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The Dilemma of Human Suffering

Dania, Fla. June 16 (AP)—A 6-year-old girl was killed today when she stepped in front of a train, telling siblings that she “wanted to be with her mother.” The authorities said that her mother had a terminal illness.

—*New York Times* (June 17, 1993, p. A12)

Happiness for a dog or a cat is straightforward. If pets are given shelter, food and drink, warmth, stimulation, play, and physical health they are contented. Without the intervention of humans, animals are often missing some of these basic things. They live, as we say, a dog’s life. Many humans also are missing such basic items too, and it is not difficult to understand the misery of a person living without them.

But many humans have *all* the things a nonverbal organism would need to be happy, and yet they are not. Humans can be warm, well fed, dry, physically well, and still be miserable. Indeed, humans can have forms of excitement and entertainment unknown in the nonhuman world—color TVs, exotic cars, and airplane trips to the Caribbean—and still be miserable. Literally nothing external that you can name—great looks, loving parents, terrific children, a caring spouse—are enough to ensure that a human will not suffer terribly. Every day a human being with every imaginable advantage takes a gun, loads a bullet into it, bites the barrel, and squeezes the trigger. Every morning a successful business person gets to the office, closes the door, and reaches quietly into the bottom drawer of the desk to find the bottle of gin hidden there.

Humans as a species are suffering creatures. Yet our most popular

underlying models of psychological health and pathology barely touch on this fact. It is the elephant in the living room that no one seems to mention.

THE UNDERLYING ASSUMPTIONS OF THE PSYCHOLOGICAL MAINSTREAM

The mental health community has simply not adequately explained its own data on the pervasiveness of human suffering. Drawing from medical metaphors, it seems to believe that psychological health is the natural homeostatic state that is disturbed only by psychological illness or distress. That is, there is the *assumption of healthy normality*.

This assumption is at the core of traditional medical approaches to physical health. Given the relative success of physical medicine, it is not surprising that the mental health community has adopted it as well. The traditional conception of physical health involves simply the absence of disease. It is assumed that, left to its own devices, the body is meant to be healthy, but that physical health can be disturbed by infection, injury, toxicity, decline of physical capacity, or disordered physical processes.

This assumption is quite sensible within the area of physical health. The structure of the human body should be designed to deliver a reasonable degree of physical health as the natural result of biological evolution. If particular humans do not have genes adequate for a degree of physical health sufficient to ensure successful reproduction, evolution would weed out these genes over time. Of course, even within physical medicine the assumption of healthy normality has its limits. The immune system can be strengthened by exercise, diet, and other psychological and behavioral factors, for example. Thus physical health is not *merely* the absence of disease, but also the presence of something (e.g., resistance to disease). In addition, some physical disease seems to be a side effect of successful biological evolution. Cancer is often caused by minor errors in cell replication that accidentally either turn on oncogenes or turn off growth inhibition genes. Yet this process cannot be readily weeded out by evolutionary contingencies, because if cell division were always 100% correct, evolution itself would be limited. Underlining this point, it is worth noting that seemingly pathologic physical processes are sometimes in reality adaptive, such as fever (Nesse & Williams, 1994). In regard to physical health the assumption of healthy normality works fairly well most of the time.

A corollary to the assumption of healthy normality is the assumption that *abnormality is a disease*. Diseases are functional entities: They are disturbances of health with a known etiology, course, and response

to treatment. The identification of syndromes—collections of signs (things the observer can see) and symptoms (things the person complains of)—is the usual first step in the identification of diseases. After syndromes are identified, the search begins to find the abnormal processes that give rise to this particular cluster of outcomes and to find ways to alter these processes so as to alter the undesirable results.

This analytic strategy is completely sensible, given the assumptions. If health is natural and is disturbed only by illness, what we need to do is to identify those with an illness and carefully examine them for some underlying deviant etiology. Psychopathology has been completely dominated by these assumptions and the analytic strategies that result. Few modern research psychologists or psychiatrists have been able to avoid adopting them.

Considering how much attention has been afforded the medical model within psychology and psychiatry, it is a bit shocking to note how little progress has been made in establishing syndromes as disease entities. After one relates the well-worn and dated example of general paresis, there are few clear success stories to tell. The “comorbidity” rates in the current diagnostic system are so high as to challenge the basic credibility of the nosology. The treatment utility of these categories is low (Hayes, Nelson, & Jarrett, 1987) inasmuch as the same treatments work with many syndromes. In addition, they cover only a portion of clients and their problems. In fully capitated managed care settings (where “diagnosing up” to receive insurance coverage is no longer necessary) a large percentage of the clients receiving psychological treatment have no diagnosable syndromal disorder at all (Strosahl, 1994). Even if clients can be given a label such as panic disorder with agoraphobia, or obsessive-compulsive disorder, many of the issues within therapy will still have to do with other problems: jobs, children, relationships, sexual identity, careers, anger, sadness, drinking problems, or the meaning of life.

The relative lack of progress in the current model is not limited to syndromal thinking per se. Often the generalized effects of psychotherapy are small, and the largest effects tend to be observed with very specific measures. The gains that are found on narrow measures very often do not generalize to gains on other narrow measures, even when the measures seem related. Yet students of psychopathology are carefully trained to know nearly every characteristic of nearly every syndromal category. Research journals in clinical psychology and psychiatry contain little else but research on syndromes, and federal funding is almost entirely dedicated to the study of these entities.

We are raising all of these points for a pragmatic reason. The clinical establishment has been approaching the area of mental health with

the assumptions of healthy normality and abnormality as a disease. If this strategy had paid off massively within psychotherapy, there would be little reason to object. "Yes," we might then say, "human suffering is ubiquitous but we must leave that to the priest, minister, or rabbi. Our job is to treat and to prevent clinical syndromes. After all, that is why people come to see us. And we do that very well indeed."

But an honest and knowledgeable clinician cannot say that today. Despite the limited success of this model, we never seem ready to back up and question whether our basic assumptions are too limited. Clinical researchers have spent perhaps too much time looking for the abnormal underpinnings of psychological difficulties, when in reality suffering seems to be so basic to human life.

The approach described in this book is called Acceptance and Commitment Therapy, or "ACT" (said as one word, not as individual letters). An ACT model traces much of psychopathology to ordinary psychological processes, particularly those involving human language. Given the traditional assumption, this strategy would not make sense, inasmuch as ordinary language can hardly be a clinical syndrome or a pathological process. The ACT model does not deny that unusual and bizarre pathological processes exist. Clearly they do. If a person suffers a brain injury and behaves inappropriately as a result, this is not due to the normal psychological process. The same may be true for schizophrenia, autism, bipolar disorder, and so on, although the actual evidence in such areas is much less robust than most clinicians and researchers seem to believe. Even with such severe mental illness, however, the ACT model holds that ordinary psychological processes may amplify the core difficulty, and thus that the assumption of healthy normality should at least be broadened.

ACT supplements the traditional view by bringing a different assumption to the study of psychological distress. It is based on the *assumption of destructive normality*: the idea that ordinary human psychological processes can themselves lead to extremely destructive and dysfunctional results and can amplify or exacerbate unusual pathological processes.

The Example of Suicide

It seems worthwhile to work through a specific clinical example to compare and contrast these working assumptions. There is no more dramatic example of the degree to which suffering is part of the human condition than suicide. Death is obviously the least functional outcome we can imagine in life, and yet a very large proportion of the human family at one time or another attempts to produce it or seriously considers pro-

ducing it. We think the high rates of even the least functional outcomes should provide a clear challenge to the assumption of healthy abnormality.

Suicide is the conscious, deliberate, and purposeful taking of one's own life. Two facts are shockingly evident in regard to suicide: (1) It is ubiquitous in human societies and (2) it is absent in all other living organisms. Existing theories of suicide have a very hard time accounting for both of these facts.

Suicide is reported in every human society, both now and in the past. Approximately 12.6 per 100,000 persons in the United States actually commit suicide every year (Schneidman, 1985). It is virtually unknown in infants and very young children, but first appears during the early school years. The chilling story with which we began this chapter describes a case in which a 6-year-old child committed suicide—one of the youngest on record. Her "reasons" will resonate with numerous other examples we will describe throughout this book: Even 6-year-olds have a hard time facing loss and pain.

Suicidal thoughts and attempts are shockingly prevalent in the general population (Chiles & Strosahl, 1995). About 10% of the human population will at some time attempt suicide. Another 20% will struggle with suicidal ideation and will have a plan and a means to accomplish the act. Yet another 20% will struggle with suicidal thoughts, but without a specific plan. Thus, half of the population will face moderate to severe levels of suicidality in their lives.

Equally important for our purposes is the fact that suicide is arguably absent in nonhumans. Several exceptions to this generalization have been suggested, but they have turned out to be false. Norwegian lemmings are the classic example. When their population density reaches a point that cannot be sustained, the entire group engages in a helter-skelter pattern of running that leads to the death of many of them—usually by drowning. But suicide does not involve only death. It involves psychological activity that is oriented toward personal death as a deliberate consequence of that activity. This is part of what is meant by suicide being "purposeful." When a lemming falls into the water, it tries to climb out. But there are many cases of a person jumping from a bridge, surviving, then crawling back to the bridge and jumping again.

In humans, self-elimination can fulfill a variety of purposes, but it is clearly purposeful. For example, when suicide notes are examined, it is found that more than half of actual or attempted suicides clearly involve an attempt to flee from an aversive situation (Loo, 1985; Smith & Bloom, 1985). These aversive situations include especially aversive states of mind such as guilt and anxiety (Bancroft, Skrimshire, & Simkins, 1976; Baumeister, 1990). Persons who commit suicide evaluate them-

selves quite negatively, believing themselves to be worthless, inadequate, rejected, or blameworthy (Maris, 1981; Rosen, 1976; Rothberg & Jones, 1987).

These psychologically driven human purposes (e.g., to avoid a feeling of worthlessness) would be hard to imagine in nonverbal organisms. For now, however, our point is more general: The example of suicide shows the limits and flaws of the purely syndromal perspective on human suffering. Suicide is not a syndrome, and many people who kill themselves do not have a well-defined clinical syndrome (Chiles & Strosahl, 1995). If the most dramatically “unhealthy” form of activity that exists is present to some degree in the lives of most humans but not at all for nonhumans, we are drawn to an obvious conclusion: There is something basic about being human that makes it so. Put more precisely, there must be a psychological process that leads so readily to suffering—one that is characteristic of humans but not of nonhumans. The research strategy we generally follow in psychopathology will probably not detect this process, because this strategy is not designed to give us adequate understanding of the ordinary facts of human existence.

Clearly, collections of signs and symptoms do exist—that is an empirical fact. Some of these will be shown to be disease entities in that a particular collection of signs and symptoms will be associated with a distinct etiology and can be treated in a particular way. Some mental health problems are pathological in the traditional sense. But short of giving nearly every citizen one or more syndromal labels, no amount of progress in the area of psychological disease will remove our need to explain and to address the pervasiveness of human suffering. Most humans are hurting—just some more than others. It is, in effect, normal to be abnormal.

If we face this obvious fact squarely, we have to ask the next obvious question. Why? This volume is our attempt at an answer.

THE ASSUMPTION OF DESTRUCTIVE NORMALITY

The assumption of destructive normality is basic to many of our cultural traditions, but it is much less dominant in psychology. For example, the Judeo-Christian tradition (and indeed most religious traditions, both Western and Eastern) embraces the idea that human suffering is the normal state of affairs for human adults. It is worth examining this religious tradition both as a concrete example of how far the medical/syndromal perspective has taken us away from our cultural roots on these issues, and as a way to begin considering the role of human language in human misery.

Religious Traditions

The Bible is very clear about the original source of human suffering. In the Genesis story, “God said, ‘Let us make man in our image, after our likeness.’ ” (Gen. 1:26), and Adam and Eve were placed in a beautiful garden. The first humans were innocent and happy: “And the man and his wife were both naked, and were not ashamed” (Gen. 2:25). They were given only one command: “ ‘But of the tree of knowledge of good and evil you shall not eat, for in the day that you eat of it you shall die’ ” (Gen. 2:17). The serpent told Eve that she will not die if she eats from that tree, but rather that “ ‘God knows that when you eat of it your eyes will be opened, and you will be like God, knowing good and evil’ ” (Gen. 3:5). The serpent turned out to be correct, to a degree, because when the fruit was eaten “the eyes of both were opened, and they knew they were naked” (Gen. 3:7).

This is a powerful story, and very instructive. Asked whether it is a good thing to recognize the difference between good and evil, most religious people would surely say that it is the very epitome of moral behavior. It may be, but the Genesis story says that this kind of evaluative knowledge is also the epitome of something else. It represents the loss of human innocence and the beginning of human suffering.

In the biblical story, the effects of evaluative knowledge are immediate and direct. The additional negative effects from God’s punishment come later. Adam and Eve were already suffering the results before God discovered their disobedience. When Adam and Eve discovered that they were naked, they immediately “sewed fig leaves together and made themselves aprons” (Gen. 3:7) and then they “hid themselves from the presence of the Lord God among the trees of the garden. But the Lord God called to the man, and said to him. ‘Where are you?’ And he said, ‘I heard the sound of thee in the garden, and I was afraid, because I was naked; and hid myself.’ [And God] said, ‘Who told you that you were naked? Have you eaten of the tree?’ ” (Gen. 3: 8–11).

There is something very sad about this story of the first instance of human shame. It touches something inside us about our own loss of innocence. Humans have eaten from the Tree of Knowledge. We can categorize, evaluate, and judge. As the story says, our eyes have been opened. But at what a terrible cost. We can judge ourselves and find ourselves to be wanting; we can imagine ideals and find the present to be unacceptable by comparison; we can reconstruct the past; we can worry about imagined futures; we can suffer with the knowledge that we will die.

Each new human life retraces this ancient story. Young children are the very essence of human innocence. They run, play, and feel—and, as

in Genesis, when they are naked they are not ashamed. Yet as in William Blake's famous picture, we adults drag our children from the Garden with each word, conversation, or story. We teach children to talk, think, compare, plan, and analyze. And as we do, their innocence falls away like petals from a flower, to be replaced by the thorns and stiff branches of fear, self criticism, and pretense. We cannot prevent this transition, nor can we soften it. Our children must enter into the terrifying world of verbal knowledge.

The world's great religions constituted one of the first organized attempts to solve the problem of human suffering. It is telling that all the great religions have a mystical side and that they all share a defining feature. All mystical traditions have practices that are oriented toward reducing or transforming the domination of analytical language over experience: Silence is observed for hours, days, weeks, or years; unsolvable verbal puzzles are contemplated; nonanalytical meditation is practiced; mantras are repeated endlessly; chants are recited for hours on end; and so on. Even the nonmystical aspects of the great religious traditions—which do rely on literal, analytical language—often focus on acts that are not themselves purely analytical. Judeo-Christian theology, for example, asks us to have *faith* in God (the root of the word means something more like fidelity than logical, analytical belief). Different religions vary the details of the story, but the themes are usually the same. In their attempt to know, humans have lost their innocence, and suffering is a natural result. There is great wisdom in this perspective. By comparison, the relatively recent tradition of psychotherapy is just now catching up.

The Positive and Negative Effects of Human Language

It seems to us (as it did to the writers of Genesis) that the psychological process that most distinguishes humans from nonhumans is knowing. The core of the ACT approach is built on the idea that this ubiquitous human process gives rise to the pervasiveness of both human achievement and misery.

For reasons we will describe in detail later, knowledge can be both nonverbal and verbal, but the kind that creates such difficulties (and wonders) is based on human language. By "human language" we do not mean mere human vocalization, nor English as opposed to French. Likewise, we are not referring merely to social communication, as when our pet dog barks for food or when the prairie dog emits an alarm cry. In somewhat commonsense terms, we mean symbolic activity in whatever domain it occurs (gestures, pictures, written forms, sounds, and so on).

Somewhat more technically, humans have extensive training in learning to derive relations between events and symbols. The ability to derive and combine verbal relations enormously increases the ability of

human beings to assess the impact of actions, to predict futures not yet experienced, to learn from the past, to maintain, build, and pass on knowledge, and to regulate the behavior of others and themselves. As a result, humans have a capacity for cultural development, progressivity of knowledge, and adaptation to environmental demands that so far outstrips the ability of other species that humans have virtually no effective competitors on the earth other than among themselves.

This was not always the case. The ascendancy of humankind began ever so gradually. Human verbal abilities themselves have gone through a remarkable progression. Although there seems to be wide agreement that the earliest humans could use symbols, based on their burial practices, for example, the sophisticated use of these abilities is astonishingly recent. The earliest permanent and unquestionable records of sophisticated human symbolic activity appear to be cave drawings from only 10,000 years ago. The earliest evidence for written language as we know it is 5,000 years old. The alphabet was invented only 3,500 years ago. Even within the formal, written record of human affairs, there is a clear progression of verbal abilities. Only a few thousand years ago ordinary people seemingly experienced self-verbalizations as statements from the gods or unseen others (Jaynes, 1976). Today we manipulate symbolic stimuli covertly from morning to night while simultaneously functioning in the world.

The progress of humankind can be related fairly directly to these same verbal milestones. The great expansion of human influence in the world did not really begin until the time of the cave drawings. The development of the great civilizations was fostered by written language, and the world's great religions developed not long after. The enormous expansion of the ability of the human species to alter the immediate environment through technology began with the gradual rise of science and has increased exponentially since then.

The resulting progress is astounding, outstripping our ability to appreciate the change. Two hundred years ago the average human life span in the United States was 37 years. By the year 2000 it will approach 80. One hundred years ago, a U. S. farmer could feed 4 others. Today, it is 200. Fifty years ago the *Oxford English Dictionary* weighed 300 pounds and took up 4 feet of shelf space. Today it weighs less than an ounce and can be plugged into a computer.

This kind of familiar "gee whiz" litany is easy to dismiss because the impact of human verbal abilities is so enormous as to be incomprehensible. But we cannot appreciate the human dilemma if we do not see the nature and speed of human progress clearly. Human misery can be understood only in the context of human achievement, because the most important source of each is the same: human symbolic activity. To borrow a phrase from the *Star Wars* trilogy, language is truly "The Force"

in human progress. It is so enormously influential in human affairs because it has such a bright side. But The Force has a dark side too. Psychotherapists know that side well.

This dual nature of human language impacts not just at the level of the group—the human species or human civilization—but also at the level of the individual. Each individual has experienced both the bright and the dark side of The Force. To ask an individual human being to challenge the nature and role of language in his or her own behavior is tantamount to asking a carpenter to question the general utility of a hammer. But hammers are not good for everything, and language is not good for everything either. We must learn to use language without being consumed by it. We must learn to manage it rather than having it manage us. We must learn to overcome the dark side.

Preparing to Go into the Lion's Den

The Zen master Seng-Ts'an had a saying: "If you work on your mind with your mind, how can you avoid great confusion?" Many human institutions (Zen Buddhism included prominently among them) have attempted to declaw the lion of human language. It is inherently difficult to use analytic language to declaw analytic language.

Yet we are writing a book, not dancing or meditating. The readers of this book are interacting with verbal material. If human language is at the core of most human psychological suffering, this presents an extreme challenge, because attempts by both the writers and readers of this book to understand destructive verbal processes will themselves be based on verbal processes.

For that reason, we will need preparation. We must be extremely careful about our philosophical assumptions and our analytic units. The next chapter will deal directly with those. The language traps that may ensnare us will have to be identified. We will need at times to use language in paradoxical and metaphorical ways in order to avoid those traps. All of this will tend to create occasional confusion, more so than in a typical book that is about something more removed from verbal processes themselves.

These are difficulties we need to face. The responsibility for altering the process of destructive normality lies in those cultural institutions designed to alleviate human suffering. In the modern era, these include most especially the behavioral sciences and psychotherapy. It is the job of psychotherapists, in part, to understand these destructive verbal processes and to work to alter them or better contain them for our clients and ourselves.