Week 145, Day 5

Working with Common Issues That Can Often Fuel Avoidance

Critical Insights

with Kelly McGonigal, PhD; Ron Siegel, PsyD; and Ruth Buczynski, PhD

Table of Contents

(click to go to a page)

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Dr. Buczynski: Hello everyone and welcome back. This is the part of the week where we're going to focus on synthesizing the ideas from this week.

I'm joined, as I always am, by my two good buddies, Drs. Kelly McGonigal and Ron Siegel. This is one of my favorite parts of the week, being in this idea-crunching session that we have.

I'm going to start, as I always do, by asking them both *what stood out to you this week?* We'll start with you, Ron, and then we'll go to you, Kelly.

How to Teach Clients to Develop Calmness

Dr. Siegel: What stood out to me was a single line by Lynn Lyons. It was just in the midst of other things she was talking about, but she said, "I don't want to overemphasize developing calmness."

Since I spend a lot of time teaching mindfulness practices both in therapy and to clinicians, I often hear this basic assumption, which is problematic in the context of avoidance: that the idea is that "Oh, I get it – we're going to learn mindfulness. We're going to learn how to be calm."

"I don't want to overemphasize developing calmness."

Jon Kabat-Zinn, while he's a great guy and he's done so much to help bring mindfulness into medicine, having brought it in, in the somewhat Trojan horse of calling it *mindfulness-based stress* reduction, kind of got us all going in the direction of thinking, "This is relaxation training."

I don't think it mostly *is* relaxation training. When we talk about stress reduction, *stress* is really a euphemism for anxiety most of the time. There are different forms of stress but we're mostly talking about the sympathetic arousal states. Folks think, "Okay, so the goal of this is to get rid of the anxiety."

We've spoken before that relaxation techniques absolutely have a useful role in treatment. They can help people move into a zone of tolerance or a green zone so that they can work with whatever they're having difficulty working with. But what happens is patients – and clinicians – wind up getting very attached to the idea of, "Oh, I can use this to get calm," and they basically turn to it the way people turn to benzodiazepines to try to get calm.

As we know, turning to benzodiazepines, while it's okay in a crisis, as a general habit isn't such a good idea. So it's far more important to communicate what we were talking about last

week, which is that the goal of this is to develop distress tolerance, is to develop the capacity to *be with* the difficulties that arise.

It got me thinking a little bit of the history of this in behavioral psychology because when we're talking about avoidance, what comes to mind historically is Wolpe and the other folks who, early on, came up with the idea of, "You have to learn how to systematically face your fears."

We had exposure-and-response prevention, which means exposing yourself to the thing which is feared, the situation which is feared, and then instead of doing our habitual response, which is, "Let me run away/Let me have a drink/Let me do something like that," I'm going to just *stay with* the difficult situation.

"We had exposure-and-response prevention, which means exposing yourself to the thing which is feared, and then instead of doing our habitual response, I'm going to just stay with the difficult situation."

In the early days of exposure work, the idea was to develop reciprocal inhibition. The idea is "I'll learn how to calm myself, and that calmness will inhibit the anxiety response, and that's how I'll get through it." After the research unfolded over some years, they came to the conclusion, "No, the reciprocal inhibition part is not necessary. It's really just facing the thing you're afraid of and not dying which is the critical learning experience in getting over this." It's useful.

Lynn Lyons just stuck it in as this little line there, but it's a very important point that she was making. Of course, mindfulness practices, as we've talked about in different ways, do help us with this distress tolerance – not believing in our thoughts so much, and being able to tolerate difficult sensations.

How to Work with Anxiety as an Addiction Instead of an Affective Disorder

Dr. Buczynski: Thank you. Kelly, how about you – what stood out to you this week?

Dr. McGonigal: First, I look forward to sharing some research that addresses this issue and introduces a different form of reciprocal inhibition that I'll share in a little bit.

But actually what stood out to me the most, looking for the common themes among the speakers, was introducing to the client how avoidance can backfire. We talked about that last week as well – about how important that as a strategy is.

"Is anxiety more like depression, where we actually really want to relieve the internal suffering – that's the primary clinical goal?..."

But at the micro level, Ron, there's something that you said that I kept thinking about. I thought it was *so* interesting. I'm just going to read it back and ask you to elaborate on it a little bit.

You said, "If I get anxious before public speaking or anxious before flying on airplanes, but I do those things anyway, I don't have an anxiety disorder; I'm just a nervous guy. But if I start to avoid flying on airplanes and avoid public speaking in order to not feel the feelings, then I have an anxiety disorder."

That's a *really* interesting way to conceptualize an affective disorder that might be really different from how the person who suffers from it conceptualizes it. With depression, would it be the case that if somebody has depressed mood and suicidal thinking but they're still able to get out of bed in the morning and they haven't yet killed themselves, do we say they don't have depression?

Is anxiety more like depression, where we actually *really* want to relieve the internal suffering – that's the primary clinical goal? Or is it more like an eating disorder where you might continue to have these thoughts and these feelings around your body, or weight, or food, but if you're managing to eat and nourish yourself and maintain a healthy weight, you've got a lot of the disorder under control?

"… Or is it more like an eating disorder where you might continue to have these thoughts and these feelings around your body, or weight, or food, but if you're managing to eat and nourish yourself and maintain a healthy weight, you've got a lot of the disorder under control?"

I am really curious. It sounds like you're talking about anxiety more from *that* model, almost like an addiction model, rather than an affective disorder model.

Dr. Siegel: It's a fascinating question. I'm really talking autobiographically: I really *am* an anxious guy, and I really *have* discovered that, if you do the things anyway, it's okay. It just feels like, "Okay, there are these arousal states, and yes, they're unpleasant. Oh, no, they don't last forever."

Except for occasional situations – like when the anxiety interferes with something autonomic, like it's three in the morning and suddenly I'm awake and I want to be asleep because I want

to be refreshed the next day – with the exception of those, it's like it's okay. It's just, "You do it in a high-arousal state, and it doesn't last forever."

It's actually a subjective self-report that you've got coming from me there: that it turns out I'm okay with being anxious. I don't feel like I have a big choice about it. As long as I face fears and go ahead and *do* the things, it doesn't feel like it's a disorder, in the sense it feels like it's a neurological style, if you will.

> "As long as I face fears and go ahead and do the things, it doesn't feel like it's a disorder, it feels like it's a neurological style."

But it's an interesting contrast that you bring with depression, because there are plenty of depressed folks who are able to function. But maybe this is the distinction: if you're depressed and functioning and you're not actually fully engaged – in other words you're not experiencing the full range of affect, you're not experiencing a sense of connectedness, you're not experiencing those things, even though you're going through the behaviors of your day – perhaps that's a situation in which the behavior that's of interest is a little bit more covert, or at least more subtle or nuanced behavior, where we're really talking about *engagement* as the behavior that we want to have happening.

Certainly when somebody's depressed and they're able, instead of being kind of shut down and dead, to feel a full range of sadness – they feel their anger, they feel their hurt, they feel their longings – well, they're actually not depressed anymore. They're with a lot of dysphoric affect, but it's alive, and it's fluid, and it's changing.

It's a very interesting question you're bringing up. It may be quite nuanced; it may be that the thing we're avoiding is more overt or more external in some disorders; more internal in other disorders. But again, where it's coming from was simply this subjective experience that "It's okay; one can live a full life being nervous."

Dr. McGonigal: But it might also seriously require reorienting the client to what the clinical goal is, because my guess is their goal is to reduce their internal suffering.

Dr. Siegel: Absolutely. An analogous area where this is true is where you're dealing with chronic pain disorders that are essentially chronic tension disorders. So often, people order their plan for recovery as, "As soon as my pain goes away, then I'm going to go back to yoga, and then I'll be able to swim, and then I'll be able to do everything."

The way out is actually, "No – it's because you go back to yoga and start swimming again, and get past your fear of the pain, the chances of it resolving are going to be increased a great deal."

Part of it is functional. It's simply also the way *through* anxiety disorders *so* involves eventually doing what you need to do, even if we're talking about respecting the defenses, that that's another reason that comes to mind for me.

Dr. McGonigal: Yes. That's a really good parallel.

How to Work with Avoidance That Stems from Trauma

Dr. Buczynski: Thanks, both of you. Ron, I want to add another wrinkle to this whole idea of do we go toward the anxiety, the trigger, or do we avoid? The wrinkle I want to add is trauma.

Peter Levine mentioned this a little bit: that sometimes patients might be avoiding things because they're triggering them back into a painful past experience. What are some thoughts about that? What are some ways that you might work with someone if you knew that trauma was involved? Someone who's maybe avoiding, so you're trying to help them confront but not get dysregulated or overwhelmed?

Dr. Siegel: That's a great question because it *is* easy to make a mistake and to do harm by basically retraumatizing somebody, having them face the thing too intensely, or without enough support, or prematurely.

Peter gave a really good clue as to one way to approach it: he talked about noting that it's really the *sensations* associated with the traumatic experience that people fear; that it's the sensations of fear or the sensations of physical pain, or a sensation of terror, or a sensation of horrible abandonment or loneliness associated with the trauma that people come to fear.

The first thing is trying to figure out the zone of tolerance, and we've talked about that before. That can be done collaboratively to get a sense of what the client or patient feels they can handle.

I find it *very* useful to discuss – and I often discuss it personally; I say, "When I examine this in myself, when I examine the things that I'm really afraid of or the feelings or situations that trigger me or freak me out, I'm at base afraid of *sensations*. I'm afraid of this

"It is easy to make a mistake and to do harm by basically retraumatizing somebody, having them face the thing too intensely, or without enough support, or prematurely."

feeling in my gut that comes from a feeling of sadness or loss. Or I'm afraid of this feeling of tension that comes from being frightened, or other tension that comes from being angry and feeling stuck in the anger."

It was actually an insight I got at my first silent meditation retreat where it's like, "Oh, my gosh – all I'm *ever* afraid of…" (and we've talked about me being nervous; I'm afraid of lots of things) "…they all boil down to being afraid of sensations." This becomes a very useful frame, because we notice that, "Hmm, sensations are impermanent, *and* we can practice developing the skill of being able to *be with* unpleasant sensations."

I think of a fellow I've worked with. I've worked with various people with this kind of difficulty who turned to substances to try to block out painful sensations. It took quite a while in treatment because I kept pointing out, "Are you taking it because there's a *sensation* that arises in the situation and you're afraid you won't be able to bear the sensation?" It took a while but he started realizing that yes, this is *absolutely* what's going on for him.

It became a very useful frame. It's actually a frame that helped him to curtail his substance use a lot, by seeing that "Okay, well, I can also ride out sensations, and they're not permanent." When you turn to the substance, you don't get to *learn* that you can ride it out, because you've interrupted it with the substance, so that's your only model for how to work with it.

So Peter's frame around the sensations is often also *very* helpful when people are working on trauma.

How to Work with Clients Whose Depression Leads to Avoidance

Dr. Buczynski: Ron, I do agree with that, but when you're dealing with depression, sometimes you're talking about starting down a hole. Like let's say somebody has had depression before and isn't so depressed now, but is afraid of a relapse.

I could see lots of scenarios where they might avoid something that would give them a relapse, like avoid something that would make them lose their confidence or something, because it would put them into a situation where they would start down that depressive place which would sink their energy, pull them in and so forth.

What are your thoughts about that?

Dr. Siegel: Well that's very understandable. We would start with how understandable that is; of course you'd be concerned about that.

We've touched on this at other times. **I** like to try to get people to be as curious as possible about what *is* the depression. Not to see it medicalized, not to see it as this solid thing, but to see what are all the different elements to it?

Because my own experience here, clinically and personally, is usually there's a whole *bundle* of feelings in there that are just kind of stuck and obscured that we experience as depression. So this is more getting back to the sort of building in resources or restorative approaches that Kelly was talking about.

Dr. Buczynski: But couldn't you say that resources are an avoidance approach?

Dr. Siegel: This is subtle, because I've have discussions about this with patients who are experimenting with building in resources. Yes and no. If it's a resource that gives us the courage to feel the difficult feeling, then it's not an avoidance approach. If it's a resource that's designed to *replace* the difficult feeling, then it might be.

So that's a very tricky and great question.

"Try to get people to be as curious as possible about what is the depression. Not to see it medicalized, but to see what are all the different elements to it?"

Dr. Buczynski: Do you have an opinion, Kelly?

Dr. Siegel: Yes, what do you think, Kelly?

Dr. McGonigal: Yes, this reminds me a lot of what we were talking about – preventative and restorative safety behaviors. I'm not sure what type of resources *you* were talking about, but if I have a friend who comes with me to support me in an important and difficult experience, that's a resource that is certainly not avoidance.

You could imagine many psychological strategies as being like bringing a friend with you to a difficult experience, so that you're not alone and you're able to handle it and process it. That's not avoidance.

Also, Ruth, when you were talking about avoiding things that you know are triggers for relapse, that to me strikes me as possibly self-care – that a lot of discernment is required. Maybe people need to leave a profession that routinely dehumanizes them and triggers episodes of depression. Not everything is biological or cognitive.

Sometimes it makes a lot of sense to avoid situations that over time have proven to bring out the worst in whatever your predispositions are and amplify harm in your life. The idea is that if you can separate it from habitual avoidance and you can practice…

A Counterintuitive Take on Working with Avoidance (and the Research Behind it)

Dr. Buczynski: I guess I wouldn't have said this before this week, as we were having this conversation with the three of us, but the idea of breaking through avoidance makes much more sense to me for anxiety than for depression.

I'm going to leave it there for now because we're not going to get to the rest of our questions, but that would be an interesting discussion. Maybe it'll come up again in the next few weeks and we can chew on it some more. I'm only throwing it out; I'm not taking a hard stand on it. I'm just saying, "Hmm…" a little bit.

In the interest of moving on, Kelly, you mentioned at the beginning that there was some research that you were excited about. Tell us.

Dr. McGonigal: Yes. It's interesting; as soon as you start to look at the scientific research on avoidance, you find a lot of behavioral studies where they invite people into the laboratory and start trying to teach them to fear and avoid something by carrying it with an electric shock – that sort of thing. A lot of the research I'm going to share this week and maybe in future weeks will have that flavor of this behavioral-conditioning kind of setup.

> "If you can encourage someone to approach something that they have learned to be threatening, you can actually help them overcome avoidance and learn that it's no longer threatening."

I wanted to introduce the idea of rewards as something that are very important for preventing or overcoming avoidance. They use a different kind of reciprocal inhibition than the idea that you need to *calm down* in order to not experience anxiety as you learn to approach something threatening. That maybe the *opposite* that you need to bring in isn't relaxation but some sort of positive approach motivation or a reward.

I wanted to share two different studies that highlight how important rewards are to the process of overcoming avoidance.

The first was this interesting study that looked at whether introducing competing rewards would help people engage in less avoidance of something they associated with an electric shock, with a threat, something they had come to fear – and whether it also reduced fear during that process.

I'll give you the bottom line. Basically, if you introduce a competing reward, so that if you can encourage someone to approach something that they have learned to be threatening, you can actually help them overcome avoidance and *learn* that it's no longer threatening. Say you remove the electric shock, you can increase people's willingness to approach and increase their ability to extinguish that fear when there's no longer a guaranteed shock and they don't actually need to avoid that anymore.

Dr. Buczynski: Can you maybe give an example here?

Dr. McGonigal: Yes. Let's say that you had a really bad experience with a dog; you had maybe a dog attack or something that made you fear dogs, and you've learned to avoid dogs. Let's say that you're trying to help someone overcome that avoidance. You might start to introduce rewards for being willing to expose yourself to dogs – maybe videos of dogs, and then being in proximity to dogs that can't actually approach you, to actually petting a dog. So you're working on that extinction process.

"By introducing the rewards, it not only decreases the avoidance behavior and facilitates fear extinction eventually, but it doesn't immediately reduce the fear. That it allows people to overcome avoidance before the fear has been extinguished."

You're actually going to introduce rewards, competing rewards – whatever that would be for an individual. It could be totally extrinsic; it doesn't have to be like some intrinsic desire to be able to spend time with your family members who have pets. That could be like a long-term reward. But like an immediate reward – so, whatever it is that would make you happy, you get it when you are willing to approach it. Sort of basic like behavioral kind of…

Dr. Buczynski: A little piece of chocolate or something.

Dr. McGonigal: Yes. What they found is that by introducing the rewards, it not only decreases the avoidance behavior and facilitates fear extinction eventually, but it doesn't immediately reduce the fear. That it allows people to overcome avoidance *before* the fear has been extinguished.

This is something that we've been talking about, that Ron was describing so well: that to get to the reduced fear or the reduced threat, you need to go through the approach process. You can't reverse-engineer it, where there's no fear and then you learn to approach.

So, introducing rewards seems to allow this process to happen in the order that it naturally occurs, which is that you have to tolerate the approach. Rewards allow this to happen.

The other study I wanted to mention, which throws a wrench into this process, was a really interesting study looking at people who have low or high tolerance of discomfort – exactly what Ron was talking about.

"They looked at the relief that people feel when the avoidance behavior worked."

It is really interesting. It looked at a behavioral thing where people are getting "punished," experiencing pain or a punishment for being exposed to something or engaging in a behavior, and then there's something they can do to avoid that pain, so they learn an avoidance behavior.

Let's say you know you're always going to get a shock every time you hear a tone, but if you press a button, sometimes you can avoid the shock. It doesn't always work, but sometimes that avoidance behavior works and you don't get the electric shock.

They looked at the *relief* that people feel when the avoidance behavior worked. It basically lights up the reward system, as if you were paying people money. It's this amazing positive experience that activates the reward system when you think that you've avoided something you didn't want to experience, through your own avoidance behavior. That makes sense.

Then they removed the threat, so it doesn't matter if you do the avoidance behavior or not anymore, you are not going to get shocked: "We've removed that from the situation. You have the ability to *learn,* but actually this is no longer threatening." But people could still engage in the avoidance behavior sort of out of habit or reflexively.

"It's this amazing positive experience that activates the reward system when you think that you've avoided something you didn't want to experience, through your own avoidance behavior."

What they found is that people with low tolerance of discomfort never stop feeling relieved. Normal people stop experiencing this incredible reward for avoiding the threat, even when like the threat's not there anymore. They've learned from it, and they don't get that same hit that's like pulling a slot machine and getting a payout. People with low tolerance of distress, they keep getting that payout every time they engage in the avoidance behavior, even though the threat's not there anymore.

I don't know if I'm explaining that right, but it's like they don't learn. Their avoidance behavior has become intrinsically rewarding and they get that same payoff, that same activation of the reward system, from engaging in the avoidance behavior, because they think they avoided a threat that's actually not real anymore.

That's *so* interesting, to have to think about *relief* as a reward that is driving a lot of avoidance behavior; that people are not updating their working models. So even if the threat isn't present anymore, people have learned to feel relief every time they engage in an avoidance

behavior. That's something that's going to need to be directly addressed. Probably you need to introduce stronger rewards than relief, to compete with that process.

One Key Strategy to Working with Anxiety That Encourages Avoidance

Dr. Buczynski: Interesting. Ron; Lynn Lyons talked about the connection between anxiety and avoidance, which is what we've been talking about, and how it can go hand in hand. Can you share a bit about how you tackle those two issues? Where do you start? What's important to consider when someone's using avoidance, and so forth?

Dr. Siegel: I talked about a number of strategies in the video segment. One that I'd like to add, which Lynn did a *wonderful* job of talking about, was this idea of *personifying* anxiety. She said, "Anxiety wants avoidance. Anxiety wants certainty and comfort."

I just think that's a lovely way to go about it, because it helps to normalize it and moves it out of the realm of personal failure or weakness. It also helps the client know what to be on the lookout for: "Okay. Oh, there's anxiety, seeking comfort again. Oh, there's anxiety, seeking certainty again." I just thought that that was very elegant.

"We become addicted to avoidance in very much the same way we become addicted to substances, or gambling, or chocolate cake, or whatever it might be that feels really good in the short run but doesn't feel very good in the long run."

There's another point that Lynn made, which totally dovetails with what Kelly was just talking about. She talked about how avoidance feels *really* good in the short run because it's such a great relief. This idea of negative reinforcement, which is the reinforcement or the reward that we get when something which is unpleasant is removed – we stop hitting ourselves over the head with the hammer: "Ah, that feels really good!"

That plays a *huge* role in anxiety disorders, and I often, when I'm working with people, talk about it as an addiction: that we become addicted to avoidance in very much the same way we become addicted to substances, or gambling, or chocolate cake, or whatever it might be that feels *really* good in the short run but doesn't feel very good in the long run.

Putting it in that context helps get it out of the self-judgment/weakness context and see it more as a very kind of natural thing but something that's worth watching out for.

Dr. Buczynski: I would just say, for *some* people that would take it out and normalize it. Other people would hear "addiction" and go into "bad, weak…" and so forth.

Dr. Siegel: Yes – that's a good point.

Dr. Buczynski: Thank you. This was a *very* rich conversation. That's it for us for this week. Now we'd like to hear from *you*: how are *you* going to use these ideas in *your* work today?

Please leave a comment below, and while you're there, go up, read other people's comments, and comment on their comments as well. That brings our whole community together.

We'll be back again next week. Take good care, everyone. Bye-bye.