Danny Lennon: Kevin, thank you so much for taking the time out and joining me on the podcast today.

Kevin Ashworth: Yeah. My pleasure. Thanks for having me. It's really, really happy that you asked me to do this. I'm looking forward to it.

Danny Lennon: Maybe you could get us started by giving people some context for the background to the work you currently do, and the kind of journey that kind of brought you to that point?

Kevin Ashworth: Yeah. Happy to. So I'm the Clinical Director at a clinic called Northwest Anxiety Institute in Portland, Oregon and we are specialized in the treatment of anxiety disorders. And so we are cognitive behavioral therapists and what that means is essentially we look at the way that the brain, our thoughts, our emotions impact our behavior and vice versa and how we can make change in clients in a short-term present moment focus to improve their lives. Cognitive behavioral therapy is a gold standard and well evidence-based research for anxiety depression for quite a few, you know, psychopathology type of things and then other just lifestyle issues whether that's, you know, sleep, motivation, all those kind of things.

And so specifically, the work that we do and what is very well supported in the literature and not actually done very often unfortunately, so there is that gap between the research and the practice, which you guys probably experience in the things that

you're working on is exposure therapy, and so exposure therapy is a gold standard treatment for treating anxiety disorders and it is essentially helping people move towards a think that they are afraid of, which is a paradox of what, you know, are in a kind of natural mechanism is to do when we feel afraid is to move away from it and that's how anxiety disorders are developed.

So we have a pretty robust clinic. We have an intensive outpatient program, which there is not many in the country and we will treat somebody a minimum for three weeks, three to four hours a day, five days a week and help them overcome their anxiety and we offer individual therapy, group therapy, and we have pediatric clinic as well that we just opened a couple of weeks ago where our emphasis there is working with parents and children.

Danny Lennon: Amazing and as I'm sure many people listening are aware because of many of the -- these problems and their prevalence right now, it's such important work and certainly getting better quality information to people's hands, including practitioners is obviously a big key for you given you talked about this distance between research and practice. And we will definitely circle back to that and I certainly want to talk about your work with exposure therapy, but I think may be a good place to start to get everyone on the same footing is when we talk about anxiety or anxiety disorders, what is the most accurate way for us to define that or so people are kind of clear what exactly it is or more importantly, what exactly it isn't?

Kevin Ashworth: Yeah. Really good question and so there is a big difference between feeling anxious and experiencing anxious and having an anxiety disorder. Quickly, a description of anxiety is, you know, any physiological experience that makes us a little bit uncomfortable that puts us in this kind of a hypervigilant state and is also very, very normal, and so our bodies are programmed to feel anxiety for any situation that really matters to us and so and there may be slight nerves or anxiety, for example, before I put on my headphones and set up this microphone for this podcast because there is a little bit of anticipatory like oh, I'm not quite sure what's going to happen there.

That one would say that that's absolutely normal. It's mildly uncomfortable. It doesn't last very long, but you time it up 50, 60 times a day and that's most of our experiences. Anything that matters in life we usually are in tune to caring about it, which

means our body gets activated. It becomes a disorder when those feelings you start anticipating more frequently than not and then you start behaving differently because of them.

And so if I have done a podcast in the past or spoken with someone in the past and I really didn't like that feeling that came up and then when you ask me to do this, I remember that and I just say, "No, thank you." And so now I've changed my behavior based on that experience. And so one could easily say that I'm starting to develop a problem.

Now not doing a podcast is not an example of impairment and so for a diagnosis of an anxiety disorder, there really has to be impairment. So people stop going to work or they stop going to school if they are children or they passed up promotions or opportunities for public speaking which then leave them to not being able to get a promotion or they go grocery shopping at 7 p.m. because it's not very busy versus at 5 p.m. They start making lots of decisions in their lives based on their psychological and physical levels of comfort and that's really when you get into the realm of an anxiety disorder. So we all experience anxt. Most of us realize that that is cured by just life stress, relationship stress, work, eating, body image, all those things, but it becomes a problem when it really becomes a problem and it starts to impact your life and you start to make lots of decisions based around it.

Danny Lennon: Right. So could we think of it as where we have this true disorder develop is a case where not only is the anxiety causing some change in behavior, but it's going to have an impairment of something that would otherwise be good or a good thing for someone to be doing? They are pulling away from it.

Kevin Ashworth: Yeah and people are also -- yeah, exactly. People are running away from it and they are also just distressed and so they are not -- they don't feel good and it's insidious and it happens, you know, it really robs people of many experiences. And so, for example, just as to be consistent with this example of I said no, thank you for this opportunity, I have likely resolved my anxiety because the second I say no, that anticipatory stress goes away and that's rewarding in the brain.

But then what happens is I have to say here now with the feelings of shame and guilt that are associated with I just pass upon a cool opportunity to talk about the work that I do. Wouldn't that be

really cool? And I actually don't know what that experience was going to be like because I have avoided it so I have disallowed myself any evidence of actually knowing if it was going to be anxiety provoking. So then there is a sense of hmm, I feel okay because I didn't do it and this is why avoidance is so powerful because I'm okay and I didn't do it. But I will never know that doing it will be okay if I avoid it and that's the trap people gets stuck in.

Danny Lennon: Right and would it be fair to assume that maybe at least from a -- I don't know if this is back from like an evolutionary standpoint or anything, but is there certain cases where that type of a predisposition for humans to react in a certain way of I had the certain feelings about doing some sort of action and so as an adaptation, I'm going to try and avoid doing that in the future?

Kevin Ashworth: Oh, absolutely -- and that's the way that we conceptualize is, you know, we are right now the top of the food chain. There are very few things that are actually dangerous for us, particularly if we live in the western part of the world and so it's very, very adaptive in that respect to "trust your instincts." So from an evolutionary point of view, if I'm leaving the cave and I hear a rustle in the bushes and my stomach starts to churn, so I go back to the cave. It's safe to say I don't know if I would have been eaten by the saber-toothed tiger or not, but I don't want to -- that's not something I'm willing to test and so we also wouldn't call that anxiety there, right? We would call that making a smart decision and so when people are in actual danger, they do not use words to describe it as anxiety.

So anxiety is really this perception of threat when there is not actual danger and so if you talk with people that have experienced, you know, a horrific car or any car accident or a mugging or any actual event that was actually scary where they were actually in danger, they don't use adjectives that are similar to the words we know around anxiety. We just say, "Man, I just reacted. That was terrifying. You know, no one says that they were T-boned in a car and then flooded with intrusive thoughts and felt panicky. They just say yeah, my body is doing exactly what it's supposed to do.

When we run from the burning building, and this is an example I always give, when you run from a burning building or an explosion and I catch up with you on the sidewalk and I say, "Tell me what's

going on in your body?" You say, "My chest is getting tight. My thoughts are rising. I feel sweaty, and hot, and a little lightheaded." I'll say, "Are you are having a panic attack?" And people would say, "No, David, I just ran from the building."

But it's when that's -- when you're on your couch and that's happening or you are driving in your car and so it used to be very, very adaptive. It's something that we still have, but we are very -- it's very infrequent that we are in actual danger and we also have evolved immensely in our cognitive ability. So we have forethought and we have the ability to anticipate things that actually haven't happened yet and we can worry about things that are going to happen in five years from now and actually feel sick about it, even though there's no evidence whatsoever that supports that that worry is rational.

Danny Lennon: Right. So and again, feel free to correct me if I'm wrong, and any of this that I pickup, but with that it kind of seems that there is this clear distinction between a stress response to something versus when there is true anxiety, it seems to be when you mentioned there is a perception of something, is that where we would typically think about this as when these thoughts arise with to do with something that's going to happen in the future, as opposed to just what's going on right now or it's just gone in the past, it's more thinking ahead too much or is that just one kind of component of that?

Kevin Ashworth: That is really one component of it, but you're right. I mean, stress is something that is likely an experience that we have until there's an end -- there's a finite something and so there is an exam at the end of it or there is a job interview or a date or you know, you either get affected or you figure out a way to pay your bills or you make the competition or you don't make the competition or you get the promotion or you don't and it's very stressful in that interim and you are, you know, it's because you care, again, it's because you care about something and so your body is activated. You are tense. And one would say that that's a very reasonable reaction to an important event in your life.

Yeah. An anxiety then, an anxiety disorder or an experience of anxiety or for individuals that are thinking today about a promotion that they actually haven't even applied for, but they are thinking about what would happen if they didn't get it and if they did get it, what would be the responsibilities and they're

anticipating all this concern that they have actually no evidence would be the case yet.

Danny Lennon: So to some degree a level of uncertainty there is something that's too hard to cope with in some cases.

Kevin Ashworth: Exactly and that anxiety, you know, for an anxiety disorder to exist, we really think about it loading on two things. One is the intolerance of uncertainty. People that are -- that struggle with anxiety disorders really do not like managing uncertainty. Most of us don't. They just don't have any tolerance for it and then intolerance of any distress and most of us don't like to feel bad, but for an anxiety disorder, there really is very minimal ability or to tolerate the stress.

And so when you are anticipating the future and you don't know what's going to happen because the truth is none of us actually do there is no actual problem-solving that can be done because we have no idea of what sometimes the problem is or what the potential concern is and we have no control over a lot of things, but because of that people churn on these anxious responses and so what's consistent with this presentation is future focus what if, what if, what if, what if. These individuals usually follow it up with a catastrophic result and so what if I don't get the promotion? People want to know I want increase my salary. I feel like a failure. My family might leave me. What if these things happened?

And there is no evidence that that's the case is. It's not that even someone has said to them good chance you are not getting the promotion. So it's always a catastrophe and that is a presentation that matters a diagnosis of generalized anxiety disorder? So it's not just general anxiety. It's a future focus chronic excessive worry more often than not about pretty normal things in everyday life, finances, job, relationships, those kind of things.

Danny Lennon: Sure. Before we dig into more stuff specifically on anxiety and some of the practices to help with that, there is one area that I think is important, particularly for maybe people who haven't looked too much into some of these areas because one thing that is quite common to see brought up in any mention around anxiety disorders tends to be also in the same type of conversation as depression. So I'm just wondering what is the best way to think of the two of these things in terms of their relationship, their

correlation, and where they stand as either distinct or paired things, if that makes sense?

Kevin Ashworth: Yeah. Yeah. We know that they are highly correlated. We see that, you know, there's a comorbidity between them that often when one is struggling with an anxiety disorder, there is a good chance that they are also experiencing major depressive disorder. Again, just using the right vocabulary, many people will talk about when I see them in practice, they will say, you know, previous clinicians have diagnosed them with anxiety and depression. And what I tell them is those are experiences and those are experiences that likely I have had both before noon Sundays, but that doesn't mean that they are problems.

So feeling sad or feeling depressed is not a major depressive disorder and feeling anxious is not an anxiety disorder. So major depressive disorder is again, you know, it's a serious mental health issue that is about impairment, severity, and stress, longevity, but they do go hand-in-hand. Sometimes it's tricky to know which one came first. Sometimes it really doesn't matter. But we know that they are often linked.

The way that I look at treatment is many times I ask people to think about if they are struggling with those feelings of sadness, more often than not, suicidal thoughts, not a lot of motivation, and whatever anxiety disorder they are coming in with, if you're not functioning based on your anxiety disorder, you do these behaviors because of OCD or you do all these avoidance because of your social anxiety. If that was treated overnight, if you woke up and that was gone, do you think you would still be depressed or if your depression was gone overnight, do you still think you'd be worried about what everybody thinks about you?

And the answer is often if my anxiety disorder was treated, I think my depression would remit as well and that's a hypothesis, but we know that feeling trapped by anxiety and start living a life based on what your anxiety wants you to do is exhausting. It's extremely demoralizing and it feels very, you know, it looks just like depression. But when it comes to treatment, it's really important to figure out how do we treat this because if you've got someone that's making 100 decisions about avoidance because of their anxiety and you're only trying to help them feel happier, you might be in a uphill battle that you are not going to win.

Danny Lennon: Right and so when we are talking about anxiety disorders and then also depression could probably we can ask the same question. So maybe there is two different answers here, but I'm thinking about are there any clear distinct differences in the anxiety disorder and/or depression that is brought on by say a specific trauma versus some of the anxiety disorders that seem to develop where people can put their finger specifically on why or exactly when it may have started, but it is just this thing that has grown over time ever since someone is like very clear of this trauma is the thing that caused this and now I can't get away from it?

Kevin Ashworth: Yeah. I mean, absolutely, I think, you know, we have -- there is a diagnosis, posttraumatic stress disorder, which is in response like it is a pathological anxiety response in response to trauma. I will say that that we know that lots of people experience trauma, and not everybody that does has a traumatic response to it. You have to give a certain amount of time, six months because we expect that if something really, really traumatic happens in your life, your body has to adjust to that and that doesn't mean you have a problem. That means you're adjusting.

I had a mother asked me once if I would retreat her children because her spouse passed away very, very unexpectedly, and then within a week their house caught fire and burned down. Both things are very, very traumatic and I said just wait, just wait because however they are responding now is however they should be responding. If they are still responding that way in six months, let's talk about that.

And so specific instances of things that shake us to our core, put our life in danger or really disrupt our sense of self can certainly change the trajectory of how you are going to see yourself day-to-day, how you are going to interact with people day-to-day so and it actually doesn't really change how we treat people.

We just live in a world where meaning is so important and so when people can say I'm living this life based on this trauma, it's just really, really nice from an etiology point of view to say, I know why wherein most people, they are always trying to piece together why they are making the decisions they are making and how do I develop this behavior related to anxiety.

Danny Lennon: And I just wanted to circle back to earlier when you talked about some of the decision-making that can go on and some of the impairment of doing certain behaviors or certain things that would typically be normal or is good for the person and you gave a couple of examples and it reminded me of a particularly useful thing that I have heard you mention before I think in one of your YouTube lectures about to try and really get to the core of some of this, getting someone to ask themselves a simple question when making a decision of am I doing this action based on fear or on preference. Can you maybe touch on the distinction between avoiding a situation because of actual anxiety versus just not wanting to do something at that time or not wanting to be social or something like that?

Kevin Ashworth: Yeah. And I really think when it comes down this is so important. I love that you brought this up. Making -- we have to make so many decisions a day and it's fighting your anxiety and I really take this approach of like bring it on, let's do this, but you can't do that all day long and so helping one get over their anxiety disorder is not, you know, in 12, 16 sessions of therapy and then you are better. It is 12, 16 sessions of therapy to teach you how to behave in a way that when you're presented with situations that trigger your anxiety. You know how to interact in those in a way that will help you maintain your -- maintain your lifestyle or maintain your non-anxious person over time.

So there is, you know, if you struggle with an anxiety disorder, you know that you are -- there's a million decisions a day that you have to make and so any example from if I struggle with panic disorder, which is really, really intense intolerance of physiological symptoms. I do not want my body to respond inaccurately to anything. Then when someone says let's get a cup of coffee, and I love coffee, and I really, really like coffee, I can say, "Oh, no, thanks. I'm not drinking caffeine right now." And I can play that off as a health benefit. I can play that off as I've already had my cup today. I can play that off as anything, but I know that the only reason I'm not taking, I'm not drinking coffee is because I'm scared that that caffeine will make my heart skip a beat, that will make my brain then say, oh, oh, this is a panic attack and that that scares me, so I will avoid that. Well, that makes your anxiety know that's running your life.

So the same person can still have panic disorder and they might, they -- only they will ever know that today if they are deciding not

to drink caffeine, it's just because it's a hot day and maybe there's a much more refreshing beverage that they want that doesn't have caffeine and that's actually their preference. So now they are making a choice out of -- a decision out of preference and not fear and only they will know that. And so you can think of if I have social anxiety and I am walking across the street and there is a person walking in my way and the idea of not knowing whether I make eye contact with that person or not and that makes me anxious and so I regularly look at my phone while I walk so I don't even have to manage that. That's making decisions based on fear.

If I am walking down the street and I notice someone that maybe is an acquaintance and I just don't want to talk to them because I'm not in the mood, well, now I'm just making a decision out of preference. But it looks the same there for everybody else and if we convince ourselves that we are making decisions based on preference when really we know they are based on fear, that is how an anxiety disorder is developed and maintained over time.

And unfortunately, if I can just add this piece, many people that go to therapy don't get that part explained and they don't understand that part because sometimes what is actually offered is yes, I can tell you the amount of people that tell me I don't drink caffeine because I have panic disorder and my therapist told me I should not drink caffeine because that would trigger a panic attack. So I should do everything I can not to trigger panic, right, because my goal is not to be panicky and I -- that's a very simplistic way of saying yeah, that's like you don't do it, but now you are afraid that now the lesson there is you actually can tolerate a panic attack and that's not true. Everybody can. They are not dangerous. They are just horrible.

And so it's just it's fundamentally shifting the way that people interact with just any -- any distress at all, you know, an example, I often give and it is I mirror it often to exercise and working out. I have often on my whole life it's just kind of comical when you reached out to me and I say as a nutritionist because I'm always trying to do something new to get myself motivated that extra stuff and it's the exact same experience that -- that I have to endure when I go to the gym or decide what I'm going to do today for exercise or any day and I told you, I feel I have got some serious script, you know, I have worked hard in my life. I have come from nothing. I have worked really tough. I've got some mental grit.

Physical grit? I've got no physical grip. So I start going for that jog or I start -- I'm on that success of that's what and I notice that oh, oh, it's starting to hurt and my respiration is shifting. I'm very quickly to make a great excuse of why I need to finish my work out and move on. And I know logically that if I keep working out regularly through that physiological distress, I actually get tolerance for it, my stamina improves, and then my strength improves, and it actually gets easier, but I don't like feeling that physically, and I know logically what I have to do, but that's a really big roadblock for me. So I use that example to people all the time.

Danny Lennon: No, that's perfect and I just really love that question when you talk about is this a decision I'm making based on fear or preference because like you say it's only really able to be answered by the person themselves, but it's such an amazing awareness tool because just simply having that in your mind, it's such a simple question. You can apply almost immediately and know the answer and it just starts I think that process of bringing awareness to certain things that may not be useful. So I've found that tremendous when I came across at first.

Kevin Ashworth: Yeah. Good. I'm glad and then, you know, what I remind people of is so once you develop that awareness, it doesn't mean because people can be, believe it or not, very critical of themselves and so it's now it opens us up to say, you know, if I'm working on something in my life, whether that's my anxiety disorder or you know my physical appearance or my diet or whatever it is, my stamina, most people become very black and white in how they do things. So if I can overcome my anxiety, I don't want to work on it and I have been there when I think about exercise.

If I can't look like I'm shredded, I don't want to work out at all because I can't imagine any day that I can get there and what this is about or if I -- I believe I have to eat 100% healthy every single day all my meals or I'm not going to do that. So now I'll just eat the opposite. I'll just eat whatever I want and so this is the same approach. If I see this as a balance and that's why I say 100 decisions a day, we know we make more than that, but if I make 100 decisions a day based on my -- based on preference, if I'm making 100 decisions a day and I just -- my goal is to make more decisions today on preference than fear, I'm winning, right?

And so and that's what I want people to see that and just own that when I'm crossing the street because I don't want to make eye contact with someone or when I'm not drinking caffeine or I'm taking -- I'm saying no to hanging up with someone because it feels scary or I'm having a drink or smoke in a bowl because I don't want to have to feel I'm anxious before I go to a social event, I'm not saying I'm not judging people for that, but just know like I have to do this right now. My goal is not to be able to do this in the future, but I'm going to make more decisions about what's preferable for me and then, you know, relating that back to diet and exercise, and that's how I have been. I'm right now probably, you know, the healthiest I have been and it's just taking that approach of saying if I can make more decisions about what I eat that are good and bad, I feel pretty good about myself and then it becomes a little competition with myself.

Danny Lennon: Yeah, for sure. And I think that's something that has been talked about quite a lot and you see it even through the literature of this framework of a flexible approach to nutrition being so much more beneficial from body composition to health versus a rigid framework in terms of someone's mentality.

Kevin Ashworth: Sure, yeah. Makes sense. Yeah.

Danny Lennon: So I'm keen to get into some of the possible strategies that you use in practice with people and to talk through some of them. I know earlier you talked about exposure therapy being one and maybe something as a gold standard that can be used in certain cases, and although the name may to some people come up and think, well, that's quite obvious, is there certain I suppose a right way and a wrong way for this to be implemented and what should a good quality exposure therapy practice look like when someone is doing that with a practitioner?

Kevin Ashworth: Yes and I'm glad you finished that sentence with a practitioner. Yeah. There is absolutely the right way and the wrong way. Their exposure therapy despite how, you know, it sounds and it's funny I had a patient this morning, a young man saying to me, I said do you know what that means because it's kind of a scary word? And he said, "Do you mean making decisions that are on the opposite of what my OCD wants me to do?" And I said, "Wow, yeah. Maybe I'll just start saying that to people now instead of exposure therapy."

So the experience of exposure is very, very simple, but it is also very, very nuanced and so we look at the principles of learning theory and that's where exposure therapy came from and so very, very quickly, you know, if you look -- if you -- we think of anxiety disorders that are often developed through classical conditioning or associative learning and so everybody if you've taken a Sec 101 class, Pavlov and the dog that a unconditioned stimulus becomes paired with a neutral stimulus to become the conditioned stimulus. And so, once you have a connection between two things, so, for example, if I have a panic attack in an elevator, those two things would be compared. So whenever I walk up to an elevator, my body goes into a panic state, which is associative learning.

How I respond to that fear is Operant conditioning and so it's based on the consequences of that behavior. So when I walk up to the elevator and feel the fear and I make a decision to avoid by taking the stairs, I feel less anxious and that is rewarded because less anxiety is good. And so through operant conditioning, all these decisions about making decisions based on fear versus preference are really, really rewarded and they actually become reinforced over time.

So with that knowledge and exposure therapy as we know is effective because anxiety is physiological experience. So we know that once sympathetic nervous system becomes activated, which is your fight-or-flight response in order to protect you, our bodies are very, very efficient. Once we let our body know that we are not actually in danger, we are not running from a bear, we are not tackling a mugger and we are not, you know, running from a burning building, body wants to turns off that system because it takes a fair amount of work to get all that going.

And so once exposure therapy is hinged on this idea that when we present you with something that is the perception of threat, not actually scary, the perception of threat and we hang out there long enough, we do that long enough till the brain realizes oh, there is no danger, turn on the parasympathetic nervous system and shut that down and that process is known as habituation and so habituation as is experience where you jumped into a pool and it's freezing and you get out immediately and you try to get back in and you get out because it's cold. Every single experience is terrible. We know everybody knows and the advice everybody

would give you is get to the pool and stay in the pool. Your body will get used to it and that's the process of habituation.

You put your shirt on today. You can feel the weight of the shirt on your shoulders after a few seconds of wearing it, we forget that we are wearing a shirt. And so we know systematically that when we expose individuals to the things that people that feel very scary, they're not dangerous, they feel very scary, and they don't run away avoid or engage in some safety behavior or something to minimize or mitigate the anxiety that their anxiety will reduce and that has to happen just a few times for their brain now to learn that oh, this experience does not actually require sympathetic nervous system.

So that is exposure therapy in a very quick and down and dirty explanation I guess, but you can imagine now how when you present yourself with something that's anxiety provoking and you avoid it, your body turns on the parasympathetic nervous system, but the message is still yeah, that thing was bad. There is no learning that that it wasn't. So there's a million things we can do to help to expose people to the things that are scary mostly because a lot of the fear is cognitive. It's a lot of, you know, it's a lot of appraisals of situations and respiratory events and things like that.

We are not talking just about like, you know, dogs, and spiders, and needles, and things like that. We are talking about events that have not happened yet and so this is -- it's a paradox because we are asking people to do the same that they generally are or genuinely are afraid of and the response is amazing. People get better.

Danny Lennon: Yeah. That is pretty impressive and it's interesting just to know it's another great example of this as well as inability for us to probably pull apart the psychological and physiological responses in many ways and that you were impacting both through a therapy like this presumably.

Kevin Ashworth: Yeah. And it's not that, you know, people are not -- people need exposure not because they are not tough or mentally tough or anything like that. They are just doing what their body is telling them to do, and so when you feel the stress or heatness, you know, your body is saying do not do that. Exposure is so difficult and I'm always in awe at the courage that my patients have

because fundamentally, when every single thing in their body is telling them to runaway, they are signing up for a therapy and paying money to sit there and endure it and of course that's because it is impairing their life in someway.

Now, initially, you said what's the -- or can it not be done correctly? The question that many people write to me are things like, you know, I am terrified of public speaking. I have a panic attack when I do that, for example, and yet I public speak every week, but that fear hasn't gone away. If exposure therapy would work, why wouldn't that work? Or I'm afraid of driving, but I have to drive to work. I do it every day. I have done it for last 10 years. If exposure therapy works, why does that work and so on? You get the point.

The problem is in order to be for exposure therapy to be effective, one has to be vulnerable to the experience of anxiety. What these folks are likely doing is they are white-knuckling the experience and so they are keeping the learning as this thing is bad, this thing is bad, I just need it over, I just need it over. So they're holding onto the steering wheel as high as they can and when they get to work, the message is you didn't die this time and then not anything can happen and you'll be okay because you can tolerate bad things happening. The message is you just, you know, what a fluke! You made it this time. And so the fear persists.

So if you engage in any safety behaviors and a safety behavior is any behavior you do to mitigate anxiety, so if you have to speak publicly and again you are managing uncertainties, you want to k now how many people are there, will there be a podium? And some people say, well, I feel safe if there is a podium. Is there a microphone? Can I have my notes? Can I have a glass of water? Can I have a minute? Can you shine the lights on me so I can't really see people out there? These are all safety behaviors that if you employ these and the presentation is successful, people even say, hey, great job. What you come up with the conclusion is ah, that was just a really nice crowd. The next crowd won't understand or that was just a fluke for me or but what if next time they don't have bottle of water or whatever it is. We come up with a reason to minimize our attempts at trying to get better.

So it's not about white-knuckling and getting through something terrible. It's not fear factor, you know, where you are closing your eyes and squinting. That's what we do just to get over something

that we, you know, will never really have to do again and that's fine, but that's not exposure.

Danny Lennon: Just what we talk about either exposure therapy or maybe anything else that might be used in practice, when it comes to using these to deal with that anxiety, is it a case that these practices actually can lead to this elimination of anxiety or the anxiety disorder, or is it simply a case of trying to increase that ability to deal with it or that increase that tolerance that we talked about earlier?

Kevin Ashworth: Yeah. The answer is it depends and everybody is different. But the truth is it's a total paradox. What I tell people is you are not in a therapy to get rid of your anxiety. You are here to change your relationship with it. With that said, once that becomes expectation and you start spending times of your day going looking for your fear, it starts to be, you know, found and over time, people no longer meet criteria for the diagnosis because once it's not impairing anymore, you don't have that disorder anymore. And so now you are just functioning like everyone else. So if you're going out looking for opportunities to trigger your social anxiety to prove to yourself you can tolerate that, I don't know if you have social anxiety anymore.

Now do you get nervous when things are embarrassing? Yes, absolutely. But that fear of being embarrassed like the rest of us, does that prevent you from going to a social event that somebody asked you to? Not anymore. So I don't know if you have social anxiety anymore. Panic is the same thing. So if you are, you know, now exercising again, a lot of people stop exercising when they get panic attacks because they don’t want to change their physiology at all. They don't want their heart to be fast. They don't want to sweat. They don't want to get hot. So if you can drink three Red Bulls and run around the block and do everything you can to trigger a panic attack and it doesn't come, you should stop being afraid of that. Then by paradox, it stops coming and you get better and you don't have it anymore.

Danny Lennon: Super interesting and I think that makes a kind of lot of intuitive sense to people here and I think it's an important point to note that even if we were to say, okay, theoretically, what you're doing is increasing this tolerance or this ability to deal with it, in the real world, once someone's progressed enough, the actual real world

implications is it's indistinguishable from just not having the disorder anyway. So I think that's a--

Kevin Ashworth: Yeah. It is not a life -- having a mental, you know, even mental health sounds so intense, but you know the prevalence rates of anxiety is so high, you know, 25% and that's so many people and you know to the point when I go out and talk to people and they ask me what I do, I just tell them I own a business because I know that I'm talking to four people, you know, at least one of them is struggling with an anxiety disorder and they're still really high functioning people and so that's the fear of people that are high functioning that they think they're the one-off bizarre individual, and when we think of mental health, we think of an individual on that side of the street, you know, kind of muttering themselves.

But the people I -- we treat here are, you know, very impaired in very specific parts of their lives, but in other parts of their lives, they are doing amazing things and their friends and families might not ever know they were getting treatment for an anxiety disorder because we are all pretty good at doing our avoidances and our safety behaviors without anyone else knowing. And so the whole goal of getting treatment is that it's no longer impairing and my argument is if it's not impairing, you don't have the diagnosis anymore.

Danny Lennon: Kevin, there is one kind of final area that I wanted to explore before we start to wrap up here and earlier you had mentioned I think in relation to some of the safety behaviors, people may put in place that even if they avoid the thing that they have this anxiety over that avoidance then can afterwards lead to feelings of guilt and shame. And I think these things even can go broader into when people maybe are focused on the past and they have maybe some guilt around something or some shame perhaps that even is embedded within a depression more broadly. So how can you prevent someone from ruminating on those things that happen in the past because that at least from the outside tends to be kind of a large part of the problem here is not necessarily never feeling these things, but this constant rumination? So how would you in practice at least start that process with someone of trying to get past something that maybe they tell themselves that they can get past?

Kevin Ashworth: Yeah. I mean, it's a very -- it's a great question. It's just a very tricky and nuanced one I answer. When I think of people that are

living in the past meaning, you know, I should have, I could have, I would have, sometimes there are very specific strategies like I ask people to take should out of their vocabulary. There is very few sentences where you can include should that help you feel good at all and there is also no rules in the world that we have to behave in certain ways and so when we say things like, you know, I should have gone to that party, that's really kind of a shaming statement versus I didn't go. I should have studied harder. I should have been a better father. I should have been a better kid. I should have whatever it is. I shouldn't behave this way. It's very different to saying well, you are behaving that way. Would you like to change that?

That did happen. I ask people, you know, how are you going to give up the hold of the better past because when your emphasis is on how can I change something that has already happened, the answer is always you can't, and so I tell people in a very simplistic way, you know, anxiety is a problem of the future, what if and depression is a problem of the past, should, could, would, and so being present is, you know, the very difficult task and the solution to both of those and so we are always pulled between all three of those.

Even in a conversation, I can be thinking of something right now that that can make me feel sad from my past and I could be anticipating the next week of work or the next hour of work and feel nervous while I'm also talking to you presently. And so, exercises and practices to try and be present can be really, really helpful.

The other thing that I think about that pulls people into the past is the experience of shame and so and shame is this experience that you are not enough and so when that's triggered, what's likely -- what likely comes up are feelings of, you know, not being good enough in various aspects of your life. So I'm not smart enough. I'm not pretty enough. I'm not thin enough. I'm not rich enough, you know, whatever it is and so when that gets triggered, for example, someone says, you know, hey, you need to redo that report or you didn't get asked out on a date or you get rejected, those are the experiences that come up, oh, I'm not enough, not just oh, that person didn't like me. They didn't want to go out again. We didn't really fit. I felt that too.

And so Brené Brown is a researcher that's really well known. She's got some amazing, you know, TED Talks and she is a researcher on shame and this is, you know, I've read all -- most of her stuff and she talks a lot about that. So I would encourage people if this small little conversation about shame picks your interest, look up Brené Brown's work also.

Danny Lennon: Perfect. I appreciate that answer, especially given as such the broad general question or overall theme at least.

Kevin Ashworth: Yeah.

Danny Lennon: Kevin, I'm going to start wrapping up here and I think it's probably important that I point out to people that there is a lot of context and nuance to a lot of these discussions that we've barely scratched the surface of trying to explain some of these, and there's a lot that they can go and do to seek help from professionals or whether that's contacting someone like yourself or elsewhere. So from first point if this has been a particularly important discussion for people to hear and something has really resonated with them, where is the best place for them to find may be more of your work online, find you, and contact you, all that type of stuff, where should they go online?

Kevin Ashworth: Yeah. Thanks. Yeah. Our website is Nwanxiety.com. Northwestanxiety.com. And then I have a YouTube channel, which is Fighting Fear with Kevin Ashworth and I have a fair amount of videos on there. They are short videos that just have tips and -- not really tips and tricks, but just ways of understanding and kind of extrapolates some of the things that we've talked about on this interview and then my email is Kevinnwanxiety.com and when I can, I'm happy to answer questions that people have or trying to direct them in ways that might be helpful and I've had some really cool interesting people tell me about some of their lives through that and so I can always get back to people depending on how much they write, but that is sometimes an option.

Danny Lennon: Perfect. And so for everyone listening, I will of course include all of that in the show notes this episode. That will be over @Sigmanutrition.com/episode236 and will link up to all of that as well as more about Kevin's background and some of the work that he is doing. So with that, Kevin, that brings us to the final question that I always in the podcast done. Simply, if you could advise

people to do one thing each day that would have a positive benefit on any area of their life, what would that one thing be?

Kevin Ashworth: Oh, that is a great one. I really believe in the science of behaving first and allowing your emotions to catch up. And so because of that, as corny as it sounds, smiling is a behavior, and when we feel distress, anx, whatever it is and we smile is a fundamental different behavior that one would engage in if you are in a natural danger, you know, or something bad was happening and so it shakes the brain a little bit I believe. And so I would smile more frequently, and I would smile on purpose when you are feeling those intrusive thoughts, when you are feeling those anxious thoughts because the brain is now saying it's a competing behavior to fear, and most people don't smile when they are scared.

And so when I'm anxious whether I'm driving on the car, I'm sitting at home or we're out to dinner, my wife will say, feeling nervous because she will look over at me and I've got this big cheesy grin on my face, there is totally disingenuous smile, but I'm active. I change my brain chemistry, change my brain chemistry. So that would be the behavior I would think people can employ.

Danny Lennon: Wonderful. Thank you so much. A quite way to round this up and so I want to say thank you not only for taking the time to do this today, Kevin, but also for the wonderful information you've given, and a great work that you continue to do. It's been awesome talking to you, so I thank you so much.

Kevin Ashworth: Yeah. Thanks so much, Danny. I appreciate it. Cheers.

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