these new institutions often comes from older institutions where disabilities were formerly evaluated with a *category-based* approach.

Finally, when the law entered into force it was decided that each regional institution should freely decide how to concretely apply it and conduct the assessment. This means that these institutions today work as local mediating systems for translating the general and abstract law into concrete guidelines for practices (Castro, 2012). The translation opens

³ This is clear in the definition: “disability is constituted by any activity limitation or any restriction to participation in life in society to which a person is subjected in his or her environment due to a substantial, durable or definitive alteration to one or more physical, sensorial, mental, cognitive or psychological functions” (Art. L. 114).

⁴ Guide Barème pour l'évaluation des déficiences et incapacités des personnes handicapées, Code de l'action sociale et des familles, Annexe 2-4, Modifié par Décret n°2007-1574 du 6 novembre 2007 (Scale Guide for the assessment of deficiencies and disabilities of handicapped persons, Law of social actions and families, appendix 2-4, modified by decree number 2007-1574, 6th of november 2007)

opportunities for their professionals to re-interpret the law and for different interpretations to allow somehow differently enacted versions of it to arise locally (Castro & Mouro, 2011), processes that are all the more complex when the creation and institutionalization of the laws are disputed (Rocher, 2002), as happened with the present one (see figure 1). Thus, 10 years after the law was adopted seemed a good moment to investigate whether the tensions between the old and the new disability models remained, and how the 10 teams managed them.

The social representations (SR) approach, seeking to understand how groups under pressure come to terms with complex and novel phenomena (Kalampaliki & Apostolidis, 2016), offers a relevant framework for this analysis. It is a theory that can elucidate how different subgroups are “creating their own” emancipated versions (Moscovici, 1988) of disability by differently interpreting the law, as often happens (Mouro & Castro, 2012), despite the new law pushing for the adopted model to become hegemonic, i.e. uniform across the nation (Moscovici, 1988). These processes – reception and re-creation of laws – have important socio-psychological and political implications, requiring further study. We will now further substantiate how the SR approach is well situated for this study, offering a perspective on political issues that, by focusing on how meaning is produced in the interaction of culture and concrete social relations (Castro & Batel, 2008; Gibson, 2015), helps overcome an individualistic approach that views the socio-psychological processes involved in the reception and appropriation of laws as misunderstandings or biases (Elcheroth, Doise, & Reicher, 2011).

A social representations approach to the appropriation of new laws

In the process of elaboration of Social Representations (SR) – i.e. shared meaning-systems – at least two dimensions are at play: one cultural, the other interactive (Bauer & Gaskell, 2008; Bertoldo & Castro, 2018; Castro & Batel, 2008; Markova 2005). Indeed, while SR draw from and express sedimented meaning categories circulating in a culture (Gibson,

2015), they are in their use simultaneously oriented towards the specific Other of the concrete ongoing interaction, where meaning can be re-constructed and changed (Castro & Batel, 2008; Batel & Castro, 2018; Jovchelovitch, 2019).

Regarding, first, the cultural component of SR, it may become manifest in the way individuals and groups draw arguments for accepting or resisting new laws from different, and sometimes contradictory, cultural meaning-systems, e.g. those debated when laws are negotiated at global and national levels (Castro & Mouro, 2011). If they indeed combine different views, this is expressive of cognitive polyphasia (Moscovici, 1961), the capacity of individuals and groups to draw from different, sometimes contradictory, meaning-systems and modes of reasoning in order to face the also contradictory requests of the various contexts and relations they enter into (Wagner, Duveen, Verma & Themel, 1999; Jovchelovitch, 2001; Provencher, 2011, Provencher, Arthi & Wagner, 2012). Cognitive polyphasia is particularly relevant in the generalization/implementation stage of legal innovation when a new law is entering society (Castro, 2012), as at this point the generic and abstract laws have to be translated into concrete contexts, and social actors are called to change old ideas and practices (Castro & Mouro, 2011). By placing the focus on the way individuals and groups face tensions between old and new ideas, the concept of cognitive polyphasia provides a framework for investigating the processes of transformation of systems of meaning and knowledge (Wagner & Hayes, 2005; Batel & Castro, 2018). For this study, the concept is useful for exploring the processes involved in the appropriation of the new disability law by professional teams, and how in practice these very processes help shape the meanings or social representations of disability.

Regarding now the interactive component of social representation, the context where laws are translated into decisions and enacted can be characterized as a *knowledge encounter*, i.e. an actual encounter in a concrete space and time between Self and Other, where different

pre-existent meaning and knowledge systems meet (Jovchelovitch & Priego-Hernandez, 2015). During these encounters, the knowledge and meaning-systems of others can be denied or recognized by the Self (see also Kadianaki & Gillespie, 2015; Castro & Santos, 2020), resulting in different forms of cognitive polyphasia (Jovchelovitch, *et al.*, 2015). A first form of polyphasia is *Hybridization*, which occurs if there is recognition of the meaning and knowledge of others and if interaction allows for integration of difference and even contradiction; in this case, the different kinds of knowledge intermingle and create a new, integrated, system of representations. A second form is *Selective Prevalence*, which occurs if there is recognition of the meanings and knowledge of others, but distinct systems of representation are retrieved separately for different decisions or for different contexts, and there is no integration of old and new. Finally, these encounters can also produce *Displacement*, which occurs when the meanings and knowledge of others are ignored and only one meaning-system is imposed on all others, with no polyphasia involved; in this case, old representations that were already hegemonic are well positioned for displacing new ones (Mouro & Castro, 2012); in the context of disability, this means that the medical model – hegemonic in many countries for a long time (Johnston, 1997; Barral, 2003) – is well placed for this.

In summary, the approach presented above adopts three of the proposals by Elcheroth and colleagues (2011) regarding what SR theory can offer to a socio-psychological approach to political issues: attention to *relations* and to *collective practices*, rather than only to individuals, and comparison of *organised wholes* (here, different professional teams). It moreover offers a temporal perspective considering appropriation of new laws as a complex process linked to the coexistence of competing meanings (Castro, 2012), and theorising the tensions this co-existence brings through the concept of polyphasia (Jovchelovitch & Priego-Hernandez, 2015). With this concept it focuses on how, through situated power dynamics at

play during knowledge encounters, different local meanings – emerging as “relational outcomes” – are re-created from cultural ones.

Drawing from it, we will explore – with 10 focus groups, – each composed of multi-disciplinary teams of professionals in charge of children in French institutions from different regions – how the law is understood and what this suggests regarding how it is applied. Specifically, we will examine (1) how the old and the new models of deficiency are arranged together for making decisions about disability and compensation and (2) what the specific group’s dynamics are during the discussions. Regarding the dynamics, i.e. the concrete relationships at play during the knowledge encounter, we hypothesize that they may express different types of encounters (Jovchelovitch & Priego-Hernandez, 2015), resulting in different relational outcomes (*hybridization*, or *displacement* or *selective prevalence*), helping shape different SRs of disability, which in turn will have consequences for the decisions and practices of compensation. In this study, the group’s dynamic specifically covers the way multi-disciplinary work is organized and power distributed (i.e. does one professional play a central role compared to others? How do teams manage contradictions between different experts?) and how legitimacy is attributed to each expert knowledge (e.g. is the medical knowledge still predominant or not? Which knowledge is considered trustworthy?).

Focus groups have some important advantages for this type of analysis. By encouraging group interactions, they offer a way to access the dynamics sustaining the re-construction of meanings (Kidd & Parshall, 2000). They also ensure that the discussion remains focused on the topic of interest for the researcher (Barbour & Kitzinger, 1999), providing, in some contexts, data as rich as long periods of ethnographic work (Bloor, et al, 2001).⁵ Moreover,

⁵ Observations of teams’ work were conducted beforehand. However, their high work load severely limits their time for discussions. Focus groups are thus an ideal method to overcome this difficulty, and have the team members make explicit the arguments and meaning categories mobilized for their decisions.

and importantly in this case, the use of natural pre-existing groups (the multi-professional teams from regional institutions) offers the opportunity to look at relations and collective practices, capturing and comparing how different representations are linked with systems of power, hegemonic meaning and conflict, studying the processes involved in the appropriation and re-construction of laws as they occur in real-life organized wholes (Elcheroth *et al.*, 2011).

Method

Participants and procedure

Ten Focus Groups (N= 65) with multi-disciplinary teams engaged in disability assessment in children were conducted in 10 French regions. The number of participants in the groups varied from 4 to 13 (see table 1), as each region was free to decide which professionals should compose the teams. However, in each group there was at least one doctor and one psychologist. Focus groups took place in the room where teams usually meet.

In a first part of the discussion, groups were asked to discuss the ideal team work (e.g. what multi-disciplinary work is and should be, how they should ideally manage their alterity, elements needed for conducting a good disability assessment, etc.). In a second part, groups had to handle a fictitious case (inspired by previous real ones) where medical and psychological information were in contradiction: the medical report stated that the child had a visual impairment which did not reach 50%, whereas the psychological report outlined that this impairment was associated with psychological suffering, feelings of exclusion, and low self-esteem. Thus, the case brings into question the tensions between the old category-based model and the new global model of disability. Indeed, on the sole basis of the medical report, the child is not considered *handicapped*, whereas according to the new model, other elements (in this case: psychological elements) should be taken into account in order to reach a conclusion. This task is quite similar to their daily tasks: based on different (and sometimes

divergent) information, they debate a case in order to reach a consensus about a tailored compensation program.

Analytical procedure

Focus groups (mean duration: 1h 44m, $SD=14$ minutes) were video-recorded and the discussions transcribed in full. A dialogical analysis was conducted (Markova, Linell, Grossen & Salazar Orvig, 2007; Caillaud & Kalampalikis, 2013) supported by Atlas-Ti (Friese, 2012) in order to outline how group interactions and their content are interrelated. Drawing on the work of Jovchelovitch & Priego-Hernandez (2015), the three potential relational outcomes for the group dynamics expected were operationally defined as follows:

(1) **hybridization**: all participants contribute in a similar way; both medical and psychological knowledge are granted legitimacy; multi-disciplinarity is fully acknowledged; contradictions are managed by integration and more information seeking; different models of disability are integrated.

(2) **selective prevalence** – participants' contributions depend on what is discussed; pluridisciplinarity is recognized in some cases, not others; the legitimacy of each knowledge is recognized in some cases, not others; contradictions are recognized and solved by referring to the context; various models of disability are resorted to depending on what is being discussed.

(3) **displacement**: the doctor participates more, in keeping with the old category-based model; medical knowledge is granted greater legitimacy, and pluridisciplinarity is not an option; contradictions are not openly acknowledged.

Codes were therefore developed for analysing the following questions:

(1) *distribution of participation*: Atlas-ti automatically codes the number of words produced by each participant during the discussion. This number was then divided by the mean number of words produced by participant (see table 2): if the number is higher than 1,

the participant contributes more (in terms of numbers of words) to the discussion than the mean level of participation in the group.

(2) *definition of pluri-disciplinarity and legitimacy of medical and psychological knowledge*: codes were inductively developed for grouping together definitions about what was (a) ideal team work (e.g. the team should compare their point of view in order to confirm the medical information), (b) pluridisciplinarity (e.g. the team as a unit doing the same job, a juxtaposition of multiple expertise), (c) the role of each professional (e.g.: psychologists should evaluate only cognitive deficiencies, psychologists should offer a global approach to the child's situation).

(3) *approaches of disability used during discussion*: based on the models of deficiency summarized in figure 1, codes were developed to characterize the arguments the group drew on to decide if the situation was one of disability or not. The codes were: medical approach (e.g., if they only considered physical deficiencies), universalist approach, person-centred approach, global approach.

(4) *Forms of managing contradiction and conflict*: 4 codes were inductively created (a) explicit disagreement, (b) implicit disagreement (e.g.: *I agree, but*; Billig, *et al.* 1988), (c) asking questions about the case, and (d) narrations (referring to previous cases) as shared meaning resources. We then calculated the frequency (in terms of word-count) of these indicators of dynamics (see table 3).

Finally, the different focus groups were compared and the different indicators were crossed. Some patterns of codes organized in systematic ways became apparent: three different team dynamics were linked to three different relational outcomes and SR of disabilities. These were: (1) a systemic approach to disability using hybridization; (2) a medical approach using displacement; and (3) a case-by-case approach using selective

prevalence. In the next section, we present these results. Figure 2 offers a summary. All excerpts were translated by the first author.

Analysis and Results

Hybridization: a systemic approach to disability

Hybridization was observed in four groups (groups 1, 3, 4 and 7). In these groups, as shown in table 2, during the discussion about the fictitious case, the doctor and the psychologist took the floor less than in other groups, whereas other professionals took the floor more. Also, all participants contributed to the discussion, and the professionals who were involved directly (doctor and psychologist) did not play a central role. This is quite consistent with the way they defined pluri-disciplinarity:

Med3: Pluridisciplinarity is when each of us is sitting around the table with our own speciality, and transdisciplinarity this means that there are exchanges between us of course, that I will shout at the psychologist, I will stick my nose into hmm, he will hmm ask question about school results.../...Well, we are never upset because someone suggests something to us in our field.

In this excerpt⁶, the doctor set pluridisciplinarity against “transdisciplinarity”, where boundaries between disciplines are crossed (“I stick my nose into”) in order to have “exchanges” on an equal level. This crossing, which might be uncomfortable, was then qualified with a disclaimer (“we are never upset”), suggesting that it was explicitly being framed as something normal. This is in keeping with the distribution of participation and also with the dynamic of the discussion: indeed, table 3 outlines that disagreements did not take up as much time as in other teams.

Rather, in these teams, participants more frequently resorted to narrations of previous cases than in other groups:

⁶ See Table 1 for the abbreviations used for the different professions in the groups.

Psy 1b: well it depends on what is asked for, well we, in the case we had (previously) studied and assessed, they were asking for school assistance, it was a request for a school assistant, and according to us well hmm, it wouldn't meet the little girl's needs, who does not feel well and the mother's suffering etc. thus we didn't say yes to the school assistant, I am right no?

Resp1: Yes.

Med1: On the other hand, we asked for a clinical consultation

Psy 1b: Yes this what we suggested instead

Med1: Because the mother was suffering a lot yeah for asking this because in this case here we don't know who is asking?

Here, when facing the contradiction contained in the fictitious case, Psychologist1b turns to a previous case (“in the case we had studied and assessed”), the doctor adds to her story and then draws a parallel with the present case (“because in this case here we don't know”). These narrations are thus used as meaning resources shared by the group, helping deal with contradictions between different types of expert knowledge. Moreover, the group dynamic is characterized by numerous and various questions (see table 3):

Diretab3: Does she have good relationships with others? Is she accepted? Must she sit at the front row? Or should she sit behind? Is she rejected by her friends? There are a lot of things.

Med3: Indeed, is she able to look at the board but maybe her visual field is reduced so that she hits the door when she wants to go out?

Resp3: and then...

Med3: Are children making fun of her because she has thick glasses and she looks ugly?

Psy3: What do we do at school, what can be done for her in order to

Med3: Did teachers suggest some adjustments .../...

Resp3: Maybe also social elements, like the family's plan how the family faces this impairment? hmm

Med3: Mm.

Resp3: Anyway, if we have a case like this we would ask for more information, but the fact that the psychologist has conducted a psychological examination and says that there is psychological pain, I think we should remain on alert.

This extract illustrates how questions can be numerous and concern different domains: school situation, social relationships, consequences on the family's life. In keeping with their discourse about *transdisciplinarity*, professionals in these teams asked questions other than

those relating to their own area of expertise (the doctor asked questions regarding social relationships: e.g. “are children making fun of her?”).

Moreover, at the end of this extract, the team’s organizer expressly stated that contradictions between expert knowledge should lead to further investigation, an idea developed in all 4 groups:

Med7b: We based our first assessment on a number only, and here we will try to have an approach

ES7d: more global.

Med7b: global, more complete.

In this extract, the team explained that facing a contradiction will lead to a more in-depth investigation into the situation (“more complete”) which is coherent with the numerous question they asked. Thus, they made efforts to gather all elements in order to reconstruct a clear and coherent image of the child, referring to a *global* approach to disability, resorting to narrations as shared categories of meaning. Finally, the environmental dimension was also taken into account:

Ensref4: now we know that depending on the school environment, from one environment to another we can have completely different effects some environments are facilitating, are kind and others are less so, there can be some school requirements that are hmm more or less different, which are hmm adapted to the child’s development or not, teachers who adapt more easily than others

Diretab3: at some point the teen was doing as much as possible to get used to the environment which was not... it was a school built on a slope with floors

In both extracts, the environment was described as the source of disability: facilitating the teaching situation, and physical accessibility creating difficulties. Thus, these teams also relied on the *universalist* model of disability.

To conclude, in these 4 groups, each professional contributed to the discussion in similar ways and was considered legitimate. Contradictions were accepted and led to further investigations in order to analyse the whole situation; narratives were resorted to as shared

meaning resources in order to cope with contradictions in expert knowledge. The relational outcome was a hybridized approach to disability, which draws on the *person-centred* (all dimensions are investigated) and the *universalist* model of disability, and can be called a systemic approach.

Displacement: relying only on the medical model

Displacement was observed in three groups (groups 5, 8 and 11). As shown in table 2, in these groups, the doctor contributed more to the discussion about the fictitious case, followed by the psychologist, and finally by the other professionals. Half of the questions asked about the case were medical (see table 3). Also, the doctor and the medical knowledge played a central role. Moreover, the discussion contained numerous implicit disagreements (table 3), usually involving a doctor and a participant who tried to oppose the medical discourse:

Med5: according to me she doesn't qualify for assistance for visual impairment, personally it (the psychological information) wouldn't change my point of view but we could encourage her to seek help elsewhere.

EnsRef5 /Psy5: Hmm.

Med5: well, to seek for help it is a case of care, not impairment.

.../...

Anim5: so

Psychologist5: erm yes, here we do not really know about the visual impairment.

Diretab5: but the doctor has established that...

Med5: he has established that, that's what we tell you

Moving from the pronoun “I” (think), to the “we” (decide), the doctor’s first sentence appeared as a strategy to avoid the acknowledgement of another view (Gillespie, 2020) and illustrates well the centrality and hegemony of medical knowledge. Afterwards, the psychologist tried to object to the doctor (“we do not really know”), but she disagreed implicitly (she first acknowledged: “erm yes”). Her proposal was blocked by the next two participants arguing that one cannot cast doubt upon medical knowledge (“has established”), illustrating how contradictions were not acknowledged.

In accordance with this group dynamic, the medical knowledge was central in disability assessment:

Med5: the first fact we talk about disability

Anim5: indeed.

Med5: it is a medical fact

Anim5: medical.

Med5: isn't it, it is the fact that we start with, if there is no medical problem there is no disability

Psy11: But first of all she really must have a visual impairment

Anim11b: But if she is a little bit short-sighted, would you provide compensation?

Psy11: Indeed, here we do not know her deficiency.

AS11a: It depends if the effects are caused by the pathology

In both extracts, the teams clearly state that, “first of all”, a medical deficiency must be acknowledged (“the first fact... is a medical fact”). The second excerpt also illustrates that impacts (like psychological disorders) must be caused by the medical pathology in order to be considered. This is also well illustrated in the next extract:

Anim5: How can the psychologist, how can she know that the psychological pain is due to the visual impairment, that's it ...?

Diretab5: she is a psychologist eye-specialist! (laughing).

The joke (she is a “psychologist eye specialist”) they all laughed about illustrates that the psychologist was seen as lacking the legitimacy that only a doctor can have for asserting that the psychological pain is due to the visual impairment. Delegitimization – in this case done through accentuating the hegemony of medical knowledge – is another strategy used to block other meaning-systems (Gillespie, 2020). The same is visible in the next extract:

Ensref: Anyway here it is clear that in the medical part there must be accurate details at optical level

Med8: yes yes, optical hmm, psychological, well paediatric psychiatric hmm psychological well all elements

Psy8: yes I agree, the difference (between a psychiatrist and a psychologist), that's real, a paediatric psychiatrist must diagnose hmm the psychological pain, say if it is invasive

In this extract, trying to find their words, the doctor introduced the distinction between a psychiatrist and a psychologist, a distinction acknowledged by the psychologist herself (“I agree, the difference...”). Also, severe psychological pain can legitimately only be diagnosed by a psychiatrist, an idea similarly developed in all three groups in this type of relational outcome.

Thus, faced with the contradiction between medical and psychological information, these teams denied the psychologist’s legitimacy and they argued that psychological disorders might be real but it must be established by a doctor or a psychiatrist. This is a way of maintaining clear boundaries between what disability is and what it is not, a boundary they perceived to become fuzzy with the new law, and to hence cause some abuses:

Med11a: Also we find ourselves with people asking to be recognized as a worker with disabilities just in order to obtain an ergonomic chair, so... and it is too much, that one must enter the category of handicapped in order to obtain such a solution... even though we are not sure we are following the WHO’s definition.

Moderator: And according to you, is this a problem due to the 2005 law or did it...?

Med11a: [sigh] I don’t know who has decided this, it is a kind of downward slide of the law, because at the beginning these cases were treated by organizational medicine and by the firm, but due to the economic context, unemployment etc. it little by little goes downhill

Here, the doctor started considering the opposition between the WHO and what people ask for (making them enter the category of handicapped unnecessarily). She drew on the past (“at the beginning...”) to legitimize the idea that the law is dangerous (“downward slide of the law”). Thus, in these teams, the centrality of medical knowledge is strategically presented as a way to protect from the limits of the law and potential abuses.

To conclude, facing the contradiction between the old and new approaches, these teams endorsed the old – and for a long time hegemonic – *category based* model, which is associated with a team dynamic marked by the supremacy of the medical aspects. Moreover, they considered the limits of the new law, and strategically used medical knowledge to block

them. Thus, it is a case of displacement and we suggest calling this relational outcome a *medical* approach.

Selective prevalence: a case-by-case approach

Selective prevalence was observed in three groups (2, 6 and 10). In these groups, during the discussion about the fictitious case, the doctor talked 1.5 times more than other participants and the psychologist did not take the floor more than other professionals, although the fictitious case directly implied psychological information (see table 2). They described pluridisciplinarity in the following way:

Med6: generally, we begin with medical elements of course, in order to have the hmm setting, so to speak, and then we ask the different professionals, the school and hmm and the social elements we have, so we put them all together and then indeed we go further into detail, you are right yeah to say that if our opinions don't converge.

Anim6a: here we go

Psy6b: absolutely.

Med6: we are going to search for positive elements and negat... well elements which lead to accepting or rejecting the request...

Here, the doctor stated the primacy of the medical aspect (“we begin with medical elements”). Other elements were used secondarily to confirm the medical point of view and to provide more details. Also, the legitimacy of the psychological knowledge was not equal to the medical knowledge, which came first. However, if the elements did not converge, the group explained that they will consider the pros and cons, and engage with other types of knowledge. This discourse about their work is in keeping with the way they faced contradictions when treating the case. Indeed, in these teams, expressing disagreements took on an important role (see table 3), and disagreements always pitted the doctor against the other participants:

Psy6a: anyway the psychological report may be relevant in this situation, should it result in compensation or not, but anyway it makes pain apparent

Med6: erm theoretically theoretically I think that hmm

Psy6a: But at least there is psychological pain.

Med6: the psychological pain will not be an element which... well maybe I'm wrong but for a sensory impairment I think that the psychological pain will not change our decision.

.../...

Psy6: In my opinion it may change our decision, it also depends on the level of visual deficiency

Med6: Hmm don't know.

Psy6a: It depends on the level... if we are far from the limit

Anim6b: yeah yeah yeah

Psy6a: in terms of visual impairment.

In this extract, the disagreement was explicitly expressed by the different professionals (they interrupted, clearly expressed their own point of view: “I think”, “but there is”), the doctor endorsed a *category-based* approach (“for a sensory impairment I think that the psychological pain will not change our decision”) and the psychologist supported a *person-centred* approach (“the psychological report may be relevant in this situation”). Facing this contradiction, Psy6b introduced the idea that their decision may depend on the level of visual impairment, an argument adopted by the other team members (and later in the discussion also by the doctor): if the impairment was close to a level which is medically recognized as a disability, then they would propose compensation, i.e. favour the *person-centred* approach. Thus, the medical aspect still played a central role, but, depending on the “level” of impairment, the medical categorisation can become flexible and other elements acknowledged through a *person-centred approach*. The three teams were found to move from one approach to another depending on the level of impairment:

Anim 10b: and we have the same situation with children who are deaf who are not really deaf but who still face difficulties erm anyway it affects learning [they all agree] all these children who are at the margins

Here, the team organizer moved from the *person-centred* to the *category-based* approach in the same sentence (“children who are deaf, but not really deaf”) paying attention, or not, to the impacts, a switch that all participants in the group easily followed (general agreement).

Med2: because we have children like this sometimes, a bit borderline concerning the level of impairment, but who are indeed experiencing significant effects, well which may be not entirely due to the sensory impairment but this makes us ask questions

Here, the doctor outlined that the “borderline” situation (i.e. using a category-based approach) may be overcome if impacts are important even if they are not caused by the visual impairment, turning thus to a *person-centred approach*.

Also, in these teams, contradictions were recognized and elements from the context were put forward in order to decide which approach is the best. They did not resort in a significant way to narratives in order to draw comparisons, and the few questions they asked concerned the level of deficiency (medical question) and other elements of the school and family contexts (see table 3).

To conclude, these teams recognized contradiction and engaged in debates to find out if some elements may tip the scale in favour of a *category-based* or a *person-centred* model. They thus refer to what may first appear as contradictory meaning-categories depending on the context (see also Gibson, 2011). This is associated with a dynamic where doctors play a central role and are opposed against the other team members. Moreover, the contextual elements that may tip the scale in favour of compensation are still medical elements. Thus, other kinds of knowledge still play a subsidiary role compared to the old medical knowledge. We call this relational outcome of cognitive polyphasia a case-by-case approach with selective prevalence.

Discussion

Nowadays legal innovations adopted at the national level are often stimulated at the international level (in our case by the WHO), calling for national translations, and are finally implemented at the local level, compelling individuals to change ideas and practices and calling for social change (Castro, 2012; De Burca, *et al*, 2013). Social psychology has much to offer to explain the phenomena brought about by the creation of these new global legal

orders, namely by developing and refining theoretical and methodological tools for understanding how the meaning-systems and categories developed in international forums are brought to the local, interactional level, and how social change occurs and/or is resisted. In this case, this meant exploring how the new WHO-instigated, global meaning-systems resurface in the dynamics of local team discussions, interacting with old ones and helping shape representations of disability in everyday life 10 years after the laws entered into force. The social representations (SR) approach is well placed to rise to this challenge because it aims to elucidate the processes by which people in relation and interaction negotiate a shared understanding of their social world (in our case, how they re-construct disability in professional interaction) by drawing on meaning-categories circulating at the cultural level (Gibson, 2015; Batel & Castro, 2018; Castro & Santos, 2020). As such, it is well situated to improving understanding of how discourses express and help reproduce power relations (i.e. the teams' dynamics and the legitimacy of different types of knowledge), opening up or closing down space for social change (Batel & Castro, 2018), i.e. for a new approach to disability. It is thus an approach instrumental for overcoming the (unhelpful) duality between a psychology interested in individual (more or less *biased*) perceptions of the law and a view of the political as concerning only institutions – a duality that forgets the interdependence of the institutional and the individual (Castro, 2012; Castro & Santos, 2020; Elcheroth, 2006; Elcheroth, *et al.*, 2011).

Drawing from this, in this paper we investigated how multi-disciplinary teams dealing with a new disability law appropriate it and represent disability in a way dependent on how they manage multidisciplinary work and their professional alterity. Drawing more specifically on the notion of cognitive polyphasia, we explored how the new and old disability models debated during the global process of legal innovation (the cultural component) and the local dynamic of teamwork (the interactive component) intertwine and give rise to different

representations of disability: emancipated representations emerging through polyphasic reconstruction of new and old models, and non-polyphasic representations reproducing the older hegemonic medical model.

Adopting a temporal and situated approach to legal innovation (Castro, 2012), we outlined some paradoxes still present in the law itself and showed how some meaning-systems at play during the legal innovation process, even if absent in the law (e.g. *universalist* approach), in some cases came back to its interpretations. This helped illustrate that social actors in relation do not just receive new laws, but actively draw from the meaning-systems culturally available to make sense of them. We followed the way professionals discussed the law locally, offering a way to understand how current, local assessments of disability participate in the practice of re-constructing and re-signifying disability models in different ways. In line with Jovchelovitch and Priego-Hernandez's (2015) proposal, our results outline three different outcomes: hybridization, selective prevalence, and displacement. These are expressive also of different relations arising during knowledge encounters, the former two supporting polyphasic representations (see figure 2). These are moreover *relational* outcomes highlighting how cognitive polyphasia is not a strictly cognitive process but has cultural, social and interactive dimensions (Kalampaliki & Haas 2008). Finally, our results confirm how old hegemonic meanings (i.e. the medical model) are well situated to strategically displace new meaning-systems and slow down their practical impact in society (Castro & Batel, 2008). Thus, these findings provide evidence that the cultural and historical context of legal innovation is not an external reality which determines SR; rather, the teams actively mobilize in their discourse some of the meaning-systems and categories circulating at the global/cultural level in different ways, depending on the local interactive context, thus clearly demonstrating that the way a new law is appropriated depends on the local relational dynamics happening in the mediating systems responsible for the law's implementation. Our

results thus prompt consideration of the fact that groups differ not only in their set of values but also in their socio-psychological functioning (i.e. group dynamics), which may shape different social representations in practice (Duveen, 2008). Moreover, they outline how SR theory can incorporate both the cultural level and the interactional level in social psychology (Castro & Batel, 2008; Gibson, 2015), contributing therefore to a societal psychology (Himmelweit & Gaskell, 1990, Howarth, et al., 2013).

In this respect, despite the existence of a unique law, our results also reveal that the teams, in practice, enact different representations of disability, potentially leading to inequalities in treatment and compensation in the French territory: thus, to inequality at a societal level. A limit of our study is certainly that the reported results are from a focus group study, so that they capture only approximately what happens in the *real* world. Further, we can only infer and suspect inequalities to occur in the final compensation of children with disabilities. However, the results highlight more generally how decisions taken at a global level (e.g. international agreements, as in the case of the WHO, but also – and notably – climate change) will be translated and appropriated in various ways at a more micro level (countries, municipalities, etc.), calling upon social psychology to pay attention to the processes by which mediating institutions minimize or maximize the potential transformations that new laws propose (Castro, 2012).

As a general conclusion, these results also support the idea that SR theory can offer new ways of looking at the political (Elcheroth, *et al.* 2011). Indeed, here we successfully operationalized three of the proposals by Elcheroth and colleagues (2011) regarding what the theory can offer to political psychology: attention to *relations* and to *collective practices* and comparison of *organised wholes*. We made use of the potentialities offered by focus groups to jointly analyse the content and the dynamics of the team discussions (Kidd *et al.*, 2000 & Caillaud, *et al.*, 2013, 2016), thereby looking at relations and collective practices in the teams.

Further, in order to know how specific SR prevail, we compared organized wholes (i.e. teams from different regions), focusing on how different SR are shaped by different systems of power and conflict. Moreover, we have done this by proposing some innovative qualitative and quantitative indicators to identify each of the three relational outcomes.

Thus, contrary to more traditional approaches, which might consider that the teams failed to understand the law correctly, a social representations perspective, by acknowledging that communicative interaction is the driving force of SR (Jovchelovitch, 2019), helps to reveal how specific dynamics shape different polyphasic outcomes, associated with different ways of making sense of disability, justifying different ways of working (Markova, 2005). For example, adopting a medical model of disability reinforces the legitimacy of doctors, contributes to their influence during team work, and thus results in reinforcing a medical approach, as a matter of social practice, and showing how practices also construct our reality (Moscovici, 1998; Jovchelovitch, 2001; Caillaud, 2016). Adopting an SR approach can, finally, support a more critical approach to law appropriation in both social and political psychology, by highlighting the power relations at play at the local level of law appropriation (Howarth, 2006; Castro & Batel, 2008) and how they contribute to the everyday (re-)creation of the political category of disability, promoting certain views over others.

References

- Barbour, R., & Kitzinger, J. (1999). *Developing Focus Group Research*. London: Sage Publications. Doi : 10.4135/9781849208857
- Barral, C. (2003). De la CIH à la CIF. Le processus de révision. In P. Le Quéau (Ed.), *La compréhension sociale du handicap* (pp. 55-71). Paris: Editions du Crédoc.
- Batel, S. & Castro, P. (2018). Reopening the dialogue between the theory of social representations and discursive psychology for examining the construction and transformation of meaning in discourse and communication. *British Journal of Social Psychology*, 57, 723-753. Doi: 10.1111/bjso.12259
- Bauer, M., & Gaskell, G. (2008). Social representations theory: a progressive research programme for social psychology. *Journal for the Theory of Social Behaviour*, 38 (4), 335-353.
- Bertoldo, R. & Castro, P. (2018). From legal to normative: A combined social representations and sociocognitive approach to diagnosing cultural change triggered by new environmental laws. *Culture and Psychology*, 25, 324–344. Doi: 10.1177/1354067X18790730
- Billig, M., Condor, S., Edwards, D., Gane, M., Middleton, D. & Padley, A. (1988). *Ideological dilemmas: a social psychology of everyday thinking*. London: Sage Publications.
- Bloor, M., Frankland, J., Thomas, M., & Robson, K. (2001). *Focus Groups in Social Research*. London: Sage publications.
- Bogalska, E. (2003). De la disqualification sociale au handicap qualifié. Handicap et processus handicapant dans les représentations des assistants de service social. In P. Le Queau (Ed.), *La compréhension sociale du handicap* (pp. 153-180). Paris: Editions du Crédoc.
- Boudaoud, A. (2008). Du handicap à la reconnaissance de la situation de handicap... *La lettre de l'enfance et de l'adolescence*, 73, 19-26.
- Brondi, S., Sarrica, M., Cibin, R., Neresini, F., & Contarello, A. (2012). The Chiampo river 30 years later: long-term effects of environmental regulations on social representations. *Journal of Community and Applied Social Psychology*, 22, 283-299. Doi: 10.1002/casp.1111.

- Caillaud, S. (2016). Social representations theory: a dialogical approach to the ecological crisis. *Papers on Social Representations*, 25, 6.1-6.30.
- Caillaud, S., Bonnot, V. Ratiu, E. & Krauth-Gruber, S. (2016). How groups cope with collective responsibility for ecological problems: symbolic coping and collective emotions. *British Journal of Social Psychology*, 55, 297-317. Doi: 10.1111/bjso.12126
- Caillaud, S., & Kalampalikis, N. (2013). Focus groups and ecological practices: a psychosocial approach. *Qualitative Research in Psychology*, 10(4), 382-401. Doi: 10.1080/14780887.2012.674176.
- Calvez, M. (2007). The mentally handicapped and the neighbourhood: a cultural analysis of handicap as representation. *Scandinavian Journal of Disability Research*, 9, 182-198. Doi: 10.1080/15017410701680654.
- Castro, P. (2012). Legal innovation for social change: exploring change and resistance to different types of sustainability laws. *Political Psychology*, 33 (1), 105-121. Doi: 10.1111/j.1467-9221.2011.00863.x
- Castro, P. & Batel, S. (2008). Social representations, change and resistance: on the difficulties of generalizing new norms. *Culture and Psychology*, 14, 477-499. Doi: 10.1177/1354067X08096512.
- Castro, P., & Mouro, C. (2011). Psycho-social processes in dealing with legal innovation in the community: insights from biodiversity conversation, 47. *American Journal of Community Psychology*, 362-373. Doi: 10.1007/s10464-010-9391-0.
- Castro, P. & Santos, T. (2020). Dialogues with the absent other: using reported speech and the vocabulary of citizenship for contesting ecological laws and institutions. *Discourse & Society*, 31, 249-267. Doi: 10.1177/0957926519889126.
- De Burca, G., Keohane, R.O. & Sabel, C.F. (2013). New Modes of Pluralist Global Governance. *New York University Journal of International Law and Politics*, 45, Available at SSRN: <https://ssrn.com/abstract=2225603>
- Duveen, G. (2008). Social actors and social groups: A return to heterogeneity in social psychology. *Journal for the Theory of Social Behaviour*, 38, 369-374. Doi: 10.1111/j.1468-5914.2008.00385.x.

- Elcheroth, G. (2006). Individual-level and community-level effects of war trauma on social representations related to humanitarian law. *European Journal of Social Psychology, 36*, 907-930. Doi: 10.1002/ejsp.330.
- Elcheroth, G., Doise, W., & Reicher, S. (2011). On the knowledge of politics and the politics of knowledge: how a social representations approach helps us rethinking the subject of political psychology. *Political Psychology, 32*, 729-758. Doi: 10.1111/j.1467-9221.2011.00834.x.
- Esnard, C. (1998). Les représentations sociales du handicap mental chez les professionnels médico-sociaux. *Revue Européenne du Handicap Mental, 5*, 10-23.
- Friese, S. (2012). *Qualitative Data Analysis with Atlas-ti*. London: Sage Publications.
- Giami, A., Korpes, J.-L., & Lavigne, C. (2007). Representations, metaphors and meanings in the term "handicap" in France. *Scandinavian Journal of Disability Research, 9*, 199-213. Doi: 10.1080/15017410701680712
- Gibson, S. (2011). Dilemmas of citizenship: young people's conceptions of unemployment rights and responsibilities. *British Journal of Social Psychology, 50*, 450-468. Doi: 10.1348/014466610X520113
- Gibson, S. (2015). From representations to representing: on social representations and discursive-rhetorical psychology. In G. Sammut, E. Andreouli, G. Gaskell & J. Valsiner (Eds) *The Cambridge Handbook of Social Representations* (pp. 210-223). Cambridge: Cambridge University Press.
- Gillespie, A. (2020). Semantic contact and semantic barriers: Reactionary responses to disruptive ideas. *Current Opinion in Psychology, 35*, 21-25. Doi: 10.1016/j.copsyc.2020.02.010
- Gzil, F., Lefevre, C., Cammelli, M., Pachoud, B., Ravaud, J.-F., & Lepage, A. (2007). Why is rehabilitation not yet fully person-centred and should it be more person centred? *Disability and Rehabilitation, 29*, 1616-1624. Doi: 10.1080/09638280701618620.
- Howarth, C. (2006). A social representation is not a quiet thing: exploring the critical potential of social representations theory. *British Journal of Social Psychology, 45*, 65-86. Doi: 10.1177/0959354306067443
- Johnston, M. (1997). Representations of disability. In K. Petrie, & J. Weinman (Eds.), *Perceptions of health and illness* (pp. 189-212). Amsterdam: Harwood Academic Publishers.

- Jovchelovitch, S. (2001). Social representations, public life, and social construction. In K. Deaux, & G. Philogène (Eds), *Representations of the Social* (pp. 165-182). London: Blakwell Publishers.
- Jovchelovitch, S. (2008). The rehabilitation of common sense: social representations, science and cognitive polyphasia. *Journal for the Theory of Social Behaviour*, 38, 431-448. Doi: 10.1111/j.1468-5914.2008.00378.x.
- Jovchelovitch, S. (2019). Discourse and representations: a comment on Batel and Castro “Re-opening the dialogue between the theory of social representations and discursive psychology”. *British Journal of Social Psychology*, 58, 415-422. Doi: 10.1111/bjso.12296
- Jovchelovitch, S., & Priego-Hernandez, J. (2015). Cognitive Polyphasia, knowledge encounters and public spheres. In G. Sammut, E. Andreouli, G. Gaskell, & J. Valsiner, *The Cambridge Handbook of Social Representations* (pp. 163-178). Cambridge: Cambridge University Press.
- Kadianaki, I. & Gillespie, A. (2015). Alterity and the transformation of social representations: a sociocultural account. *Integrative Psychological and Behavioral Science*, 49, 73-88. Doi: 10.1007/s12124-014-9285-z
- Kalampalakis, N., & Apostolidis, T. (2016). La perspective sociogénétique des représentations sociales. In G. Lo Monaco, S. Delouvé, & P. Rateau, *Les représentations sociales. Théorie, méthodes et applications* (pp. 69-83). Louvain-la-Neuve: De Boeck Supérieur.
- Kalampalakis, N., & Haas, V. (2008). More than a theory: a new map of social thought. *Journal for the Theory of Social Behaviour*, 38 (4), 449-459. Doi: 10.1111/j.1468-5914.2008.00381.x
- Kidd, P., & Parshall, M. (2000). Getting the focus and the group: enhancing analytical rigor in focus groups research. *Qualitative Health Research*, 10 (3), 293-308. Doi: 10.1177/104973200129118453
- Markova, I. (2005). *Dialogicality and social representations. The dynamics of mind*. Cambridge: Cambridge University Press.
- Markova, I., Linell, P., Grossen, M., & Salazar Orvig, A. (2007). *Dialogue in Focus Groups. Exploring Socially Shared Knowledge*. London: Equinox Publishing.

- Moscovici, S. (1961). *La psychanalyse, son image et son public*. Paris: Presses Universitaires de France.
- Moscovici, S. (1988). Notes towards a description of Social Representations. *European Journal of Social Psychology*, 18(3), 211-250. Doi: 10.1002/ejsp.2420180303
- Moscovici, S. (1998). The history and actuality of social representations. In U. Flick (Ed), *The psychology of the social* (pp. 209-247). Cambridge: Cambridge University Press.
- Mouro, C., & Castro, P. (2012). Cognitive Polyphasia in the Reception of Legal Innovations. *Papers on Social Representations*, 21, 3.1-3.21.
- Provencher, C. (2011). Towards a better understanding of cognitive polyphasia. *Journal for the Theory of Social Behaviour*, 41, 377-395. Doi: 10.1111/j.1468-5914.2011.00468.x.
- Provencher, C., Arthi & Wagner, W. (2012). Cognitive polyphasia. Introductory article. *Papers on Social Representations*, 21, 1.1-1.15.
- Rioux, M. (1997). Disability: the place of judgement in a world of fact. *Journal of Intellectual Disability Research*, 41, 102-111. Doi: 10.1111/j.1365-2788.1997.tb00686.x.
- Rocher, G. (2002). Les représentations sociales: perspectives dialectiques. *Social Sciences Information*, 41, 83-99. Doi: 10.1177/0539018402041001006.
- Sarrica, M., Brondi, S., Piccolo, C., & Mazzara, B. (2016). Environmental consciousness and sustainable energy policies: Italian parliamentary debates in the years 2009-2012. *Society and Natural Resources*, 1-17. Doi: 10.1080/08941920.2015.1095379.
- Stiker, H.-J. (2000). De l'infirmité au handicap: un basculement sémantique. In C. Barral, F. Patterson, H.-J. Stiker, & M. Chauvière (Eds), *L'institution du handicap. Le rôle des associations* (pp. 31-38). Rennes: Presses Universitaires de Rennes.
- Stiker, H.-J. (2003). Sens de la construction du régime du handicap. Vers son dépassement. In P. Le Queau (Ed.), *La compréhension sociale du handicap* (pp. 15-27). Paris: Publications du Crédoc.
- Stiker, H.-J. (2014). Une perspective en histoire du handicap. *European Journal of Disability Research*, 8, 1-19. Doi: 10.1016/j.alter.2013.11.003.
- Wagner, W., & Hayes, N. (2005). *Everyday discourse and common sense. The theory of social representations*. New York: Palgrave Macmillan.

Wagner, W., Duveen, G., Verma, J., & Themel, M. (2000). "I have some faith and at the same time I don't believe". Cognitive polyphasia and cultural change in India. *Journal of Community and Applied Social Psychology*, 10, 301-314. doi:10.1002/1099-1298(200007/08)10:4<301::AID-CASP585>3.0.CO;2-V.

Winance, M., Ville, I., & Ravaud, J.-F. (2007). Disability policies in France: changes and tensions between the category-based, universalist and personalized approaches. *Scandinavian Journal of Disability Research*, 9, 160-181. Doi: 10.1080/15017410701680795.

ONE (NEW) LAW, MANY PRACTICES?

Figure 1 Tensions between different representations of disabilities and outcomes on different levels

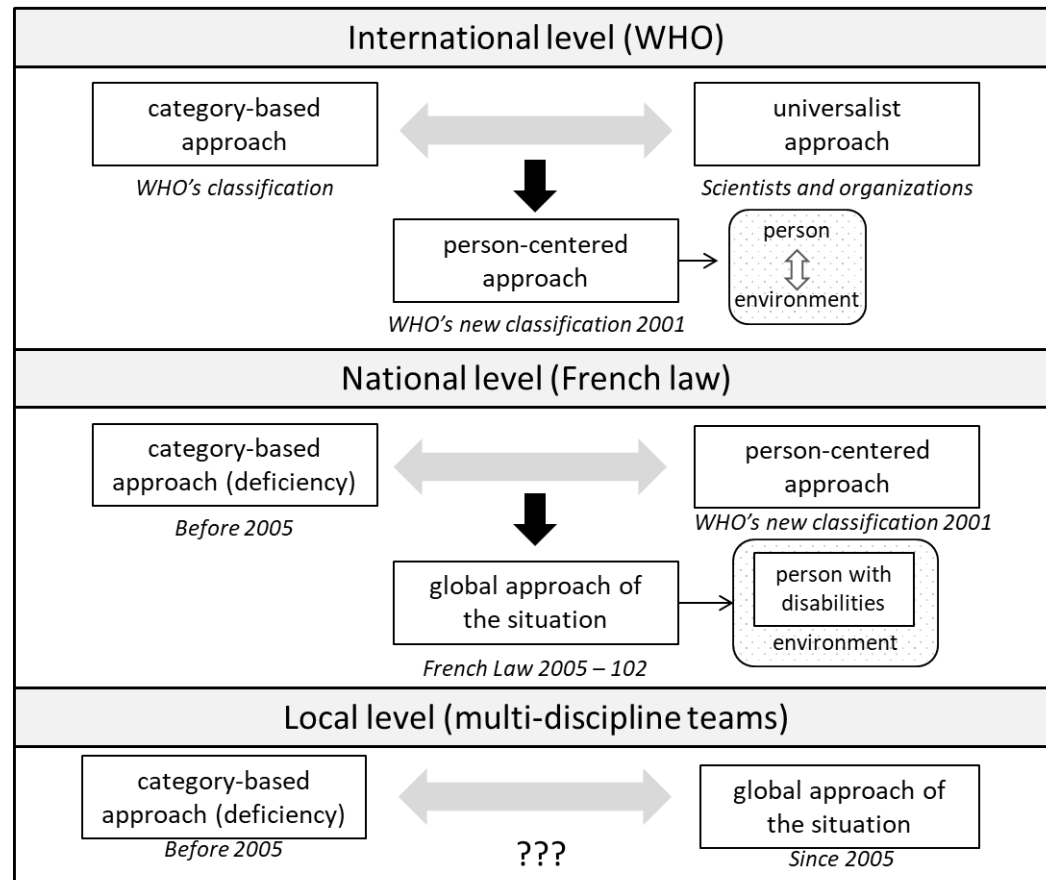
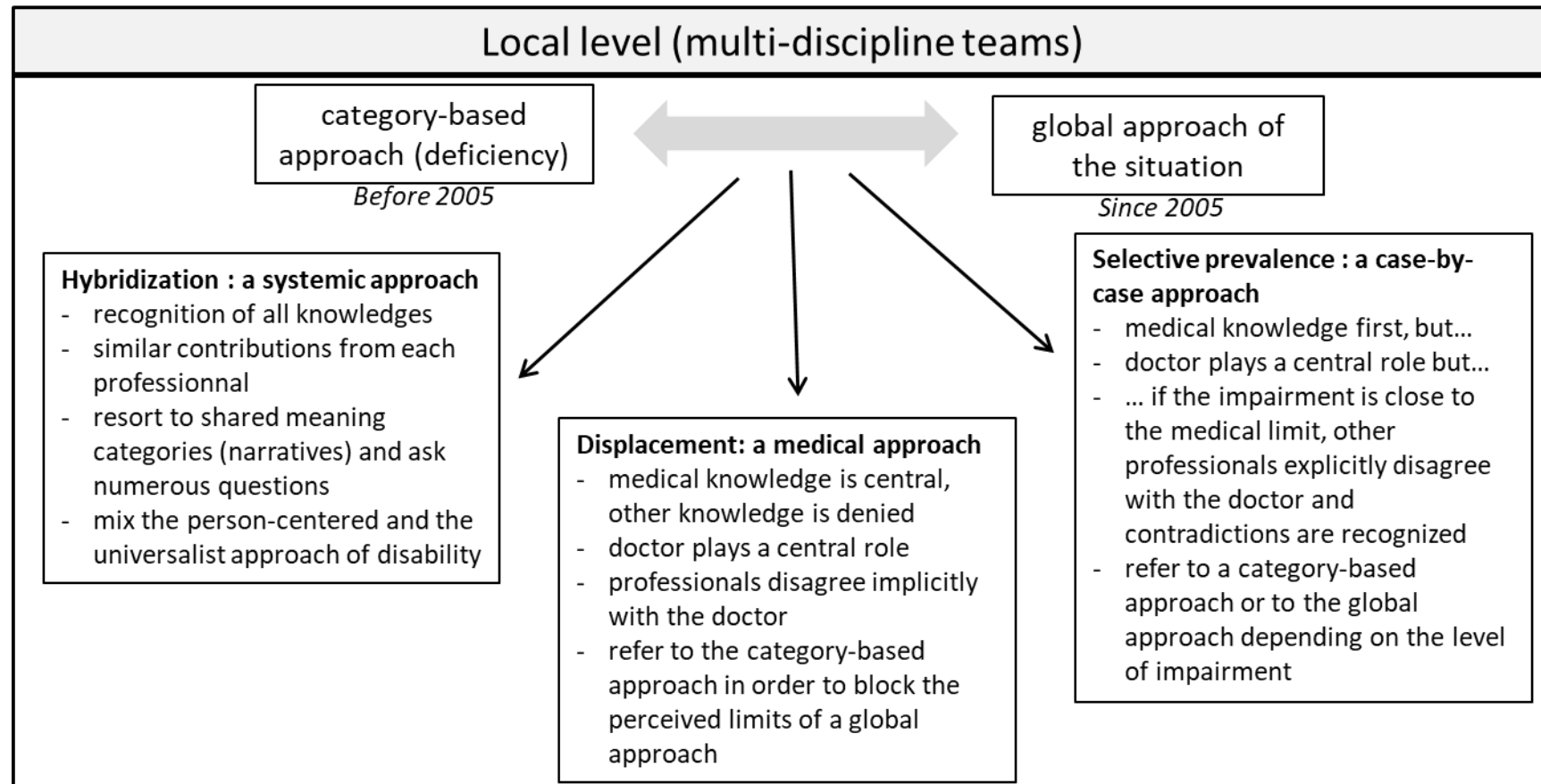


Figure 2 Outcomes of the tensions between the old and new approaches of disability at the local level



ONE (NEW) LAW, MANY PRACTICES?

	codes	FG1	FG2	FG3	FG4	FG5	FG6	FG7	FG8	FG10	FG11	Total
team organizer	Anim	1	1	1	2	1	2	1		2	3	14
social worker	Assist				1	1		2			4	8
in charge of a special institute	Diretab		1	1		1		1				4
physician	Med	1	1	1	1	1	1	2	1	1	2	12
teacher	EnsRef		1		1	1		4	1			8
psychologist	Psy	3	1	1	1	1	2	3	2	1		16
other health staff	Ergo/Inf										3	3
Total		5	5	4	6	6	5	13	4	4	12	65

Table 1 Focus Groups compositions and abbreviations used for the different roles.

ONE (NEW) LAW, MANY PRACTICES?

	systemic approach	medical approach	borderline situation
physician	0.94	1.34	1.49
psychologist	0.81	1.12	0.96
other professionals	1.42	0.96	0.92

Table 2 Relative contribution of participants depending on their profession when discussing the case

ONE (NEW) LAW, MANY PRACTICES?

	Systemic approach	Medical approach	Borderline situation	Total
Explicit disagreement	0.82%	8.19%	11.33%	4.99%
Implicit disagreement	1.07%	18.11%	0.52%	6.19%
Use narratives	22.38%	5.5%	7.59%	12.15%
Ask for questions:	23.61%	16.86%	7.29%	17.34%
- for medical information	5.42%	8.31%	1.87%	5.26%
- for psychological information	11%	3%	0%	6%
- for other information	7.55%	5.39%	5.42%	6.38%

Table 3 Part of the discussion (%) about the case dedicated to different group dynamics