Chapter 11

Commitment in the Clinic

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HUMAN BEINGS are difficult to understand in large part because they are so irrational. If they would simply maximize their inclusive fitness in a straightforward way, their actions—and their difficulties—would be far easier to understand and treat; but they don’t. Their behavior (our behavior!) often arises from passions that induce actions that seem to have nothing to do with a sensible reproductive strategy.

- A woman comes to the clinic depressed because her life is constricting as she cares for her demanding husband, who is being progressively impaired by multiple sclerosis. Attractive, wealthy men encourage her to leave, but she stays.

- A couple is in the midst of a divorce. One day both call their mutual friends to reveal damaging secrets about one another. The next day they make up and vow to love each other forever.

- A middle manager in a large corporation impulsively quits after having been insulted by his supervisor. He has no other job prospects.

- An attractive and intelligent young woman is brought to a clinic by her parents after she tells them about her religious cult’s plans for a mass suicide.

- A single middle-aged woman gives up her lucrative career and spends most of her time teaching piano to friends who pay her a pittance.
• Teenagers drive wildly on manicured lawns, wrecking them for no apparent reason, despite the risks of being caught.

• A man who gets into college and the priesthood chooses the priesthood.

• A father drives for hours every night, looking for the men who raped his daughter a year ago, even though he has no way to recognize them.

• An attractive young man is so shy that he cannot even talk to the many women who want to date him.

• A woman reports that she wants to have a family but cannot because she has been unable to consummate her marriage after three years.

The psychiatric clinic is the birthplace and graveyard of theories of human nature. Clinicians are desperate to find ways to explain what they see. They winnow and stack the rich data from clinical observations into diverse theories, many of which do well in describing the phenomena and sometimes even predicting how people will act. Personality theories, psychodynamics, theories based on attachment and self, family dynamics, behaviorism, and cognitive theories all flourish. The thoughtful clinician is overwhelmed. None of the theories start from first principles, and criteria for choosing among them are not clear-cut. Most clinicians, however, do choose. Many remain loyal to Freud's perspective, while others denigrate it. Some cling to learning theory and try to recondition their patients. Some blame societal conditions. Others emphasize the roles of family and marital conflicts, or emphasize faulty patterns of thinking. Still others focus on individual differences in genes and brain structures to seek the causes of mental disorders.

Each of these perspectives contains some truth. Yet eclecticism is a swamp in which both patients and clinicians quickly become mired. Successful treatment requires a framework that makes sense of problems. A narrative with a villain provides a target to attack. This may be why most clinicians hold fast to one or another school of thought that blames one or another causal factor (Frank 1975). Yet the same rich data that gives rise to theories also challenges them. When they tackle the complexities and apparent unpredictability of individual human passions, theories crash and burn.

What we lack is a solid theory that explains how relationships work. Medicine has physiology; psychology needs a comparable understanding of relationships and motivation. When we have it, we will do much better at understanding why people are so often in con-
flicts that give rise to hate, love, anxiety, guilt, and depression. An evolutionary approach to relationships grounded in biology would seem to offer just what the doctor ordered; indeed its arrival has occasioned much excitement and some real progress (McGuire and Fairbanks 1977; Wenegrat 1984; Glantz 1987; Slavin and Kriegman 1992; Gilbert, Price, and Allen 1995; McGuire and Troisi 1998). In particular some clinicians now attend far more than previously to the significance of genetic kinship (Essock-Vitale and Fairbanks 1979), and some have begun analyzing how resources are exchanged in reciprocity and hierarchical relationships, and how emotions mediate the negotiation of these exchanges (Sloman et al. 1994; Gilbert, Price, and Allen 1995; Sloman and Gilbert 2000). For those who are not already familiar with these ideas, they will be reviewed briefly prior to illustrating their value in the clinic, how they quickly meet their limits, and what an understanding of commitment can add.

The basic principles of kin selection are just now beginning to transform how clinicians understand relationships. For instance, many advocates for abused children remain unaware of the powerful role of biological kinship in protecting against child abuse (Daly and Wilson 1981; Gelles and Lancaster 1987).

In the clinic the influence of kinship is illustrated vividly by a case in which the family had split into two warring camps, the woman and her children from a previous marriage versus the man and his daughters from a previous marriage. In another case, when a ten-year-old boy was evaluated for depression, he said his father cared only about the other two children, not him. The mother denied it and tried to end the treatment, but after long patient inquiry, the father finally admitted that he had never believed that the boy was his own son.

The nature of cooperation and competition between siblings also is illuminated by an inclusive fitness perspective. Siblings have good genetic reasons to help each other outside the family, but within the family they compete for resources. Cultural traditions that gave priority to one child, usually the eldest son, now have been replaced by an expectation that all children will be treated equally. Often children recognize that this is not the case, despite their parents’ protestations. These insights gradually are making their way into family therapy circles where sibling conflict more often is seen as expected now— something to be managed, not cured.

Relationships between mothers and infants also appear dramatically different from an evolutionary perspective (Hrdy 1999; Low 2000). Wildly speculative theories about infant psychology and the trauma of weaning (Klein 1988) now can be replaced by knowledge about the intrinsic conflicts of interest between mothers and infants (Trivers 1974). We now know that, as suggested by many previous
theories, a time does exist early in life when the interests of the mother and her child are nearly, but not quite, in complete synchrony. We also know that mothers tend to allocate resources according to what best will enhance their inclusive fitness. In wealthy societies these choices can be avoided or concealed, but in our ancestral environment mothers had to make choices that today seem impossibly difficult (Shostak 1983; Hrdy 1999). Even in utero, conflicts between mothers and fetuses can result in serious problems such as diabetes and hypertension of pregnancy (Haig 1993). Later in life, weaning conflicts, struggles with a "willful child," and conflicts in adolescence (Weisfeld 1977) all make far more sense when viewed in light of evolutionary principles. Much remains to be done to better understand the role of kinship in human relationships, how it is mediated, and how it goes wrong and causes conflict and suffering (Davis and Daly 1997). Such work eventually will improve treatment, as principles of kin selection are incorporated as a foundation for understanding family relationships and conflicts.

Increasing understanding about the workings of reciprocity relationships also is starting to influence clinical practice. Trading favors judiciously gives a selective advantage that has almost certainly shaped special capacities to accomplish this (Trivers 1971; Axelrod 1984; Glantz 1987). Usually modeled using game theory and the prisoner’s dilemma, the benefits of repeated cooperation are substantial but unstable, because of the temptation to defect and the risk that the other will defect. Following the lead of Trivers and others (Trivers 1971; Tooby and Cosmides 1990), I have argued elsewhere that the four boxes defined by the prisoner’s dilemma define situations that have arisen so frequently in the course of our evolution, and with such a profound influence on fitness, that each has shaped distinct emotions that increase the ability to cope with them (Nesse 1990). Repeated cooperation leads to friendship and trust. An intuition that the other will defect leads to suspicion. Recognition that the other already has defected leads to anger. A temptation to defect leads to anxiety, and betrayal of a social obligation arouses guilt. Such exchanges, and the emotions that mediate them, are the bedrock of social life; covering it is a rich organic soil of culture and traditions that give rise to luxuriant vegetation that varies wildly in different locations, and involves much pathology.

Clinicians, even those who know and appreciate the power of kin selection and reciprocity, find that these principles do scant justice to the tangled webs of relationships that give rise to individual psychopathology. For instance, when someone fails to follow through on a commitment, say to get married, the result is not "Oh well, I will find someone else"—blind rage is more likely. Yes, one person has de-
fected and anger is the emotion expected in an evolutionary view of reciprocity. Yet clinicians who spend dozens of hours over a period of weeks talking to the participants in such a debacle are swept up in a conflict whose escalation quickly leads them to consider higher levels of complexity.

For instance, the therapist gradually begins to understand that the jilted bride had not told her fiancé that she might not be able to have children. He had not told her that he was planning to drop out of law school. Their parents' consent was privately grudging owing to religious differences. Then there was that phone call from his high school girlfriend. She thought she had found a man who would provide the secure kind of environment that her father had not been able to, but then her fiancé insisted on leaving her on her own while he went hunting. He thought he was treating her as an adult, but she felt abandoned and began acting more dependent on him, and asking for more reassurance. She began demanding that he make public declarations of his commitment; this made him more fearful and more insistent that she participate eagerly in new kinds of sex, just when she only wanted to be cuddled. No theory will ever be able to embrace all the factors that shape such a situation. This is why providing psychological treatment always will be an art form as well as a science. To incorporate as much information as possible, a clinical narrative is the most comprehensive and efficient framework, but the scientific value of such ideographic approaches is severely limited.

This chapter considers the role of subjective commitment in complex human relationships and psychopathology and argues that:

- much of the complexity in human sociality arises because many relationships are based on subjective commitment;
- natural selection may have shaped specific emotional capacities to mediate such commitments;
- much psychopathology arises from the exigencies of those commitments; and understanding the mechanisms that mediate subjective commitment will lead to more effective treatments. More broadly, understanding commitment strategies may offer a link between the vast complexity of human lives and the forces of natural selection that have shaped their minds. We humans think and talk and make complex multistep plans to prepare for situations years ahead of time. Our actions depend not just on stimuli we respond to, but also on what we believe about human nature in general, and about the future actions of specific individuals. If natural selection has shaped mechanisms to allow us to cope with complex and competing commitments, this knowledge should yield a deeper understanding of psychopathology, and should also give us new powers to make life more bearable.
Overview of Subjective Commitment

Commitments influence others by signaling an individual’s future intentions. A commitment is more than a mere prediction, plan, or wish. A commitment implies that an individual will keep trying to reach a self-imposed goal or expectation, even if that becomes difficult or disadvantageous (Klinger 2000). Saying you will eat dinner tonight is not a commitment. Saying you will fast for three days is far more difficult, and thus a commitment. Promising to meet someone for lunch is a small commitment. Promising to stay with and help one partner for the rest of your life—now that is a serious commitment. Plans become commitments only when they are likely to require sacrifice (Hirshleifer 1987). This is very different from a model of an animal acting straightforwardly to maximize inclusive fitness. The whole idea of a commitment is that, in some specified future circumstance, an individual will act in ways that are the opposite of those that would increase fitness (Frank 1988).

Many people are put off by attempts to interpret personal relationships in terms of simple reciprocity (Kohn 1990). They insist, often vehemently, that their relationships are not merely to exploit others in order to benefit their genes. While it must be true that genes that influence behavior can become more common only if they result in behaviors that tend to advance a person’s genetic interests must be true, these indignant objections are, nonetheless, understandable. The advantage does not go to those who take advantage of others, it goes to those who can convince others that they will behave in ways that are not necessarily in their best interests—that is, that they will fulfill their commitments. As in defecting in a prisoner’s dilemma game, the maximum short-term advantage may come from not following through on a commitment, but often—in fact usually—people must do what they say they will do, or suffer the terrible consequences of exclusion. Even more than satisfying our desires, we seem to be designed to want to please others. Anxiety and guilt may have special utility in a species that relies on subjective commitments (Brickman 1987; Gilbert 1989; O’Connor and Berry 1999).

Most commitments are contingent: a person commits to doing X if the other does Y. While some commitments are to personal goals, most are promises to help someone or threats to harm someone. If two people both believe that the other will help them, even when that would offer no advantage at all, they can form an alliance far stronger and more valuable than any that could be created by calculated self-interest. Social institutions facilitate such agreements by creating new incentives enforced by third parties (contract law is the exemplar).
Personal relationships such as marriage or friendship, however, even when socially defined, depend primarily on subjective commitment. Internal states and their attendant feelings mediate actions in personal relationships. The link between subjective and externally enforced commitments is complex. Social constructions such as marriage that change the external contingencies also change the subjective emotional response to a situation. If escape from the commitment is impossible, the mind runs far less to the alternatives with all the attendant desire, guilt, and ambivalence.

A capacity for commitment generally is valued. We associate making and keeping commitments with character, and we admire (or fear) people who do this. Sometimes we describe such people as noble or having character. Reputation is so important because it makes our commitments potent influences. One of the most crucial facts about a person is whether she or he has a reputation for following through on commitments. People who lack or lose such a reputation are consigned to the social periphery.

**Attachment**

That human relationships are based on something more than learning and optimal exchange has long been obvious. Our deepest relationships and feelings arise from emotional commitments to other people. This is often called *attachment*, following the work of John Bowlby (Bowlby 1969). Harlow's studies put to rest the notion that infant monkeys behaved mainly to get food (Harlow and Harlow 1962). They preferred foodless terry cloth surrogate mothers to wire forms supplied with a milk bottle. Even geese, in Lorenz's studies, followed not the source of food, but whatever they saw moving during a critical period early in life (Alcock 1997). This imprinting object was not only a safety signal early in life, but also later served as a model for finding appropriate mates. Bowlby put these findings together with his clinical experience as a psychoanalyst and concluded that human infants got a selective advantage by their motivation to stay close to their mothers. He called this tendency attachment. Even though Bowlby did not know about kin selection and the difficulties with group selection, he recognized that natural selection likely had shaped specific motivational mechanisms to ensure the proximity of mothers and infants.

This insight provided the impetus for an enormous amount of research, much of it focused on variations in attachment (Ainsworth et al. 1978). We now know that an infant's pattern of attachment to its mother is remarkably consistent across months and even years. In-
fants who are securely attached tend to stay that way unless they experience trauma, while avoidant or anxiously attached infants tend to stay that way. The theory assumes that these patterns of attachment are determined primarily by how the mother treats the infant. Typically, “normal” attachment is seen as desirable, while any other pattern is thought to be pathological. The possibility that genetic differences may account for individual differences in attachment style, and that genes shared by the mother and child may account for the similarities of their attachment patterns, has been met with considerable resistance (Goldsmith and Carman 1994). In a similar vein, only recently has any interest been shown in considering the possibility that differences of attachment style are facultative adaptations that may improve a baby’s chances in certain kinds of situations (Chessholm 1996). Bowlby relied heavily on developmental explanations for adult patterns of relationships. This has spilled over into a strong tendency to describe adult attachments in terms of the utility of attachment for infants, when very good and very different reasons exist for adults to have emotional attachments.

Hazen and Shaver have found ways to categorize people in terms of their attachment style (Hazen and Shaver 1994). The consistency of attachment styles across time seems to depend on the “internal working model” a person has of how others will act toward them and how they should act in return (Berscheid 1994). Adults who are “secure” see others favorably, and tend to trust people and be capable of close relationships. “Ambivalent” individuals want relationships but are untrusting and believe others are likely to disappoint them. “Avoidant” individuals have a negative view of human nature and tend to assume that others are untrustworthy (Reis and Patrick 1996). Bartholomew and Horowitz offer a four-category scheme that includes secure, dismissing, preoccupied, and fearful attachment styles (Bartholomew and Horowitz 1991). The distinctive characteristics of attachment styles may make sense as strategies for managing committed relationships. Their consistency over time may arise not only from genes, but also from the self-perpetuating nature of beliefs about others. People who can trust others often find trustworthy partners. Those who cannot trust others have their negative beliefs repeatedly confirmed.

We may assume that early experiences set a developmental trajectory that settles into self-perpetuating expectations about relationships with good reason. Also, our adult attachments may well utilize the same brain and mental mechanisms as those that make infantile attachment possible. Nonetheless, the functions of attachment in adult life may be quite different and important in their own right. Subjec-
tive commitment may be the engine generating the strong feelings that bind us to others in adulthood. People who lack these capacities suffer serious disadvantages.

Syndromes Related to Subjective Commitment

One of the best ways to identify the functions of a trait is to observe what happens when it is absent or malfunctioning. Several syndromes of absent or otherwise defective commitment are especially constructive in this regard.

Obsessive-compulsive personality (OCP) is a syndrome very different from obsessive-compulsive disorder (OCD) (Diaferia et al. 1997). People with OCD are preoccupied with the fear that some small oversight will lead to catastrophe that will harm others. They perform apparently bizarre rituals—repeatedly washing, organizing, or checking things to prevent the danger, or at least to try to relieve their pervasive anxiety (Goodman et al. 1989). All kinds of people get OCD. In some cases it seems to result from streptococcal-induced autoimmune damage to a part of the brain called the caudate nucleus (Goodman et al. 1989). Our focus here is a different disorder, obsessive-compulsive personality disorder.

People with OCP tend to have an analytical, intellectualized, cold view of life. They are preoccupied with duty and often outraged by other people who are not so constrained. They are very concerned with their obligations and those of others. They try to control everything and everyone in their vicinity. They often cannot understand why others become frustrated with them. Many of them do not experience passions in the same way that other people do, and they cannot understand other people's emotional outbursts. Predictably, people with OCP can be extremely difficult to live with. While most people make romantic commitments in a state of passion, the person with obsessive-compulsive personality is more prone to negotiate a contract. While others express rage at some betrayal, the person with OCP is liable to harbor silent, steady, simmering fantasies of revenge.

Obsessive-compulsive personality disorder can be interpreted as a deficiency in the emotions that make subjective commitment possible. The person with OCP simply cannot understand it when others act on passions. Such people have trouble believing that others are sincere in their fervent promises. They experience invitations to emotional commitment as attempts at manipulation. Since they tend to do their duty exactly and with great scrupulousness, and expect the same of others, they are often disappointed in this regard. People
with OCP have a huge capacity for moral commitment but a deficient capacity for emotional commitment.

Other disorders are characterized by nearly the opposite condition: a proneness to make quick, profound emotional attachments, but to be lackadaisical about moral commitments. In previous times this often was called hysteria. In both sexes, however, some individuals are prone to make rash, passionate commitments. The person who cannot understand falling in love has one kind of problem; the person who falls in love head over heels in a moment, but for only a few days, has a different kind of problem.

The term *borderline personality* refers to a condition that once was thought to be in between neurosis and psychosis, but now is recognized as a distinct syndrome characterized by extraordinarily quick development of intimacy, followed by profound insecurity and demanding behavior that frighten others away (Swartz et al. 1990; Gunderson and Phillips 1991). People tend to develop deep relationships over a period of months and years. During this time they test each other's reliability and personal characteristics. Some desperate individuals, however, want to bypass all that and make lifelong promises quickly. They often idealize potential partners. Other people naturally are intrigued but wary. They soon find that they fail to live up to the exaggerated expectations. People lured into the emotional orbit of such a desperate person often become frightened and withdraw. This creates, in the life of someone with a borderline personality disorder, a long history of quick intimacies followed by rejection. The expectation that this will be the pattern for future relationships sets up a positive-feedback spiral leading to profound and sometimes intractable pathology. Patients with borderline personality disorder also tend to use certain interpersonal strategies excessively and rigidly (Paris 1994). In particular they use a strategy called *splitting*, in which they idealize and offer to help one person, while denigrating that person's friends. The strategy can work, and appears frequently in everyday life, especially in politics. Patients with borderline personality disorder, however, use the strategy so crudely and consistently that it dominates their lives. In essence splitting is a desperate attempt to establish committed relationships by promising more than can be delivered, and by undermining other competing relationships.

Thus far the discussion has focused mainly on commitments to help others, but threats are equally effective commitments, and they too are associated with specific kinds of pathology. Some individuals learn early on that threats are effective social manipulators and may use them as a rigid and nearly exclusive strategy. If such people can attain a position of power, they sometimes can succeed with this lim-
ited repertoire. If not, they alienate people and enter a downward spiral. Conversely, those who cannot use threats at all are likely to be vulnerable to manipulation unless they live in a very well-ordered social group. People who repeatedly make threats they don't follow through on soon find their threats ignored.

Sociopathy can be viewed as a defect in the capacity for commitment. Many sociopaths who lack a capacity for guilt can, nonetheless, imitate commitment exceedingly well. Sociopathy in fact can be interpreted as a strategy that exploits people's wishes for committed relationships (Cleckley 1964; Mealey 1995). The sociopath often is expert in knowing what others want and how to get their trust. He does not, however, keep his commitments. Often he has been raised in a home where the expectation of others to keep their commitments simply doesn't exist (Rutter, Giller, and Hagell 1998). While many phenomena associated with sociopathy can be interpreted in reciprocity terms, the manipulative sociopath gets people to believe his promises. In short, he pretends to make emotional commitments, and then exploits those who believe him. Here the concept of commitment helps to bridge the gap between attachment pathology and the origins of sociopathy.

In the clinic suicide threats are of particular significance. Some simply reflect the hopelessness that attends interminable pain, physical or psychic. Frequently, however, a suicide threat is a communication that reminds others of what they might lose. All too often, though, such threats do not reunite the social network. They can become chronic as others vacillate between attempts to help and wishes to criticize or avoid the person making the threat. The relationship between depressive disorder and its associated suicidal wishes thoroughly complicates this matter to the point where even experienced clinicians have great difficulty. Suicide threats tragically illustrate the paradox of commitment strategies when a person who has threatened suicide feels compelled to take action in order to maintain his or her reputation for following through on commitments. This may help to explain why it is so difficult and dangerous for relatives and friends to challenge the seriousness of the suicidal threats.

Origins of Psychopathology

Psychopathology often arises, as we all know, from relationship difficulties. On one hand, this is not surprising. After all, the main determinants of reproductive success for humans are relationships and social success, and groups are the main venue of competition (Humphrey 1992; Buss 1984; Tooby and Cosmides 1989; Cosmides and Tooby 1989). On the other hand, why must life be so difficult? Why
can't people simply make and keep stable relationships? Life would be so much easier and happier. The reciprocity model only begins to explain the difficulty. From its perspective, we are all trying to find generous cooperators, and yet we are on the lookout for cheats and we attempt to deceive others to gain an advantage when we can. Some evolutionists see social systems as providing rewards to those who can cheat in the subtlest ways (Trivers 1976; Alexander 1987). The prisoner's dilemma provides a good model for business, but it is very limited when it comes to intimate relationships and even politics, where influence is exercised by promises and threats backed up by reputation.

Extraordinary complexities arise from the apparent intrinsic contradictions of commitment strategies. The goal in making a commitment is to convince others that you will follow through on behavior that will not be in your interests in some future situation. How can you convince them of this? You can tell them in ever more fervent and sincere tones but it is usually more effective to put your reputation on the line by making public proclamations of your commitment or to engage a third party to enforce the contract. The most convincing evidence, however, is beginning to carry out the commitment. Thus when potential mates become ill, they watch to see if their partner becomes more or less helpful. Zahavi has argued that individuals often “test the bond” by acting uncooperative to see if the partner's commitment will persevere despite difficulties and lack of rewards (Zahavi 1976). He cites the example of courting birds—cardinals—in which the male must provide food to and accept days of abuse from the female before she will agree to mate. An alternative explanation is that she is testing his abilities more than his commitment, and is comparing his prowess to those of other males. Her actions also constrain him from pursuing other mates, thus perhaps decreasing the risk that he will desert the nest after mating.

Something very similar seems to go on in human relationships, most notably in so-called lovers’ spats. In the early phases of courtship partners sometimes withdraw from one another, perhaps to see if the other will tolerate this; but acting cold, hostile, or stingy in order to see how the other reacts is a risky strategy that is notoriously prone to misfiring. Both partners are, after all, trying to discern the other's commitment. What is testing of the bond from one perspective simply may be abandonment and demonstration of unfaithfulness from the other's perspective. That relationships develop slowly with gradually increasing exchanges of resources and obligations is interesting in and of itself. Our best friends are old friends, and to begin to trust others takes a long time. This time can be cut considerably, and the risks of commitments reduced dramatically, if both part-
ners are members of a group that provides both increased information about a person's character and increased punishments for defection.

The presence of third parties inserts complications into committed relationships. Clinicians who study families and groups repeatedly note that the primary structure of social life is the triad (Zuk 1981). The purity of any relationship is shaken by compromises required when a third person is involved. One in fact could generalize this to multiperson political interactions. Individuals attempt to create alliances with third parties, but every such commitment is likely to conflict with some other commitment. Thus the great difficulties faced by politicians who must try to ingratiate themselves with members of different groups. People are listening to see if these politicians will say one thing to one group and one thing to another. To succeed, they must. Unfortunately straightforwardness seems not to work very well, except when an advantage can be gained by getting strong support from one group at the expense of another. In short, conflict between competing commitments is a fact—perhaps the most basic fact—of everyday social life.

Our psychodynamics seem to be designed to protect us from excessive cognizance of these difficulties (Nesse and Lloyd 1992; Slavin and Kriegman 1992). Some people are, however, all too aware of them, and suffer greatly in trying to please everyone all the time. A comment on neurosis is germane here. The essence of neurosis is a deep fear that others will abandon you or attack in response to any apparent misdeed (Shapiro 1965). Neurotic people feel that they have no alternatives in situations when others become angry or threaten to leave. Neurotics try to understand what they might have done differently and how better to please the other (Horney 1937). One cannot, of course, please everyone all the time. Worse still, exploiters are attracted to such people and take advantage of them until they reach a breaking point. One wonders whether the prevalence of neurosis in modern societies, and the proliferation of treatments to ameliorate the symptoms, may be related to the contrast between our mass society and the small groups from which we evolved. In ancestral societies people had only a few social roles and obligations and did not have to juggle many roles, and they may often have had alternatives if the current situation became intolerable. By contrast, in modern societies most of us juggle multiple conflicting commitments in social groups from which there is no escape. We can't please all of the people all of the time, and the pressure on our identities is substantial.

This leads naturally to a brief consideration of guilt, a common psychiatric symptom. While sometimes interpreted by evolutionists as a manipulation, I suspect guilt is better interpreted as an internal
motivator to maintain commitments (Gilbert 1997; Keltner and Busswell 1996). The fear of experiencing anxiety before a violation of commitment, and of experiencing guilt after a violation, provide strong motivators to maintain subjective commitments even in situations where doing so is obviously not in the person’s interests (O’Connor and Berry 1999). This provides powerful motivation for moral behavior. The fact of guilt, and the human capacity for moral behavior, provides some of the most powerful evidence that natural selection has shaped the human capacity for subjective commitment.

As noted earlier in the section on attachment, what people believe about their own capacity for commitments and other people’s capacity for commitments has a profound effect on how they live their lives. Someone who never has had experience with others fulfilling their promises will be unwilling to trust others and unwilling to enter into commitments. Such a person’s social world is fundamentally different from that of someone who believes that subjective commitments are possible. An extensive psychiatric literature describes the importance of a capacity for “basic trust,” and the pathology that characterizes its absence (Balint 1979). People who believe that committed relationships are possible are capable of such relationships and they thus gain advantages, even though they are vulnerable to exploitation. People who believe that others are incapable of making commitments will be unable to do so themselves; this belief is thus self-perpetuating. Those who hold it, and who are held by it, live in a world that is genuinely more ruthless than the parallel social world occupied by others.

The preoccupation of many social scientists with social constructions and their effects on social and individual life is germane here. What people believe about others and their relationships certainly is influenced by what they learn in childhood. Later in life, learning to view others as, for instance, Homo economicus, has tangible effects on behavior. Economists, for example, are less prone to public contributions, most likely a result of being exposed to the field, not because of preexisting personality traits (Frank 1992). With good reason we may expect that similar effects result from exposure to views that humans are just fitness maximizers.

Psychotherapy

Psychotherapy is a solution with a problem. Hundreds of different brands each claim to be effective. As noted earlier, it appears that many are helpful, especially those that can recruit the confidence of both therapist and patient (Frank 1975). Interestingly, most all of them are based to one extent or another on creating a relationship. Abso-
lutely crucial, and at the heart of every therapeutic relationship, is trust. Trust first that the treatment will work, but equally important is trust in the therapist's ability and willingness to fulfill commitments. One of my teachers once said, "Lie to your mother, lie to your lover, lie to your boss, but never never give any patient the least reason to mistrust anything you say or do." If one of the mechanisms of change in psychotherapy is learning how to create and manage committed relationships, then one easily can see why trust is so central.

The therapeutic relationship is, however, inherently paradoxical. Psychotherapy is, as Malcolm has said, "the impossible profession" (Malcolm 1982). It is not exactly an exchange of friendship for money, but often it seems that way to patients, especially in the early stages of therapy. They suspect that a therapist who demands payment cannot have a genuine emotional commitment. Patients keep trying to figure out whether this is a reciprocity relationship or a committed relationship. They provoke confrontations to test the therapist's commitment. Beginning therapists are likely to suspect their own motives; and some therapists lack a real commitment to the other person's welfare. In many cases, though, a therapist can offer a novel experience of a committed relationship that can literally change a person's social reality. Some people can use this experience to escape from their prior assumptions, habits of behavior, and misconceptions about others in order to create kinds of relationships of which they previously were incapable. If all goes well, at a certain point this capacity becomes self-generating and the person is off into a new social world with a new set of skills and capacities. This is not easy, however, and the outcome is by no means assured.

The other bedrock of psychotherapy is empathy. In evolutionary writings empathy has been seen as a mind-reading skill that gives advantages not only by allowing one to sense what others need in order to provide it, but also to use this knowledge to better manipulate others (Krebs and Dawkins 1984). In the psychotherapeutic literature empathy generally refers to deeply intuitive understanding of what life is like for the other. The essence of empathy is understanding a person's goals, how they are pursuing those goals, what resources they have, what resources they need, the obstacles that limit their ability to achieve their goals, the threats to the resources they have, the dilemmas they face in making decisions about how to pursue goals, and the complex trade-offs involved in pursuing conflicting goals. This is too much to process logically; instead the mind seems to have a special capacity to allow us to experience life from the point of view of another. Good therapists start with a native capacity for empathy and hone it by long experience. As a result, they really are sometimes aware of situations and feelings that their patients are not.
As I write this, I am struck by how old fashioned some of these concepts seem. Instead of a review of the data on the efficacy of behavioral versus cognitive behavioral versus interpersonal therapy, the discussion here is about commitment, empathy, guilt, trust, identity, and the delicacy of dealing with the unconscious. That the quality of the relationship is crucial to the success of the treatment is certain; why then do newer therapies tend so consistently to objectify syndromes and emphasize cognitions over emotions and standardization over individualized interventions? Perhaps this tendency arises from the same cultural factors that have given us *Homo economicus* as a model for ourselves. Perhaps understanding the biology of commitment can offer a route to the scientific study of phenomena that have faded from sight as measurements and money have ascended.

**Commitment to Goals**

Commitment to reaching a goal is substantially different from the kinds of commitment discussed so far. Commitments to threats and promises influence others by letting them know you will not behave according to short-term self-interest. A commitment to a goal also involves an intent to persist despite difficulty, but its influence is not on the other so much as on the self (Klinger 1975). The extent to which human action is organized in terms of goal pursuit, and its strong influence on mood, is striking once you begin to look for it (Gollwitzer and Moskowitz 1996). We can be conditioned to respond to cues, but more often we try to achieve a goal we have in mind. Our behavior, like that of all organisms, is not fragmented into bouts of only a few minutes for obvious reasons—the main one being the start-up costs involved in any activity, whether eating, hunting, or helping a child. Stopping a task before some natural end point is wasteful. Humans differ from most other organisms, however, in that our actions are structured around goals that persist across days and months. We see an end in mind and strategize the best way to reach it. When one tactic does not work, we try another. Whether the goal is moving a rock, planting a field, catching a tiger, winning an election, or publishing a paper does not matter—action is organized in pursuit of the goal (Martin and Tesser 1996).

One difficulty with this kind of behavioral organization is the possibility that much effort may be wasted in pursuit of an unreachable goal. At some point, when apparently efforts will not succeed, to give up and do something else is best (Carver and Scheier 1990). Note that the decision depends on a belief about the future—whether efforts eventually will or will not succeed. A large literature in psychology documents the tendency for unproductive efforts to arouse low mood
that disengages effort from an unreachable goal (Brickman 1987; Diener and Fujita 1995; Emmons and King 1988; Klinger 1975). When a person is unable to give up trying to attain an unreachable goal, because the goal is crucial to the person's overall life strategy or because so much has been invested in getting this enterprise started, then low mood escalates into depression in which all motivation is turned off. The obvious question is why people don't behave rationally. If one potential spouse repeatedly rejects you, why waste the effort? Why not turn to someone else? If you can't get a promotion at one job, why not quit and take another? The answers to such questions help to explain why people stick with commitments to difficult goals, and thus the origins of many depressions (Nesse 2000).

The mechanisms that regulate goal pursuit seem irrational. People don't just give up their dreams the way a foraging animal would give up on one patch and move to another (Charnov 1976). Our commitment to a goal often seems senseless. As Buddhists have long noted, desires that persist even when unfulfilled are the cause of much suffering (Miller 1995). There are several possible evolutionary answers to this conundrum. The first and most obvious is that precisely when a goal is unreachable is hard to determine. If considerable effort has been put into reaching a goal, and alternative enterprises are not available, then the slightest possibility of success may be enough to justify persistence. This may help to explain the Concorde effect—the psychological tendency for people to continue investing in a project even when no net payoff is forthcoming. The big goals for humans, of course, are social. Here prediction is tricky at best. Perhaps the heir to the crown will marry you after all if you persist in your courtship! Perhaps your efforts to lead a group will suddenly be welcomed if the leader falls ill.

The advantages of persisting are of particular interest. Just as a capacity for subjective commitment can induce costly behavior that gives an advantage only in the long run and on the average, a tendency to persist in the pursuit of a goal can maintain effort and planning through dry spells when an enterprise gives no benefits. In both cases the capacity for commitment provides a long-term advantage that carries strategies over periods where efforts apparently are being wasted.

Goals do not, of course, exist in isolation; effort toward each one is a trade-off. Time spent in the gym takes time away from working. Deciding to have a family dramatically decreases the resources available for everything else in life. Major conflicts between strategies create a life crisis. When one of two physician spouses gets a good job offer in a small town, the crisis is obvious. When a woman wants to have children and her husband thinks they cannot afford them, the
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problem is more subtle, but equally serious. Such situations pit commitments to goals against commitments to people. People are extremely reluctant to give up either kind of commitment. Emotionally they are torn by such situations with a power that testifies to the depth of commitments. A game theory optimal solution may be an alternative, but that is not what people seek. They want to proceed with their commitments intact. Often, this is not possible. The conflict arouses depression until something gives.

This outline touches on only a few of the aspects of psychopathology and treatment that can be illuminated by subjective commitment. Much more can be said, especially about the role of commitment in relationships and difficulties therein. The goal here is only to illustrate some of the ways the theory of subjective commitment can assist in understanding psychopathology. My hope is that this theory will provide a bridge between the basic biology of relationships and the complex phenomena seen in the clinic.

References


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pathology in the Context of Evolutionary Biology. New York: Grune and Stratton.
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