

Assimilation of Suffering

Patients frequently disallow their disease and refuse to accept its existence. One key facet of the disease experience that is not allowed is suffering. Yet, suffering quickly becomes one of the salient issues medical patients have to address, as their lives are soon taken over by it. Health care providers need to closely watch how patients respond to suffering, to assess if their response helps or hinders adaptation. This chapter will discuss an irrational, maladaptive response to suffering and then offers a rational, adaptive substitute that is termed the *assimilation of suffering*.

THE NATURE OF SUFFERING

Suffering is the feeling of distress and pain, both psychological and/or physical. The archaic definition of disease aptly distills the experience of suffering: a lack of ease in one's life—dis-ease. It is a state of misery, but it is also a response to misery. It is how the patient *chooses* to act—on a conscious or unconscious level—when faced with a disagreeable, unpleasant, unwanted, distressful activating event.

What are those activating events? What are experiences that commonly result in suffering?

- a. Disease of the anatomy results in negative physical sensations such as pain, itching, tingling, burning, bloating, etc. Suffering is both the physical response (e.g., throbbing, burning, aching) and the affective response (e.g., hate, irritation) to anatomical damage. In addition, there is a third component: the evaluation of the physical sensations (“This stinks,” “This is not right”). The affective state and the evaluation together comprise the psychological distress that the patient feels from having to endure physical discomfort. This definition of physical suffering

- is based on Melzack and Wall's gate control model for pain (1970).
- b. Undesirable physical conditions such as muscle weakness, fatigue, tremor, or instability when walking results in distress and frustration. Again, suffering includes the affective response (e.g., fear, frustration) and the evaluation of the physical condition (e.g., "This fatigue is terrible.").
 - c. The treatment for the disease and side effects from treatment can result in suffering. Treatment can be painful, onerous, debilitating, or cause loss (e.g., appearance decrements). There is substantial waiting time to see health providers and therapists, and treatment itself can involve substantial time commitments. That in turn causes other problems, such as loss of work or time away from the family. Health providers themselves can also cause suffering by being insensitive or difficult. There are repeated surgeries that cause the patient recurring pain and time away from work during recovery. There is disease that results in surgery that cuts away a part of the body that supports identity, such as the breasts or testicles.
 - d. The ongoing uncertainty, worry, and anguish that accompany many diseases frequently result in suffering.
 - e. There are difficult, harmful consequences from disease that cause suffering, such as financial loss, job loss, role performance decrement, inability to meet other people's expectations, or adverse, pejorative changes in friendships and family relationships. Again, there is the affective response to those consequences and the evaluative response ("It's awful not being able to work.") to those consequences.
 - f. There is suffering due to the loss of a lifestyle or "normal living."
 - g. There is suffering stemming from the entire medical experience, such as anger, helplessness, and powerlessness dealing with forces more powerful than the individual (e.g., HMOs, insurance companies, hospitals).

In fact, medical patients can suffer from two diseases. One is the actual disease of the body with its inherent symptoms. In addition, there can be a psychological affliction from not being able to suffer well, from not being able to cope with high levels of pain, distress, loss, and misery. This is the difficulty of not being able to manage the many changes and losses that come with disease. The *inability to suffer is possibly the major cause of depression and suicidal ideation among chronic and terminal illness patients, and not the disease itself*. See manual and disc to assess patient's degree of suffering.

THE REJECTION OF SUFFERING

To sum up, chronic and terminal diseases will result in some degree of suffering that is unavoidable. To state an obvious point, suffering is unpleasant and unwanted. At some point, virtually all chronic and terminal illness patients institute a coping strategy that rejects further suffering. While not wise, adaptive, or rational, the rejection of suffering is a way to address the shocking, jarring realization that the disease and its consequences are permanent for as long as the patient is alive.

While the rejection of suffering is an irrational, maladaptive coping strategy, it does offer some measure of satisfaction by responding to the powerlessness imposed by disease.

- It channels all of the emotions that result from having a disease and having to treat it (e.g., sadness, anger, and anxiety) into a uniform protest (“This is awful—what is happening to me!”). This protest takes a stand against unpleasant sensations, losses, and unremitting, unwanted conditions.
- It facilitates movement through treatment and eases side effects by complaining.
- It provides for venting and catharsis, which reduces frustration.
- It places limits on provider’s behavior, bodily sensations, or treatments that cause misery (“No more hurting; I’ve had it”).
- It offers comfort to patients via self-pity (“Why me? I don’t deserve this”).
- It removes patients from the situation via depression so they do not have to feel further suffering. Depression provides disengagement on both a physical and psychological level.
- It offers patients a final out from their torment—suicide.

The rejection of suffering can be detected in various ways:

- As complaints about the disease. The physical condition is renounced and spoken about derisively.
- As general irritability, impatience, and frequent rages.
- As brooding, dejection, and discontent that is part of depression.
- As difficult, demanding, or cantankerous behavior (e.g., frequent complaining and bickering with others).
- As self-pity, manifested as bemoaning existence.
- As frequent blaming of everything on the disease.
- As hatred of the condition.
- As talk about the limits of one’s tolerance (“I cannot go on this way any longer”).

- As assertions about fairness (“It’s not right what has happened to me”).
- Through choice of language, e.g., discussing a cure as imperative.
- Through plaintive or wistful yearnings for the pre-illness “good ol’ days.”
- Outright, overt rejection of suffering.
- Repudiation or dismissal of family members or health providers who try to help the patient accept the disease.
- Doggedly pursuing a cure in the hope that it can eradicate further suffering.
- As doctor-shopping and treatment-experimentation, again to find the illusive salvation.
- Avoidance of anything that can increase suffering, e.g., seeking a sedentary lifestyle in order to decrease pain and suffering. Decisions about how to live are geared around not aggravating the condition.

While on the surface the goal of eliminating suffering appears to make sense, it is nevertheless maladaptive because it underemphasizes coping with the disease and adjustment. It does not point the patient in the needed direction of learning how to manage and tolerate. The coping strategy is also irrational because it wants an end to something that will not end. By definition, chronic means an unending condition; hence, no cure. Terminal means there will be an eventual end. Even when the disease recedes, enters remission, or becomes asymptomatic, it continues to be a major factor in planning and living life. The fact is that chronic and terminal illness patients will have to face significant suffering that simply comes with the territory. *Rejection of suffering fights against accepting reality and instead seeks to change it.*

Overall, a rejection of suffering strategy causes more problems in the long run. It is actually magical thinking seeking salvation, born out of frustration, futility, and impotency. When patients finally realize that they cannot escape from their situation, suffering, bitterness, hopelessness, and desperation engulf them. When they realize that a cure is not forthcoming, they feel even more desperate and discouraged.

While suffering is not wanted, it does have to be addressed as an unfortunate, unwanted part of life. A way has to be found to coexist and make peace with it. It is the elephant sitting in the living room who will not go away. Ignoring, avoiding, or protesting will not eradicate it. The only way out is assimilation of suffering.

THE ASSIMILATION OF SUFFERING

When suffering occurs, a response tendency—*the assimilation of suffering*—is needed. It is incorporated into activities of daily living as a *response substitution strategy* for the rejection of suffering. Inserted into the cognitive and affective process at prescribed times and places, it interrupts pejorative responses and leads to an alternative stimulus-response chain. The cycle goes as follows: pain escalates, health providers frustrate, treatment drags on, fatigue does not cease, or altered appearance does not change. In each case suffering is felt. Now the patient refuses to suffer any longer. In place of that response, the assimilation of suffering tactic is utilized to override it.

This coping strategy offers several benefits. It reifies abstract ideas like acceptance, forbearance, and forgiveness, so they are able to take on a concrete existence. It allows patients to ***allow, accept, and absorb*** further distress and discomfort. It halts the protest against suffering. It admits and makes room for negative experiences that cannot be avoided. It makes peace with symptomatology and treatment side effects and facilitates coexistence with them. It allows suffering to be part of everyday movements and activities, so they can recede into the background of the mind. Let's now see how it is presented to patients.

INDUCTION PHASE

To lower resistance to and increase usage of this coping strategy, providers need to present it in the following way. Chronic and terminally ill patients will often rebel against this strategy because it calls for living with suffering, which is the opposite of what they want to hear from health care providers.

First, secure a phenomenological description of the person's experience. What is the disease and the treatment for that patient? Once patients have had ample time to ventilate and express anguish about having a chronic or terminal illness, introduce the idea of assimilating suffering.

You really face an awful situation. You did not want this disease to happen, but it has. That's rotten. It should not be this way, but it is. I can see why you think it is unfair. Disease is not pleasant, and there is a natural urge to reject it. You hate to accept the fact that you are stuck with a condition

that will cause you to suffer (or end your life). That's a hard realization to take in. I would think that would make you feel both angry and sad. Anyone would feel that way. It is hard to come to terms with the fact that your life will change (or end) so much now. That, too, is a hard fact to accept. You need to find a way to lower your level of suffering, and I know that is what you want. I have a way for you to do that. Hearing what I have to say, you may think that my strategy is contradictory to what you want. But if you try it out, it can help you in the long run.

Notice that the induction both agrees with and validates the patient's subjective reality, such as rating the disease as awful or rotten. It does not argue with the patient if the subjective reality is correct, as in REBT (Ellis and Abrams, 1994). Changing patients' evaluation of their disease (e.g., "It's awful") is not needed, providing they embrace coping as their primary objective. The induction informs the patient about what reality is, however. CCT does emphasize what is objective reality. Finally, the induction unites the therapist and patient to seek what the latter yearns for—a reduction in suffering. Paradoxically, that will come with assimilation of suffering.

EDUCATION PHASE

Once patients are willing to learn about assimilation of suffering, they can proceed to an education phase where they will learn how the skill can help.

You have a disease that causes you to suffer. That's a terrible thing to have happened to you. But if you know how to suffer, then suffering will not hurt you so much. If you are able to suffer well, you will not be so distressed about having a chronic (or terminal) illness. You may have substantial pain, but the pain will not bother you as much, once you learn the skill I will show you. People may frustrate and disappoint you. You may not be able to complete all of your responsibilities. Your symptoms may continue. All of that will cause you to suffer. But if you know how to suffer well, then the trouble that comes with having a chronic (or terminal) illness will not get to you nearly as much. Knowing how to cope can lessen the amount of suffering you feel overall.

Once patients are interested in learning how the skill operates, the therapist presents the three subskills that comprise this ability.

Acceptance

Acceptance is a mind-set and internal activity. It is commonly confused with surrender. The former is a mind-set for a situation, while the latter is a behavior. The behavior involves two options: surrender (suspend behavior trying to change a situation), or not surrender (seek a way to change the situation). With acceptance comes an affective state of grace, a peace of mind, and tranquility. Main ideas of acceptance:

- Realization that suffering—distress, discomfort—is an unavoidable by-product of chronic or terminal illness. The focus is on understanding and recognizing what is objective reality.
- Allowance of the fact that suffering and disease will exist because neither can be eradicated. Effort is expended on not hating this fact nor rejecting disease.
- Disallowance of hatred of reality. That keeps the unpleasant fact that disease will be a part of life in the foreground of the mind.
- Acceptance of the fact that a cure will not be forthcoming—at least for now. A cure may be found in the future, but if suffering is occurring in the present, then no cure is available now. Willingness is present to live with the inability to alter disease processes that are essentially beyond the self.
- Recognition that diseases are not supposed to be pleasant. Symptoms show a breakdown in normal anatomical functioning and are supposed to remove ease from a person's life. They inform the person that something is wrong. Patients are urged to face up to this fact with all of its implications.
- Acceptance of the necessity that coping with symptoms and suffering are most important and need to be of the highest priority.

While this message is grim, there is an underlying premise that embracing reality will make people feel better in the long run. Essentially, the assimilation of suffering forces medical patients to confront the disease's harsh, dark reality head on: "This is your lot in life. It is a heavy load to bear, but it is your load and only you can carry it." Because the message is grim, it must be delivered in a caring, inspirational way.

Forbearance

At this point, the second subskill, *forbearance*, is promoted. This is a different way to define suffering—to bear or *suffer one's fate gracefully* as

part of the daily passage through life. The patient is asked to show patience, tolerance, and restraint in the face of provocation—provocation from one's body, uncaring, demanding family or coworkers, or health providers showing little compassion. To be able to endure harm, injury, loss, or punishment now becomes the goal. Once such endurance is achieved, the patient can gain a heroic transcendence over unfortunate circumstances that might otherwise result in bitterness and disenchantment with life. Hence, the assimilation of suffering helps people to endure, suffer with dignity, and free themselves from the endless regret of what life should have become.

Forgiveness

The third subskill is *forgiveness*. This includes excusing one's body for coming down with the disease, and God, fate, or fortune for causing it. Forgiveness entails renouncing anger and resentment for having such a hard life to bear. It means overlooking the failings of the body, oneself, or others such as health providers. It means not holding the self accountable for years of smoking, drinking, drugging, and/or poor health habits that may have contributed to the disease. The patient lives with the consequences from his/her actions without rancor, disgust, self-criticism, or self-downing.

There are major benefits from incorporating this coping strategy. It helps patients avoid the vortex of self-pity and the corrosive effects from bitterness over having a painful existence, a lesser life compared with healthy people. This strategy integrates and absorbs suffering into everyday life experience so that it does not remain in the foreground of consciousness. When suffering drifts into the background, the perceived intensity of it is reduced. Misery no longer is the dominant life experience, and that allows other, more positive experiences to reach the foreground. Suffering then becomes a routine *but unwanted* aspect of daily life. When this happens, the secondary disorder from chronic illness—the inability to suffer the body's symptomatology—is ameliorated. Once the patient has been inducted into assimilating his/her suffering, the next step is teaching the tactics for accomplishing it in daily life.

TACTICS

These tactics can be implemented in any of the following situations.

- 1) The patient faces a situation that will increase his/her level of suffering (e.g., cleaning the house, getting out of bed, or completing a

work assignment). Have the patient monitor the activity and evaluate the level of suffering while performing it, from zero to five, with five being extreme suffering. This is a *misery or distress rating*.

2) The patient has a moderate to severe level of suffering (a level of three or higher on the scale from zero to five) at that moment in time.

3) The patient has a moderate to severe level of negative emotion (e.g., anger, frustration, sadness) concerning his disease, symptoms, or treatment side effects on a scale from zero to five.

4) The patient manifests a sign of rejection of suffering.

A. SELF-INSTRUCTION TRAINING

Self-instruction training (Meichenbaum, 1977) is one method of inculcating the beliefs supporting the assimilation of suffering. It will also be used to avoid and counteract the rejection of suffering. The dialogue directs what the patient will think about and how to respond to situations. The self-instructions have several purposes:

- To direct a person to think a desired, rational, realistic thought, e.g., “My symptoms are part of my life now. Accept them?”
- To direct the self to engage in self-evaluation, e.g., to check the level of pain or anger about suffering.
- To cue a coping skill, such as relaxation or problem solving.
- To cease an automatic way of responding, such as the maladaptive coping strategy of rejection of suffering (e.g., “Don’t fall into hating the disease”).
- To initiate and guide the use of a desired behavior (e.g., “Be assertive and tell him I feel too tired to do this”).
- To motivate the self, offer encouragement, and inspire desired behavior (e.g., “I can do this even though I am in pain”).

The patient and therapist design the dialogue together for all phases of an activity. First the therapist acts as a role model and repeats the self-instructions out loud and then silently. The reason for this is to show the patient that the self-dialogue becomes part of internal speech. The patient says the words out loud and then silently. Situations are then listed where the dialogue is to be used, such as when pain becomes severe. See manual and disc for handouts to patients to develop assimilation of suffering.

The self-dialogue is written for each phase of a situation that could result in suffering: a) before beginning that activity, b) when first experiencing suffering, and c) when feeling most incensed about the abject quality of life. Here is an example of a self-dialogue for a chronic illness patient.*** The dialogue works to inculcate acceptance, forbearance, and forgiveness.

Self-Talk Before Beginning Activities

I am about to start this activity. It will not be easy. I will feel pain and that will be upsetting. Prepare for it.

Let the disease run its course. Let it do its thing. Allow the symptoms to exist. They cannot be avoided.

Don't be afraid of the symptoms. I can handle them.

Don't hate the disease. Don't hate the symptoms. They are a part of me.

My body is me. Don't hate my body. Don't hate what my body has become.

Live with the difficulties while doing tasks. Don't get agitated.

Put my attention to other things. Don't dwell on what's distressing.

It would be preferable if I didn't have this disease but I do have it.

I must accept the disease. Live with it. It's part of me now.

Suffer my disease well. I want to feel proud of myself. I can bear this.

Don't be angry with my body for getting sick. Forgive it.

Self-Talk While Experiencing Suffering

I am going to suffer while doing this normal life activity and that has to be accepted. It comes with having a chronic illness.

Completing this activity is difficult, but I can do it. I can bear up.

Things will not come as easily as they used to. Accept that. Don't get mad because life isn't as easy as it used to be.

I feel some pain. Don't get mad about it.

Don't hate the pain. Pain is just part of my life now, a part of me. Let it in. Don't try to keep it out. It will feel worse if I do.

Don't be at war with my pain.

Don't make my distress foreground. Notice what's pleasant in this situation, regardless of the pain.

Self-Talk When Hatred of Illness Rises

I'm having problems dealing with my illness. I hate being in pain. That means I am fighting reality. That's not good.

Hating this disease means I hate my body. Focus on what I like about my body and not on what I hate about it.

Don't get angry. Take a few deep breaths. Relax.

My suffering cannot be avoided. I can live with it. I'm tough.

I can stand having this condition if I choose to.

I will feel worse when I hate what my body is doing.

I don't want to get involved in thinking that this isn't fair, that I don't deserve this. Thinking that way will only make me feel worse.

B. IMAGERY

Imagery can also be used to assimilate suffering into everyday life. It, too, operates as a response substitution when rejection of suffering occurs. For example:

Turbulent waters are crashing into a wall with a gate in the middle. The turbulent water stands for rejection and hatred of symptomatology and suffering. Then the gate opens and the water comes rushing in violently, threatening to wash over everything inside the walls. This stands for the initial shock of realizing that suffering will become part of your life, and how much it will negatively dominate life. After a few minutes the waters spread and become calm. The calm water represents you accepting suffering, and being willing to suffer your plight. The water at this point is absorbed onto the land and not noticed any more.

There is also real-time imagery, where a fantasy makes an invisible process visible. For example, the patient visualizes an ice cube that represents pain, diminishing with the aid of medication, heat, or exercise.

C. THERAPEUTIC METAPHORS

Therapeutic metaphors (Haley, 1967; Haley, 1973; Bandler and Grinder, 1975; Gordon, 1978; Gordon and Myers-Anderson, 1981; Zeig, 1980) gives patients a different perspective on the same set of facts. In the example below, the metaphor is given to the conscious mind.

Don, an angina patient, felt deeply saddened about the precarious nature of his heart disease that could kill or cripple him at any time. He was suffering from loss of self-esteem and thinking of his body as inadequate, weak, and crumbling. The therapist gave him a metaphor that he could use when he “fell into” this pejorative self-concept.

While you can think of yourself in several ways, I want to give you one way to see yourself. You are like a grand old house that has weathered many storms and seasons. While the house does have extensive structural damage in many places, it is still quite capable of providing its occupants with many good years of use. This is a home with history and unique charms. New homes don't have the look of these grand old homes.

Metaphors can also be delivered in an indirect way as part of casual conversation. In that case they are aimed at the unconscious. In this example, the therapist makes small talk with a cancer patient suffering from uncertainty about her future. The therapist nonchalantly brings up what he is thinking of doing that summer—taking his family to see relatives in Colorado. The therapist then reminisces about an experience he had many years ago.

I was taking this raft trip down a very pretty, rugged river in Utah. The river was breathtaking. We had this experienced guide take us downstream, and that made me feel quite safe, even though the currents were moving very fast. I was not even fazed by how dangerous this experience could be. We were having a relaxing time and everything was wonderful, when all of a sudden we descended down a small waterfall and landed on a rock that could not be seen from the surface. We were suspended and unable to move off the rock. The guide said that this was very dangerous because we could flip over and anything could happen in the swirling water. The trip that started out so safely had suddenly become quite perilous. We were all very worried and I was scared. While we were stuck on that rock, not knowing what would happen next, I started looking around at the river, seeing it from a unique angle. Stuck a few feet below the oncoming water, I was eye level with the swift water coming directly at us, but then it slipped underneath us. Sitting on that rock, in that dangerous position, I had a chance to experience this amazing sight.

The therapist delivers this metaphor without explaining it, that life is a powerful river that is both beautiful and dangerous at the same time. He gives the patient another way to view life, as not just depriving. He wants her to see that even in uncertain, dangerous times there are still wonderful things to behold if someone wants to notice them.

D. SYMBOLIC GESTURING

Symbolic gesturing is a technique that uses a physical movement to create an internal state. It can be combined with self-instructions or imagery. When patients notice that they feel upset and are engaging in rejection of suffering, the symbolic gesture is deployed. For example:

- A slowly moving, horizontal hand gesture stands for a calm life gained by assimilation of suffering. If imagery is combined with this, the patient can imagine a calm, flat ocean along with the hand movement.
- The hands can slowly move toward the body, as if the person is pressing something into him/herself. This stands for letting suffering into the patient's life. If self-instructions are combined with this, the patient can say a small phrase to him/herself like, "Let it be" or "Let it in" as the movement is occurring.
- The hands can slowly push away from the person, as if gaining breathing room from the disease and its symptoms.
- The hands cascade down like a waterfall, to stand for water running off a duck's back. The water is other people's criticism of the patient for not meeting their expectations. The water washes away and does not hurt the duck. This is a way to avoid getting upset about others' criticism.
- A noxious stimuli is felt (e.g., pain, burning) and at that moment the patient raises his/her head and holds the hand suspended in the air. This symbolizes rising above the negative sensation, to facilitate forbearance.

When used over time, *symbolic gesturing intertwines self-instructions with the gesture* that instructs the person in how to feel and act. In time the gesture stands for the self-talk. For instance, when a patient moves his hand horizontally, he automatically and subconsciously gives himself instructions.

E. OUTCOME ENACTMENT

Solutions-oriented therapy (de Shazer, 1985, 1988, 1991; Selekman, 1999) focuses on times when patients are acting in a way that is part of the desired outcome state. This is referred to as an exception moment, when they are performing actions that are a useful solution for resolving the problem that has brought them to therapy. The treatment rests on encouraging the patient to continue doing what is working, and avoiding actions that do not contribute to the desired outcome state.

Using this idea, CCT asks patients to think of when they are using coping responses that lead to the desired outcome state. For instance, in the case of medical patients, the outcome state may be feeling satisfied with the positive elements of life and not being immersed in what has been lost. The patient is then asked to notice times when s/he is achieving that desired outcome state (referred to as the miracle state, when everything is falling into place). S/he is to take note of what is being done to contribute to that successful outcome. The patient is then asked to continue using that coping response (to do what is already working).

However, if the desired outcome state is not occurring (the miracle has not happened), then the patient is asked to act as if it were happening (Berg and Miller, 1992). S/he is to enact the behaviors and attitude specified in therapy that can lead to the desired outcome state.

F. ENACTING THE ROLE MODEL

This technique uses a role model to stimulate patient behavior. Medical patients are asked to take notice of anyone they have known who handles problems well. Patients are then asked how did they do it? What coping skills does that person possess that allows him/her to act in a productive way? CCT then asks patients to take on the coping responses of that person to achieve the desired outcome state. The patient incorporates those actions by pretending to be the role model when rejection of suffering is detected. The patient leaves his own personality and for a period of time acts as the role model, using his/her positive traits and actions (Sharoff, 2002). Time is spent role-playing the model in general. The patient is encouraged to stay in that role, like an actor. Portions of a day are given over to play-acting that person, at work, in church, visiting others, etc. Another option is having the role model as a mentor. Patients are asked who has been an inspiration to them, or who is

someone they respect and admire. They then pretend that the role model is speaking to them in a situation, guiding their actions.

G. ANCHORING

The final tactic uses the Neuro-Linguistic Programming technique of anchoring (Bandler and Grinder, 1975, 1982; King et al., 1983). In this technique, patients first imagine a specific time when they were able to assimilate suffering, when they were able to accept it into their life. To make those situations more vivid, patients can see parts of the scene, smell particular objects in the scene, hear the sounds in the scene, and so on. Then, at the moment the scene is clearly being remembered, the patient touches a particular part of his/her body (e.g., the first knuckle on the right hand). Continuing on, the patient remembers other moments when there was assimilation of suffering and follows the same protocol. Several scenes are remembered and each time the patient touches that same spot. This creates an *anchor to entire positive experiences where the coping skill was employed successfully*. When patients then face a difficult situation in the present, or when experiencing a rejection or suffering, the anchor is used at that moment. The anchor allows patients to rekindle the positive coping moment, which helps them deal with suffering.

Summary

Disallowance of disease can take the form of rejection of suffering. There are various signs of this, including protest against the disease, hatred of it, and the obsessive seeking of a cure. This response needs to be replaced by another that facilitates acceptance of reality, a willingness to bear distress, and forgiveness of the body, oneself, God, fate, or fortune for causing the disease. This response is termed the assimilation of suffering. There are various tactics and techniques to develop assimilation of suffering, including: self-instruction training, imagery, symbolic gesturing, solution-oriented therapy, therapeutic metaphors, becoming the role model, and anchoring.