A CBT therapist wonders why the client is so adamant about letting go of unhealthy core values. A psychodynamically trained therapist wonders if might be acceptable to assign homework. How can each of them stretch beyond their initial learning without going back to school?

My training was in classical psychoanalysis, but soon after I entered practice, I was challenged by early life trauma, for which I had no preparation, then addiction. From trauma work I gained a lasting interest in how therapy works, and from addicted people I came to appreciate the power of behavior. Gradually I tried integrating different approaches, and, in the process, became a better therapist.

The Affect Avoidance Model is a way of simplifying and unifying our thinking about problems that are treatable in psychotherapy. It is based on a Darwinian view of the mind/brain and, with a minimum of adjustment, is compatible with all traditional and contemporary theories.

The core proposition of the Affect Avoidance Model is that: Essentially all the pathology treatable in psychotherapy (excluding primarily biological conditions) is a result of the mind/brain's instinctive avoidance of actual or predicted negative affects.

It would certainly simplify things if such a broad statement were true. But could such a broad principle actually apply to the vast range of problems that bring people to therapy? The answer is actually, yes, but how it is true requires a bit
Psychological theories tend to be rooted in philosophy and overvalue consciousness and rational thought. This time, let's approach pathology from a more biological point of view, starting with the mammalian brain from which ours evolved. Neurobiology views mammals as possessing a brain admirably adapted for survival of their species. It's basic functioning is to appraise incoming information, including that from the animal itself, comparing this to expectations and past experience, and to make predictions about the survival value of what is encountered. Roughly, circumstances divide into either opportunities or dangers. Research, especially on fears and bodily needs, shows that this appraisal triggers emotional circuits and motivational circuits. These energize and direct behavioral reactions, again in relation to past experience and expectations, that are adapted to promote the species.

The Human Mind/Brain

Humans have the same capability of appraisal, emotional activation, motivation and reaction. In addition, we have consciousness. It turns out, however, that somewhere between 95% and 99% of information processing goes on outside of consciousness. We are privy to a small, but greatly prized, sampling of our own mental activity.

Work with alcoholics in early recovery gave me insight into how our human capabilities work together with those we have inherited. One of the reasons AA promotes sponsorship is that in early recovery, it is very common for alcoholics to have ideas pop into their consciousness that, if followed, will soon lead to relapse. The sponsor, having been there before, is more able to recognize when it is “the disease talking.” The most common example is the thought, “maybe I'm not really an alcoholic,” which regularly floats into awareness. Logically, this leads to the next thought, that drinking on a controlled basis should be possible. Hopefully, the addicted person listens to the sponsor and realizes that those thoughts had a purpose and elects not to follow them.

These observations show an important way in which consciousness works. The essence of the addiction is this: Mammalian emotional and motivational circuits have been hijacked into “believing” that survival of the species depends on getting the next drink. They have the capacity to generate thoughts that promote what the mammalian brain determines is best for the species. Mammals are doomed to follow such “thoughts” (perhaps in the form of images or impulses) on into action. The small variation that is (relatively) unique to humans, is that we have the capacity to think out the possible consequences of our own thoughts and to recognize which ones are consistent with our conscious values and goals.

The implications are profound. What this means is what every therapist has observed, that our conscious stream of thoughts is actually an unlabeled mixture of ideas whose origin is either from our mammalian instincts or from our rational thinking. In my experience, listening to the subtlety of alcoholic thoughts, the mammalian brain has the same IQ as the rational one. It even knows how take advantage of “one thing leads to another” as it works to
overcome rationality and achieve its aim. At this point, I am ready to postulate that 200,000 years ago, when homo sapiens first evolved, and much of our mental architecture was as it is now, it is likely that this kind of competition between reason and instinct actually gave a survival advantage. In other words, our Dionysian and Apollonian tendencies create an adaptive balance that has helped us thrive under rapidly changing conditions.

Let's take another example. The most common phobia is fear of public speaking. Our rational mind determines that this is the opportunity of a lifetime, but instinct, perhaps more adapted to life 200,000 years ago, says that speaking out is tantamount to challenging the alpha human and potentially dangerous. We are left to struggle within ourselves to determine which tendency wins out.

**Avoidance of Negative Affect**

Many therapeutic traditions have identified fear and avoidance of painful, overwhelming, or uncomfortable emotions as the basis of pathology. The problem with this view is that many instinctive reactions happen without conscious awareness of negative affect. Modern neurophysiology helps resolve the dilemma. Our “core” emotional circuits, listed as rage, fear, lust, care, panic, and play by Jaak Panksepp (2012), a pioneer in emotional biology, are closely analogous, anatomically and physiologically, to those of other mammals. These deep circuits, as opposed to conscious feelings, are what trigger those maladaptive reactions that are the targets of psychotherapy.

The important subtlety that the field of psychotherapy is just beginning to absorb is that conscious affect does not have a simple 1:1 relationship with activation of core emotions. For example, a narcissistic individual may have no awareness of a threat to self-esteem yet issues an insult automatically with no conscious thought. Furthermore, the subtle emotions we express in poetry may be far more complex and nuanced than the excitation of limbic neurons. We may also be intellectually aware of some sensations we identify as “feelings” in the absence of activation of core emotions.

What does appear to be important for the field of psychotherapy is that when we are aware of affect, defined as conscious feeling accompanied by visceral concomitants, it is a good indicator that core emotions have been activated. This is important because the two main ways that therapy can modify instinctive reactions require that core emotions be activated. Until we have instruments to detect the state of these deep emotional circuits, the best way we have of knowing they have been activated is the conscious experience of affect. Because the model is aimed at helping with clinical practice, it puts the emphasis on affect rather than core emotions.

Below is a schematic view of the organization of the human mind/brain for self-protection showing how processing multiple inputs leads to activation of core emotions, then to the production of familiar contents of consciousness.
Not only does the mind/brain's apparatus produce thoughts, its products also include conscious feelings, impulses to act, and visceral sensations such as a pounding heart or tingling in the abdomen. Like automatic thoughts, all of these products have a powerful influence on our decision making, for better or worse.

The next proposition of the Affect Avoidance Model is fairly self-explanatory: Patterns of Appraisal and of Reaction, after they are first elaborated, are stored in memory as information, verbal, nonverbal, procedural, declarative, embodied in the synapses that make up neural networks. They tend to be re-used in later situations, but their form often reflects the developmental assets available at the time of their origin.

More significantly for the purposes of therapy is the next proposition: Those maladaptive patterns that are the focus of psychotherapy are essentially always instinctive reactions to negative core emotions. One of the rare exceptions is that addiction is sometimes initiated by the seeking of pleasure. One reason for this bias towards avoidance of negative core emotions is that evolution spends more energy reacting to danger than to opportunity. More importantly, the more dire the danger, the more any attempt to modify or soften an established defensive reaction is appraised as an additional threat. The result is that the mind/brain works to resist change in defenses, even when they are maladaptive. This is known in practically every therapeutic tradition as “resistance,” the instinctive tendency to avoid therapeutic change.

Therapeutic Implications

The Affect Avoidance Model goes on to specify the following with regard to the action of psychotherapy:

So far, neuroscience has only identified three ways in which therapy can change or override maladaptive patterns held in memory:

1. Add new learning of healthy patterns of appraisal or reaction.
2. Block, by inhibitory signals from the cortex, the ability of core emotions to trigger an unhealthy reaction. This is called extinction and requires simultaneous activation of the core emotion along with exposure to “disconfirming” information, for example, conditions of safety instead of threat.
3. Reconsolidation. This is a recently discovered mechanism by which the connection from an appraisal to the core emotion responsible for triggering a maladaptive reaction is “unlearned.” This, too, requires simultaneous activation of the core emotion along with disconfirming information.
This very limited number of low level change mechanisms has profound implications for understanding the action of psychotherapy. In order to accomplish these three end results, all varieties of psychotherapy are ultimately aimed at accomplishing one or more of these seven objectives:

1. Help the client acquire new, healthy information, both verbal and experiential.
2. Identify and challenge maladaptive patterns of appraisal and reaction.
3. Required for both extinction and reconsolidation: Activate troublesome affects that have been responsible for maladaptive reactions.
4. Also required for extinction and reconsolidation: Simultaneously expose the client to positive disconfirming information. Often, especially with nonverbal patterns, a positive therapeutic relationship is the vehicle for providing this disconfirming information.
5. Facilitating motivation for change may be needed to overcome instinctive resistance and to encourage “behavioral experiments.”
6. Since excess or insufficient levels of arousal inhibit these change processes, an additional function of therapy is to help modulate the level of arousal. Once again, the therapeutic relationship is a prime instrument.
7. Ensure safety and informed consent.

The combination of #3 and #4 is equivalent to Franz Alexander's classic “corrective emotional experience.”

**Is All Pathology Affect Avoidance?**

Finally, as promised at the beginning of this article, I'll argue that essentially all the types of pathology that can successfully be treated in psychotherapy have in common that they are instinctive reactions to appraised danger triggered by the activation of core emotions. In other words, the Affect Avoidance Modal applies to everything a therapist can treat. The grouping below are based on forms of defense against danger rather than diagnostic categories. This taxonomy is intended to be useful to the clinician in that therapy within each group tends to require similar approaches.

It is also important to note that in actual clinical practice, these avoidance mechanisms occur in layers. Most clients exhibit multiple layers. Pathology often starts with one layer, then, under the threat that that layer may fail, additional layers are elaborated. In therapy, we usually start with the most accessible and identifiable layers and work down to those that were established earlier and are most resistant to change. This list is taken from a draft paper by Smith and Johnson, visible on ResearchGate.com under the name Jeffery Steven Smith.

1. **Automatic relational patterns:** These are the characteristic reactions of attachment disorders and personality disorders. They are learned as adaptations, mostly to adverse conditions, and are maintained mainly because they shield the individual from corrective experience (Bowlby, 1968; Levy, Johnson, Clouthier, Scala, & Temes, 2015). For instance, one with borderline personality may learn at a young age that the only way to obtain care from one's parents (and avoid core emotions related to unfulfilled interpersonal needs) is to cut oneself to the point of needing medical
attention. However, this individual may later repeatedly lose close relationships as an adult due to cutting when distressed.

2. **Maladaptive emotional reactions:** Depression, obsessive compulsive symptoms, anxiety disorders and dissociation make up this group and can arguably be seen as resulting from the mind/brain's self-preservative functions gone awry. Anxiety may serve to deter an individual from entering dangerous situations, but when misapplied, also narrows the individual's world, preventing positive experiences as well. Importantly, psychotherapy aims not to eliminate the often-strong biological component of these conditions (i.e., the goal is not to prevent one's vital ability to experience anxiety), but to strengthen coping with anxiety and redirect the individual's (maladaptive) efforts to eliminate uncomfortable emotions. Similarly, in depression, which evokes a tendency to isolate and self-protect, behavioral activation (Martell, Dimidjian, & Herman-Dunn, 2013) helps to reverse this protective mechanism when it becomes inappropriately applied or detrimental. Likewise, one may dissociate during highly stressful or traumatic experiences in order to mentally distance and protect oneself from being overly taxed by stress, but psychotherapeutic treatment aims to reduce the impact of traumatic events so that, indirectly, the biological support for dissociation will be eliminated (Foa, Rothbaum, Riggs, & Murdock 1991), thus lessening the negative effects of posttraumatic symptoms on the individual's wellbeing.

3. **Maladaptive internalized ideals, values, attitudes, and prohibitions:** The quintessential example is identification with the aggressor, in which the individual, driven by the need for interpersonal connection or with the goal of self-preservation, by molding to the wishes of an aggressor, identifies with the attitudes of the abuser towards the self (Ferenczi, 1949; Frankel, 2002). The result is pathological shame and low self-esteem (Stuewig & McCloskey, 2005). Internalization of these important types of mental content can be recognized by inappropriate shame and guilt.

4. **Maladaptive ideational models:** Learned semantic information about the way the world seems to work can lead to maladaptive goals and responses (Persons, 2012; Clarkin, Yeomans, & Kernberg, 2005). These are based on a higher cognitive level than automatic relational patterns (cf. Bowlby, 1968), and have more ideational content. An example is a belief that only if one is perfect, can one be loved.

5. **Guilty quests:** This group includes the classic Oedipus complex, in which the individual's pursuit of his or her most cherished goals is internally inhibited, resulting in repeated failure to achieve what is most desired in adult life. Inhibition, originally to avoid feared retribution or loss of important relationships, is generalized to the point of blocking healthy and appropriate pursuits.

6. **Addictions and compulsive behaviors:** Maladaptive behaviors, driven as much or more by pain avoidance than pleasure seeking (e.g., Cooper, Frone, Russell, & Mudar, 1995), grow out of behaviors that distort basic biological motivational systems (e.g., dopamine receptor activation; Hyman & Malenka, 2001), which then operate dysfunctionally and override the ability of conscious free will to control them.

**Conclusion**

To summarize, the Affect Avoidance Model holds that pathology addressable in psychotherapy consists of instinctive but maladaptive patterns of appraisal and
reaction to internal and external inputs, evaluated outside of consciousness as
dangers. Among the products of this process are conscious thoughts, feelings,
impulses and visceral reactions, which further influence decision making.
Modification of these patterns requires changes in stored information, making
use of a very limited number of neurological pathways. All effective
psychotherapies seek to affect these pathways via seven distinct objectives,
most prominently, new learning and the simultaneous activation of core
emotions and presentation of disconfirming information. Finally, the argument
is presented that all individual pathologies treated in clinical practice can be
understood within the unifying framework of the Affect Avoidance Model.

The aim of this model is to simplify teaching of psychotherapy and ongoing
clinical formulation for purposes of therapy. In addition, it provides a common
framework from which researchers and practitioners can more easily
understand techniques from different traditions and evaluate clinical decisions
about where and how to combine techniques in working with individual clients.

For more about the Affect Avoidance Model, see the bookstore at
professionals and How We Heal and Grow is intended for consumers.

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5 Comments

**jane mizrahi**
May 11, 2018 at 11:30 am

Thank you Jeffrey.

I really enjoyed this article and will discuss it in my next Therapist Peer Supervision.

[Reply]

**BWI**
May 11, 2018 at 12:19 pm

Good article. It does help me a lot ot understand how things work as far as psychotherapy. Thank you, Dr. Smith.

[Reply]
Hello. I have written on this blog previously, under the name “Beth”. I write again here because I have experienced a fundamental change and am not relating as the same person. I feel that I made a lot of progress since trying to talk to the therapist about the “why” of how I wanted him to hug me. I ended up not getting my explanation out, but breaking down in tears, which he asked if I wanted to talk about, but I didn’t, and I took the step of listening to myself and NOT explaining to him, and merely crying. I felt so much closer afterwards – not necessarily so much to him, but to myself; I stayed true to my inner voice that screamed I did not want to explain my tears, I just wanted to have them. So trying to talk was a really good idea. But I still want to have physical contact.

Actually, I’ve had physical contact with him more than one time. Three, to be exact. Each time, I asked to touch fingers. The first time, I pushed his finger away because of the way he had been sitting during therapy triggered me. The second time, I just felt that he let me touch his index finger. The 3rd time, I locked index fingers with him, and it felt sexual, so I told him about that in the next session (we locked fingers at the end) and told him that I can’t touch him because of that. He said OK.

I had another session the other day. I told him I wanted him to lay his hand on me. He said that considering that when we touched fingers it was problematic for me, he didn’t think that him doing that would be beneficial. So I kept talking to him about how confusing and weird it is sometimes when other people ask me for hugs and/or I hug other people. We talked about leaving conversations with people and just having conversations. And other things. It’s a really good idea to talk or try to talk about these desires is how I’m finding it. That trying to talk or actually being able to talk and how the therapist responds melts a lot of inner wants.

But then I went home, and I had so much inner pressure from all that was stirred up. It was hard to handle. I wrote what TLC calls “drunken emails”, and felt ashamed later. Of not having an adult way to get those childhood desires met, immediately. It’s not adult to get your needs met immediately necessarily. But it FEELS so urgent and uncontainable that I need to keep talking. I’m going to go slower next time and I’m going to tell him how fast it goes and how can he help me handle this, slowing down? It was going so fast because I started to remember, something that has not stopped.

It seems like it is keep going. I feel the negative affect. I remember now the darkened room when I was sick and my eyes hurt from the light, and I was left alone. I think they brought me dinner once, and I was in there for a week. I can’t remember it stopping, but I remember hurting myself years later when someone left me in a love relationship.

I’m so ashamed of the emails I wrote, childish emails. Yet I remember how it all started. I’m reaching out to say that sometimes we avoid emotions because we don’t remember when they started. In the other post, under the name of Beth, I wrote of my fears of annihilation if my therapist was not “present” in therapy. He couldn’t “be” there, because I was not “there”. To start talking of what it would mean to have him hug me, even without the explanation resulting in words, started a cascade of good results in therapy and in my life. (It’s hard to change the way I am relating to my husband, and stop the constant criticisms and put-downs, but I am working on it.) Now it’s early morning and I am reaching out of my darkened room to say that even tho I’m shamed of myself for not handling the overwhelm better: I’m writing to tell someone I remember when they left me. I never thought of that emotionally before. Now I connected with it emotionally, when I was 5, and there was no one there. Someone is here, people read this blog. I responded to TLC as Beth on a previous blog. TLC, I read when you wrote of the disruption in your family.

My heart goes out to you.

I am estranged from my parents now because of emotionally connecting with the harm my mother did to me and my father’s complicitly allowing it even though he knew better. He was wrapped around my
mother's finger, and though he could see something was wrong, did become a hero in my life. I don't fault him for this, his own father was physically abusive to him and he grew up in extreme poverty, but I had to set an emotional and physical boundary with my parents (limit time spent with them, when I used to go over there a lot both to caretake and socialize) and, when I occasionally visit, not to talk about anything substantial. So I get that the one son and his family had to leave the family in order to protect themselves. I feel the pain of a family disruption, but I also feel the strength in that son if setting such a boundary will change the experience in his family for future generations. I hope, that as you all process the effects of the abuse, and learn of your value and worth, and how to care for yourselves in the horror of sexual abuse and emotional neglect, that in the mending of yourselves, there will be family mending.

First you must honor yourself. Jeffrey, I think that it's such a process, and that affect avoidance sometimes results because you can't remember the feeling of the event because you are just not emotionally prepared to self-care in the face of it.

The way that I self-cared last night was varied, and difficult. I listened to an app on my phone. I would recommend it to others who have a smart phone. It is available for iPhone, I'm not sure about android. it is simply called “Calm”. It's no charge and is a collection of musics for “focus, relax, or nature melodies”. My therapist recommended it to me and I am finding it immensely helpful. Not all at once, mind you 😊 It took some gentle nudging to get me to start using it, but I'm picking up on my self-care by using it, which is sooo important in the aftermath of therapy sessions. He's not there with me, and hallucinating him is distressing, and writing childish emails is embarrassing, so learning self-care in super important. It makes feeling the negative affect possible.

I think that focusing on ways to self-care when the negative emotions come up and one is seemingly alone, is a really important aspect of learning to lean into and not avoid negative emotions. Talking in therapy can help them come up, and the therapist being there can be so soothing, but then when he's gone, BAM! It's so distressing unless you have ways to soothe and care for yourself. I'm still learning this, obviously since I wrote those drunken emails. But I wanted to write about the positives that have come out from taking the step of talking over the “why” of Oh-so-very-much (desperately, even) NEEDING a hug, or holding, or leaning snuggled against, or whatever kind of physical contact. I just wanted to say I feel a lot of progress since then 😊

Judith

October 24, 2018 at 4:47 pm

Dear Sylvia, dear Beth,

I do remember your earlier posts. I finally had time to read through this article and I found it very useful. Your post made me think of the fact that I actually never talked here about my trauma and why my life became a constant struggle with attachment issues.

I had an emotionally unavailable mother to say the least. I had a physical trauma caused by her behavior as well, which was that she forced my head under running cold water to cool me down if I was crying too much. I don't know which age it was, but I have memories, so it must have been the age when I started to have my own will and wanting to do things alone. Since I have a sister who is much older than me, I have seen in done on her too. And I remember that Mom used to be so angry at her when she was a teenager and I was just so small and I was making promises to myself that I will never be such a bad child as my sister. This is so sad. I also remember being left alone to cry in the dark because the ideas of how to bring up a child in the 70s was like just leave them and they will learn to stop or otherwise the they will be spoilt. Well done.

The maladaptive behavior that I developed is instead of feeling my abandonment, I will take care of the other and I will push my own emotions down to the cellars. So that is what happened in my therapy. The center of my attention was my therapist, always. The care and hugs and everything I so so wanted from her
were the things that I was the most afraid of. I'm still totally afraid of becoming vulnerable, because I learnt earlier that nobody will come to my help. As I have learnt to soothe myself in the very many hours when my therapist was not with me, now I can cope with this better.

I have never ever let myself be vulnerable in the therapy room. I had anxiety. The final decision of leaving this therapy came about only recently. I felt I was totally stuck, not understanding why am I trapped in this pattern but than with some help I came to the realization that this pattern is being kept up as a running circuit not only because of me! This is where counter transference came in the picture. I don't want to go into more details about this, but this pattern in my therapy was also partly a reaction to the way my therapist's personality and attachment pattern works. I think her pattern triggered mine. But the key to the corrective emotional experience: Even though her pattern immediately triggered mine, at least we could work on it and she was not able to give me the comfort cause I was literally afraid of her and of getting it and because I think she kind of not capable either maybe, so we can say that she could not help me anymore but did she want to help me? The answer is Yes. And you see that is the key. The key is that she was conscious, she put effort in, she crossed many boundaries for me, she put herself in situations she does not go to, she told me a lot about herself, so she really really did everything she could. Ok, I pay her for this haha, but I never ever questioned if she had the best intention for me or if she wanted to help me or not. I still wonder of course what I mean to her. Emotionally, or in her work and carrier. For the second I do have an answer.

Now after I said goodbye I had a dream. I was standing in the light, darkness around me and I was singing like Whitney Houston. I could really physically feel the air and the power of my throat and my voice. It was a wonderful feeling. I took this dream to a gestalt therapist as Im in training now to become one and I had an AHA moment. Light darkness, voice and power of voice....its my birth. I so much knew that once I leave my first therapist will be kind of a symbolic rebirth as I was working with very early trauma and had experiences and dreams of being under water (in the womb) a lot during my therapy years. Tears came to my eyes when I understood that this beautiful dream of mine is not a traumatic but a wonderful memory of being born. At least I like to think its a memory, but could be a memory that have been rewritten or a memory that have always been there but had too much pain covering it. Sorry for being so exhausting! I don't really know if any of this makes sense to other people, but it does to me and thank You that you let me (us) share it here, Jeffery.

Thank you, Judith, I think I can speak for all of us. JS
Jeffery Smith MD

“When I finished psychiatry residency, no one really understood how therapy works or how people change. Seeking clear answers is my personal passion and sharing them, my mission.” Read More...

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Recent field experiments on vertebrates showed that the mere presence of a predator would cause a dramatic change of prey demography. Fear of predators increases the survival probability of prey, but leads to a cost of prey reproduction. Based on the experimental findings, we } Mathematical analyses show that the fear effect can interplay with maturation delay between juvenile prey and adult prey in determining the long-term population dynamics. A positive equilibrium may lose stability with an intermediate value of delay and regain stability if the delay is large. This avoidance was especially pronounced in earlier years, when few states required documented proof of age and when there was greater gain to marrying out of state because of wider variation in laws. Our results have important implications about the quality of administrative data when it is poorly monitored; about the effect of laws when agents can avoid them; and about the validly of estimates using cross-state variation in laws as an instrumental variable. By contrasting two data sources, we achieve a more complete picture of behavioral response than would be possible with either one alone.