Conceptualizing an active responsive self

Based on the collective work of Response-based Practice
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Response-based practice maintains that people are active and responsive actors in their lives (Wade, 1999). We do not subscribe to an objectified version of personhood where people are seen as passively effected or impacted by the world. Whatever the self is, we prefer to maintain that it is complex and constantly responding to the world in which it lives. It is not static; it moves and responds intelligently according to both environment and social conditions.

Importantly, this occurs in the real world through real interactions which differs from the idea of a self that is shaped, moulded, or conditioned by the world, a passive positioning. The conceptualisation of "self" differs across cultural contexts as it is dependent on what is an accepted established narrative across cultural contexts.

Narratives are co-created understandings that people, i.e., individuals and groups, create to describe and make sense of our collective, social, political, and material realities. These understandings give meaning to certain actions and provide measurements from which to *shape up to* or *contrast against* regarding the worlds they inhabit. Narratives evolve over time, and they tend to exist in their own time spirit. They are extremely influential in the construction and co-construction of what we consider to be "our-selves". Providing the framework from which we make meaning, perceive ourselves, give importance to and consider relevant.

The concept of narratives is not new, but they are less understood for their significance politically and their influence over the way things are generally conceptualised. Established narratives become taken-for-granted facts about the nature of things. However, to reach an established status they have to compete against other ways of thinking. This competition and promotion can be more political than factual. Therefore, it is important to include an analysis of power in the construction of narratives and some consideration towards who is promoting them and why.

This is particularly important because once a narrative gains political status and power it becomes very difficult to argue against, even with extremely valid reasoning. A good case example is the serotonin theory. The serotonin theory has, and still does, promote among certain groups e.g., general public and GP's, the idea of depression being a chemical imbalance. This is despite many academics having abandoned the notion long ago due to it being problematically unsubstantiated (Kirsch, 2010; Whitaker, 2010). Researchers Deacon & Spielman (2017)[1] trace the promotion of this narrative directly to pharmaceutical marketing,

"… the dominant cultural story of antidepressant medications bears little resemblance to the available scientific evidence. Of greater concern is that it never has." (p. 3)

[1] For further reading on this subject, I highly recommended Deacon & Spielmans (2017) Is the Efficacy of "Antidepressant" Medications Overrated?

Most problematically the narrative regarding depression, when discussed in the psychiatric world, even among those who have abandoned the serotonin theory, still focuses on issues of *cause* and *disease* outside of real-world *situation* and *context*. Significantly, the focus is on what is purported to be occurring within the brain of the person, not their life.

To simplify the current narrative regarding depression and chemical imbalances, it is more a case of, "*we just haven't quite got it right yet"* (Balcombe, 2023). To be clear here, the dispute is not whether brain chemicals play a part in the *experience* of any state, undoubtably they do. Without bio-chemical responses we couldn't physically experience anything at all. The dispute is the positioning of "cause of" rather than "response to". I describe this as a literal "wagging the dog" scenario, the absurd idea that the tail wags the dog rather than a dog wagging their tail e.g., in response to being petted.

Considering Problems

How we consider and frame a problem lends to how the problem will be considered and resolved. You wouldn't go to a lawyer's office for surgery, or to a doctor's office for legal advice. So, it matters how problems are considered. The current and dominant narrative with mental health and how people respond to violence has encapsulated them into a medicalised narrative.

The focus on medicalised solutions for social problems has not produced good outcomes for people experiencing adversity. If anything, this has made their difficulties more abstract and deflected support away from the core issues.

There is a particular way in which the medicalised narrative constrains us when it comes to the constructing or co-constructing of our self-narrative. In this narrative we are considered to be *affected by trauma* or *impacted by events,* and therefore restricted to the object/effected position. This is a passive/inactive position which leaves people "appearing" to be effected by trauma, depression, anxiety… and so on.

Under the conceptualization of an *effected person*, solutions have largely become about what is inside the person e.g., the brain, theorised psychological attributes, effects of trauma, and bio-chemicals. Rather than, responding to and resisting violence in a situational and contextual setting.

These very influential and dominant narratives are the threads from which we are supposed to make sense of our experience. Problematically, the medicalised narrative does not account for the operations of power in the face of adversity. Nor does it have any meaningful analysis of the operations of violence in the real world.

Violence is social because it is an interaction between two or more people. Most often it is unilateral, e.g., one person/group towards another. It is deliberate, e.g., aggressors anticipate resistance and work to overcome and undermine the person/groups' ability to respond or resist.

Rather, the medical narrative places substantial responsibility on the victim. Sometimes directly, and sometimes in less overt ways like the prescribing of medication because brain chemicals/receptors are purported to be the problem. Or, to undertake therapy to better themselves, e.g., to be more assertive, to be more resilient, to increase their confidence. All

of which are narratives and theorised to be psychological attributes that live inside the mind/brain of the individual. Whereas these attributes are better described and understood as collective (social) achievements.

In addition, there is an unhelpful idea that resistance must be a visible action to impede adversity in order to be respected or considered relevant. This means that all of the everyday responses and resistances (to violence and adversity) that people engage in are discounted. More than not being valued, they are not considered to exist. These in turn support many victim blaming practices. Under these circumstances it becomes very difficult for the person to measure their responses and resistance to adversity, holistically and realistically.

How can a person feel esteem when they are not being treated with care and esteem?
How can a person feel resilience when they are being continuously undermined?
How can a person feel confidence when they are being continually criticised and cut down?

In my clinical practice I have witnessed the most intelligent, competent, resilient people rendered down to a level of incapacity and barely functioning. Done so through toxic, critical, aggressive, and demeaning social conditions. Obviously, social interaction matters, yet when it comes to many of these so-called psychological attributes, inadequate consideration is given to them.

References

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