The Radical Act of Inward Looking

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Abstract

In keeping with the new wave of context -focused behavioral treatment approaches such as Acceptance and Commitment Therapy (ACT), Mindfulness Based Stress Reduction (MBSR) and Mindfulness Based Cognitive Therapy (MBCT), we discuss an innovative behavioral intervention referred to as the Act of Inward Looking. The theoretical underpinnings of this intervention are based on the assumption that the primary cause of human psychological suffering is a pervasive fear of life which is established at birth and thereafter operates as an unconscious psychological context or core belief. Problematic symptoms, negative behavioral traits and reactions as well as our attempts to get rid of them are seen as effects of this lifelong pernicious context. The Act of Inward Looking primarily targets and modifies this context and is thought to subsequently lessen or extinguish many of the aforementioned effects. The Act of Inward Looking is described in detail and viewed, in part, through the lens of In Vivo Exposure Therapy, as well as contrasted with mindfulness-based practices.

Keywords: mindfulness, exposure therapy, the act of inward looking

The Radical Act of Inward Looking

Anxiety and depressive disorders are the most common psychological disturbances in the western world. Based on the most recent statistics (2005 to 2008) from the National Institute of Mental Health (NIMH), the 12-month prevalence rate for depression in the general (non-institutionalized) American population is 6.7 % and lifetime prevalence is 16.5%. At the same time, the 12-month prevalence rate for anxiety disorders is 18.1% and lifetime prevalence is 28.8%. According to these statistics, almost half (45.3%) the general population in America will have an anxiety or depressive disorder during some period in their lives. Based on 2004 U.S. Census data, in a given year approximately 20.9 million American adults will have a mood disorder (e.g. Major Depressive Disorder, Dysthymic Disorder and Bipolar Disorder) and approximately 40 million American adults will have an anxiety disorder. These astronomical numbers represent almost a quarter of the American population.

There is also a growing body of research supporting the view that there may be much more commonality or overlap between disorders than difference or distinction. For example, between 62 and 80 percent of individuals diagnosed with Post Traumatic Stress Disorder (PTSD), which is classified as an anxiety disorder, meet the criteria for at least one other disorder (Davidson and Fairbank, 1993). As well, the significant comorbidity between PTSD and depression is extensively documented (Keane & Wolfe, 1990; Kessler, Sonnega, Bromet, Hughes, Nelson, 1995) and PTSD co-occurring with substance abuse is so common that clinically it is to be expected (Najavits, 2001; Oiimette & Brown, 2003; Ruzek, Polusny, Abueg, 1998). At the same time, pharmaceutical treatments for both depression and anxiety disorders are similar, that is, both are typically treated with antidepressants; which claim billions of dollars in annual sales in the U.S. (Whittacker, 2010, p.3). In fact, in any given 30 day period, 14% of the

civilian population in America is prescribed antidepressants (Center for Disease Control and Prevention, United States, 2011). The examples above are but a few of the many providing evidence that there is an incredible prevalence of people being diagnosed with anxiety and mood disorders, as well as a considerable overlap between apparently distinct classifications of disorders, leading one to wonder whether these classifications reflect distinct pathologies at all.

Dr. Sheldon Preskorn, a fellow of the American Psychiatric Association and the American Psychopathological Association explored this overlap between DSM-IV syndromes. He examined the diagnostic and associated features listed in the DSM-IV for Bipolar Disorder Type I and then compared their features with those for other psychiatric syndromes, which included other mood disorders, anxiety disorders, psychotic disorders, and personality disorders (see Appendice). Dr.Preskorn explains his findings:

Given this considerable overlap in signs and symptoms, it should be no surprise that many patients have features and may meet criteria for more than one psychiatric syndrome. Depending on the orientation of the clinician or researcher, they may be given multiple "comorbid" diagnoses, even though the same signs and symptoms are the basis for these different diagnoses. Alternatively, patients with the same condition may receive different diagnoses based on which diagnosis is favored by a specific clinician. Thus, the same patient might be diagnosed as having schizoaffective disorder by one clinician and borderline personality disorder by another because of the overlap of symptoms; or the same patient might be diagnosed as having both schizoaffective disorder and borderline personality disorder (Preskorn & Baker, 2002, p.5).

Barlow and colleagues (2004) similarly observe that, “...the nature of emotional disorders reveals that commonalities in etiology and latent structure among these disorders

supersedes differences" (p.205). They go on to explain that, there is wide agreement that the DSM-IV represents the zenith of a splitting approach to nosology, with the obtained advantage of high rates of diagnostic reliability. But there is growing suspicion that this achievement has come at the expense of diagnostic validity, and that the current system… may be erroneously distinguishing categories that are minor variations of broader underlying syndromes. (Barlow, Allen, Choate, 2004, p. 211).

The question seems unavoidable as to whether these disorders are mostly a result of individual factors, such as genetics and temperament, and hence distinct, or might they also reflect underlying processes which are more endemic or generic to human experience? The wholesale application of similar treatment approaches to a wide range of problems suggests that the problem may be more endemic. For example, Mindfulness-Based Stress Reduction (Kabat-Zinn, 1990), Acceptance and Commitment Therapy (Hayes, Strosahl, Wilson, 2003) and Mindfulness-Based Cognitive Therapy (Segal, Williams, Teasdale, 2002) apply similar strategies to a broad range of problems and disorders versus particular interventions that would be tailored to treating only specific disorders. Again, this suggests commonality over differences. At the same time, these approaches tend to focus on alleviating a common process or problem, that is, our reactions to negative mind/body experiences, especially our propensity towards experiential avoidance [1]. Experiential avoidance as a long-term strategy to alleviate negative symptoms ends up doing the opposite and exacerbates our suffering. As well, many of the strategies that we use in order to rid ourselves of feelings such as anxiousness, sadness, and anger may eventually cause these affects to become "disordered" (Eifert & Forsyth 2005, p. 55; Linehan, 1993). In other words, often our efforts to cure may actually be contributing to the disease, and sometimes it even seems as though the struggle to control symptoms has become the disease. We can all

agree that pain in life is inevitable, but the degree to which - and perhaps even what and certainly how - we suffer is quite malleable.

1. Experiential Avoidance is a process whereby you are unwilling to connect to private experiences, such as, negatively evaluated emotional states, traumatic memories, negative thoughts, or unpleasant physiological sensations (e.g. rapid heart rate) and actively work to escape such experiences (Walser & Westrup, 2007, p.10).

"Context is Decisive"

– Werner Erhard

It is quite apparent when examining your internal negative narratives that your mind can generate all kinds of catastrophic thinking that seems to threaten you and your sense of safety. Hayes and colleagues (2003) have discussed how psychological suffering is often contextually bound through language–based processes. They draw on the philosophy of functional contextualism, as well as relational frame theory in providing a rationale for using Acceptance and Commitment Therapy (ACT) interventions. ACT interventions largely aim at changing the context and relationship with verbal processes rather than their content. In fact, many of the treatment approaches that incorporate mindfulness are in some way attempting to change the context in which psychological suffering occurs. Typically this is done by encouraging a welcoming, accepting and curious stance towards what are usually perceived as aversive phenomena: unpleasant thoughts, feelings and sensations. By not focusing solely on the content of aversive phenomena, but rather by adjusting the psychological context, the nature of the relationship fundamentally changes. For example, a typical Acceptance and Commitment Therapy intervention used in working with people experiencing intrusive mental imagery is to imagine that the images are being seen as if on a television screen. A welcoming stance is invited

as the person tries to observe the aversive images, for example, in black and white, colour, with and without subtitles etc…This type of experiential exercise changes the person's relationship (context) to what has previously been experienced only as aversive (Harris, 2007). As Skinner put it, "all these ways of changing a man's mind reduce to manipulating his environment verbal or otherwise" (Skinner, 1969, p. 239). Here especially, context, "verbal or otherwise", is everything.

But What if?

But what if at birth a pernicious context is established and which, for the most part, operates outside of awareness? A grand context in which future psychological attempts and approaches to mend one's mind and life has us doomed from the start? What if many of our attempts to modify cognitions (Burns, 1990; Beck; 1995; Greenberger & Padesky, 1995), to become more accepting and present (Kabat- Zinn, 1990; Kornfield, 1993; Bennett- Goleman, 2001; Kumar, 2009), to process disavowed feelings (Fosha, 2000; McCullough, 2003; Greenberg & Johnson, 1988), to engage in solution focused strategies (Miller, Hubble, Duncan, 1996), and to create new empowering narratives (White & Epstein, 1990) are, in fact, tainted in such a way that the game is more rigged than we know and our efforts are already sabotaged?

John Sherman (2011) proposes that such a sabotaging context does in fact exist. It is likely created at birth and shapes and influences all other psychological contexts. This context of all contexts, this grand schema, is primary and foundational. Essentially, this largely unconscious grand schema holds that life is to be feared and living should be fearful.

The Delivery

Sherman is certainly not alone in identifying human birth as traumatic, having a profound impact on future psychological and behavioral development (Rank, 1924; Janov, 1983; Verny, 1982 and others). Slotkin and Seider (1988) who extensively studied the universal stress response in human birth found that even normal uncomplicated delivery "is accompanied by a surge of stress hormones, including catecholamines and corticosteroids" (p.283). It must be noted that while we consider regular birth as traumatic enough to establish the fear of life (the grand schema), birth trauma in the form of removal by forceps, oxygen deprivation, caesarean delivery, to name only a few, is incredibly common. Dr. William Emerson (1987), for example, found 55 percent of a sample of 200 children had moderate to severe birth trauma. Sherman below, however, describes the stress likely experienced in a physiologically uncomplicated birth. The fear of life rises up automatically in us, most likely when we are ejected from the womb at actual physical birth. Without warning, we are abruptly awakened into a wild, raging storm of what we will eventually come to call experience, feeling, sensation, emotion, and so forth. Consciousness of our existence is driven from its deep slumber in the womb into a startling eruption of violent and erratic movement, pain, pressure, noise, glaring light, and all the drama that attends our expulsion into the world. Fear and contraction inevitably ensue (Sherman, 2011, p 1).

John Rowan (1996), psychologist and Fellow of the British Psychological Society, who writes extensively on the trauma of birth essentially names this "fear and contraction" as a traumatic reaction and acknowledges its long-reaching effects on the human being.

The way that birth or early trauma occurs, persists, and is repeated indefinitely shows the same logic and pattern as characterizing adult Post-Traumatic Stress Disorder (PTSD). The trauma of birth for the baby and of the soldier affects them similarly (p.36).

Psychiatrist Michael Scheeringa and his research team found that "a post-traumatic syndrome does appear to exist in infants and children exposed to traumatic events." Their conclusion from their research is that, "any lingering notion that infants cannot be affected by trauma because of their limited perceptual or cognitive capacities ought to be dispelled by these empirical findings" (Scheeringa, Zeanah, Drell, Larrieu, 1995, p.199). It seems that despite common beliefs that infants are unaware and unaffected by their births, infants are in fact capable of registering threat. Moreover, Rochat (2003), for example, states:

It appears that immediately after birth; infants are capable of demonstrating already a sense of their own body as a differentiated entity: an entity among other entities in the environment...From birth, infants differentiate self vs. non self-touch, between stimulation originating from either their own body or an external source. Contrary to the assumption of many classical theories of child development, infants are not born in a state of fusion or confusion with the environment (p.722).

This capacity to register trauma and its long-reaching effects is vividly exemplified in the words of an 85-year-old woman regarding her cesarean birth:

Well, it came to me as clear as a bell. My blessed mother, bless her heart, was cut open and they yanked me out, and hard at that. I didn't know I was born that way. But I checked my mother's diary, and sure enough I was. Now I know why I've been so afraid of people my whole life and why I've never been a touchy person. Don't like to be touched at all. My first touch of humans was utterly shocking, just disgusting. It wasn't right. And I've been mighty frightened of people

and particularly touching ever since. I never realized I could know such things about my birth (Emerson, 2001, p.9).

Certainly there are variations in the intensity and type of trauma resulting from birth, as well as differences of later response and repair. Nevertheless, Otto Rank (1924) viewed all human beings as suffering trauma simply by being born and of the inevitably violent, physical and psychic separation from our mothers. Rank believed that in birth, where the infant moves from a state of harmonious union with the mother to a state of painful rupture due to the violent and traumatic circumstances of birth, constitutes the earliest anxiety that a human being experiences (Woolverton, 2011). That anxiety, according to Rank, constitutes the blueprint for all other anxieties experienced later in life, referencing Freud's passing note in The Interpretation of Dreams (1909), when he writes that "the act of birth is the first experience of anxiety, and thus the source and prototype of the affect of anxiety" (p.525-526). Further, Rank (1924) holds that trauma forms the "nucleus of the unconscious" and that we have all been born into it (p.xxiii).

In this context, any traumatic event later experienced may also actually be a re-traumatization, which is to say, that any later experience of trauma will compound, exacerbate and make more complex that which is already there, and may not necessarily be the wholly and uniquely distinguishing genesis of the victim's problems. We all experience trauma by being born and consequently the foundational background of our psyches is the experience of trauma. How can the initial experience or relationship to life not be anxious and insecure, even phobic? Parental attempts to soothe and reassure their infants are perhaps actually attempts to counteract and repair this initial traumatic experience or breach, if you will.

The Set Up

Sherman maintains that the trauma of birth, which it would seem is pretty much a given, creates an unconscious fear of life or primary schema, which, in turn, taints all subsequent experience. Again, this primary schema holds that we must be vigilant and fearful because life is dangerous. This stance operates outside of awareness yet plays itself out almost incessantly in our reactions in life, both interpersonally and intra-psychically. It is the stage to our experience of living. Sherman further proposes that the development of psychological and neurotic defense structures, problematic traits and behaviors, and the cognitive schemas that accompany them, have the imperative to serve this grand schema. In this way, we can see how experiential avoidance, behaviorally enacted through actual avoidance in day to day life, or enacted intra-psychically through cognitive strategies such as distraction, rumination, fantasy, dissociation etc…is, in one way or another, ubiquitous to human experience, as well as inherent in most psychological formulations regardless of the particular theoretical model.

Clinically, we see evidence of the effects of the fear of life in our work with clients and, for that matter, with the many people we encounter in day to day life. We see this process in therapy with the so called "worried well" who are generally able to function in life, but feel that something is inherently wrong, that something needs to be changed or fixed in some way. Simply put, there is a problem and it somehow has to do with life and their relationship to it.

Is it not common for clients suffering with mood and anxiety disorders to perceive their own thoughts, feelings and sensations with a sense of vigilance? Are we not always on the lookout for some kind of attack or, conversely, for positive experiences that might carry or catapult us away from this threatening life, if even momentarily? Is it possible, that many of the control-based coping strategies that Acceptance and Commitment therapists see as being doomed

from the onset are not entirely doomed due to problematic language based processes, but doomed perhaps because these processes are occurring within a context that assumes life itself is threatening?

This notion of an inherent problematic context in human life echoes some of the ancient wisdom traditions. For example, in Buddhism, the term Duhkha refers the unexamined sea of discontent that the human being finds himself in; swimming or drowning rather well or rather poorly depending on your point of view. Steven Hagen, in his book, Buddhism: Plain and Simple, explains:

The first truth of the Buddha-dharma likens human life to the out-of-kilter wheel. Something basic and important isn't right. It bothers us, makes us unhappy, time after time. With each turn of the wheel, each passing day, we experience pain. Of course there are moments of pleasure. But no matter how hard we try to cultivate pleasure and keep it coming our way, eventually the pleasure recedes and the disturbance and vexation returns (p.26).

Many forms of treatment are directed solely towards ameliorating symptoms. According to Sherman, while these treatments help to manage symptoms, none of these treatments are targeting the context in which the problems arose, namely, the context that sees life as the enemy. It can feel as though negative symptoms or experiences, especially if intense, only confirm this context and positive emotions or experiences seem only a temporary fluke, soon to be taken away as we are returned rightfully to the status quo of fear-based existence. Sherman sees symptoms, their sequelae, and all of our attempts to get rid of them as <u>effects</u> of this long-standing unexamined context, as well as the subsequent and incessant wound of alienation from life itself.

Sherman views this problem as being akin to a type of auto immune disease, which has profoundly afflicted humanity and left deep gouges in our collective psyches. Used like a slow-release antidote, he suggests a simple act, which he refers to as inward looking. Over time, this act of inward looking eliminates the fear of life and ameliorates its long standing effects, including many of the neurotic preoccupations, defensive contortions and psychological structures, which came into effect to keep this assumedly fearful life at bay.

We've been trying forever to fix our lives by reforming our minds; we try to make the mind sweet, loving, and open-hearted rather than closed and mean-spirited; intelligent rather than stupid; sane rather than insane; clear rather than confused. But the mind — its character, its strengths, its weaknesses, its assumptions, its point of view, its volatility, its emotions, its thoughts, its wrongness and its rightness — the mind is not the problem. The mind is nothing really but a cloud of effects, many of which are symptoms of the fear of life... And of course, nothing works. How could it? There is nothing inherently wrong with seeking relief from the symptoms, but treating the symptoms will not cure this disease (Sherman, 2011, p.3-4).

Exposure

In behavior therapy it is accepted that treating phobias requires exposure to the aversive stimuli and the attendant associated feelings (McCullough, Kuhn, Andrews, Kaplan, Wolf, Hurley, 2003). We have found that the principles of exposure therapy are useful in conceptualizing the act of inward looking. With inward looking, however, the aversive stimuli is not specific in the typical or traditional sense, like spiders or heights, but is a rather grand and abstract concept, that is, life or being within the living (in vivo) world. As well, in traditional exposure the aversive stimulus is explicit, whereas, prior to engaging in the act of inward looking the aversive stimulus is at most implicit and likely unconscious.

The primary goal of inward looking is to directly experience the unchanging you. With this comes the recognition that the fundamental you has not been harmed by any of life's experiences. The assumption that we require constant protection from and outward vigilance towards life is thus challenged by seeing - on an experiential level- that you are now exactly as you have always been. Experiencing the certainty of this begins to erode the fear-based context. As the fear-based context departs, life becomes more directly experienced and the attendant fears and neuroses about life are subsequently faced. This is in reverse order to traditional exposure therapy. In traditional exposure therapy you face the feared object or environment, as well as the attendant feelings and this exposure usually has the effect of indirectly changing the psychological and emotional context in which the experience arises. This also includes the interpretations that follow from this contextual shift; for example, not all spiders will harm you. With inward looking, however, the context in which experience arises is initially and directly changed by the act itself resulting in a subsequently less defended exposure to the feared environment (life). In turn, many of the neuroses constructed out of the fear-based context begin to fall away because there is no longer any context to support them; on an experiential level they become irrelevant. Over time this allows for the possibility of having an increasingly natural relationship with life. In Sherman's words, "to be safe and sane in your own life" (Sherman, 2011, p.1). In the chart below we compare traditional exposure to the act of inward looking.

	Traditional Exposure Therapy	The Act of Inward Looking
Aversive Stimuli	Heights	Living and being in the world, which is aversive due to the context of fear established at birth
Consequences	Inability to engage in activities that involve being near high places	The development of a fear-based life which includes psychological/behavioral fear-based avoidant strategies and defensive mechanisms that developed in order to protect you from your life
How You Approach the Aversive Stimuli	Being exposed to high places	Engaging in the act of inward looking erodes the context that assumes life must be kept at bay. Experiencing this brings you into direct or unmediated contact with life itself
What Often Initially Shows Up	Anxiety and fear	• Anxiety and fear • A feeling as if you have done something terribly wrong • Increased awareness of the fearful context that has been your life • Increase in the defensive strategies that you have used to keep life at bay
What Departs or Lessens	The assumption that you need to fear high places and be protected from them	• The assumption that you need to fear life and be protected from it • Many of the defensive and neurotic strategies that developed in order to protect you from life
The Outcome	An ability to engage in behaviors that require you to be in high places	The ability, over time, to be fully immersed, to feel safe and at home in life; a natural life

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While we have used some of the principles of exposure therapy as an explanatory lens, it is not necessary to have a full understanding of the theoretical underpinnings of exposure therapy in order to benefit from a traditional intervention. Simply engaging in the exposure, that is, facing the attendant feelings associated with the feared object, situation or context, begins to erode the fear. Likewise, with the act of inward looking, all that is needed is to engage in the act. This does not result in the appearance of something brand new, but rather the falling away of old fear-based reactive behaviors (Sherman, 2010). A similar falling away results in traditional exposure, but obviously the scale of what falls away is profoundly different.

Other similarities exist between the act of inward looking and engaging in exposure therapy. From hundreds of anecdotal accounts, people who engage in the act of inward looking often report increases or spikes in their feelings of anxiety, at least initially. In much the same way, people who engage in exposure therapy experience an increase in anxiety, that is, until their fears are extinguished. As an adjunct to exposure therapy, they will typically use a wide range of strategies and interventions to help regulate their anxiety. Some of these approaches may include mindfulness meditation, yoga, progressive muscle relaxation, as well as various psychotherapeutic interventions.

Sherman recommends the use of simple mindfulness training which can be used to stabilize attention prior to engaging in the act of inward looking, as well as providing a skillful means of managing the period that occurs subsequent to engaging in the act in which neurotic defenses may to varying degrees rise and fall. In other words, mindful attention can facilitate the way into and through the looking as many of the neurotic behavioral traits and problematic reactions lessen or fall away once there is no fear-based context to support them.

It is important here to highlight some significant differences between the act of inward looking and mindfulness practice. Bishop and colleagues (2004) conceptualize mindfulness as being comprised of two components:

1. The self-regulation of attention so that it is maintained on immediate experience.
2. The adopting of a particular orientation towards one's experience characterized by curiosity, openness, and acceptance.

While Sherman's act of inward looking also requires an inward focus of attention, mindfulness intends to connect to immediate experience or the present, whereas, the act of inward looking intends to connect to "presence," meaning you, who is, in fact, always here in the present. At the same time, some mindfulness practices do draw on the concept of "the observer", which may in some ways seem to approximate inward looking, but it is still very much in the service of maintaining a focus on what shows up in the present. Sherman's act, however, exclusively directs focus on the constancy of you. This emphasis has an important and qualitatively profound difference and potentially different consequences or results. Unlike the second component of mindfulness, Sherman's act does not require an emphasis on any particular attitudinal orientation, other than perhaps an earnest intent and attempt to make momentary contact with the felt sense of "person-ness" (you). The act of inward looking is a specific behavioral act that aims to extinguish the fear of life which, according to Sherman, is the primary cause of human suffering. This intervention also appears to bring you into the actual or perhaps natural context of life which, as it turns out, is mostly to be trusted.

Sherman's use of the personal pronoun seems a deliberate attempt to reduce the objectification, rarefication or abstraction of the unmediated subject (you), which is the tendency when using names or terms like "the observer", "witness", "true self", your name etc… Still,

even the personal pronoun is an abstraction, in that once something is named it becomes a named thing, something other than what it actually is; we are very much bound by language. Nevertheless, the personal pronoun seems to be the least embroidered of such terms. Here, it is important to think of the word “me” or “you” as a pointer to the direct experience of you or, if you will, the smallest make-believe diving board or jumping off point possible. In this context, it is tempting to interpret the famous verse in Exodus 3:14 when God refuses to be named and utters the words “I am that I am” or “I will be what I will be” as a way to not become an abstraction, a concept, a false object of worship, an idol, but rather as a way to maintain direct divine subjectivity; to be a “living God”.

Inward Looking

The following, taken from Sherman's 2011 article entitled, "The Fear of Life and the Simple Act of Inward Looking that Snuffs it Out” (p.7) describes the act of inward looking, which is simultaneously the antidote for the fear of life.

Step 1:

Learn to Move the Beam of Your Attention at Will.

To begin, just relax for a moment, and notice the obvious fact that you have the power to move your attention at will. As you read this, move your attention away from the text for a moment, and direct it instead to the feel of your breathing. Notice the feel of your chest and belly expanding and contracting, and then bring it back here to this page. Do that a couple of times so that you become familiar with what I mean by "moving the beam of your attention at will." That action of moving attention at will, as you just did, is all that's needed to accomplish what I am asking you to do. The more you practice this simple act, the more you'll become

familiar with how it feels to do it. And the more familiar you become with the feel of it, the more skillful and direct you will be in the effort to move the beam of attention where it must go.

Step 2:

Turn the Beam of Your Attention Inward.

Use that skill to actually turn the beam of attention inward, trying to make direct, unmediated contact with the reality of your own nature, by which I mean you, just plain and simple you. You know what you are, and you will surely recognize yourself when you see yourself in this way. It really is that simple. Repeat this as often as it occurs to you to do so.

Some Problems with Simple

While the act of inward looking may seem simple, performing the act can be confusing, challenging, and anxiety provoking. Attention is easily drawn to all kinds of phenomena, including thoughts, feelings, sensations, as well as stimuli in the environment that come and go in consciousness. Our capacity for attention essentially comes out of our need to scan the environment for phenomena that can either help us, harm us, or are of no consequence (Sherman, 2007). Attention, however, seems heavily weighted towards detecting threat. If our attention, for example, is drawn to ambiguous material in the environment, that is, unsure if friend, food or foe, survival value demands we interpret it as threatening. When our lives may be at stake, "better to be safe than sorry" is the rule. In other words, when the choices are between threatening, ambiguous and benign material, the first two thirds are interpreted as threatening (Wilson, 2008, p.10). This ultimately has tremendous survival value, but is somewhat punishing on one's quality of life. Attention's primary role is to protect us from possible harm by locating threat. Protecting us from actual threat is obviously a vital function. That which is new and different must be assessed for threat. The act of turning our attention inward runs counter to this

as attention must suspend its duty of constant outward vigilance. Sherman's act also feels contrary or unnatural, in that you place your attention on that which never changes, on that which has never been modified by any of life's experience versus attending to an ever-changing environment, as well as, adapting behaviorally based on experience. Most of us on occasion have caught a glimpse of this unchanging and unmodified sense of ourselves or the you that has always been you and will be you. For example, sometimes when looking in the mirror at yourself you might be struck by the fact that the image of the person you see has rather dramatically changed over the years, at times even to the point of looking like an impostor, and yet, in there it still feels like you. The feeling or experience of you when 6, 13, 24, 37 and now, for example, is exactly the same and you likely feel it with an indisputable certainty. Sherman is inviting us to turn our attention on exactly this, the sensate experience of unchanging you.

Some Help with Simple

It seems that the purposeful, conscious, movement of attention towards the unmediated feeling of you (the process), which is inherent in the act of inward looking (and not the “seeing” or viewing of anything) is what extinguishes the context of fear. In other words, what is involved is the earnest intention towards the felt sense of you and not arriving at some particular vantage point or the seeing of something new. It is also important not to confuse the felt sense of you with anything related to your identity, for example, your personality, traits, characteristics, personal narrative, image, thoughts and emotions. Again, it is the singular unchanging distinct feeling of you that is the invited focus of attention.

As inward looking has much to do with attention, sense and feeling it is really quite difficult to instruct someone on how to exactly perform this act or to see if they are doing it correctly. Sherman, however, provides some helpful guidance:

1. Try to bring to mind a memory of a moment in your early childhood. It doesn't need to be anything important: being in a room with adults, leaving a movie theatre, looking out the window, any memory will do, so long as you can evoke a reasonably accurate memory of the feel of it. Now, just for a second, see if you can remember what it felt like to be you then. Not what the event felt like, but what it felt like to be you. You may get just a fleeting whiff of it and, if you do, you will almost certainly recognize that it is exactly the feel of you now.
2. Notice the fact that you are certain of your own existence, in a way that you are certain of nothing else in the world. Look there, at that certainty, because that certainty itself is just another name for you.
3. Look for what is always here, what never moves, or changes, or comes, or goes. Everything in the universe moves. Everything moves but you.
4. Look for the person-ness of you. Nothing in the universe feels like a person but you.

(Sherman, 2011, p.9-10)

Anecdotal Reports

Anecdotal reports from thousands of people worldwide suggest this intervention can profoundly affect your relationship with yourself and your life. The following includes some of the common effects that people have reported as a result of engaging in this act. (Sherman, podcasts, 2010-2012)

1. A falling away of the sense of urgency that something needs to be changed or fixed about you or your life.

2. An increased skillfulness in managing the day to day challenges of life.

3. A sense that the gap between yourself and your life is closing. Life feels more immediate. You might feel everything with greater intensity, but find that it somehow bothers you less.

4. People often report the awakening of a deep sense of gratitude for just being alive, even in the midst of seemingly stressful and "negative" situations.

Qualifying Statement

Sherman's act of inward looking is not being presented as an alternative to psychotherapy, psychopharmacology, or any other healing pursuit. Rather, it is being proposed as a radically new behavioral intervention that can be enacted on its own or as an adjunct to any treatment or healing modality, traditional or alternative. Nothing is required other than a sincere willingness to engage in this act whenever it occurs to you to do so. No new belief needs to be taken on and no existing belief or practice needs to be discarded. Anecdotally, people have reported that as the effects of the context of fear begin to fall away, their psychotherapeutic work, meditation practice, as well as other healing pursuits seem to move along more quickly and with greater ease. This is no surprise as they report feeling less "at stake" or "on the line" in the psychotherapeutic process and in life in general.

Invitation and Recommendations

A) You are invited to try the act of inward looking for yourself, in earnest. Rather than looking for something new to appear as a result of engaging in this intervention, Sherman's suggestion is to take note of well-worn fear-based neurotic patterns and behaviors that naturally start to fall away (Sherman, 2011).

B) We recommend that individuals take it upon themselves to be fully informed about inward looking and its possible effects prior to engaging in the act. We also recommend that individuals have access to supports that can help them in dealing with a possible increase in anxiety or any other distress that might arise from engaging in the act of inward looking.

C) Given the large numbers of individuals who have reported significant benefit from engaging in the act of inward looking, we are planning clinical research aimed at measuring outcomes relative to various other interventions.

With deep gratitude to John and Carla Sherman for their pioneering efforts towards ameliorating human suffering

Appendice

Table

1. Shared diagnostic and associated features listed in the DSM-IV for selected psychiatric syndromes

- X = diagnostic features
- (A) = associated features

	Depressed mood		Lability of mood	Irritability	Anger/aggression	Concentration disturbance	Impulsivity	Reckless activity	Increased sexual behavior	Substance abuse	Suicidal ideation/ attempts
MOOD EPISODES											
Major depressive episode	X			X	X	X				(A)	X
Manic episode		X	X	X	(A)	X	X	X	X	(A)	(A)
Mixed episode		X	X	X	X	X	X	X	X	(A)	X
Hypomanic episode		X	X	X		X	(A)	(A)	(A)	(A)	
MOOD DISORDERS											
Major depressive	X			X	X	X				(A)	X
Dysthymia	X			X	(A)	X				(A)	
Bipolar type 1		X	X	X	(A)	X	X	X	X	(A)	(A)
Bipolar type II	X	X	X	X	X	X	(A)	(A)	(A)	(A)	X
Cyclothymia	X	X	X	X	X	X	(A)	(A)	(A)	(A)	(A)
ANXIETY DISORDERS											
Generalized anxiety				X		X				(A)	
Posttraumatic stress disorder				X	X	X	(A)			(A)	
PERSONALITY DISORDERS											
Borderline	X		X	X	X		X	X	X	X	X
Antisocial	(A)			X	X		X	X	X	(A)	(A)
Psychotic Disorders											
Schizoaffective	X	X	X	X	X	X	X	X	X	(A)	X

(Preskorn & Baker, 2002)

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