

# When Action Has Lost Its Promise

Depression, adaptive history, constrained agency and the clinical meaning of a next step

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The client says she did not make the call. A small pause follows. The therapist remembers the care with which they chose it: a manageable task, connected to a stated goal, broken into steps. There is a familiar temptation to make it smaller again. There is also the possibility that the unmade call contains information the original plan did not include. Before another intervention, someone has to become interested in what happened between the session and the telephone.

Consider Nerina, an invented client whose story will remain deliberately incomplete. She describes herself as unmotivated. Her work schedule changes with little notice; she helps an ill relative and has recently lost interest in activities she once enjoyed. She sleeps poorly and feels slowed down in the morning, then tense when messages from work arrive. She wants therapy to help her become less difficult about ordinary responsibilities. Her account already contains depressive symptoms, burdens, self-criticism, and an account of what she believes other people require.

The proposed call was to ask her supervisor for a more predictable schedule. At the next session Nerina says she simply could not make herself do it. Asked what she pictured, she describes a coworker whose hours were cut after raising a concern. She also remembers a parent who could welcome a request one day and experience it as an accusation the next. The earlier history matters. So does the coworker's experience. Neither should be used to erase the other.

The therapist offers a provisional understanding: perhaps asking has become associated with danger. Nerina says this is partly right, but the immediate problem is that she cannot afford fewer hours. The correction changes the work. A proposal intended to strengthen agency had asked her to risk a resource on which she depends. Receiving that fact requires the therapist to relinquish a preferred image of progress and become more accurate about the client's circumstances.

Warmth becomes clinically consequential at this point. It includes the therapist's willingness to be corrected without withdrawing interest or returning the client to an explanation that no longer fits. A possible response is, "I did not give enough weight to what you could lose. Before we decide on another step, I want to understand that better." The purpose is to restore the client's authority within the encounter and improve the formulation. Feeling reassured, grateful or newly motivated is not the required response.

## The presenting difficulty deserves a differential account

A depressive syndrome and a functional account of withdrawal answer different questions. The former concerns a pattern of symptoms, impairment, course and differential diagnosis. The latter asks what a particular response may do in a particular context. A good functional formulation does not rule out an illness; a diagnosis does not exhaust the relational, developmental or social meaning of the person's life.

NIMH's clinical overview emphasizes depression's varied presentation and multiple contributing factors. Assessment should include the relevant symptom pattern and course, impairment, medical and medication factors, and possible bipolar or other presentations. Current risk and the need for professional care require their own clinical attention. Neither a compelling childhood narrative nor apparent insight provides a substitute for that work. <sup>[1]</sup>

Nerina's slowing, reduced interest and disrupted sleep warrant clinical inquiry alongside the workplace problem. The therapist would also want to understand what has changed, what persists across settings, what helps, and whether there are periods of markedly different mood, energy or behavior. Family history belongs in this account as more than a history of relational injury. Illness, genetic vulnerability, care, losses and material conditions can all be relevant. No particular answer is supplied by this vignette.

The term motivation can conceal several different difficulties. Is the person less interested? Unable to enjoy what occurs? Unable to initiate? Expecting an action to be ineffective? Afraid of the consequences of effectiveness? Facing a task that is genuinely inaccessible? Treadway and Zald's review distinguishes motivational and consummatory aspects of anhedonia. Clinically, that supports more precise description; it does not let us infer a reward-circuit explanation from a missed appointment. <sup>[3]</sup>

Ask for one encounter rather than a global self-rating. What was the task? What did the person want? What resources and obligations were present? What occurred at the moment of approaching it? What happened after setting it aside? Relief may suggest an immediate reduction in burden or threat, but it does not by itself identify the original cause. There may be shame, numbness, competing tasks or no clearly observable shift. The account should preserve those absences.

Two errors become easier to see through this distinction. We may interpret depleted capacity as avoidance and press for action. We may interpret costly avoidance as incapacity and inadvertently make the person's world smaller. Often both processes are present. The next useful intervention is the one that helps discriminate them without requiring the client to demonstrate wellness, courage or insight on demand.

## Adaptive history is a hypothesis about function

A child in an emotionally unpredictable or depriving environment may learn that initiative destabilizes connection. A request can become an accusation in the adult's mind. Distress can bring ridicule, competition or collapse. Pleasure can draw attention the child does not want. In such circumstances, becoming less expectant, less visible or more useful may reduce particular interpersonal costs. This is a possible account of specific patterns, open to correction by the person whose history is being discussed.

The phrase intelligent adaptation can relieve an unnecessary moral accusation. A response may have fitted the child's available options even while diminishing later possibilities. The phrase becomes misleading when it assigns a purpose to depression as a whole, assumes all low mood is trauma-based, or makes the client responsible for retaining a once-useful defense. An account can be compassionate and still be empirically overconfident. Precision is part of the compassion.

Humphreys and colleagues' meta-analysis associates childhood maltreatment with depression. Hanson and colleagues' longitudinal adolescent study relates emotional neglect, ventral-striatal development and later symptoms. These findings support taking developmental adversity seriously. They do not establish that an adult's depression functions to preserve attachment, that a particular neural process is present, or that reconstructing an adaptive narrative will produce remission. Function requires its own situated inquiry. <sup>[4], [5]</sup>

Bowlby's attachment theory gives that inquiry a relational focus: what happens to proximity, support and the expectation of care when the person signals need? The adult may approach help and brace against it in the same encounter. An interpretation of anticipated unavailability should be held alongside evidence about the availability of actual people. Present neglect cannot be made into a merely internal expectation. <sup>[23]</sup>

Bowen's account of differentiation brings a different emphasis: a considered position can develop within realistic dependence and continuing relationship. The clinical invitation is to discover what the person thinks, wants and can responsibly choose under pressure. This is not a hierarchy in which greater independence proves maturity. For a depressed, materially dependent client, accepting another person's help may be one of the available expressions of a position of their own. <sup>[22]</sup>

Winnicott's true- and false-self distinction offers a conceptual question about compliance and spontaneous personal experience. Has being a satisfactory patient become another task in which the client loses contact with preference? The language needs care. A client who adapts to social expectations is not therefore false, and a therapist cannot certify authenticity by observing animation, tears or disagreement. The relevant inquiry is whether the person recognizes the proposed movement as their own. <sup>[30]</sup>

With Nerina, the developmental formulation remains live but narrower. She recognizes an expectation that asking will burden or anger someone. She also knows there is a practical workplace threat. Rather than helping her prove the threat is old, the therapist asks where the expectation appears when the consequences are different. She identifies a trusted cousin with whom a modest request might be possible. Even that possibility remains hers to decline.

## An embodied account must remain open

Schore's work on attachment and affect regulation emphasizes the developmental importance of interaction and repair. The cited synthesis is infant-focused; using it to think about adult treatment is a clinical extension. In Nerina's session, attention may turn to whether the pace, demand and interpersonal response make thinking more or less available. We cannot identify an adult hemisphere, early lesion or neural repair from the client's posture or a moment of relief. <sup>[25]</sup>

Damasio and Carvalho's account of feelings as embodied experiences adds a reason to ask what effort, anticipation or discouragement feels like, when the client finds that useful. Bodily information does not interpret itself. A heavy chest, agitation or absence of sensation can have different meanings and contributors. The clinician should invite description without making the body an authority that overrides the client's words or the need for medical consideration. <sup>[26]</sup>

Siegel's integration framework keeps distinctness and linkage in view. Applied here, integration is a way of asking whether bodily experience, thought, relationship and circumstance can be considered together without collapsing them into one story. The framework is a conceptual orientation, not evidence that a reflection exercise has integrated a neural network or made a person healthy. That boundary allows the formulation to remain rich without becoming an account of an unseen brain. <sup>[28]</sup>

Van der Kolk's publisher excerpt describes trauma's effects on pleasure, intimacy and the effort of continuing to function. It contributes an embodied-trauma perspective. NIMH's PTSD overview supplies a distinct clinical frame that includes avoidance and changes in emotional experience. Depression, PTSD, dissociation and ordinary restraint should not be treated as interchangeable. Their overlap is an invitation to assess, rather than a reason to call every difficulty trauma. <sup>[16], [19]</sup>

Grounding therefore remains an option rather than a universal gateway. A person may find external orientation, water, food, a more comfortable seat, less stimulation or the therapist's unhurried presence useful. Another may experience an inward focus as disorganizing. The relevant question is what increases enough choice and contact for this encounter. A requirement to become calm can make understandable anger, agitation or exhausted flatness into another obstacle to being helped.

No sensation or image establishes that a historical event occurred. This pathway does not invite recovered memories, prolonged contact with traumatic material, cathartic release or self-directed exposure. If ordinary reflection produces marked disorientation, escalating distress or loss of contact with the present, the educational experiment has exceeded its useful conditions. The response is to stop and arrange suitable support, rather than reinterpret the difficulty as proof that an important hidden truth is emerging.

## Emotion, privacy and grief are different clinical questions

Maté's account of adaptation to unmet needs helps ask about the cost of belonging under restrictive conditions. A clinician may wonder which wishes became difficult to acknowledge and which forms of self-presentation preserved connection. His broad trauma language and cultural synthesis require boundaries: they do not establish a diagnosis, a universal cause of illness or an obligation to disclose in order to become authentic. The useful question should remain available without the universal claim. <sup>[15]</sup>

Expressive suppression, experiential avoidance and involuntary emotional numbing require different descriptions. A client can know exactly what they feel while choosing not to show it. Another may move away from experience before it becomes recognizable. A third may have little access to feeling without making any deliberate choice. Aldao and colleagues' meta-analysis concerns associations between regulation strategies and psychopathology. It does not establish that suppressing a feeling caused an individual depression. <sup>[17]</sup>

Bonanno and colleagues' work on expressive flexibility provides a contextual counterweight. The capacity to modulate expression in more than one direction can matter. Privacy, cultural meaning, task demands and actual interpersonal danger belong in the discussion. The therapeutic aim should concern available choice and fitting support, with room for restraint as well as expression. Tears, anger and visible relief are poor standalone measures of successful processing. <sup>[18]</sup>

The emotional field may include sadness, protest, fear, tenderness, pride, enjoyment and the risk of hoping. We can ask which experiences are difficult to admit and what happens around them. The question should not assume that every person has a vivid feeling waiting underneath numbness. Low access may itself be the present experience, and clinical care may be more urgent than an explanatory account of what has been excluded.

Schwartz's parts-oriented model can help a client describe a wish to participate alongside a concern that participation will bring disappointment or exploitation. This is optional model language. The clinician can inquire about a response's concern without declaring that depression is a protector or that the client must locate an exile. Declining the language is useful corrective information, not resistance to an underlying system the therapist has already decided exists. <sup>[27]</sup>

Undigested grief is a metaphor for loss insufficiently acknowledged, accompanied or integrated into a life. It is neither a substance retained in the body nor a diagnosis. The loss may involve a death, an unavailable parent, illness, an unlived possibility or a future that has become less trustworthy. The kinds of loss should remain distinguishable. APA's prolonged-grief overview concerns a specific death-related disorder and should not be extended to every form of sorrow. <sup>[20]</sup>

With Nerina, the therapist might notice sadness after she says she has never expected anyone to make life easier for her. It would be premature to call this the grief causing her depression. The more immediate question is whether she wants company with that recognition, wants to say something further, or needs to return to the work problem. The recognition can remain

unfinished. Its clinical significance includes how it is met, and whether she retains a say in the pace.

## **Depth psychology widens the question; it does not settle the cause**

Moore's introduction to *Dark Nights of the Soul* opens a meaning-oriented vocabulary for periods in which familiar orientation fails. It can help a therapist tolerate the absence of a quick constructive account. We need not adopt a division between illness and meaningful experience, or suggest that symptom relief interrupts necessary development. A person can seek relief and explore meaning, in a sequence that respects their needs. <sup>[11]</sup>

Hollis's interview about depression and work is especially useful where duties conflict. The client may need an income while being depleted by how it is earned. Asking what a life arrangement costs and serves can expose a real conflict without implying that the person secretly chose the illness. Hollis's interpretive language should not replace contemporary differential assessment or make a vocational change the prescribed demonstration of personal authority. <sup>[14]</sup>

Bly's author-site account of the shadow supplies an image for what is excluded from a familiar identity. In this pathway it supports inquiry into disallowed wishes or qualities, rather than a theory of stored emotional energy. His interview on storytelling also questions heroic accounts with little place for grief. Those invitations can be used without gendered initiation scripts, a mandatory descent or a promise that sorrow releases vitality. <sup>[12], [33]</sup>

The depth traditions are most helpful when they alter the therapist's listening. An absence of enthusiasm may deserve a question about the life being offered, the duties being carried, or an imagination that has had little companionship. It may also be an illness-related absence of enthusiasm. Theories of meaning become less humane when the clinician needs the client's symptoms to deliver a message before allowing them to be symptoms.

A further discipline is needed when a beautifully phrased interpretation evokes agreement. Agreement can express recognition, relief at being understood, uncertainty, politeness, or the wish to be a good client. Ask what fits, what does not, and what the interpretation leaves out. The client should not have to reject the therapist's warmth in order to reject the account being offered. This is especially relevant where accommodation has been part of the presenting difficulty.

## **The workplace, the relationship and the shared world remain in the room**

Hillman's original interview challenges psychotherapy's tendency to relocate social and environmental failures inside the individual. Its clinical value here is to keep actual conditions visible. It does not require abandoning personal treatment until the world is repaired. The therapist can work on suffering and agency while also recognizing exploitation, racism, exclusion or material deprivation as conditions requiring outward responses. <sup>[13]</sup>

WHO's account of mental health at work names psychosocial risks and the importance of organizational interventions. The formulation should ask who controls workload, schedule, livelihood and consequences. A client may have little power to negotiate alone. Practical advice, access to appropriate services, accommodations or organized support may be relevant, with informed attention to confidentiality and retaliation. Individual regulation should not become the employer's substitute for safer conditions. <sup>[9]</sup>

In intimate relationships, the same inquiry becomes specific. What happens when the person asks to rest, disagrees, seeks friendship or uses money? Who carries the consequences of the other's decisions? Sue Johnson's attachment-oriented account can help understand bids for connection within protective cycles; Tatkin's secure-functioning principle asks how care includes both partners. These are clinical frameworks, not evidence that vulnerability will be met well or that each partner bears equal responsibility for harm. <sup>[24], [29]</sup>

Where coercion or intimidation is present, a joint experiment in requesting support may be inappropriate. The client's private understanding, individual assistance and realistic options matter first. The therapist should not rehearse greater disclosure simply because disclosure fits a preferred model of intimacy. In a mutually responsive relationship, by contrast, a bounded request can help test whether the available care fits the person's need. The conduct of the other person remains part of the result.

Climate change and threats to social or political stability may narrow the felt future. IPCC and WHO accounts support taking climate-related mental-health risks seriously. A clinician need not settle every public claim in order to ask about direct exposure, credible information, uncertainty, loss and participation. Concern can be proportionate to a real threat while depression also constricts the person's capacity to imagine or act. Neither proposition cancels the other. <sup>[8], [10]</sup>

The therapist's own political certainty can become another demand. Curious listening includes what the client values and what their circumstances make dangerous or costly. Shared action can offer an avenue of participation, but activism should not be prescribed as a cure or moral obligation. A person with limited resources may contribute differently, need help receiving resources, or decide that protecting basic functioning is the available responsibility for now.

## **Agency is larger than self-mobilization**

Bandura distinguishes personal, proxy and collective agency. That is a useful corrective to treating agency as solitary willpower. A client may act directly, obtain another person's assistance, or participate in a group whose combined effort changes available conditions. The shared denominator is meaningful participation under actual constraints. Dependence does not negate agency, and an outcome outside the person's control does not establish its absence. <sup>[7]</sup>

Maier and Seligman's later account of learned helplessness revises the early explanatory story, emphasizing the role of learning control within research largely involving animals. It does not justify telling a client they have learned to give up or attributing their depression to a

particular brain mechanism. A modest clinical question survives: where is influence available, where has it been absent, and how can the difference be encountered without blame? <sup>[6]</sup>

Behavioral activation has a research base as a clinical treatment for adult depression. The Cochrane review reports variable certainty across comparisons. A BKL educational experiment should therefore be described as an original learning activity informed by attention to action and consequence, not as a validated depression intervention or a shortened version of a treatment protocol. Treatment decisions belong within the appropriate clinical relationship. <sup>[2]</sup>

Return to Nerina. After the therapist acknowledges the risk of approaching her supervisor, she identifies a different possible step: asking her cousin to stay on the phone while she writes down the schedule changes. The purpose is to make the situation less difficult to organize and consider what advice she might need. It is not to produce a complaint or persuade her to confront anyone. She predicts that company may help her begin, but worries that her cousin will push her toward action.

They establish conditions she chooses: ten minutes, no advice unless requested, permission to end, and the alternative of writing one factual note alone or postponing while seeking help. At the next session she reports that she wrote down three changes, became tired, and stopped. Her cousin respected the limit. She felt briefly less alone and was still depressed the next morning. The therapist can recognize the useful conditions without upgrading the event into a recovery narrative.

Fosha and Thoma's clinical process paper invites attention to the experience of a change, with the limits of its case-based evidence retained. Here the question might be what it was like to have a limit respected. Nerina may feel relief, sadness, suspicion, neutrality or something else. Examining the result includes the cost and what did not change. It does not require savoring a positive experience the therapist believes should have occurred. <sup>[21]</sup>

A subsequent formulation could be: this kind of company helped one organizational task and did not remove depressive symptoms; asking is possible with this cousin under these conditions; the workplace problem still needs practical attention. That formulation has more useful detail than "she is becoming empowered." It leaves clinical care, grief, relational expectation and present power in the account, while creating a specific basis for the next decision.

The setting of a limit is especially informative. If a task helps for ten minutes and becomes draining at fifteen, the therapist can preserve the useful dose rather than treat the limit as the next obstacle. A successful encounter can be harmed by an unexamined escalation of expectation. The same is true of interpersonal help: receiving a ride or brief company does not create an obligation to accept advice, disclose more, or become available in return before the person can do so.

What happens between appointments deserves a similarly modest account. A useful hour of therapy does not establish that the rest of the week has become easier. The client may return to an unchanged environment, sleep badly, lose access to support, or encounter symptoms that insight did not alter. Asking about these conditions protects treatment from becoming a

succession of compelling in-session explanations with little contact with the person's everyday life.

Where no experiment is attempted, the review can still discriminate among explanations. Was the proposal forgotten, too complicated, unwanted, unaffordable, unsafe, physically inaccessible, or eclipsed by an urgent obligation? Did the client agree in the room without recognizing the agreement as a choice? The clinician should not require a psychologically meaningful reason where a practical one is sufficient. If the activity was simply too much, that finding belongs directly in the next care decision.

Conversely, an improvement in one condition should not be used to dismiss symptoms. Nerina can become more organized with company and still need a fuller assessment and treatment for depression. A person can exercise real influence and continue to experience helplessness in other domains. We need room for this unevenness: the person's agency is neither wholly restored nor wholly absent, and a single result should not carry a larger conclusion than it can support.

## **What the therapist's own effort can obscure**

Depression can evoke urgency, helplessness, frustration and a wish to supply hope. The therapist may begin carrying the anticipation of improvement for both people. A carefully designed task can then become important to the therapist's sense that treatment is working. Noncompletion threatens more than the intervention; it can threaten the clinician's confidence and invite persuasion, reassurance or retreat into theory.

The supervisory question is concrete: what response am I hoping this client will give me? Perhaps I want visible relief after an interpretation, acknowledgment after a repair, a completed activity after collaboration, or gratitude for not pushing. None is a dependable measure of the client's agency. A client may become more able to choose while becoming less willing to perform the signs that reassure the therapist.

Aponte and Kissil's Person-of-the-Therapist Training model gives this inquiry a further direction. The therapist's enduring personal struggles, described in the model as signature themes, can become resources for connection, assessment and intervention. The task includes learning to use the self as it is in the present encounter, while taking responsibility for its effects. Familiarity with one's own helplessness may deepen sensitivity to the client's experience; that possibility requires deliberate clinical use and continuing supervision. <sup>[35]</sup>

In the invented encounter with Nerina, imagine that the therapist recognizes a familiar personal equation: unless I can help someone change, I am failing them. Her unmade call may then stir a wish to restore the therapist's own sense of usefulness. Recognizing that struggle could also make another experience more imaginable: how painful it might be for Nerina to return unchanged and face someone else's hope for her improvement. This is a question to explore with her. The therapist's resonance supplies no privileged knowledge of what she feels.

The next intervention might make room for that question: "When you thought about telling me you had not made the call, what did you expect from me?" Nerina may describe shame,

annoyance, relief or no particular concern. The therapist can use familiarity with feeling inadequate to stay interested in her answer, including an answer that challenges the formulation. Personal history need not be disclosed for this use of self to occur. In supervision, the inquiry becomes specific: how did recognizing my struggle change my listening, assessment or next intervention? POTT directs attention toward that purposeful clinical use, with ongoing responsibility for the therapist's own needs. <sup>[35]</sup>

Melville's *Bartleby* answers a work request, "I would prefer not to." The narrator's bewilderment exposes how another person's usefulness can organize the observer's concern. This is a literary question, not a retrospective diagnosis of the character: when the client ceases to meet our expectation of movement, can we remain interested in the person and examine the expectation? Clinical responsibility includes responding to deterioration; curiosity need not become passivity. <sup>[34]</sup>

O'Donohue's blessing *For One Who Is Exhausted* offers the line, "Be excessively gentle with yourself." Its use here concerns the clinician's manner of approaching effort. The poem's spiritual account and promised return are not clinical findings. Gentleness can coexist with direct inquiry, practical arrangements and decisive care. It changes how the person is met while leaving the seriousness of the situation intact. <sup>[32]</sup>

Inviting correction once is insufficient if the therapist's response makes correction costly. Notice whether the client must soften a disagreement, defend it at length, or care for the therapist afterwards. Repair may require changing the activity, accepting a different goal, or returning to a question the clinician prematurely closed. The resulting relationship is assessed through what the client can actually do within it, including decline, remain uncertain and ask for a different kind of help.

## **Translating the formulation into a learning pathway**

The client companion, *When Life Becomes Hard to Reach*, begins with ordinary experience before introducing explanation. Depression, Motivation, and Recovering Agency then follows five capacities: describing the difficulty, considering the risks once attached to wanting and feeling, recognizing present restrictions, trying a chosen bounded action, and developing sustainable participation in an uncertain world. The sequence provides a direction without making the learner's history conform to it.

Every module retains a complete learning cycle. An encounter is described; an explanation is offered provisionally; the learner can correct it; an optional experiment specifies its purpose, prediction, conditions, stopping point and alternative; the actual result is examined; and the understanding is revised for use beyond the exercise. Helped, unchanged, harder, mixed, did not fit and not tried remain legitimate outcomes. An experiment is incomplete if it asks only whether the learner complied.

The optional reflection keeps capacities separate from present circumstances. It uses no total, diagnostic cutoff, causal assignment or safety clearance. A selected concern can suggest a module, while frequency answers cannot prescribe treatment. The common BKL baseline is separately optional, with blanks, uncertainty, nonapplicability and privacy preserved.

Repeated answers can support discussion of context and opportunity; they cannot establish clinical improvement or the program's effectiveness.

The modules offer reading, fictional rehearsal, small private practices and supported alternatives. They do not require childhood disclosure, emotional exposure, confrontation, a body scan or optimism. The ninety-minute core is flexible planning guidance that can be divided, shortened or skipped. For some learners, taking a paragraph to a therapist or asking someone to help arrange care will be the most useful participation available.

The central clinical commitment is to make the next response more fitting. A person may need symptom treatment, a less punishing relationship, a different arrangement at work, accompaniment with loss, rest, practical resources, a chosen action, or several of these together. A formulation earns its place by helping us notice the difference and respond, while remaining answerable to the person whose life it describes.

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Explore Depression, Motivation, and Recovering Agency

When Life Becomes Hard to Reach