

WISSENSRAUM NO. 10

DEPRESSION AS A BLOCKED TRANSITION

When life loses its inner mobility

“Healing begins with the first transition that can be experienced again.”

AKADEMIE DER WEISHEIT — WISSENSRÄUME

◆ 1. When the Next State Becomes Unreachable

Thoughts return to the same place. Exhaustion finds no way into recovery. Feelings scarcely change.

Anyone trying to describe depression usually begins with a definition: a mental illness, marked by this symptom and that. But before a name is found, something quieter happens. The future no longer appears as a space of its own but as a mere extension of the present, and even where movement still takes place outwardly, inner experience keeps returning to the same place.

From this arises the real question of this Wissensraum: What happens to a person when the next inner state exists in theory, yet remains almost unreachable for them? What stands at the center is not the absence of feeling, nor a single missing thought. It is the loss of movement between states itself — that quiet transition which otherwise lets a person be someone different tomorrow than today, without ceasing to be the same person.

For this loss, this Wissensraum introduces a term meant to carry the argument throughout: the blocked transition. It names no new illness and no new diagnosis. It names a way of looking — the attempt to see in depression not primarily a disorder of mood, but a disorder of the very capacity by which a life can change at all without losing itself.

The word blocked itself deserves a closer look here. It sounds binary, as though there were only two states: transition present or transition prevented. Experience itself is more finely grained. A depression can slow, narrow, hinder, decouple, or subjectively place a transition out of reach — gradations that differ markedly in lived experience. Blocked transition is therefore less a claim of complete standstill than a guiding image: a person can function outwardly and still barely experience transition inwardly.

Depression stands at the beginning of this text not as a diagnosis and not as a case description, but as a quiet starting point: it changes what a person can still reach of their own next possible state. From here, this Wissensraum approaches being human through transition, coherence, and relationship, and asks what carries a person when the next step seems unreachable: their knowledge, their relationships, their will — or that quiet transitional capacity which remains, even when it cannot be felt right now.

“A person can function outwardly and still barely experience transition inwardly.”

◆ 2. Depression — Clinical Picture, Variety, and Human Experience

However philosophical this Wissensraum becomes from here on, it begins deliberately on medical ground.

Depressive disorders can, among other things, involve depressed mood, loss of interest and pleasure, changes in sleep, loss of energy, difficulties with concentration, feelings of guilt and worthlessness, psychomotor changes, and thoughts of death or suicide. This clinical level is indispensable, for it carries diagnosis, treatment, and care — fields no philosophical reflection can or should replace.

The model of blocked transitional capacity is therefore not a medical definition of depression. It replaces neither diagnostics nor existing explanatory and treatment models, but stands alongside them as an additional, philosophical-anthropological perspective. This deliberate boundary protects the model's own integrity: it does not try to explain what depression is neurobiologically or psychodynamically, but to make understandable what happens to a person when transitions life would otherwise bring forth on its own become blocked.

What appears here as a single clinical picture is, moreover, in reality no uniform occurrence. Depressive disorders are more varied than the collective term suggests: the single depressive episode, recurrent depression with returning phases, chronic courses, depressive episodes within bipolar illness, depression with psychotic features, seasonal and peripartum forms, and depressive symptoms in connection with physical illness, medication, substances, or other mental disorders. This is not a textbook page but an epistemic consequence.

To speak of depression is to gather under one term experiences whose origin, course, severity, and treatment can differ considerably. The blocked transition therefore names no uniform disease process. It describes a possible structure of experience that can occur within very different depressive states — a shared space of experience, not a diagnostic category of its own.

“A shared space of experience — not a diagnostic category of its own.”

◆ 3. Transitional Capacity — A Basic Structure of the Living

At the origin of the model stands no observation of the ill, but a far more fundamental question.

It comes from Pierre Kuchenbecker, and at its core it asks:

“What underlying structure must remain invariant for continuous state transitions to exist at all?”

This question seeks no explanation of depression at first. It asks something more basic: What must be preserved for change to be possible at all? A state A becomes state B — childhood becomes youth, closeness becomes distance, activity becomes rest, an injury becomes a memory, grief changes its shape, certainty becomes doubt. An identity keeps changing, and the person still experiences themselves as the same person.

In precisely this observation lies the origin of the actual model: the puzzle of the living is not change itself, but the fact that it can happen without tearing apart the coherence of a life. From this question grows the true heart of this Wissensraum: the concept of transitional capacity.

Transitional capacity means more than adaptability or resilience. It names the possibility of changing while preserving coherence — not by a person staying the same, but by remaining connected to themselves across every change. Four dimensions can be distinguished within it: the present state, the transition, the coherence that carries this transition, and the new form that emerges from it. None of these four stands alone. A state without transition freezes; a transition without coherence tears identity apart; and a new form with no relation to the one before it would not be transformation but rupture.

“Life preserves itself through transformation. Its constancy is grounded in the capacity to carry coherence through every change.”

This sentence has become the core of the entire body of material from which this Wissensraum grew. It describes no exceptional situation, but the quiet, underlying order by which a life ordinarily proceeds — so self-evident that it becomes visible only where it is missing.

Transitional capacity means neither permanent change nor an obligation to develop. Made into the sole measure, it would easily produce a narrow picture: healthy equals mobile, ill equals immobile. The living equally needs the capacity to remain. Grief need not transform as quickly as possible. Exhaustion may demand rest. Pain need not be transformed at once. What matters is the freedom of transition: being able to stay without being trapped, and being able to change without losing oneself.

◆ 4. Depression as a Disturbance of Livable Transitions

Only from here can we understand what is actually blocked in depression.

Emotionally, feelings lose their mobility or seem frozen. Cognitively, thoughts circle and produce few new perspectives. In time, the present feels endless while the future loses its character as possibility. Physically, drive and scope for action can be considerably reduced. Relationally, contact reaches the person less easily, or is hard to answer. And existentially, the next state of one's own life becomes almost unimaginable.

This is a far more precise statement than saying depression is standstill. For biologically and psychically, a great deal continues to happen during this time — the person is not resting, they are struggling. What is blocked, in this model, is above all the felt possibility and the actual carrying out of transition: the next state may well exist, but it can be neither felt nor reached.

“The next state may well exist, but it can be neither felt nor reached.”

◆ 5. Time Loses Its Direction

In this view, depression does not affect mood alone. It changes one's relationship to time itself.

What is ordinarily experienced as yesterday, today, and tomorrow condenses subjectively into a single, repeating present: today, today, today. The future then hardly retains the character of an open possibility; it feels instead like the mere continuation of what already is.

From this arises one of the hardest questions this model poses. Hope presupposes a difference — the notion that something could be other than it is now. Where that difference can no longer be felt, the word hope, too, loses its usual footing. This is precisely why well-meant reassurance so often falls flat: it speaks of a future the person in this moment cannot experience as their own.

“What does hope mean when the future can no longer be experienced as different from the present?”

◆ 6. Between Knowing and Doing — When the Transition into Action Is Missing

A person can recognize a path and still have no access to its first step.

A person living with depression may well know what might possibly help them — getting up, calling someone, moving, waiting for a situation to pass. And still, the step does not happen. This is something other than a lack of will or insight. Some people, in this time, do not know what could help them; others can name possibilities in thought but do not experience them as within reach. Between recognizing and enacting lies a transition of its own, and precisely this transition can be blocked without the knowledge of the possibility being lost.

The body, too, continually performs transitions: from sleep to waking, from rest to activation, from hunger to satiety, from tension to relaxation, from withdrawal to contact, from exhaustion to regeneration. Depression changes not only thoughts about the future but equally this rhythm, this activation, this bodily experienced possibility. Sometimes healing begins earlier than it can be thought — the first transition can happen in the body before a person names it philosophically or psychologically.

“Between recognizing and enacting lies a transition of its own.”

◆ 7. Relationship as a Space for Transition — the Borrowed Transition

A person does not generate transitions entirely on their own.

Another person can, for a time, carry something that is barely reachable in one's own experience: rhythm, time, relationship, possibility, movement. They need offer no solutions and force no comfort. Often it is enough that they stay, where the person affected cannot yet see a next step — and by staying, hold in trust a transitional capacity that is not felt in the moment but need not be gone.

Therapeutic and other professional accompaniment can, in this light, be understood as the opening of such spaces for transition — naturally in addition to the respective specialist treatment approaches, never in their place. This thought connects this Wissensraum directly with Wissensraum No. 7 — Beyond Listening: The Essence of True Presence, which is concerned with exactly that quality of staying present that does not want to be a solution, but a space.

Where a person can barely reach their own next possible state, relationship can carry the in-between space. The other does not walk the path in the affected person's place. But their presence can hold a connection to a possibility that the affected person cannot hold themselves right now — a borrowed transition that no one can force and no one can replace, yet one that helps bridge the time until one's own transitional capacity becomes felt again.

This thought connects depression with nursing, palliative care, education, accompaniment, and resonance alike: wherever a person cannot see their next step alone, another person can hold the bridge for a while, without having to walk it themselves.

“A borrowed transition that no one can force and no one can replace.”

◆ 8. The Smallest Possible Transition

From all this follows the practical center of this Wissensraum — and, at the same time, its most careful question.

It does not ask: How do I become again the person I once was? It asks: Which transition is possible now? From lying down to sitting up, from a closed window to an open one, from falling silent to a single sentence, from isolation to five minutes of encounter, from the thought “It will always be like this” to the barely different thought: “I don't know whether it will always be like this.”

The difference can be tiny in words. Structurally it is enormous, for at least two possible states exist again for the first time, instead of only one, unchanging one. Here the model gains its practical dimension — without becoming a self-help method, for it promises no outcome. It merely reopens the possibility that an outcome might be conceivable at all.

“Which transition is possible now?”

◆ 9. Healing as Regaining Movement

This model would use the word healing only with great care.

It claims no specific healing effect. Instead, it opens a different question: Must healing always mean returning? Or can recovery also mean that viable transitions become possible again and one's own space of possibility widens? The goal would then be neither the former self nor a state of lasting happiness. It would be, first and more fundamentally, to regain inner mobility.

Healing can be unfolded here into several questions that do not mean the same thing. Remission asks about symptoms. Functioning asks about daily life and participation. Recovery asks about the individual's life with and after the illness. Transitional capacity asks whether possibilities can be felt and carried out again. The model therefore need not claim what healing is. It asks a different, more modest question instead: Has a future come into being again?

This thought also connects to a larger body of work in which depression is already considered between illness, loss of identity, threshold, silence, and transformation — themes this Wissensraum only touches on, and which are explored more deeply elsewhere.

“Has a future come into being again?”

◆ 10. Where the Model Has Its Limits

An independent model of thought gains strength when it limits its own reach.

Depression cannot be fully explained through blocked transitional capacity. Biological, neuropsychological, social, biographical, and other factors remain independent, equally valid levels of explanation, which this model neither replaces nor relativizes. It describes a structure of experience and transformation — no more, but also no less. It claims no diagnostic category and no exclusive authority over the truth of a person.

Precisely because of this, it can be taken seriously: not because it explains everything, but because it knows exactly what it does not explain.

“Not because it explains everything, but because it knows exactly what it does not explain.”

◆ 11. From Depression to a General Model

Only here does the door open wide.

Transitional capacity concerns not only depression. It concerns relationship and separation, grief and loss, aging and illness, identity crises, education and learning, organizations and leadership, societal transformation, dying and death. What was a Wissensraum about depression thus becomes something considerably larger: an anthropology of transition.

Here, connections emerge to several existing Wissensräume in this series. Wissensraum No. 9 — Burnout in the Shadow of the Perpetual Motion Machine asks about the lost inner measure, when a life becomes mere administration. Wissensraum No. 8 — The Echo of Life asks about

finitude and presence. Wissensraum No. 7 — Beyond Listening asks about presence. And Depression as a Blocked Transition asks what carries a person from one reality into the next.

“*A Wissensraum about depression becomes an anthropology of transition.*”

◆ 12. When No Tomorrow Seems Reachable Anymore

Sometimes the space of possibility narrows so far that the transition into another future seems to vanish as well.

A wish to die can, in depressive experience, be bound to a radical narrowing of the space of possibility. The present state then appears permanent, and another form of life becomes subjectively unreachable — not because it is objectively impossible, but because it can no longer be reached inwardly. In this lies, directly, the model of this Wissensraum: the farthest-reaching blocked transition is the one toward a livable tomorrow.

At the same time, a distinction matters: a wish to die, passive thoughts of death, suicidal ideation, suicidal intent, and self-determined decisions at the end of life are not conceptually or clinically the same. This Wissensraum deepens only the level of experience considered here, in which the space of possibility within depression narrows so far that a livable tomorrow seems subjectively almost out of reach. The medical, ethical, and legal questions that go beyond this, concerning assisted dying, accompanied voluntary death, and assisted suicide, belong to a space of their own, set aside for that purpose, and are deliberately not pursued further here.

Where suicidal thoughts arise, professional help is available and necessary — an acute crisis is a medical emergency, not a philosophical topic.

◆ 13. The NOTHING as an In-Between Space

Here a very careful thread continues, one this Wissensraum only wishes to open, not to walk.

For a larger book project has long carried a related architecture: depression, the dissolution of the self, silence, emptiness, and the NOTHING are treated there as different levels of a shared threshold space. Its earlier prologue already works with the image of a person falling into depth and yet remaining part of a larger whole.

Yet a distinction is essential here: the NOTHING is not identical with depression. Depressive emptiness and philosophical Nothingness must not be confused with one another. And yet, at exactly this border, a question arises that touches both levels: What lies between a form that has

passed and a form that has not yet taken shape? That would be the bridge to a larger, independent work titled THE LOSS OF THE REALITY OF NOTHING — Depression and the Dissolution of the Self, which follows these threads further elsewhere.

The emptiness of depression and the emptiness of spiritual experience carry the same name and can yet denote fundamentally different realities. Where one closes off possibility, the other can open into expanse. To equate the two too quickly would mean either glorifying illness or pathologizing spiritual experience. What the in-between space demands, above all, is the capacity to distinguish.

“Suffering is no proof of transformation, and not every darkness is already a threshold.”

◆ 14. Conclusion — A Person Is More Than Their Present State

This Wissensraum wants to keep its ending deliberately quiet.

No ten pieces of practical advice. No positive resolution that covers what was heavy with a quick lightness. A state can occupy a person’s entire horizon — and yet a state remains something other than wholeness.

Between what has been and what has not yet taken shape lies that barely visible space in which transition can become possible again. Sometimes transformation begins precisely where a person cannot yet see a path.

“Life preserves itself through transformation — and sometimes transformation begins with a barely visible next step.”

∞ Further Exploration

Those who wish to pursue the questions touched on here will find adjacent explorations in the WISSENSRÄUME series:

- Wissensraum No. 7 — Beyond Listening: The Essence of True Presence (relationship as a space for transition)
- Wissensraum No. 8 — The Echo of Life (finitude and presence)
- Wissensraum No. 9 — Burnout in the Shadow of the Perpetual Motion Machine (the lost inner measure)

◇ Sources & Lines of Thought

This Wissensraum is not a scientific treatise. The following sources mark the professional and scholarly lines of thought to which its central statements connect — above all those of chapters 2, 4, 5, 7, 9 and 12.

- Bundesärztekammer, Kassenärztliche Bundesvereinigung, AWMF: Nationale VersorgungsLeitlinie Unipolare Depression [National Care Guideline on Unipolar Depression]. Version 3, 2022, AWMF register no. nvl-005. Clinical framework for diagnosis, treatment and care (chapters 2 and 12).
- World Health Organization: ICD-11, chapter 6, depressive disorders (6A70–6A7Z). Geneva 2019, in force since 2022. Classification of depressive disorders (chapter 2).
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). Washington, DC 2022. Criteria and forms of depressive disorders (chapter 2).
- Eugène Minkowski: *Le temps vécu. Études phénoménologiques et psychopathologiques*. Paris 1933. Altered experience of time in melancholia (chapter 5).
- Hubertus Tellenbach: *Melancholie. Zur Problemgeschichte, Typologie, Pathogenese und Klinik*. Berlin 1961. Lagging behind oneself (remanence) as a structural feature of melancholic experience (chapters 4 and 5).
- Thomas Fuchs: Temporality and psychopathology. *Phenomenology and the Cognitive Sciences* 12 (2013), 75–104. Disturbed temporality and the blocked future in depression (chapters 4 and 5).
- Thomas Fuchs: Depression, intercorporeality, and interaffectivity. *Journal of Consciousness Studies* 20 (2013), nos. 7–8, 219–238. Depression as a loss of bodily and interpersonal resonance (chapter 7).
- Mike Slade: *Personal Recovery and Mental Illness. A Guide for Mental Health Professionals*. Cambridge 2009. The distinction between clinical and personal recovery (chapter 9).

○ WISSENSRÄUME — Appreciation

The WISSENSRÄUME series is a labor of love — free of charge, but not to be taken for granted. If these impulses have spoken to you and you would like to give something back, a voluntary contribution is warmly welcomed: [PayPal.me/VossKati](https://paypal.me/VossKati)

Thank you for your appreciation. It helps such content continue to come into being — quietly, lovingly, and in service of wholeness.

△ WISSENSRÄUME — Notes

The WISSENSRÄUME offer professional orientation, deeper reflection, and personal engagement with topics from health, nursing, palliative care, spiritual care, psychology, and philosophy. They do not replace individual medical, therapeutic, nursing, or legal advice — for acute or serious concerns, please consult appropriately qualified professionals.

The model of transition unfolded here is a model of thought: not a diagnostic category, not a treatment recommendation, and not an established scientific doctrine. The sources named stand for possible connections, not for a complete account of the respective works.

If you are experiencing acute suicidal thoughts, please reach out immediately to a crisis line — in Germany, the Telefonseelsorge (free and anonymous, nationwide: 0800 111 0 111 or 0800 111 0 222) or emergency services (112); internationally, the 988 Suicide & Crisis Lifeline (US) or your local emergency number.