Agency in Illness and Recovery

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Abstract.—In the closing words of his article on hospital treatment at The Menninger Clinic, one of us (RLM) proposed that treatment must address the patient's "willingness to accept agency for the illness" (p. 185).[1] Embracing this idea, we clinicians are emphasizing the importance of agency in our patient education programs. Yet the intuitively appealing concept of accepting agency for one's illness requires careful explication lest patients feel unjustifiably blamed for something beyond their control. This article represents our ongoing effort to spell out our treatment philosophy.[2] Although we developed this paper primarily for patient education, we intend it to be useful to family members and to our professional colleagues as well. At one time or another, we all wrestle with the problem of agency in our illnesses.

The idea of accepting agency for your illness requires some mental juggling, because agency and illness are mutually exclusive concepts. Agency involves the exercise of power. An agent is an originating cause; agents initiate action.[3] Imagine sitting in your kitchen and, out of the corner of your eye, spotting a small crumb moving along the floor. Looking more closely, you see an ant tugging it along. The ant, not the crumb, is the agent. As an agent, you *make* things happen. In contrast, illness happens *to* you. In short, agency involves active doing whereas illness involves passive suffering.

Yet we'll argue that being ill does not preclude agency. You're ill *and* you're an agent. We'll encourage you to appreciate the potential role of agency—your own actions—in the development and maintenance of your illness, as well as in recovering and remaining well. In advocating agency, we're encouraging you to take hold of your illness. Our perspective offers hope: Enhancing agency is empowering, and agency is a cornerstone of hope.[4]

It's an opportune time in psychiatry to be promoting the role of agency in illness. We've just come out of the Decade of the Brain. The field is dominated increasingly by enthrallment with the biological perspective on psychiatric disorders and treatment. At worst, patients and clinicians alike can be seduced by what we call "biomania," the penchant to explain everything psychiatric in biological terms. We, too, are firmly committed to making full use of biological knowledge to understand and treat psychiatric illness. Yet, if we embrace biological psychiatry exclusively, we run the risk of dehumanizing psychiatric problems and taking the whole person as agent out of the picture, as if the person were a helpless carrier of psychiatric disturbance.

You might think, for example, "I have a biochemical-imbalance depression"— and rightly so. This is a legitimate perspective on depression. But it's only one perspective. By advocating agency, we're encouraging you to juggle multiple perspectives. We aim to reinforce your sense of yourself as a whole person with problems and to counter the temptation to become carried away with any kind of explanation that leaves your agency out. Of course, you're likely to need help on the biological front, for example, from medication. Yet going solely down the biological path can leave you feeling helpless in the face of psychiatric illness that does not respond to biological treatment—or leave you feeling utterly dependent on medication.

You won't need any technical background to understand this article, but you won't find it to be light reading; the topic's complexity matches its importance. We proceed as follows. First, we define our key terms, agency and illness. Second, we tackle the fundamental challenge in accepting agency for illness: taking responsibility for your illness without condemning yourself for it. Third, we consider the role of agency in creating and perpetuating illness. Fourth, we describe various ways in which agency plays a role in recovery and wellness. Fifth, we discuss how treatment enhances agency. We conclude by considering the role of agency in hope.

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Agency

Agents initiate action—intentional, goal-directed behavior. Animals are agents, and we humans are *self-conscious rational agents*. Agency implies will, autonomy, freedom, choice, and responsibility. Psychiatrist Daniel Stern defined self-agency as "the sense of authorship of one's own actions" (p. 71).[5] Contemporary philosopher John Searle defined an agent as "a conscious entity that has the capacity to initiate and carry out actions under the presupposition of freedom," adding that agents "can consciously try to do something" (p. 83).[6] He went on to locate human agency in the *self*, an agent capable of conscious reasoning about its actions.

As self-conscious rational agents, we're aware of acting on the basis of reasons. A caveat: We're *potentially* self-conscious and rational agents. We're not always aware of reasons for our actions, and much of the time as we go about our daily activities we need not reason deliberately about what we're doing.[7] When we get into difficulty, however, we must become more self-aware so as to enhance our agency and thereby exert greater control over our actions. For example, relationship conflicts often stem from lack of awareness of the impact of our behavior on other persons; resolving these conflicts requires greater awareness. So it is with psychiatric illness. To anticipate our argument: Unwitting actions often play a role in the development of illness; expanding the dominion of conscious reasoning enhances agency and provides greater leverage over illness.

A key point: Agency is not an all-or-none phenomenon; it's a matter of degree. We can sharpen the concept of agency by considering its opposites, thinking of active agency at one end of the spectrum and passive helplessness at the other end. We enhance agency when we act deliberately. We diminish agency when we act mindlessly, thoughtlessly, and unwittingly. Agency entails voluntary action; its contrary includes involuntary responses such as reflexes. You can't help being startled by a sudden loud noise—you don't act; you react. Agency entails activity; its converse is passivity. Agency entails power and control. When your agency is undermined, you feel helpless and out of control. Traumatic events are extreme examples: They're overpowering, rendering you helpless, and they're traumatizing by virtue of undermining agency.[8]

To varying degrees, your agency—your freedom of choice—is limited by *constraints*.[9] Your agency can be constrained in many ways, by anything that limits your range of choices or possibilities. Such constraint may range from being incarcerated to being handicapped in a multitude of ways. And just as you can be prevented from taking action, you can be forced to act in ways that go against your will. You can be physically overpowered or psychologically coerced. Your agency also may be constrained from within to the extent that you feel forced into action by an internal compulsion, such as an addiction.

Pure freedom of action—agency without limit—is an impossibility. You make choices continually, but you cannot choose to do absolutely anything. You always choose among a limited set of possible alternatives. When you think about it, many things are beyond your control. Your genetic makeup imposes constraints, partly evident in temperament—biologically based personality characteristics that are modifiable only to a degree with considerable effort.[10] Your environment also imposes constraints: You're born at a particular time into a particular culture and a particular family, potentially affected by social constraints such as poverty, racism, and sexism.

Of course, as an active agent, you'll play an important part in shaping whatever environment you're born into and your interpersonal relationships in particular. The influence is reciprocal throughout life: You shape your environment, and your environment shapes you. Similarly with personality development: Your temperament, your environment, and your history of exerting agency all play a role in the enduring patterns of behavior and relationships you develop—your habits. Your personality, in turn, imposes constraints on the extent of change. Similarly, partly as a result of agency, you develop a social reputation that imposes social constraints as well as providing social opportunities.

Most crucially for our purposes, *illness constrains agency* to varying degrees. When you become ill—depressed or addicted, for example—your constraints expand and your agency diminishes. Yet, thinking in terms of degree, we don't want to exclude agency entirely when considering constraints. No doubt, your agency can be completely undermined; you can be physically overpowered. You can be immobilized by profound depression. But short of these extremes, your agency is diminished but not entirely eradicated by illness. Being depressed, you can be sluggish without being utterly paralyzed. Generally, you're not dealing with absolutes.

A crucial point here: You must distinguish between *difficult and painful choices* and *no choice*.[11] When you've become ill, the challenge is to use your remaining agency to get well and to *increase* your range of freedom and choice. You can build agency on agency; the more you recover, the easier it becomes to recover further.

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Illness

The concept of illness refers to sickness and disease. All these terms indicate a departure from health. Disease—dis-ease—has multiple meanings ranging from uneasiness and distress to a specific biological ailment. When we starkly contrast agency and illness in this article, we're thinking of the narrow sense of *disease*: "a particular destructive process in the body, with a specific cause and characteristic symptoms."[12] Disease runs counter to agency: It's not something you *do*; it invades, overtakes, happens. In what follows, we'll use "disease" in its narrow sense in contrast to the broader term, "illness." The term, psychiatric *disorder*, is neutral with respect to causation. Biological disease plays some role in the development of many psychiatric disorders, along with a host of psychosocial factors such as relationships, patterns of thinking and behavior— ways of living.

The most generally accepted prototype of illness is physical; we more straightforwardly apply the concept to general medical conditions and physical injuries than to psychiatric disorders. Is mental illness really illness? Yes, although not just in the narrow sense of disease. Yet, with increasing success and sophistication, the field of biological psychiatry is applying the model of disease to an ever-expanding array of psychiatric disorders. Burgeoning research demonstrates the neurobiological basis of psychiatric disorders such as depression, obsessive-compulsive disorder, schizophrenia, posttraumatic stress disorder, and substance dependence. For decades, researchers have been documenting substantial genetic contributions to serious mental disorders. Effective somatic treatments that alter brain functioning, such as medications and electroconvulsive therapy (ECT), also attest to the physical basis of psychiatric disorders. More recently, with the advent of neuroimaging, researchers are linking symptoms of psychiatric disorders to patterns of activity in different areas of the brain.

Here's where we need to be careful to keep our balance and avoid getting thoroughly swept up in the excitement of biomania. A potential trap: If it's biological, it's out of my control. *All* action, from playing tennis to reading this article, has a partly biological basis. Biology per se is not contrary to agency; rather, *disordered* biological structure and function, such as occurs with disease, constrains agency to varying degrees. If you're debilitated by the flu, you cannot work. Likewise with psychiatric illness: You might be so enervated with depression that you can hardly get out of bed. Disease undermines agency to the extreme if you're rendered paralyzed or unconscious.

Sociologist Talcott Parsons brilliantly introduced agency into the domain of medicine by construing illness not only as a physical condition but also as a *social role*: "the role of the sick person is a socially structured and in a sense institutionalized role."[13] Parsons made several points. Being ill, you're legitimately excused from social and occupational obligations. Being ill, you also incur obligations. To remain legitimately excused, you must seek and cooperate with treatment so as to become well as soon as possible. Here's his most important point for our purposes: "the sick person…cannot reasonably be expected to 'pull himself together' by *a mere act of will*." Plainly, Parsons was emphasizing how illness constrains agency—you cannot recover by a mere act of will—while still according agency a crucial role in recovery.

Parsons surely had it right: Being ill, you can't just recover by *a mere act* of will. Don't lose sight of that point as we nudge you toward adopting greater agency for your illness. Think of it this way: You cannot recover by one monumental act of will, but you *can* recover by *many acts of will* over an extended time period. Recovery is especially difficult, of course, when you're affected by an illness like depression that saps your energy. Recovering on your own can be well nigh impossible; then you'll need help from others. Effective agents avail themselves of help when they need it.[14]

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Responsibility and Blame

By this point, if not from the very beginning of this article, you might be feeling defensive. Here's the potential wrong turn in the line of reasoning we've proposed: Agency entails freedom of choice, and freedom of choice entails responsibility. By implication, as the agent, you're responsible for your illness. Being held responsible, you might resent being blamed for something that's not in your control and not your fault. Alternatively, accepting responsibility for your illness, you might adopt a self-punitive attitude.

We believe this experience of feeling misunderstood and unjustifiably blamed happens all the time to persons with psychiatric disorders, and such blame is one of the elements contributing to stigma. Furthermore, even if you don't feel blamed by others, you might blame yourself. The problem of responsibility and blame is the main reason for the careful thought we're giving to the challenge of accepting agency for psychiatric illness. We're aiming for empowerment, not condemnation.

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Agency, Responsibility, and Moral Judgment

Initially, we invited you to juggle two perspectives, psychological and biological. Now we've introduced a third: the moral perspective. Here's how we get from agency to morality: Agency entails having choices and making decisions. Thus agency entails responsibility; you're accountable, always open to having to justify your actions with reasons. Value judgments come into play here: As a self-governing agent, you'll be evaluated negatively when your self-governance is deemed faulty, that is, when others believe that your actions aren't justifiable.[15] Then you're open to criticism.

When our actions have an adverse impact on others or our relationships, we enter the domain of *moral* judgments, potentially moving from responsibility to moral blame. Contemporary American philosopher Daniel Dennett defined a responsible *moral agent* as one who "chooses freely for considered reasons and may be held morally accountable for the acts chosen."[16] Thomas Nagel spelled out this relation in more detail:

We cannot evade our freedom. Once we have developed the capacity to recognize our own desires and motives, we are faced with the choice of whether to act as they incline us to act, and in facing that choice we are inevitably faced with an evaluative question. Even if we refuse to think about it, that refusal can itself be evaluated….The applicability to us of moral concepts is the consequence of our freedom—freedom that comes from the ability to see ourselves objectively, through the new choices which that ability forces on us.[17]

As you well know from having struggled with psychiatric illness, to the extent that you're perceived as a free agent—making choices and thereby held responsible for your depressive withdrawal, manic spending sprees, compulsive rituals, or addictive behavior—you've been judged; perhaps resented, criticized, and blamed. Even if you've been spared from others' criticism, you might have berated yourself.

Recognize that we're grappling with a problem that's long bedeviled the social view of psychiatric disorders. Are these true illnesses or moral failings? Alcoholism is the most glaring

example: Disease or sin? How about depression: Illness or laziness? You might be surprised to learn that the concept of illness has a moral edge to it. Look up "ill" in the dictionary, and you'll find these archaic connotations: "morally evil, wicked, depraved."[18] In this sense, we continue to refer to some persons as "ill tempered" or "ill willed." With these condemnatory connotations in the background, it's no wonder that modern psychiatry considers itself enlightened in regarding psychiatric disorders as brain diseases rather than moral failings.

Yet, as advocates of agency, we have no desire to escape the moral arena by focusing all our attention on the brain. On the contrary, we must take this bull by the horns. That's because, short of being unconscious, you're an agent. The stakes are high. Sacrificing agency to biology for the sake of circumventing value judgments is a costly idea. Helplessness is a high price to pay. Gaining a sense of power over illness demands agency, and agency entails moral evaluations.

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Striving for Balance

Being unable to escape value judgments, it's crucially important to judge properly. Specifically, *to get the moral perspective right, we must evaluate the degree to which illness constrains agency for any given person at any point in time*. Given our limited—albeit growing—understanding of the extent of biological disease in psychiatric disorders, properly estimating the degree is no small challenge. Consciously or unconsciously, patients, family members, and mental health professionals make more or less educated guesses about the extent to which illness and disease constrain agency, and moral judgments accompany these estimations. For example, being depressed, you might retreat to your bedroom rather than joining the family gathering. Some family members might feel hurt and critical (you don't care enough to make the effort); others might be more sympathetic (you don't have the energy because you're so depressed). Such judgments are difficult to make—even for the depressed person.

Walking a tightrope in relation to agency, we can make two serious mistakes: taking responsibility for things we can't control, and failing to take responsibility for things we can control. The venerable serenity prayer captures the challenge: "God grant me the serenity to accept the things I cannot change, the courage to change things I can, and the wisdom to tell the difference." We must strive to get the extent of agency and responsibility right; we need knowledge as well as wisdom. Yet, with limited biological knowledge, we inevitably resort to guessing about the extent of biological disease in mental illness, the extent of constraint on agency. Here we might be guided by a broad historical trend in neurobiological research on psychiatric disorders, which increasingly reveals the extent of disordered biological structure and function associated with mental illness. Historically, we've tended to underestimate the role of disease, erring in the direction of blaming persons for actions over which their control was more limited than we knew.

Consider how knowledge of recent research findings might make a difference in the following situation. A wife burdened with household responsibilities on top of a demanding job increasingly resents her depressed husband's lack of participation in managing the family finances. Researchers are now linking major depression to compromised functioning of the prefrontal cortex,[19] an area of the brain that not only regulates emotional distress but also plays a prominent role in "executive" functioning—deliberating, planning, decision making and complex problem solving.[20] Would appreciating the role of impaired brain functioning in depression influence his wife's judgments and feelings about her husband's ostensible abdication of responsibility? Would this knowledge also temper his self-criticism?

In trying to judge the extent of agency and illness, only one thing is fairly certain: We'll get it wrong if we think in terms of absolutes—either agency without constraint or no agency at all.

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Compassionate Criticism
Here's the tightrope we walk: Can we increase the sense of agency — and responsibility—for illness without invoking blame and condemnation? We're not attempting to avoid all criticism; on the contrary, we encourage a self-critical perspective. The challenge, as with all criticism, is to engage in *constructive criticism*.

Being morally responsible for actions with harmful results implies that you reevaluate and change; it does *not* require that you suffer or be punished as a consequence.[15] Self-reproach and guilt feelings can motivate constructive change; yet many persons struggling with psychiatric disorders already feel a crushing sense of guilt and shame—taking upon themselves the harshest moral connotations of illness. Overpowering shame will undermine agency, whereas we aspire to enhance it. Ideally, appreciating the full extent of your agency in your illness, you'll feel challenged, not reproached.

We've taken pains to sort out the moral perspective in relation to degrees of agency and constraints to set the stage for you to consider the extent of your active role in creating and perpetuating your illness. If we've succeeded, you'll be thinking open-mindedly in terms of degrees, moving from self-reproach to constructive self-criticism tempered with compassion and common sense, all for the purpose of taking up the challenge of recovering and remaining well.

Agency in Becoming and Remaining Ill
Now we're prepared for the hard part: the active role you may play in being ill. Here's where we must be especially careful with responsibility and blame. The mitigating factor is this: You can *unwittingly* play a role in being ill. We're into the realm of unconscious motivation and, as we've already foreshadowed in emphasizing self-conscious rational agency, an important part of treatment is to make the unconscious conscious, thus expanding the dominion of agency. Here we distinguish between the *creation* of illness and the *perpetuation* of illness.

A Role in Creating Illness
To reiterate, illness is something that happens. We fall ill or come down with illness against our wishes. It's rare, although not unheard of, for persons deliberately to make themselves ill. Most often, whatever active role we play in creating illness is unintentional. Yet we must bring this active role to light. If, in hindsight, you can discern how your thoughts and actions may have unwittingly contributed to the development of your illness, you'll be in a better position to recover and remain well. If you can see how your thoughts and actions played a part in creating your illness, you can better avoid re-creating it in the future in the form of a relapse or recurrence.

To appreciate the potential role of agency in the creation of illness, consider contemporary philosopher Robert Solomon's perspective on the development of alcoholism:

one creates oneself through his or her actions whether or not these actions are knowingly so directed, indeed, whether or not these actions are even fully intentional. A person does not take a drink in order to become an alcoholic, but this may be the end result and, at some point, one might well say (unsympathetically) that he has 'made himself' what he is. Indeed his drinking itself may soon become 'incontinent,' against not only his better judgment but even, in an obvious sense, against his will. Nevertheless, he has created himself, made himself into what he is.[21]

Solomon plunges us directly into the moral perspective. We advocate a sympathetic attitude, but this doesn't preclude criticism or self-criticism. Solomon's example is instructive in illustrating a shift from greater agency (early drinking behavior) to lesser agency (addiction). Recovery restores the alcoholic's agency, evidenced by the freedom to refrain from taking another drink. But the addict remains vulnerable; taking the first drink is liable to radically undermine—but not entirely obliterate—agency. How many drinks it takes to completely obliterate agency is an interesting question, and individuals doubtlessly differ from one another in this regard.

We can draw a parallel to alcoholism in considering the development of depression. Psychiatrist Michael Thase and colleagues construed depression as reflecting "the brain's response to sustained stress." [22] Some of the stress that contributes to depression is unavoidable—losses and hardships too numerous to contemplate.[23] Yet a substantial amount of stress that contributes to depression is partly a result of actions; *some degree* of agency is involved.[24] Prime examples are recurrent interpersonal conflicts and a self-chosen stressful lifestyle.

Of course, you don't work yourself to the bone and sacrifice your own health for the *purpose* of becoming depressed, just as the prospective alcoholic doesn't start drinking for the purpose of developing alcoholism. Yet, looking back and taking stock of your life, you could see your illness as an unwitting creation; an agent was involved, namely, you. Your unwitting actions played some part in the development of your illness. In the process, as Thase and colleagues proposed, the sustained stress may have altered the structure and functioning of your brain, just as addiction to alcohol and drugs will do.[25] Paralleling addiction, depression erodes your agency. Once stress has put your mind, brain, and physiology into what psychiatrist Aaron Beck[26] aptly called the depressed *mode*, you're ill. Then you can't just turn it all around by a mere act of will.

We worked with a patient who entered the hospital in a suicidal state after reaching a level of utter desperation with his escalating anxiety. He'd gone into investment banking with his father, who subsequently developed emphysema, which sharply curtailed his father's day-to-day involvement with the business. His high-powered father had been characteristically domineering and critical, and the patient had become increasingly resentful—indeed, quite often infuriated with him. Unbeknownst to his father, who was financially conservative, the patient made a huge investment that went sour. In a frantic effort to recoup his losses before his father found out, he began making increasingly risky investments, only getting deeper into the hole. Throughout, he'd seen himself as the victim of circumstances, stressed out and suffering from panic attacks. In the course of his hospital treatment, when he came to see how his resentment toward his father played a significant role in his squandering the funds of the firm, he saw himself as an agent in the development of his illness. He could see his pattern of reckless investing as an *aggressive action*. Of course, his evolving illness eroded his capacity to make sound decisions; illness increasingly constrained his agency.

To repeat, the purpose of discerning the role of agency in creating illness is not to assign blame but rather to expand your realm of control. Recognizing his penchant for aggressive retaliation gave the patient greater control and decreased the likelihood of his repeating this potentially catastrophic behavior in the future. Thus it's helpful to consider the possibility that, coupled with your biological vulnerabilities, your actions—drinking when upset or engaging in behavior that contributes to stress pileup—unwittingly put you into an ill state that undermined your agency. A simple point: In treatment, you can translate hindsight into foresight, taking actions that promote health and refraining from actions that increase the risk of illness.

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A Role in Perpetuating Illness

Having become ill, you're suffering, and you want to become well. This obvious premise overlooks a ubiquitous phenomenon, *resistance* to treatment. As psychiatrist Glen Gabbard put it, resistance "defends the patient's illness" and is based on "an attempt to avoid unpleasant feelings."[27] What could be more unpleasant than suffering illness? Paradoxically, it turns out that change can be even more unpleasant than illness. In Gabbard's words, a "major principle of dynamic psychiatry involves the patient's wish to preserve the status quo, to oppose the treater's efforts to produce insight and change." Of course, resistance isn't based on a wish to preserve the status quo for its own sake but rather reflects fear of change.

Freud discovered this seemingly paradoxical phenomenon of resistance. Patients came to him in a state of suffering, seeking his help. He told them what to do to get well and quickly discovered that they didn't do it. Here's what he asked them to do: Lie down on the couch and free associate—just say whatever comes to mind. If you think about doing this for a moment,

you'll empathize with his patients' resistance. Censoring quickly came into play—but seemed to be defeating the very treatment that the patient had sought.

We now think of resistance broadly as actions that block treatment efforts. Agency thus comes into play, and these actions can be more or less conscious. Examples of resistance are numerous, ranging from forgetting to take medicine to avoiding discussing painful but crucial topics in therapy sessions. Such actions, witting or unwitting, run contrary to exerting agency in the service of recovery. When unwitting, we look for unconscious motivation and try to bring it to light, so as to expand the realm of agency, removing obstacles to recovery.

In fact, there are many reasons why sufferers actively perpetuate illness or passively avoid actions that would speed recovery. One general reason, going back to Freud, is *secondary gain*—the benefits that accrue from illness. We'd not be surprised if a person struggling with a long medical illness were a bit ambivalent about recovering if that meant returning to a detested job. As Parsons said, illness provides a legitimate excuse. But some ill persons stretch this legitimacy to the limit—or beyond. The same applies to persons with psychiatric disorders.

Sometimes there's no subtlety in the process of perpetuating illness. Addictions are a prime example: The temptation to relapse is ever-present. We can see the role of agency here, as the person who is addicted to drugs may do various things to set the stage for a relapse: actively avoiding 12-step meetings, hanging out in bars, and seeking contact with friends who use drugs. Similarly, persons with bipolar disorder may welcome some aspects of the manic state, such as enhanced productivity and increased involvement in pleasurable activities. One route to a manic episode is to stop taking anti-manic medications. Others include getting too little sleep or diving headlong into a pattern of hyperactivity, such as by seeking risky adventures like gambling or reckless investing.

But it's also common for persons to perpetuate illnesses that entail more blatant suffering. Many persons struggling with chronic depression also feel ambivalent about recovery. As already noted, depression is typically a response to a huge pileup of stress—a kind of collapse or crash.[8] The depressed person withdraws, isolates, and retreats. Recovering from depression entails facing what seemed to be insurmountable problems and putting yourself back into the arena of stress. And recovery also commonly requires that you decrease stress, sometimes having to make painful decisions that entail losses, such as giving up valued activities or positions. Furthermore, reducing interpersonal stress often requires confronting conflicts in relationships. Depressive retreat, although it entails suffering, feels safe in its sheer familiarity. It's a "comfortable" cocoon. Hence depressed persons may simultaneously desire to recover and fear recovery owing to all the challenges recovery entails.

Thus there's some validity to the idea of choosing—however ambivalently—to remain ill. In this instance, your actions oppose treatment; more or less unwittingly, you use your agency to block change. Choosing actions that speed recovery may be difficult; there's choice, but they're hard choices. A crucial part of treatment is bringing resistances to light so that greater agency can be brought to bear on recovery. Keep in mind what Freud discovered: Resistance isn't the surprising exception; it's the norm. Illness has its benefits, and health has its costs. Change is always anxiety provoking, especially when old patterns have had considerable survival value.

But you've sought treatment with the intention of recovering and, however large or small a role it has played in the development and perpetuation of your illness, agency will play a paramount role in recovering and remaining well.

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Agency in Recovering and Remaining Well

Recall Parsons's point that illness legitimately excuses you from some obligations while conferring another major one: to seek treatment so as to become well. We're back to the moral arena. You'll be spared resentment and criticism to the extent that you're perceived as actively working toward recovery. And recovery from psychiatric illness generally requires an

exceptionally active effort over a considerable period of time. After discussing the absence of agency—incapacitation—we'll distinguish several levels of increasing agency, ranging from active participation in diagnosis to maintaining your health after recovery.

Incapacitation
If you're severely injured and immobilized in a car wreck, you must be transported to the emergency room, perhaps needing a blood transfusion and surgery. Your role is to lie quietly and keep breathing. Similarly, if you're in a floridly psychotic state, completely out of touch with reality, you may need to be transported to an emergency room, contained, and given intramuscular medication. In such instances, some degree of recovery may be needed before you can adopt any meaningful sense of agency. The same applies to severe depression and to addiction. You may be so ill that the concept of agency hardly applies.

Yet, while struggling with illness, some patients present themselves as more incapacitated than they are—as victims rather than agents. For example, a young woman with bipolar disorder had struggled with a gambling addiction since mid-adolescence. She married a man who was working two jobs to purchase a home that would allow them and their young son to move out of their cramped apartment. After numerous failed attempts to persuade her to stop gambling, her husband's patience wore thin, and he filed for divorce. Panicked, she came for treatment. But she was outraged: "How could he divorce me for gambling when he knew I had bipolar disorder?" Was she completely incapacitated by her bipolar disorder? Difficult and painful choices or no choice? Psychology and biology, agency and disease conspire here—in what proportions? These are hard questions. Inescapably, her husband made a moral judgment and acted accordingly.

Agency in Diagnosis and Finding Treatment
The first step toward recovery is determining just what's wrong. Not necessarily easy. You might have confusing or fluctuating symptoms that are hard to diagnose. This may be true of general medical symptoms as well as psychiatric symptoms. And these may overlap. Symptoms like depression and anxiety, for example, may be caused by a general medical condition, such as a hypothyroid or hyperthyroid. Imagine blaming yourself for being lazy or hypersensitive only to discover that your thyroid is out of whack. You'd have erred on the side of taking too much responsibility, giving short shrift to disease and its constraints.

Even without the involvement of general medical conditions, psychiatric symptoms can be challenging to diagnose. Not infrequently, patients struggle with a combination of symptoms and problems like the following: mood disturbance, such as depression, in conjunction with anxiety; problems concentrating and confused thinking; recurrent interpersonal conflicts; excessive use of mood-altering substances; and side effects of prescribed medications. It's hard to know what's causing what.

In the face of such hard-to-diagnose symptoms, you might need to exert considerable effort over an extended period of time to find proper treatment. You'll need to find a doctor and perhaps to seek out experts and investigate specialized treatment centers. You may need to take distressing or painful diagnostic tests. Throughout the process, you'll need to provide a history of your illness and records of previous diagnostic and treatment interventions. You're likely to be grappling with dauntingly cumbersome insurance matters. And you'll need to do all this when you are ill—perhaps apprehensive, frustrated, and exhausted.

Consider the agency involved here from the moral perspective: Given the obstacles and the extent of your illness, having taken on these challenges is downright admirable. Of course, the more ill you are, the more constrained your capacity for agency will be, and the more help you will need from others. Seeking help also calls upon agency. Having found treatment, take credit for all you've done on your behalf.

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Agency in Accepting Treatment
Seeking treatment voluntarily exemplifies agency and may be the single most crucial action

you take. At the most minimal level, agency for recovery entails merely allowing yourself to be treated rather than actively fighting treatment. Of course, you might find even this minimal level of agency to be difficult; you might feel threatened, frightened, or resentful.

Yet, difficult as it may be, merely accepting treatment—taking the role of patient—may not go far toward agency. Indeed, the terms, "agent" and "patient" are sometimes construed as antithetical. Minimal agency would be this: You enter the hospital, imploring your doctor, "Fix me!" This is not an entirely unreasonable attitude. When you're ill, you want someone to do something that will make you feel better. Ideally, starting in childhood, you've had experience that fostered this wish and attests to its reasonableness. When you were sick, someone took care of you. To a degree, the same attitude remains eminently reasonable with regard to many general medical illnesses in adulthood. But it's rarely appropriate for psychiatric disorders.

Agency in Taking Medication

Given the potential ordeal of figuring out what's wrong and finding appropriate treatment, you might have had enough of agency! Most often in modern psychiatry, the wish to be "fixed"—as a patient rather than an agent—is expressed in the desire to find the proper medication. Psychiatrists share this desire with their patients.

Notice, however, that agency plays an important role here. Medication can't help you if you don't take it. Agency often fails at this juncture; medication compliance in all areas of medicine is notoriously poor. Yet, difficult as it may be, taking medication as prescribed fails to do justice to the extent of agency involved. Not infrequently, you and your psychiatrist often will need to experiment with different medications and doses. You'll need to endure and keep track of side effects, reporting them to your psychiatrist. Concomitantly, you'll need to keep track of benefits. And you may need to do all this over a long time. Moreover, you're likely to be encouraged to continue on medications for some time after your symptoms have abated. Again, the moral perspective: Such persistence is admirable, and you can give yourself credit for it.

Agency in Hospital Treatment

Having serious psychiatric disorders typically requires participation in a range of treatment interventions beyond medication, and such participation places an even higher premium on agency. Taking inpatient treatment as a model, you might participate in individual and group psychotherapy, educational groups, family therapy, and a range of therapeutic activities. If you're struggling with an addiction, you'll work hard in a 12-step program that encourages you to take ownership of your illness and to work the steps actively. And then you'll need to participate in formulating a discharge plan and a wellness plan.

Central to all psychotherapeutic modalities and a major determinant of treatment outcome is a *therapeutic alliance*, which we've construed as *active collaboration* toward goals established with your therapist.[28] Psychotherapeutic treatment requires active self-exploration, which often requires considerable courage. And participation in treatment entails active efforts to change longstanding patterns of behavior. You must actively confide in your therapists and fellow patients, likely revealing painful matters. You'll need to work on altering ingrained patterns of thinking. And you'll need to experiment with new ways of interacting with others. All your efforts to change will run up against emotional barriers—resistances.

To appreciate the role of agency in psychotherapeutic treatment, you might consider an analogy with obtaining a college education. You could go to college, plunk yourself down in a classroom, and take the attitude: Educate me! But all education is ultimately self-education; you must actively acquire knowledge and fit whatever you learn into whatever you already know, expanding your knowledge in the process. In the process of self-education, you need the help of knowledgeable experts—teachers and mentors. So it is with psychotherapeutic treatment. You engage in self-healing with the benefit of expert guidance.

This is easier said than done. Imagine attending college when you're psychiatrically ill. Illness constrains agency. Consider trying to go to college, for example, when you're profoundly depressed. So, too, depression interferes with benefiting from treatment—what we call the

catch 22's of depression.[29] Fortunately, although such illness constrains agency, it doesn't eliminate it. When you're severely depressed, you may not be in a position to continue in college—or to work or run a household—but you can participate in your recovery so that you can return to those other endeavors.

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Agency in Wellness

Many general medical conditions tend to be chronic or recurrent. Diabetes is a good example. It's not enough to get your blood sugar back into normal range; you must also work to maintain it, for example, by careful diet, exercise, and medication.

Many psychiatric disorders also tend to be recurrent. Mood disorders and substance abuse are prime examples. By taking agency for your illness, you can influence your odds of staying well considerably. Continuing to take maintenance medication and seeking psychotherapy and family treatment as needed play an important role in staying well.

But preventing recurrence of psychiatric disorders requires more than continued psychiatric treatment. Persons who have chronic physical illness such as diabetes are notoriously sensitive to stress. So too are persons who struggle with mood disorders, anxiety disorders, psychotic disorders, posttraumatic stress disorder, or substance abuse. Thus stress management is crucial in wellness, and you must weave it into your lifestyle. Your physical health plays a major role in your resilience to stress—your ability to cope without falling ill.[30] Sleeping and eating well, exercising, refraining from smoking and excess use of caffeine and alcohol, all play an important role. Maintaining supportive close relationships plays a crucial part in wellness. Being active on your own behalf to maintain good health—physical, mental, and spiritual—is extremely important.

Treatment Enhances Agency by Promoting Mentalizing

As humans, we have the *capacity* to function as rational self-conscious agents. But we don't always use that capacity and, as we've contended in this paper, failure to use that capacity contributes to psychiatric disorder. Treatment endeavors to enhance agency so as to foster recovery and wellness.

In a previous article, we described how *mentalizing*—understanding actions of oneself and others as based on mental states—plays a central role in treatment.[2] Here we describe how treatment relationships enhance agency by fostering mentalizing. To set the stage, we locate agency in the broader domain of rationality.

Rationality

In clarifying what we mean by free will, Dennet[31] proposed that people want some *elbowroom.* This metaphor neatly pinpoints the tension between agency and constraint. You might think of using treatment to increase your elbowroom, to expand your freedom of choice and flexibility. Instead of exploding in a rage or reaching for the bottle of liquor at the moment you feel angry, you can consider more effective coping skills. But you need mental elbowroom to do so.

Agency requires elbowroom. As we noted earlier, all animals are agents, but we humans are *rational* agents; our actions are governed by reasons.[15] Our capacity for rational action is based on shifting from our usual subjective perspective to a more detached, objective perspective—in Nagel's words, "stepping back and taking ourselves as objects of contemplation."[17] Constructive self-criticism, for example, requires this capacity for objectivity. Our rationality gives us a great deal of *potential* elbowroom, but we must cultivate and make use of it.

We're hardly breaking new ground in advocating rationality.[7] As rational agents, we employ judgment,[32] anticipating the consequences of our actions and conforming our behavior to these anticipations: "I'd better cool off before confronting him about this to avoid a blowup." We reason about our desires: "Do I *really* want to do this?" We employ reasoning to *alter* our desires: "Do I really *want* to want this?"[33] We even reason about our reasons: "Is this a good

enough reason to consider divorce?" Most commonly, and often with great effort, we use reasoning in the service of prudence, bolstering our resolve to refrain from immediate gratification for the sake of longer-range satisfactions: "I'd rather have a few beers than study, but it's more important to pass the course."

Plainly, much of treatment fosters agency by promoting rationality. In psychotherapy, for example, we continually explore—and question—reasons for beliefs, feelings, and actions. We promote rationality in the frequent injunction: Think before you act.

In advocating rationality, we don't want to ignore emotion. Two millennia of philosophy pitted reason against passion, and no one doubts that strong emotions can undermine reason—and agency. Yet we don't equate rationality with cold logic. On the contrary, in keeping with contemporary philosophy and psychology, we believe that reason must be informed by emotion.[34] Without gut feelings to guide us, we're unable to make sound decisions.[35] Thus, rather than striving for reason unencumbered by passion, we might aim for passionate reasoning and reasonable passion.[8] Put differently, we might aspire not to become *un*emotional but rather to become *intelligently* emotional.[36]

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Mentalizing

Problems in your relationships—not just how you relate to other persons but also how you relate to yourself—play a paramount role in psychiatric disorders. Much of treatment entails becoming aware of longstanding patterns of thought and action that unwittingly perpetuate these problems. As just discussed, in treatment, we explore reasons behind these patterns. Much of the reasoning we do in treatment revolves around making sense of mental states in oneself and others—what Peter Fonagy, director of research in the Menninger Child and Family Program, calls *mentalization*.[37] Mentalizing is the domain of rationality of greatest relevance to psychiatric treatment.

Mentalizing entails interpreting actions as governed by mental states, such as desires, emotions, beliefs, and reasons. Most of the time you mentalize intuitively, for example, when you empathize with another person or engage in conversation, automatically taking the other person's perspective into account. When problems arise, however, it's helpful to reflect more deliberately. We call self-conscious reasoning about mental states *mentalizing explicitly*.[38] You mentalize explicitly, for example, when you put your feelings into words, as you will do continually in psychotherapy.

We can best appreciate the role of mentalizing in agency from a developmental perspective. Of course, our human capacity for sophisticated agency—self-governance—is a feat of evolution, biological and cultural.[16] And each of us individuals must develop this capacity anew. We don't emerge from the womb as self-conscious rational agents. Rather, agency develops in degrees. Fonagy and his colleagues spelled out five levels in the development of agency. [39] From the start, infants are *physical agents*, capable of exerting force that brings about physical changes, for example, moving their own limbs as well as objects in the environment. Also, being sensitive to the interpersonal world from birth, infants quickly become *social agents*, for example, discovering that their emotional expressions, such as crying, influence their caregivers' behavior. At around 8-9 months, infants become *teleological agents* (from the Greek, *telos*, meaning purpose); they're capable of interpreting actions as being rationally goal directed. For example, the 9-month old knows that the rational way to get from point A to point B is a straight line and becomes perplexed when an agent takes an unnecessarily circuitous route.[40]

During the second year, infants become *intentional agents*, capable of interpreting goal-directed actions as caused by mental states such as desires and feelings. Finally, at about 3-4 years of age, infants become *representational agents*, that is, mentalizers capable of interpreting goal-directed actions as guided by mental representations, such as beliefs—including false beliefs. To illustrate, imagine that Sally sees Billy put a box of cookies in the cupboard, after which he leaves the room. While Billie is out of the room, Sally sees their

mother take the cookies from the cupboard and put them in the freezer. When Billie comes back to look for the cookies, Sally anticipates that he'll look in the cupboard, based on her understanding of his false belief. Children who have not become such full-fledged mentalizers would expect Billy to look in the freezer—confusing Billy's state of mind with their own knowledge of reality. Mentalizers can imagine others' states of mind as separate from their own—something we must continue to do throughout life, and not always without effort.

Mentalizing capacity is central to rational agency in two senses. First, awareness of your own mind—desires, impulses, emotions, beliefs, and reasons—is essential to being a *self-conscious* rational agent. You'll have a hard time reasoning about your actions if you don't know your own mind. And knowing your own mind isn't something you can take for granted; you'll work hard at it in treatment and, hopefully, thereafter in everyday life. Second, a crucial domain of agency involves interacting effectively with other persons. Relationships go best when we *mentalize interactively*, when each person has the other person's mind in mind. Indeed, it's by virtue of such interactions—most prominently in attachment relationships—that we begin developing the capacity to mentalize in infancy.[41]

Consistent with our view that reason is best married to passion, our highest aspiration in treatment is fostering the capacity to *mentalize emotionally*.[8] Mentalizing emotionally entails remaining self-aware and aware of others' mental states when you're in the throes of strong emotions—anxiety, frustration, shame, and the like. To put it plainly, as Fonagy and colleagues have done, mentalizing emotionally requires feeling and thinking about feeling at the same time.[39]

As we've said, strong emotions tend to erode our agency. When we're feeling panicky or furious, we're more inclined to act impulsively or thoughtlessly—"irrationally," not acting on the basis of "considered reasons," as Dennet put it. Sometimes, of course, automatic emotionally-driven actions are most adaptive, as when the fight-or-flight response ensures we'll quickly get out of harm's way. Most often, however, we're best guided by ongoing reappraisals of our unfolding emotions.[42]

In the midst of strong impulses or emotions, it's often essential that you refrain from instinctive action—such as lashing out—and push a mental *pause button.*[8] In so doing, you interrupt yourself to give yourself more elbowroom—leverage over yourself—before you plunge into ill-considered and potentially destructive or self-destructive action. Pushing the pause button entails mentalizing emotionally, being self-aware in the midst of emotion. Self-awareness promotes self-governance—agency. Quite often, you'll be struggling with strong emotions in the context of interacting with other persons, in which case mentalizing emotionally requires that you be aware of their mental states as well as your own; you'll be mentalizing *interactively* as well as emotionally. In short, relationship conflicts are best resolved by two passionately reasoning agents mentalizing interactively and emotionally.

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Treatment Relationships and Mentalizing

As we indicated at the outset, a wide range of treatment interventions, including taking medication, bolster agency. Yet hospital treatment revolves around interpersonal relationships, interactions with staff members and fellow patients. There's good reason for this: Mentalizing isn't a solitary activity. As noted earlier, we become mentalizers in the context of relationships. In early infancy, mentalizing develops nonverbally; as infants, we begin to learn what we feel by means of feedback from our caregivers' emotional attunement.[41] In early childhood, in the course of becoming representational agents, we learn to talk about what we think and feel.[43]

We continue to need relationships throughout life to support our mentalizing capacity. We continue to need emotional mirroring and dialogue. Self-awareness doesn't flourish in social isolation. Often, in the throes of troubles, you don't know what you think and feel until you talk a situation through with a trusted confidant. So it is in treatment: Through interactions with patients and staff members, you come to know your own mind.

As Fonagy and colleagues' work has shown, mentalizing develops optimally and continues to flourish in the context of *secure attachment* relationships, that is, relationships in which you have confidence that, when you're distressed or ill, the other person will be emotionally responsive—will have your mind in mind. Much of treatment is devoted to working on interpersonal conflicts for the purpose of fostering more secure attachment relationships. There's an important synergy here: Not only does secure attachment facilitate mentalizing but also mentalizing promotes secure attachment. Thus developing your capacity to mentalize emotionally in close relationships—for example, in group therapy, psychodrama, and family work—plays a key role in building secure attachments.

Agency in Hope

To recapitulate, we started from the premise that treatment must address your willingness to accept agency for your illness. Accepting agency for your illness, you recognize that, to a greater or lesser degree, you've played an active—if unwitting—role in the development and maintenance of your illness. Through agency you give your illness meaning; you're not only struggling with disease but also with problems in living that begin to make more sense. And accepting agency for your illness means that you play an active role in recovering and remaining well. Ideally, in the process you become an increasingly self-conscious—and other-conscious—emotionally rational agent.

We noted at the outset that, in being empowering, agency affords hope. To continue a theme we've been developing, hope requires a marriage of reason and emotion.[8] Psychiatrist Karl Menninger, for example, construed hope as involving a motive force (emotion) for a plan of action (reason) that has prospects of succeeding.[44] Germane to our terminology, psychologist Rick Snyder proposed that hope combines *agency* (the emotional motive force) and *pathways* (the reasoned plan of action).[4] In Snyder's view, agency refers to determination and commitment, providing the energy and drive; pathways provide a sense of direction. In emphasizing rational self-conscious agency, we've put more reason into the engine of hope. Agency entails meaning making, which itself provides some direction.

Oncologist-hematologist Jerome Groopman defined hope as "the elevating feeling we experience when we see—in the mind's eye—a path to a better future."[45] With increasing agency to overcome the constraints of illness, you're freer to move forward along this path.

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