How to Help Your Patients Overcome Anxiety with Mindfulness

How to Help Clients Stop Using Counterproductive Anxiety Management Strategies

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Dr. Siegel: Clinicians and researchers are fond of making a distinction between fear and anxiety, and while that has some utility, it also can be overblown a little bit.

Typically, fear is described as this fight or flight response that comes up in response to an immediate threat.

It is very present-oriented; we know where the precipitant is –- there really is a line here or there really is a bus bearing down on me.

It is associated with a surge of panic and a desire to do something really quickly for survival.

We have this response both to physical threats and social threats.

Anxiety is seen as more long-range fear. It's more future-oriented.

Sometimes the precipitant is unclear: we feel anxious and we're not sure what we're anxious about.

It's associated less with immediate panic or immediate responding and more with a kind of chronic tension and chronic arousal – although obviously *some* anxiety does result in panic attacks as well.

And the idea for understanding anxiety in this way is that it's for preparedness.

But anxiety and fear tend to blend into one another. For example, in the case of panic, panic is obviously an anxiety problem and yet it's a rush of pure fear – it feels as though the danger is quite immediate.

I find a somewhat more useful distinction is to think of this kind of arousal - whether we call it fear or anxiety – and to decide, "Is it signal or is it noise?"

Signal means we are having this arousal and there really is a danger and it really does call for some kind of emergency response.

So, if I step off the sidewalk and a bus is bearing down on me and I get anxious or I get frightened, and that causes me to jump back, that's signal. That is important information and the amygdala, the hypothalamus, and the whole body is reacting to this important information.

When it's *noise*, it's three in the morning, and suddenly I find myself awake and I'm beginning to go over my "to do" list. I'm beginning to think of all the challenges that I might face in the coming day.

It's very helpful in working with patients to help them to begin to differentiate "what's signal and what's noise."

People who are stuck in anxiety tend to relate to the whole thing as a big problem: "I want this arousal to stop," but of course, some of that arousal is useful to us.

The other important thing to keep in mind here – and this is important to talk to patients about – is that it is not *things* but it is *our interpretation* of things that determines whether or not we will be aroused.

To go back to the type one error and the type two error: it's only if *I think* it's a lion – not a beige rock that I'm going to go into my whole psychophysiological response to it.

And very often stimuli are ambiguous. You see somebody walking down the street - is it potentially a hooligan or a mugger who's going to attack me or is it just another person who's law-abiding and walking down the street?

How we interpret these ambiguous stimuli is colored very much by our past experience, including, as we'll discuss, how much unresolved trauma we've had.

Very often, if we've been hurt in the past and we haven't resolved all the feelings about that, we're going to experience all sorts of ambiguous stimuli as quite threatening.

For most people struggling with anxiety, they want it to go away.

Anxiety is, understandably, unpleasant. In fact, if it hadn't been unpleasant, it wouldn't have worked well for us.

Part of how anxiety works is, yes, to get us activated and to get us out of the emergent situation.

But also, part of how anxiety works is to make us avoid things that have brought up this unpleasant feeling of fear or anxiety in the past. So, when we feel anxious near anything that looks like a snake, that's going to help keep us away from snakes and it's going to serve an adaptive function.

We are hardwired to experience the arousal of anxiety as aversive – as something we want to get rid of – and indeed, people want us to make it go away.

If we're a prescribing provider, they want us to give them a benzodiazepine or something to make the anxiety stop medicinally, or if we work in psychosocial ways, they want us to provide some kind of coping strategy that's going to help them to relax and calm down.

Now, while there can be value in these approaches – and we'll talk about the use of benzodiazepines and other medicines a bit later – and there's value to doing relaxation exercises sometime, these tend to be temporary fixes.

They also come with considerable cost. The big cost is they reinforce the idea that getting rid of the anxiety – getting rid of the arousal – is actually the goal of treatment.

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But what we're going to see throughout the course is that the much more important goal of treatment is to help people to be able to accept the experience of arousal and not to freak out with aversion responses to that experience of arousal.

Basically, we want to help people learn to *avoid* avoidance – to avoid this natural tendency to get rid of what's uncomfortable for us.

And there are countless examples of this natural tendency to get rid of discomfort that gets us into trouble.

If you've ever seen one of those Chinese finger traps or finger handcuffs which you put your fingers into and you try to pull the fingers apart, and the harder you pull, the tighter it grips – this is how many, many different mental processes work.

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Insomnia is a very obvious example. You know what it's like on a Friday night and you're trying to fall asleep and you don't have to work on Saturday morning. It's much, much easier than if it's a Sunday night and you're trying to fall asleep and you've got to get to work on Monday morning.

We see how the effort to *not* have insomnia – the effort to get to sleep – is *precisely* what keeps us awake.

Or – I talk to men about this all the time – if you've ever had the experience of being in a sexual encounter where you really want to perform well – the need to perform well is exactly what gets in the way of performance. We call this erectile dysfunctional or premature ejaculation.

It's only when we're no longer trying to fix the problem that the problem tends to go away on its own.

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This is the same in any approach that we use for working with anxiety. If we're trying to get the anxiety to go away, the very *effort* to get rid of anxiety reinforces the fear of the anxiety and keeps the problem going.

Even mindfulness-based stress reduction, which is a wonderful eight-week structured program that introduces mindfulness practices to people – it's secular and it's been used in countless medical and educational settings – suggests the idea of trying to *get rid* of this arousal state because we call it *stress reduction*. (In fact, *stress* is really a euphemism or a comfortable phrase that we use to describe fear and anxiety.)

So we have a certain paradox here: people are going to want the feeling to go away and yet our overarching goal, while we may use these techniques temporarily with them, is going to be to face fears – especially to face the fear of anxiety.

Sometimes anxiety is adaptive.

Anxiety can help us to think, "You know, I'd really *better* start doing my homework or I'm not going to get it done on time." There's always a kind of balance between preparing for the future and practicing acceptance.

What happens to folks with anxiety disorders is this balance often gets thrown off – so much and so many of their energies go into preparing for the future, trying to ward off discomfort, that they don't get to learn how to practice acceptance of discomfort and acceptance of outcomes.

We also know that you need a certain amount of anxiety or a certain amount of arousal to function optimally.

If you remember the Yerkes-Dodson curve from the early 20th century – the way the curve looks is, on the vertical axis what you have is a measure of performance – it could be a performance in almost any task and the horizontal axis is the degree of arousal.

So, if you're over here and you have very little arousal, performance could be low because you don't have enough energy to get interested in it.

As arousal picks up, performance starts to go up because you get interested in it.

But then there's this kind of optimal point at which you're aroused – kind of anxious, kind of invested, so you're doing well – but if you get aroused beyond that point and you start to get into the panicking realm, that gets in the way of our performance.

We want a certain amount of arousal in life. We don't want to be painting a picture with our clients or patients that anxiety is a bad thing, but rather that these arousal states are something that we want to try to coax toward an optimal level.

This involves finding a balance between acceptance and change and is what Marsha Linehan, in developing dialectical behavior therapy, a mindfulness-based approach to working with borderline personality disorder, talks about as the central dialectic in life – the dialectic between acceptance and change.

One exercise that can be really useful to do with your clients or patients is to ask them, "To what extent does worry or anxiety help you?"

This helps them to start to look at how worry or anxiety has been useful in life: how has it been helpful/how has it been not so helpful?

And then to ask: "To what degree have efforts to *avoid* future discomfort – efforts to avoid anxiety, actually been unhelpful?"

Until people start to see that there is both a value to arousal *and* a cost to arousal, they get stuck in the either/or and they particularly get stuck in starting to think that, "Anxiety is something bad and I need to get rid of it."

Now, that said, people who are *very* happy-go-lucky – they're folks with the bumper sticker that I see around here sometimes, and forgive me the coarse language, but it says, "Shit happens."

Now, I kind of think that "shit happens" disproportionately to people who have bumper stickers that say, "shit happens" because they're maybe *not* anxious enough – they're maybe *not* doing enough planning!

It's important to validate for people that their anxious approach to life has probably been useful for them – it plays a lot of positive functions, but it can get in the way.

The antidote to it isn't so much going to be how to calm down, but how to practice more acceptance, and this is both acceptance of adverse outcomes in life – in other words, "All right, so I didn't show up at the

airport three hours in advance and, yes, I was somewhat rushed, and that was okay" – as well as to be able to accept the various levels of arousal that happen as anxiety emerges.

Most people with anxiety disorders have already been involved in lots and lots of self-treatment. They've done all sorts of things to try to get rid of it.

What do people typically do? The first thing they do is what we discussed before: they tend to narrow their attention, focus on the thing that they're afraid of, and try to somehow get rid of what they're afraid of.

They also get involved in a lot of self-criticism and judgment about "how bad it is that I'm this anxious."

The other thing that people do a lot of is self-medicating, both legally and illegally.

They do a lot of distracting of themselves so as not to feel the anxiety, and they try to escape mentally – to talk themselves out of the anxiety, to go through all of the reasons why, "Oh, it'll be okay and maybe it's a low-probability event."

Finally, people try to avoid the triggers. They try to go through the world and see if it's possible to never encounter the thing that's going to arouse their anxiety.

Unfortunately, almost all of these things that we do naturally to try to take care of ourselves tend to perpetuate the disorder.

The narrowed attention, the self-criticism, the trying to escape mentally by talking ourselves out of it, and the avoidance of triggers all tend to perpetuate this kind of anxious avoidance stance in the world.

The alternative, which we are going to help people work toward, is really a kind of mindful opening to the experience of life as well as to the experience of the anxiety when it comes up.

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I'd like to finish this first segment of the course with an exercise, and this is an exercise that I'd like you to try yourself first and then see about introducing to clients or patients for whom it might be comfortable.

You might do this right now as I'm speaking, if you're in a situation where you can close your eyes.

Close your eyes and think back or recall a moment or a situation in the past week when you felt anxious, and take a moment to really generate or really enter the situation in your memory.

Try to relive it as vividly as possible: What was the setting? How did your body feel at the time? What were the thoughts going through your mind? How did your body react to it? What was this experience of anxiety really like? And just see if you can breathe and feel what the anxiety was like in that moment.

Then, what did you say or do? How did you respond to the anxiety? Were other emotions present – perhaps sadness or anger or longing?

Really just try to *be with*, in a mindful moment-to-moment way, what the anxiety was like.

Just stay with that for a few moments, feeling the anxiety and particularly noticing the thoughts, emotions, physical behaviors, physical sensations and behaviors that naturally occurred when you were anxious.

You can use this exercise – and we're just doing it for a couple of minutes now – but stretch it out into five minutes or 10 minutes even with your patient, and ask them to just stay with it and see what they can remember of it.

This begins to shift our approach to anxiety from the normal one, which is, "How do I get rid of it?" toward a mindfulness-based one which is about, "How can I explore it, feel it, and see how it's working for me?"

In general, anxiety turns away from uncomfortable experience; mindfulness turns toward the experience it had - and in that way it's basically going to take a different approach to moment-to-moment unfolding of whatever's happening in consciousness.