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Languages of suffering

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Abstract

Human beings are meaning-making creatures, who not only suffer in an immediately felt way, but who can interpret and articulate their discontents through the use of language. The goal of this article is to map different languages of suffering that have been—and still are—in use, when human beings make sense of their problems in living. I argue that our current conception of suffering has been pathologized and biomedicalized with the diagnostic manuals serving as a significant source from which a diagnostic language of suffering emanates. I briefly present four other languages of suffering—religious, existential, moral, and political ones—that are today often delegitimatized by the dominant psychiatric language. Building on pragmatist and hermeneutic philosophies, my goal is to argue that different languages enable different forms of understanding and action, and that we need many different languages in order to fully understand the human condition.

Keywords

hermeneutics, morality, pragmatism, psychiatric diagnoses, suffering

In a discussion of psychiatric "disorders without borders," Nikolas Rose argues that:

> At any time and place, human discontents are inescapably shaped, moulded, given expression, judged and responded to in terms of certain languages of description and explanation, articulated by experts and authorities, leading to specific styles and forms of intervention. What, then, is specific to today? (2006, p. 479)

By invoking the notion of "languages of description and explanation" that shape human discontents, Rose hints at what I shall here address as "languages of suffering," i.e., vocabularies that we use to interpret, make sense of, and regulate our experiences of distress, discontents, or what Thomas Szasz famously called "problems in living"

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(Szasz, 1961). Rose's own recent work has pointed to the roles of biomedicine (Rose, 2007) and the neurosciences (Rose & Abi-Rached, 2013) in shaping our current ideas of mental disorder and also our very image of what a human being is. According to Rose (2003), the human being is becoming a "neurochemical self." Peter Conrad's (2007) influential analysis of the medicalization of society is now being developed into analyses of biomedicalization and pharmaceuticalization (Abraham, 2010), emphasizing the functions of "Big Pharma" in defining health and illness for people in the 21st century.

Another significant voice, giving critical comments on these developments from inside psychiatry, is David Healy's, whose recent book on *Pharmageddon* not only critically discusses the pharmaceutical industry and the emerging hegemony of evidence-based medicine, but also delivers something like a cultural critique of the ways that human experience of suffering is now changing in societies that increasingly draw upon biomedical resources when seeking to understand somatic and mental health:

> In previous times we passed on a culture to our children embodied in fairy tales, folklore about health, national myths, and religious precepts, in which the life's risks were put in a larger context of meaning. Now an increasing part of what is transmitted centers on personal health for its own sake: figures for sugar and lipid levels, as increasing numbers of our children have diabetes or other dangerous metabolic states, or figures for peak respiratory flows as increasing numbers of young people have asthma, or statistics on some chemical imbalance as increasing numbers are being treated for ADHD, depression, or anxiety. Not only is such a culture two-dimensional, it changes the very nature of human experience. (Healy, 2012, p. 176)

According to Healy, the processes of biomedicalization and pharmaceuticalization are reducing the multi-dimensional phenomena of life to a two-dimensional one. Today, "personal troubles" (to borrow a term from Mills, 1959/2000) are routinely being pathologized, and behaviors that are seen as disturbing in the eyes of the majority are transformed into mental disorders (Busfield, 2011, p. 5). Critics, such as those cited here, explicitly or implicitly argue that we are increasingly blinding ourselves to dimensions of human distress that cannot be conceived within a psychiatric and diagnostic framework. But it is rarely discussed what these other dimensions are. Through which languages can they be articulated? And what would we win—if anything—by retrieving some of the other (non-psychiatric) languages of suffering? These are some of the questions that I set out to address in this article that aims to map a number of different languages of suffering.

By drawing on pragmatism and hermeneutics, I will first explain in greater detail what I mean by a "language of suffering." Then, I will give a more precise characterization of the common psychiatric understanding of suffering, concentrating here on what I call the "diagnostic language" of psychiatry, which has become very influential in defining human distress. I will stress at the outset that my point is *not* to say that this language is useless or illegitimate, but rather that it is simply one among a large range of languages that are valuable in enabling us to understand various dimensions of human life and its problems. The following sections present and unfold some of these other languages, including religious, existential, moral, and political languages. Obviously, the list

of languages of suffering addressed here is not exhaustive, and the categories are not monolithic or defined by strict boundaries. Still, I hope that it is clear that they represent different aspects of human life and suffering that are important to bear in mind when seeking to fully understand the problems that people face. I end by discussing what roles the different languages ought to play in both theoretical and practical contexts in relation to human distress.

Although the paper develops and operates with a notion of "languages" that is close to the notion of "discourses" found in different varieties of discourse analysis, I should make clear now that unlike discourse studies as such, the analysis here is not based on close readings of empirical materials. Doing so has obvious strengths, and many interesting studies of psychiatric discourses have appeared based on discourse analysis, but I believe that my approach to more overarching vocabularies and hermeneutic frameworks in the present text is also legitimate and inscribes itself as part of a social psychological and sociological tradition of discussing and theorizing the relationship between society and culture on the one hand, and categories of social pathologies (Keohane & Petersen, 2013) and diagnoses (Jutel, 2011), on the other. I return to this issue in the next section when I discuss the very concept of languages of suffering. A significant goal of the paper is to develop this concept in a fruitful direction, paving the way for future studies, which is why I dwell on it at some length.

What is a language of suffering?

Obviously, I am not the first to suggest that it is fruitful to develop a notion of languages of suffering. In cultural psychology, Richard Shweder and co-workers have for years worked to articulate and refine a distinction between what they refer to as the "Big Three" cultural metanarratives of suffering (Shweder, 2008; Shweder, Much, Mahapatra, & Park, 1997). The "Big Three" are traditions that explain suffering across the divide between somatic and mental health problems, and they highlight the immense variety concerning how (what we call) mental illness and suffering are conceptualized. According to Shweder, the three main metanarratives are: (a) the biomedical narrative, according to which suffering is explained as a result of material events (e.g., harmful molecular processes in the body), (b) the moral narrative, which frames suffering as a consequence of a breach in the moral order (e.g., expressed in the Buddhist idea of karma), and (c) the interpersonal narrative that refers to magic, witchcraft, or spirits as driving forces behind experienced suffering (Shweder et al., 1997, p. 127). Most people in the imagined hemisphere of the West today subscribe to some version of (a), but Shweder has estimated that only around 15% of the world's explanations of suffering belong in this category. Most conceptualizations of suffering draw upon the moral and interpersonal metanarratives, so the world is still "superstitious" when seen through the prism of Western science. (a) and (c) share the assumption that suffering is *causally* inflicted (either by molecules or magical techniques), whereas (b) distinguishes itself by framing suffering as a *meaningful* (rather than causal) phenomenon, invoking some notion of a cosmic order that can be breached or polluted (I return to this fundamental distinction below).

Although the psychiatric understanding of mental problems has become hugely influential, building on a biomedical narrative, it is significant that there used to be much

more openness to the moral understanding in particular, and its associated treatments, in our culture. Early forms of mental treatment were significantly called *moral treatment*, and were particularly associated with the names of Tuke (England), Pinel (France), and Chiarugi (Italy) in the first half of the 19th century (Lilleleht, 2003). The term "moral" then signified something much broader than our contemporary understanding of morality (as the human and social sciences were seen as belonging to "the moral sciences"), but moral treatment was nonetheless based on explicit moral values, and "involved the creation and administration of corrective experience within a specialized setting" (Lilleleht, 2003, p. 169). Pioneers of psychiatric treatment practiced a kind of moral cure, which involved work and occupational therapy, general encouragement, and a gradual moral edification of the patients' characters. In short, people's suffering was framed within a moral rather than a medical discourse. Modern forms of psychotherapy have since evolved in two main directions, both of them departing from the original basis in moral values. The first direction is that of medical health care, where morality became significantly downplayed when moral "sinners" became psychiatric "degenerates" and morality was "medicalized" in the course of the 19th century (Rimke & Hunt, 2002). The second direction is the humanistic one, where psychotherapy became a secular technology of self-realization, incarnated most clearly in Carl Rogers' client-centered therapy (Brinkmann, 2008). This, however, has only played a minor role within psychiatric settings, but has had a huge impact on the Western culture as a whole.

My emphasis here on *languages* of suffering is inspired by the pragmatist notion of vocabularies, articulated most forcefully by Richard Rorty (1979). For a pragmatist like Rorty, our ways of understanding and acting in the world are mediated by the linguistic resources at our disposal. Vocabularies—like other human inventions—are tools that do not simply copy the world, but which are useful (or not) in enabling us to cope with the world, to rehearse the catch-phrase made famous by Rorty. Within cultural psychology, this process is conceptualized as semiotic mediation: the use of signs and symbols to regulate thoughts, feelings, and actions concerning important matters (Valsiner, 2007). Stating that something is existential melancholy, for example, implies one set of understandings and action possibilities, whereas stating that it is clinical depression implies another set. For Rorty, there is no rational grounding to, or ways of assessing the relative values of, different vocabularies over and above their instrumental roles, i.e., how well they enable human beings to reach their goals (of happiness, growth, democratic living, etc.). From the pragmatists' perspective, the relevant question to ask of a vocabulary is not "Is it true?," but "What kinds of experiences and actions does the vocabulary make possible?" This question should be kept in mind throughout this article.

What Rorty did not develop, however, was a more specific analysis of how languages or vocabularies become inscribed into societies, social practices, and personal understandings. In order to conduct such an analysis, with specific reference to languages of suffering, we need, in my view, to supplement the pragmatist interest in the workings of vocabularies with a hermeneutic perspective on how languages mediate and become sedimented in personal and cultural self-understandings (the issue of how pragmatism and hermeneutics may supplement each other is difficult, but the reader may consult Brinkmann, 2011).

The influential hermeneutic philosopher and social theorist Charles Taylor has distinguished between three levels of social understanding, which we may apply to an understanding of suffering in this case: (a) an "upper" level of explicit doctrines (about society, cosmos, or suffering), (b) a "middle" level of the symbolic (expressed in rituals, works of art, and cultural symbols for example), and (c) a "lower" level of the habitus (embodied understanding; Taylor, 1999, p. 167). These three levels of understanding are more or less ordered along a continuum ranging from the implicit to the explicit. At the upper level, we have for example the explicit metanarratives of suffering that Shweder has studied. These are made explicit in scientific articles, diagnostic manuals, and self-help literature for example. At the middle level, we have all the rituals of suffering related to diagnosis, treatment, healing, and a range of cultural activities performed by self-help groups and much more. Finally, we have the embodied level, where suffering is felt and experienced, and where the experience cannot be divorced from the explicit vocabularies and symbolic acts associated with human distress. Together, the explicit, symbolic, and embodied levels constitute our cultural *practices of suffering*, i.e., how we *do* suffering, enact, feel, and perform it. I stress this in order to counter an idealistic interpretation of the notion of "languages of suffering," according to which this notion refers to explicit language only. From the pragmatist and hermeneutic perspectives taken here, languages of suffering work in our lives through social practices, with various associated rituals and symbols, and are inscribed into the human body and its habitus. There is no formula for how this happens, and it may happen quite differently in relation to different kinds of problems, but the important point is, as Taylor insists, that we should learn to rethink the relations between "base" and "superstructure," (explicit) ideas and (implicit) material and institutional factors:

> What we see in human history is ranges of human practices that are both at once, that is, material practices carried out by human beings in space and time, and very often coercively maintained, and at the same time, self-conceptions, modes of understanding. (Taylor, 2004, p. 31)

We cannot separate ideas (of demonic possession, ADHD, or other problems) from the institutional and material bases from which such ideas arise and influence our understandings; both are aspects of social practices, and the linguistic articulations of practices (e.g., the languages of suffering) necessarily operate within a complex field of social practices with symbolic and embodied aspects.

When articulating the different languages of suffering below—diagnostic, religious, existential, moral, and political—I will thus briefly relate each of these languages to the social practices of which they are a part (with their symbolic and embodied aspects). This, however, can only be sketchy and programmatic due to the limitations of the article format, and I will end the article by discussing how the various languages and associated practices present people with quite different positions to act (thereby returning to the pragmatist theme of the action possibilities opened up by the various languages).

The diagnostic language

As the word testifies, a diagnostic language is one that understands suffering in terms of symptoms as listed in the reigning diagnostic manuals (DSM and ICD). The

contemporary manuals are constructed around certain key assumptions about mental illness: That there is a boundary between the normal and the sick; that there are discrete mental illnesses; and that psychiatry's focus should primarily be on the biological aspects of mental illness (Angel, 2012, p. 8). As is well known from different sociological and historical studies (Horwitz, 2002; Kutchins & Kirk, 1997), a revolution took place in psychiatry around 1980 with the creation of DSM-III, which replaced the older etiological understanding of mental illness with a pure diagnostic understanding, based on actual symptoms within a given period of time. Before DSM-III a diagnosis was formulated on the background of the patient's biography, his or her experiences, actions, and relationships, and psychiatrists often employed theoretical terminology when describing the patient, typically from psychoanalysis. Unfortunately, this diagnostic practice was quite unreliable, which prompted the shift to the diagnostic approach of DSM-III and beyond. Now, a diagnosis is formulated if the patient has at least x number of symptoms from a given list within y weeks or months (depending on the specific diagnostic category).

Incidentally, the psychiatric vocabulary of DSM in particular (and to a lesser extent ICD) has traveled widely outside medical and psychiatric circles, and has become inscribed in people's everyday understandings of suffering and distress. This can be referred to as a process of psychiatrization, and is something for which the makers of the manuals cannot as such be held accountable. But the DSM has come to function as a "connective tissue" for many different groups with a stake in psychiatry (Pickersgill, 2012, p. 331). In that sense, the psychiatric diagnoses have become very significant boundary objects in the contemporary West, i.e., objects of knowledge which "inhabit several communities of practice *and* satisfy the informational requirements of each of them" (Bowker & Star, 2000, p. 16). ADHD, for example, is on the one hand a "something" that is sufficiently stable across communities of practice, as defined in the diagnostic manuals, but is on the other polyvalent in its meanings for children, parents, teachers, doctors, researchers, the medical industry, the public, etc. The diagnoses are categories that connect these very different sets of actors and their communities of practice, although not necessarily in harmonious or homogenous ways.

The increasing influence of psychiatric diagnoses on human self-understanding is connected to a more general development in medical practices. Armstrong (1995) has charted how medicine has developed historically from Library Medicine (with a focus on the classical learning of the physician) to Bedside Medicine (with physicians addressing the concrete problems of illness) and Hospital Medicine (with the establishment of large hospitals at the end of the 18th century) and today to what Armstrong calls Surveillance Medicine of the 20th century and beyond. The latter kind of medicine functions by targeting everyone through screenings, surveys, a focus on risk factors, and a problematization of the normal. People can now diagnose themselves by taking tests in magazines, self-help literature, or on the internet. Or they are diagnosed when taking part in some of the large-scale epidemiological studies that seemingly demonstrate that in any one year, more than a third of the European population could be diagnosed with a mental or brain disorder (Wittchen et al., 2011; and there are similar prevalence numbers for the US and many other countries).

For psychiatry, this whole development has meant that the psychiatric language and its diagnostic categories have become more important for our self-understanding than ever before. Terms that have specific meanings within psychiatry, such as stress, anxiety, depression, and mania, have become part of people's everyday vocabularies. We use such terms to understand the behaviors, reactions, and emotions of ourselves and others. To mention just one example, a recent large-scale study of 122 Danish public schools demonstrates that teachers believe that, on average, 24.9 % of their pupils have problems to such an extent that they could (and should) be given a psychiatric diagnosis (Nordahl, Sunnevåg, Aasen, & Kostøl, 2010). For the boys in particular, the figure is a striking 30.8 %. Teachers are probably not special in this regard, but represent a tendency to conceive of problems, deviance, and eccentricity in diagnostic terms. We should bear in mind that even if this paper focuses on languages of suffering, it is not necessarily the suffering of the person who has been given the diagnosis, which is significant, but how this person inflicts suffering on others (classmates, parent, teachers), although the DSM-5 states that socially deviant behavior is not a mental disorder unless it results from an individual dysfunction (which, however, is extremely difficult to establish, partly due to the lack of biomarkers for mental disorders).

Numerous critics have addressed the psychiatrization of suffering. They have argued that the extreme prevalence estimates mentioned above represent a huge number of false positives leading to massive pathologization of normality (Wakefield, 2010). This can happen when these estimates become news stories that trigger something like moral panic among politicians, resulting in new processes of screening and intervening, leading to even more people using the diagnostic language to understand themselves and their afflictions in something like a vicious diagnostic cycle on a cultural level. Many traits and behaviors that used to be considered as normal human problems (sorrow, melancholia, guilt, shyness, etc.) are therefore now conceptualised as mental disorders that can be diagnosed and treated medically and therapeutically. Other critics focus on the role of the industry in marketing illnesses that profit hugely from pathologizing human problems (Ebeling, 2011), perhaps with something like "pharmageddon" as a result (Healy, 2012). Such pathologization runs the risk of "cultivating vulnerability" in human beings that may become less able to tolerate pain and distress as they are constantly on the lookout for emergent symptoms (Furedi, 2004). As Barsky (1988) argued some years ago, there seems to be a "paradox of health" since more and more people historically experience more and more symptoms and subjective distress at the same time as (and perhaps as a consequence of) more and more treatments become available. When new treatments become available along with new diagnostic categories, new ways of suffering emerge that can be "taken up" by individuals in a dynamic process that Ian Hacking has called "the looping effect of human kinds" (e.g., Hacking, 1995), referring to an interaction between categories that designate human doings and sufferings on the one hand and human beings who may act and interpret their lives in light of these categories on the other. This invites everyone into seeing oneself as a victim or a patient, although this invitation can be resisted and is even attacked by different organizations such as the Hearing Voices Network, seeking to de-pathologize voice hearing.

Despite the criticism, we should certainly not forget to inquire into possible benefits that may arise from using the diagnostic language to conceive of human suffering. There are two broad kinds of benefits: one is connected to the functioning of modern welfare societies in which psychiatric diagnoses are often the key to access different forms of benefits ranging from special education to pensions. In relation to this, there is a debate concerning how to weigh the benefits accrued to individuals versus the possible skewing of the public health resources in the direction of minor mental health problems at the expense of major psychiatric problems (Williams, 2009). Some will argue that the losers are the traditional psychiatric patients (e.g., people suffering from schizophrenia) when so many resources are used to treat minor episodes of depression, anxiety, and stress-related disorders. The other category of conceivable benefits concerns the possibility of the diagnostic language being able to "externalize" people's problems through the diagnostic categories. The idea of externalizing has been developed within narrative therapy to help people appreciate that *they* are not the problem, but that "the problem is the problem" (White, 2007). A diagnosis may give people a language that can help frame, objectify, and externalize the problem so that the sufferer can regain some sense of personal agency and become able to cope with the difficulties. However, we know very little about when and how a diagnostic process can lead to externalization and reinvigorated agency and when it leads in the opposite direction: to the formation of patient identity, fixing the person in a sick role. So far, we can only say that sometimes, the use of the diagnostic language is itself therapeutic (Wykes & Callard, 2010, p. 301), possibly because of its externalizing potentials, but sometimes it seems to cultivate passivity and vulnerability (Wainwright & Calnan, 2002).

In summing up on the diagnostic language and its implications for cultural understandings of suffering, we can say that this language has worked very efficiently at the explicit level of understanding (see Taylor's three levels described above), most obviously with the diagnostic manuals operating as powerful connecting tissues in and between a large number of social practices and the diagnoses themselves being central boundary objects within many communities of practice of modern societies. But we also see its impact on the levels of the symbolic and ritual, e.g., in the many tests that are ritualistically performed to assess mental health in a variety of settings, and not least at the embodied level, where human beings have appropriated the diagnostic language as a form of self-interpretation of suffering. Perhaps even the physical body is affected by the diagnostic language, as hinted at by Margaret Lock's concept of "local biologies," highlighting the ways that our embodied experience, including that of illness and health, is mediated by local categories of knowledge (Lock, 2001). People today for example easily interpret their "butterflies in the stomach" as anxiety or weariness as depression, representing a kind of embodied "looping effect" (see Hacking, 1995).

In the following sections, I will briefly address four other languages that offer alternative understandings of human suffering, but which have been somewhat depreciated by the status of the diagnostic language.

The religious language

In his song *God* from 1970, John Lennon opens with the famous line that "God is a concept by which we measure our pain." This is so important to Lennon that he repeats it in

a quite curious way ("I'll say it again: God is a concept …"). From sociological and cultural psychological perspectives, religion has certainly been ascribed many functions such as "social cement," as opium for the people, as exchange and social control (Turner, 1991), but there is no doubt that the capacity of religion to explain and render pain and suffering meaningful is a major sociocultural function of belief systems as articulated through religious languages. Religions provide a way of seeing oneself within a larger horizon of meaning—an *ontic logos* (Taylor, 1989)—that typically explicates the proper (and forbidden) paths of human beings through their lives. Religions can provide people with the "whys" of their lives (in Nietzschean fashion: "if we possess a *why* of life, we can put up with almost any *how*"), and they traditionally tell people that even if their sufferings are painful, they are not intolerable because they are a result of God's will, a temporary block towards salvation or something similar.

As we saw earlier in Shweder's analyses, religious languages (which will typically belong in his interpersonal category, where spirits and demons may interfere with human affairs) are still very widespread around the world and are used to make sense of human suffering. Clearly, the religious language is made explicit in holy scriptures of different kinds, and has a large range of symbolic and ritualistic practices attached to it that can be used to alleviate human problems (ranging from confessions and exorcism to shamanistic rituals and voodoo ceremonies). And, for the believer, the religious language of suffering is also made personal and embodied as a form of understanding in one's everyday life, and may involve prayers and other symbolic resources (Zittoun, 2006) that people use to semiotically regulate their thoughts, feelings, and action.

A thorough analysis of the religious language of suffering is obviously outside the scope of this paper. Suffice it to say here that this language has not disappeared, just as religion has not disappeared in spite of secularization, but instead has become something like an optional choice that demands personal reasons to be thought of as legitimate. Furthermore, as summarized by Charles Taylor in his magnum opus on secularism: "What was formerly sin is often now seen as sickness" (Taylor, 2007, p. 618). This pathologization of the human condition and its problems, which were originally seen as religious, rests on the one hand, as Taylor observes, on a humanist call for dignity and enlightenment, but may on the other hand end up abasing human dignity. How so? Because we might end up with a two-dimensional understanding of human suffering, and experience more broadly, which Søren Kierkegaard famously referred to as "leveling"; a flattening of qualitative distinctions in human life leading to difficulties in understanding differences between the significant and insignificant. This takes us to another language that in some dialects is closely related to the religious, viz., the existential.

The existential language

An existential language of suffering sees various human problems as inescapable parts of our existence. This language may, as was the case with Kierkegaard, be coupled with a religious sensibility, or it may be atheist. In any case, the point is that phenomena such as death anxiety or despair are regarded not as pathological conditions to be treated medically or therapeutically, but as defining features of human life. The capacity for such emotions and experiences is exactly what makes us human. Famously, Kierkegaard

wrote about the *Sickness unto Death* (Kierkegaard, 1849/1995), but the sickness in question was not conceived in medical terms (something to be treated with medicine, therapy, or exercise, for example), but in existential terms, having to do with problems arising from reflexive selfhood. The sickness, i.e., the feeling of despair is thus the normal, according to Kierkegaard, and not something that hits a few unlucky souls. Likewise Kierkegaard's analysis of *The Concept of Anxiety* (Kierkegaard, 1844/1981) does not address a psychiatric phenomenon, but concerns an aspect of human existence, which is related to finitude, and to our confrontation with our own mortality. In Kierkegaard's eyes, this kind of anxiety has literally nothing as its object, which is why it is, in a sense, the gateway to freedom and authenticity (because nothingness is related to the possibility to act, to bring that which does not yet exist into the world). It is not that humans should be constantly mentally tortured by anxiety, but rather that an understanding of our existential depths demands the potentials to feelings of this kind.

Anxiety in the face of death reminds us that life is finite, and that we therefore ought to take it seriously (only humans can feel anxiety in this object-less way, while the (other) animals can fear specific objects). Perhaps the most significant discussion about a possible pathologization of the existential in recent years concerns grief. Grief was included in the appendix to the DSM-5, which, critics argue, represents an obvious example of how the diagnostic language can infiltrate an existential issue (Kofod, 2013). As Kofod recounts, bereaved individuals who experience intense longing, sorrow, and emotional pain after the first year of their loss might receive a diagnosis called Adjustment Disorder Related to Bereavement—insofar as these experiences are judged by professionals to be disproportionate. Or they may be diagnosed with depression, since the so-called bereavement exclusion has now been eliminated from the DSM (in the DSM-IV this excluded people who experienced "depressive symptoms" lasting less than 2 months after the death of a loved one from a diagnosis of depression). Although grief is a very painful phenomenon, it seems to be a good example of a human phenomenon that is at the same time deeply meaningful (it maintains an emotional relationship to the deceased), and something most people would not have removed medically (if, for example, a pill existed that could eliminate the feeling of grief). "Grief is love that has become homeless," as it is sometimes put (in Danish, here translated), so the painful phenomenon of grief seems to be the price of something that we would not live without, viz., love.

Apart from the existential writings (most significantly Kierkegaard's), it is difficult to find remnants of explicit articulations of the existential approach to suffering. Those who (still) subscribe to this way of understanding and doing suffering are perhaps unlikely to articulate it explicitly, but it still exists rather more implicitly in certain parts of the world that have so far resisted the ever-growing therapy culture (Furedi, 2004). In my own country it is my impression that rural communities in particular still sometimes embody an ethos of stoicism and an acceptance of the hardships of life to a greater extent than people in the urban areas. This, however, is difficult to assess, and one should beware of romanticizing these matters. On a more global scale, however, we have some evidence that the Western pathologization of people's reactions to traumatic events, such as the 2004 tsunami in Asia, sits uneasily with local social practices of coping with such disasters (Watters, 2010). There are still communities in which one turns to friends, neighbors, and elders for help and advice on how to rebuild one's life, relationships, and house when

facing existential turmoil, without a need for professional counselors, therapists, or psychiatrists. We thus find a variety of local practices and rituals for dealing with existential suffering, including emotional, social, and material support, across the world's cultures, but they typically and largely function in tacit and implicit ways.

The moral language

Notwithstanding the fact that the moral narrative is one of Shweder's Big Three, it might seem odd to include the moral language among the resources for making sense of suffering. In the West, we have become used to thinking of morality as a very narrow slice of human life that has to do only with evaluations of individual actions in light of moral values. However, in a broader sense, morality has to do with the "oughtness" of life as such, all the ways that normativity permeates our doings and sufferings (Brinkmann, 2011). One obvious and important link between morality and suffering is represented by the moral emotions such as guilt and shame, both of which can be extremely painful. Through guilt, we experience having done something wrong, and through shame we feel the negative evaluation of the community of our selves (even if it is only imagined). Looked at through a diagnostic lens, however, such phenomena are quickly transformed into psychiatric conditions. If, for example, someone has acted immorally, say, has had an extra-marital affair, and subsequently suffers from a guilty conscience, ruminates and worries, develops negative automatic thoughts, and perhaps changes patterns of sleeping and eating as a consequence, that person is very likely to score extremely high on most standard depression tests. But, at least from a common sense perspective, the person in question does not have a psychiatric problem, but rather a moral problem. In order to be able to distinguish one from the other, it seems to be important to maintain a moral language of suffering, for merely counting symptoms will not do the trick.

More fundamentally, there is a vital difference between the ways we can explain and understand human actions psychiatrically on the one hand, and morally on the other (see Brinkmann, 2013). In the first case, we typically invoke a causal perspective, while the latter involves reference to reasons. If we ask: "Why did Jack and Jill go up the hill?," an explanation in terms of causes can state that they did so because their brains initiated a reaction in the locomotive system that made their legs move (a physiological explanation), because their genes wanted to replicate themselves in organisms known as offspring (a sociobiological explanation), or because they were forced to go up there by an inner demon (a psychiatric explanation that invokes a psychotic symptom). However different these are (and they need not rule one another out), they are all species of causal explanation that frame the situation as *behavior* rather than *action*. The "behavior," in this context, designates that something simply *happens* as a consequence of some mechanism (in the brain, genes, or body) that is either working well or in a pathological way, but without invoking meaning or normativity. However, we may also say that Jack and Jill went up the hill because they wanted to smell the daisies. In this case, we understand the episode not as a causal happening but as human *action* that is based on a *reason* and an *intention* and express *meaning* (Jack and Jill have heard that the hill is full of daisies and wish to experience the scent of these wonderful flowers). In this case, we conceive of Jack and Jill as agents that can act for a reason and to some extent articulate the reason

that individuates their action (thereby *accounting* for their action). And we may hold the actors responsible for what they have done—i.e., praise or blame them (Robinson, 2002). It is difficult to imagine what human life would be like if we had no recourse to a language of reasons, of praise and blame, also in relation to suffering and distress. That is, it seems impossible to uphold an understanding of ourselves or others as agents without a normative language of reasons. According to MacIntyre (1999), an understanding of what others are doing emerges only through ascribing reasons to them. The moral language is thus important because it builds on a fundamental perspective on humans as creatures, who are uniquely capable of giving and receiving reasons for action.

The discussion of reasons versus causes is enormous in philosophy, but here I will simply highlight three aspects that I find important in order to characterize moral reason-giving: (a) that there is a primacy of reasons over causes in explanation of human action; (b) that reasons, unlike causes, are intransitive; and (c) that reasons are particularistic. As Hollis (1977) has argued regarding the first point, it seems to be the case that reasons are generally enough to explain actions. If a person does something and we are provided with a reason that satisfactorily explains the action, then the search for explanation normally stops. Only *irrational* actions call for causal explanations, i.e., if we cannot find a *reason*-able explanation as to why someone did something. Furthermore, unlike causes, reasons are not transitive. That is, if A is the cause of B, and B is the cause of C, then A is the cause of C. But this does not go for reasons, for if A is the reason for my action B, then I am responsible for B, but I am not similarly responsible "for what others do autonomously because of what I set in motion" (Hollis, 1977, p. 108). Responsibility and other moral concepts are not transitive in a simple way like causality. Finally, causes-explanations work by bringing particular observations under a general law, but reasons-explanations work differently, viz., by explaining "the particular by the particular" (p. 108). In general people do not act because their actions are instances of a general causal law (e.g., I do not love my wife because there is a general law specifying that humans of type X are attracted to humans of type Y, but because she is lovable!). Even if there *is* a general law, this is not the *reason* why we act as we do.

If we relate these general considerations to the theme of pathologization, we can say that pathologizing some action often means suspending our common reason-giving practices and reinterpreting the action in light of a causal explanation. This can involve understanding the individual's behavior as an instance of a general law ("this is what ADHD patients generally do"), or even invoking some causal mechanism in explaining a given occurrence ("it was the ADHD that caused him to …"), rather than invoking particularistic circumstances that render the action meaningful. This form of pathologizing can be, but need not be, driven by forces outside of the individual, but sometimes individuals are themselves active participants in processes of self-pathologization (e.g., in the process recently identified as ADHD-adoption, when undiagnosed individuals spread the word that they have ADHD, because it gives them certain benefits; see Singh, 2011).

Using Taylor's distinction between explicit, symbolic, and embodied aspects of understanding in relation to *moral* suffering, we can conclude that explicitly, there are few social representations of this way of rendering suffering meaningful. The moral narrative lives, as also Shweder's research has shown, in many corners of the world, but most often in embodied and implicit social practices of giving reasons for the ways

that people feel and act. Historically, however, the moral language has been much more influential on explicit levels, when people's sufferings and eccentricities were seen as moral defects, requiring moral therapy. But even today, I suspect that most of us intuitively feel that it is important to maintain a moral language that enables us, at least sometimes, to hold people responsible for their sufferings (e.g., in relation to acts that call for guilt or shame). Where to draw the line between moral and causal understandings of misery will likely remain a crucial question in the years to come, not least because of the pressure that the psychiatric diagnoses exert on national health systems, giving people access to benefits when a diagnosis reduces their personal responsibility (Williams, 2009).

The political language

Politics is a domain of our social life, where we struggle for and over rights, rules, and goods. In a democracy, political processes are ideally organized so that all citizens are capable of being heard and affect the decisions that are made. When citizens experience social injustice, e.g., marginalization, disenfranchisement, discrimination, or violations of rights, it is relevant to express one's disapproval in a political language. Traditionally, this language has been collective in the sense that political arguments are seen as legitimate to the extent that they refer to the rights and interests of the citizenry as a whole (or at least large groups such as workers, women, etc.) rather than specific individuals. It is not a legitimate political move—in a normative sense—to strive to change the law so that I benefit from it; one must argue that it is fair to change the law so that the conditions of my group are improved (e.g., the rights of university professors).

In recent years, however, some analysts have argued that the political language is gradually being transformed into a diagnostic language. Mary Boyle (2011) has argued that this is a process of "making the world go away," which converts "distress and problem behaviours to 'symptoms' and 'disorders'" (Boyle, 2011, p. 28). As a result, there is a grave risk of overlooking the fact that poverty, unemployment, marginalization, etc., are very often the cause of (what is allegedly) "mental disorder" rather than a consequence of it. Viewing people's lives through a diagnostic lens de-politicizes their problems and turns them into a matter of personal health and illness, to be treated pharmacologically or therapeutically (Smail, 2011). To give just one example we may mention the "work stress epidemic," which has led to a wave of therapists, coaches, and mindfulness instructors acting on employees and individuals, but with the risk of ignoring the roles of the sociomaterial environments on people's lives (Wainwright & Calnan, 2002). Detrimental work conditions were once something to be dealt with politically and collectively—centered on the work of unions—but today it is increasingly met with an individualizing and pathologizing response. Hermann and Kristensen pinpoint this development and argue that while workers used to engage in strike action collectively in order to protest against debilitating work conditions, people in the individualized late-modern capitalism are left with the option of being sick with stress (Hermann & Kristensen, 2005). A political process has turned pathological and emotional, which might be a more general tendency in what Eva Illouz (2007) has termed an age of "emotional capitalism."

Politics, of course, is a huge and heterogeneous field with many explicit (e.g., ideologies), symbolic (e.g., ritualized meetings and demonstrations), and embodied (e.g., feelings of injustice) levels of understanding. There is no danger that politics as such will disappear, but, if the analysis here has some validity, there is a risk that those aspects of human suffering that were formerly articulated in a political language of rights and duties, social justice and injustice, are increasingly addressed in individualized and diagnostic terms, thereby covering over the social backgrounds to human suffering.

Languages of suffering and possibilities for action

After reviewing the languages of suffering that I have singled out as important, I will now, as a kind of conclusion, address some of the possibilities for action that the different languages—and their associated social practices—enable. But first it might be useful to remind ourselves of how varied the landscape of suffering and distress actually is.

In a discussion of mental disorder and its personal meanings, Bolton (2010) makes a distinction between three kinds of human distress of which the kind that results from mental disorder is only one. In addition to *pathological* distress, we have the kind of distress that is connected to normal *life transitions* (e.g., in work, education, or family contexts), and distress connected to various forms of *social deprivation or exclusion*. From the analyses of the languages of suffering above, it is quite obvious that different languages are suitable for articulating different kinds of distress. A political language is most obviously connected to the third category mentioned by Bolton—intent, as it is, to thematize processes of power and social (in)justice, whereas a moral language is often relevant in relation to life transitions (a divorce, for example, may be the result of one party's deceitful behavior), which can also be said of the existential language (relevant, for example, in relation to experiences of loss). The religious language can be, like the diagnostic one, a colonizing language that seeks to dominate the understanding of suffering, which happens when all the problems that befall on humans (from physical illness to poverty) are interpreted as the reactions of an almighty deity to the sinful actions of human beings. But, on a less "imperialist" reading, the religious language can be said, like the existential and moral languages, to concern itself with making suffering meaningful by placing it within a cosmic framework or what Taylor has called an *ontic logos* (Taylor, 1989).

One way to take the analysis of the present article is to engage in further cultural critique of the imperialist tendencies of the current diagnostic language. This is no doubt important, and will be done in forthcoming papers. But quite another way concerns the normative question of when to use a given language. How do we in fact know when to use a given language in relation to a specific instance of human distress? How do we know when, say, my diffuse sense of sadness and emptiness is clinical depression (diagnostic language), and when it is my human response to mortality and sin (religious language), an expression of existential despair (existential language), a manifestation of guilty conscience (moral language), or a sign of stress felt when working in a socially accelerating late modern world (political language)? These are different hermeneutic readings of the same "symptoms" (psychological and physical) that enable different aspects of one's situation to appear as salient. Different opportunities for action will also

appear in the process of interpretation, and the pragmatists will insist that the question is not simply which one of the languages is the *correct* one (according to a correspondence theory of truth), but which one of the languages will lead to *fruitful* consequences in terms of actions and experiences.

Continuing on the pragmatist note, we can say that the different languages offer the suffering person different subject positions, i.e., involve different forms of positioning (see Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009, for a recent exposition of positioning theory). To simplify, we can say that the diagnostic language in some cases will position the person as a patient, literally as a passive site for psychiatric dysfunctions (possibly rooted in the brain) that happen to affect the person in detrimental ways. Given this perspective, one is not an agent as such, but a location in a chain of causal processes. However, in other cases, the diagnostic language may also lead to externalizations of the person's problems in a way that actually does position the person as agent, i.e., as active in relation to "coping" with one's problems through the diagnostic framing and all that follows from a diagnosis (e.g., access to patient organizations, psychoeducation, and problem-solving exercises in one's everyday life). The point is, however, that the resources for this kind of active positioning through the diagnostic language must come from outside of the diagnostic language itself. In itself, the diagnostic language is one of causes and effects rather than one of persons and actions. So, in order to enable an active positioning, the diagnostic language must look in particular to the existential and moral resources, which "specialize" in agential language. The argument here is analogous to Harré's argument that understanding others through the Person-grammar, thus positioning them as persons that perform meaningful acts and can articulate reasons for action, is and ought to be primary over grammars (languages or vocabularies) that approach others as organisms (O-grammar) or clusters of molecules (M-grammar; Harré, 2002). These reductive languages are not useless or redundant just because they are reductive, for they are important conceptual resources that enable us to address vital features of human beings. But, and this is an important but, they are necessarily parasitic on a more fundamental understanding of others as persons (Harré develops this into the so-called Taxonomic Priority Principle, which states that we can only approach something as an organismic or molecular aspect of a psychological process—e.g., depression—once it has been identified as a process experienced or enacted by persons). Likewise, the diagnostic language is parasitic on those languages that position others as acting persons and articulate suffering as something that can, at least in principle, be a meaningful response to the world's events. And only when no reasons are within discursive reach should we turn to causal explanations. Sadly, however, the ways that the diagnostic language is used often conceals this very fact, thereby giving us something like the two-dimensional view of life described by Healy at the beginning of this paper.

There is thus a risk of blocking the necessary understanding of human agency if the diagnostic language becomes hegemonic in relation to human suffering. But there is also the adverse risk of positioning the person as an agent in relation to matters that are completely outside that person's control. This has been little discussed in the literature that is critical of diagnostic psychiatry, but it can in fact be detrimental to human well-being if one is addressed as an agent in relation to "non-agential" issues, i.e., matters beyond one's control. Thus, there might be a limit to pragmatism in a sense: the strength of

pragmatism lies in its idea that the language we use, and the kinds of positioning involved, can lead to human growth and development toward greater autonomy and enhanced agency. But not any kind of positioning is realistic, and an overly "optimistic" form of agential positioning may even lead to new problems for the persons involved, as they risk blaming themselves for their inadequacies (following the logic of "If I am a free agent with the capacity of choosing, and yet I am still suffering, then I must be the one to blame," which may lead to worsened suffering and so on in a vicious cycle of blaming the victim). That is why, to put it somewhat schematically, we must supplement the pragmatic interest in action possibilities (afforded by different languages inherent in social practices) with a hermeneutic interest in interpreting the person and her suffering in her life situation as it presents itself in its "facticity" (to borrow a term from Heidegger). In relation to this, we should also bear in mind that the question of languages, and which one to use, is rarely a matter of either/or. In practice, different languages often work simultaneously in people's self-understandings, and most people are capable of not only tolerating this, but also benefiting from it. A person diagnosed with ADHD may thus invoke one language in conversations with a psychiatrist, and other languages when meeting employers, friends, and family, for example.[1] A certain kind of linguistic flexibility is often at play, and the languages of suffering, including the diagnostic one, do not determine people's self-understandings mechanically.

At least one hugely important conclusion for mental health professionals follows from this: there seems to be no way of outsourcing judgments about when to use which language in relation to a given suffering person. No algorithm or manual seems capable of doing the trick, for these (e.g., the diagnostic tests) presuppose that the judgment concerning which language to use has already been passed. Simply diagnosing various forms of human suffering through tests and symptom checklists thus misses the process of understanding and analyzing the situated, contextual particulars that are often crucial. What is worse, it may lead to the blocking of otherwise fertile developmental pathways for persons if they come to appropriate a misleading language when articulating their problems, e.g., one that positions them as passive patients of symptoms rather than acting persons.

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Note

1. I am currently conducting fieldwork in a support group for adults diagnosed with ADHD and am struck by the linguistic creativity demonstrated by my informants in accounting for their lives and problems. They use several of the languages discussed in this article, but are also aware of the near-hegemonic status of the diagnostic language in relation to the welfare state in which they live. In future publications I shall describe in much greater detail how these people experience and perform their sufferings.

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