

THE CRUCIBLE OF AWAKENING

Issue 40 August 2008

Facebook has a newly-formed group for people who have worked with me and/or who are interested in my work/writings to connect and discuss my work/writing or anything related to it. Periodically I'll answer questions sent to me from the group administrator, Arthur Gillard.

If you're not already a member of Facebook, it is easy to join at:

<http://www.facebook.com>.

Once you have joined, simply search for "Robert Augustus Masters" and then click to join the group. Please invite anyone you know who might be interested in my work and/or writing. If you have any questions, email Arthur at aqalicious@yahoo.com.

DISTINGUISHING SANITY FROM INSANITY

Can sanity and insanity be distinguished, and if so, how? And by whom? And, furthermore, assuming that sanity and insanity actually *can* be distinguished, can those possessing supposed — that is, culturally sanctioned — expertise in making such a distinction actually do so?

Consider the following scenario: If sane people— specifically defined here as those not having the symptoms of serious psychiatric disorders — were to fake mental illness so as to be admitted to mental hospitals, and were then to completely cease such fakery, would their sanity be detected during their stay? If it was, this would be pretty solid evidence that sanity and insanity — at least as defined by contemporary psychiatry — can be distinguished by those who are in the business of being able to recognize the difference.

Such an experiment did take place. Sane volunteers — referred to from now on as pseudopatients — claimed to be hearing internal voices, so as to gain admission to various psychiatric hospitals in the United States. Once admitted, they then dropped all pretense, except for the use of pseudonyms and, in

The Crucible of Awakening

the case of those who were mental health professionals, the claim to be in a profession other than their own. In short, they consistently behaved as they normally would, but were, in *all* cases, never recognized as being sane by the staff, being consistently treated with aversion or disinterest, stuck with the label they had been given upon admission — schizophrenic. Upon discharge, each was categorized with a diagnosis of “schizophrenia in remission.”

It’s worth noting that the sanity of the pseudopatients was actually detected in the hospitals — but only by *other patients*.

It is very difficult to fully shed the label of being mentally ill. Even the suggestion of possibly being mentally ill can stigmatize a person. If we’re informed that someone is mentally ill, we tend to display more aversion to that person than if we were told that he or she is *physically* ill.

Many might not view psychiatric labeling as a problem, since what it purportedly describes still exists. And yet why then are those who are thus categorized generally treated so badly, like they were second-class humans? Would they be treated so poorly if they weren’t labeled thus? Perhaps, if their behavior was sufficiently upsetting or aberrant to others. However, what if their behavior was not significantly upsetting to others, nor at all indicative of any psychiatric abnormality, but they were nonetheless still labeled as being mentally ill? That the label still makes a difference is clearly demonstrated by the above study.

It may seem that the question is whether or not to label, but this is not the real concern, since it is all but impossible not to label. What primarily matters is *how* we label and *what we do* with labels, psychiatric or otherwise — are they seen as such, or are they given undue authority, allowed to masquerade as what they’re supposedly describing? Are they taken literally or metaphorically? Are they taken as solid certainty, or are they taken more lightly, like transparent signs or pointers?

Some claim that changing the name of the type of mental illness won’t eliminate the public’s negative attitude toward mental illness. They are right, but only partially right: So-called mental illness, especially in its more bizarre forms, is feared by many and treated as something to avoid or lock away, but facile naming only makes things worse, in that it comes close to legitimizing the mistreatment of the apparently crazy (both outside *and* inside ourselves).

More than a change of name is needed here.

A deeper understanding — a more than merely rational one — is necessary. This, in large part, means facing, meeting, illuminating, and ultimately integrating what we fear or cannot stand about *ourselves*, for which the so-called mentally ill provide a large, detailed, and eloquently accurate mirror. They are simply exaggerating what the rest of us are *already* tending to do, however privately — is there anyone who does not hear inner voices and debates, irrational imperatives, whispers of darkly subterranean possibilities?

A psychiatrist may demonstrate that a patient is out of contact with him, but the fact that he may also be out of contact with the patient can easily be overlooked, so that it “officially” appears there is something wrong with the patient, but not with the psychiatrist. The behavior of the staff in the preceding study is worth examining more closely here: With the pseudopatients (not to mention the regular patients), they *consistently* displayed signs of depersonalization, emotional blunting, social withdrawal, inane or incongruent speech, semi-delusional tendencies (not recognizing the pseudopatients as sane), and isolationism — all of which could, in sum, arguably justify applying to them a label similar to that which they applied to the pseudopatients.

If I treat my patients as though they do not exist as persons, what right do I have to claim that I am sane?

It is crucial to recognize what is associated with a particular name. If you think or assume that I am schizophrenic, then you will likely interpret my *current* behavior in the context of schizophrenia, or at least in the context of what you’ve been taught about schizophrenia. If you, on the other hand, see the *identical* behavior, but think or assume that I’m having a shamanistic breakthrough or am in the midst of a spiritual emergency, then you will likely interpret what I’m doing in *that* context.

The first of these interpretations, based on an illness model, has its obvious dangers, as I’ve already described — but so too does the second. If you, for example, take my hallucinatory activity and paranoia as simply being signs of some sort of spiritual crisis and nothing else, you may then easily overlook my possibly very real need for actual medical help (or, worse, even view my resorting to such help as a failure!).

A more benign, humanistic, or even spiritually oriented labeling will not, therefore, necessarily improve the situation. The very act of labeling, whatever its connotations, needs to be made the object of awakened attentiveness, so that the phenomena to which the labeling points can be given a deserving and fitting focus.

The Crucible of Awakening

In defence of the staff in the study, it should be noted that the supposedly insane often have times of sanity. That is, observing some sanity or times of sanity does not automatically mean that sanity has been established or reestablished. However, if obvious mental health is consistently observed over a sufficient period of time (none of the histories of the pseudopatients were seriously pathological, other than the “recent episode” of auditory hallucinations that brought them to seek admission), then it’s absurd to keep on claiming that mental illness is the case.

To have not even bothered to look for signs of sanity — that is, avoiding taking a *conscious* look — as appeared to happen in the study, is proof enough that the given psychiatric labels served as remarkably effective blinders for the staff in question. *Whatever* the pseudopatients did tended to be viewed — and viewed *automatically* — within the framework of their alleged condition. With chilling regularity, their symptoms and actions were taken out of context. Even their psychosocial history, however “normal”-sounding, was explained in terms of their psychiatric diagnosis.

The status quo psychiatric view not only tends to literalize symptoms, but also tends to uproot (or unnecessarily separate) them from their historical context. Patients’ stories are fed into a left-brained, emotionally illiterate shredder, and those symptoms which are extracted from the resulting fragments are held under the lenses of psychiatric criteria lists for making various diagnoses. Reducing patients to their symptoms makes for drive-through diagnosis, facile labeling, rapid patient encounters, and less than a rudimentary appreciation of their actual state.

Amazingly, the staff in question completely overlooked the prodigious and out-in-the-open note-taking of the pseudopatients. Just as amazing was the unrelenting giving of suppressive medication (averaging over 13 pills *every* day for each pseudopatient) to people who consistently showed no signs of needing any.

The preceding study is a call to deeply investigate not just psychiatric labeling, but labeling in general. To do so requires more than good intentions, more than the creation of “better” names. Innocuous or sterilized namings may be less harmful than their pejorative counterparts, but they may still unnecessarily separate us from what they “describe.” Can we not do better than “mentally challenged”? Better “dead” or “terminally inconvenienced”? Am I “bald” or just “hair-disadvantaged”? Am I green or turquoise? Description is necessary — and inevitable — so why not permit it vitality, color, visceral accuracy, poetic

precision, left *and* right hemispheric input, and, especially, sufficient awareness to keep it as *transparent* as possible to what it is describing?

The questions raised by the preceding sanity/insanity study are too important to be dismissed through intellectual legerdemain. When the culturally sanctioned experts on sanity are themselves arguably not particularly sane — especially when it comes to detecting sanity — what are we to do?

Well, first of all, there are a few signs that it's already starting to be done: Rationality (including dissociative or disembodied rationality) may still reign supreme in psychiatric diagnosis, but nonrational and rationality-transcending modes of knowing — like intuition or contemplative awareness — are starting to be given some respect in a few psychiatric circles. Psychiatry, though still tending to be suspicious of “alternative” approaches to well-being, is in some quarters beginning to recognize that wisdom and knowledge are not necessarily synonymous. The anti-spiritual bias of psychiatry in general — a hangover from both an overdose of scientific materialism and Freud's dour dismissal of mystical experience — is becoming less ossified. The inclusion of a new category — “Spiritual or Religious Problem” — in the DSM-IV (psychiatry's diagnostic bible) is highly significant; it is no small feat to make such a crack in the ultra-conservative armor of mainstream psychiatry.

Sanity and rationality are not synonymous. Insanity and nonrationality are not synonymous. Psychiatry itself tends to suffer from “Pervasive Labeling Disorder.” This disorder, proposed by David Levy, has some very interesting features, including typically being not recognized until the person in question has reached a position of social power. Recovery from Pervasive Labeling Disorder (PLD) is reportedly very unlikely once once the person in question's annual income exceeds six figures.

Psychiatry has the added burden of being inclined in the direction of what could be called “Hyperrational Dissociative Disorder,” the recommended medication for which is a freshly brewed blend of meditative and compassion-enhancing practices, taken daily.

Daily medicine for us all.

It is insanity not to recognize and live according to the realization that what we do to another we do to ourselves. To recognize right to our core the inseparability of all that was, is, and will be, is not some arcane act, but rather the very foundation of a sane life. Basic sanity is rooted in the ongoing commitment to awaken and to compassionately integrate all that we are. In

such an atmosphere, healing is inevitable, bringing together the best of both conventional and alternative practices. Diagnosis with dignity.

When the “gnosis” — the knowledge-transcending knowingness innate to us all — is put back in “diagnosis,” then the dichotomy of doctor and patient, helper and helpee, gracefully yields to the natural intimacy of two unique manifestations of the same magnificent Life interacting in a way that maximally benefits both.

INSIDE THE DSM-IV: DIAGNOSIS WITHOUT GNOSIS

Psychiatry’s *Diagnostic and Statistical Manual of Mental Disorders* (fourth and most recent edition) — commonly known as DSM-IV — is of central importance to the vast majority of psychiatrists (and, to a lesser extent, other health professionals as well) in assessing their patients. Bear with me, and you’ll see that it’s also of central importance that we all have some familiarity with what DSM-IV is and represents.

In their *Synopsis of Psychiatry*, the authors (all professors of psychiatry) state that “DSM-IV is now the law of the land.” If it is indeed the law, then exactly what is it outlawing? Does the widespread — and largely unquestioning — use of DSM-IV necessarily validate it? What are its dangers? Does it have a right use?

Let’s start digging into these questions by looking — verbatim — at some of the DSM-IV diagnostic criteria for schizophrenia:

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

- (1) delusions
- (2) hallucinations
- (3) disorganized speech (e.g., frequent derailment or incoherence)
- (4) grossly disorganized or catatonic behavior
- (5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

The above may seem straightforward, but poking through its apparent orderliness is a chaos of interpretive possibilities. Who *doesn't* have delusions? And what about the delusions we may have about others' delusions? Let us not forget that egoity — the act of identifying with our personality — is essentially delusional, constituting a case of mistaken identity.

And hallucinations? A convincing argument can be made for status-quo reality being little more than a collective hallucination. Dreams are private hallucinations. Object-permanence is a hallucination. In fact, to view *anything* as being an object, a solid or autonomously existing something, is but a hallucination, as contemporary physics (in close conjunction with the wisdom-teachings of mature spirituality) clearly demonstrates.

And, as for an inner voice keeping up a running commentary on our behavior or thoughts, who among us doesn't have something closely akin to this occurring more often than not? How often are we *not* busy talking to ourselves about ourselves? And how often are we even aware that this is happening? Furthermore, if our delusions are indeed “bizarre” — meaning apparently having no basis in reality — who can say for sure that they don't make sense in a different, yet arguably still relevant context?

And “affective flattening”? Sounds a lot like the kind of emotional state that is valued — or even given top billing — in the sterilized “objectivity” still frequently made a virtue of in scientific enterprises. And so on. What's missing in DSM-IV-centered diagnostic practice is not only etiology (“etiology” being that branch of knowledge which deals with the causes and origins of particular phenomena), but also any emphasis on cultivating a perspective that can view symptoms without concretizing or pathologizing them.

If we will not allow ourselves to enter into any significant dialogue with another's “delusions”— both specifically and contextually — how can we come to understand that other and the possible sense that his or her “delusions” may be making?

To its credit, DSM-IV does provide an exhaustive nuts-and-bolts lingua franca for mental health clinicians. This is an advantage insofar as it gives a consensual base or common ground, however insubstantial, from which a deeper, more

The Crucible of Awakening

humane language and understanding can emerge. However, the nosology (“nosology” means the listing or classification of diseases) of DSM-IV, with its reliance on descriptive rather than causal criteria, makes it too easy to look no further than the symptoms of the patient.

Clinicians whose common habit it is to see many — or too many — patients in as short a time as possible are likely going to be very tempted by the “efficiency” of DSM-IV, with its neatly compartmentalized — that is, put into parts which are then *mentalized* — (and therefore insurance-friendly) descriptive criteria.

DSM-IV’s supposedly atheoretical approach — designed to show no favoritism to any particular diagnostic school — not only camouflages its theoretical allegiance to logical empiricism and literalism, but also leaves the clinician out of the picture, much like the hypothetically objective — and therefore fictional — observer conducting a scientific experiment. When clinicians just observe the “data”(patients’ symptoms) and then classify it without any significant concern for what underlies it, they are, through such *non-intimacy* with their patients (and therefore also with the history and psychodynamics of their patients), actually in the way of the very *healing* — not a fashionable concept for DSM-IV — that needs to happen.

The advantage of DSM-IV’s purely descriptive approach, namely that of situational reliability — that is, high consistency in diagnostic labeling — is outweighed not only by its insensitivity to both patient and clinician, but also by its potential inaccuracy (brought about largely via omission and superficiality) with regard to the patient’s *actual* situation.

In making reliability more relevant than validity, DSM-IV strands itself in the shallows of diagnosis (unless, of course, it’s used in wise conjunction with other, more caring and integrated modes of attuning to what patients need). If diagnostic “efficiency” (read: speed) — lining up under the time pressures of managed care — is given too much focus (as by assembly-line psychiatry with its drug-dispensing automaticities and excesses), then there is not enough time to explore roots and psychodynamics, not enough time to really hear the patient’s story, to permit intuition to take its rightful course.

It’s easier to medicate than to liberate. Taking insufficient time with a patient actually wastes time, leaving far too little room for those qualities — like compassion — that are supportive of the healing of that patient. Sometimes medication is called for, but it nevertheless tends to be overrelied on, since it is a lot quicker to give, say, Paxil or Ritalin than to actively work with what underlies the symptoms that signal the “need” for Paxil or Ritalin.

Like most other oversized centralizing systems — exemplified by the multinational corporations currently colonizing the world — DSM-IV is ecologically illiterate. It not only does not significantly address the familial or social context of patients' syndromes, but also does not take into account, in considering the factors which are affecting patients, the cultural/political *madness* that continues to devastate — and simultaneously continues to rationalize the devastation of — the biosphere.

In fact, DSM-IV, whatever its virtues, is part of that madness. Suppressing patients' symptoms may offer temporary relief, but does not ultimately work; whatever it is that animates symptoms simply finds other outlets, other somatic and mental locales, through which to express itself. We can only bury so much garbage before it spills out, often far beyond its originating source. It is becoming more and more difficult to separate our individual troubles from our collective troubles, but DSM-IV, being bereft of ecopsychological and transrational awareness, tacitly supports the separation — and resulting alienation — of self from community (human and otherwise), thereby reinforcing the self-centeredness that largely fuels our runaway consumerism.

DSM-IV classification schemata squat in a moral vacuum, a sealed-in cultism governed by minds committed to the operational preferences of a disembodied, sterile rationality. Its language has no depth, no body, no color. This has its technical advantages — much like instructions found in a vehicle manual — but also is dangerous, in that it situates both patient and clinician in a flattened, dry, emotionally eviscerated, and exaggeratedly abstract terrain. Deadened language (which is also the predominant language of professional psychology) tends to deaden its users.

The language of DSM-IV, like that of most academically-corraled writing, has forgotten to breathe. If it did, it might start to notice that it displays many of the very symptoms that it associates with mental disorders: flattened affect, fragmentation of self, depersonalization, obsessive-compulsive behavior. One could even say that DSM-IV is intoxicated with its neatly partitioned sobriety, using its “scientific” tone and syntax to lend weight to its authority. Its supposed flexibility, its apparent openness to change (DSM-II to DSM-III to DSM-IV), superficially mask its actual rigidity and obsessive-compulsive labeling — it is no more flexible than are oil companies environmentalist or tobacco companies truly concerned with smokers' health.

Nevertheless, in spite of its spiritless language and approach, DSM-IV does have the advantage of helping a clinician quickly get to what is needed in certain

The Crucible of Awakening

acute cases, when medication is clearly necessary. Unfortunately, though, if help stops here, healing will likely be obstructed. Though medication may provide a much needed leveling or braking for a while, it is meant, in most cases, to only serve as scaffolding for the next step, whatever that might be.

To the point: Health professionals who unquestioningly or too closely follow DSM-IV are in danger of placing too much emphasis on symptoms. They are likely to confuse the seeming disappearance (or suppression) of symptoms with actual cure (and, to thicken the plot, “cure” as a goal may at times be simply a denial of the *need* to more deeply *enter* one’s woundedness). When a patient is reduced to being little more than a carrier of symptoms, overreliance on psychiatric drugs is not far behind. After all, in the *short* run — which has been until recently the only race in contemporary Western culture, a resources-exhausting sprint for maximum profit — isn’t it much more cost-effective to classify and medicate depression than to actually explore it?

Let’s get down into depression a bit: Depression, except in its debilitating or suicidal extremes, is not so much a feeling as a *suppression* of feeling, consuming an enormous amount of life-energy in its pressing-down or sinking of feeling. It could be said to be the weighted-down sensation of nearly-successful repression, minus any significantly satisfying compensatory lift. It is a pain that walls away a deeper or more primal pain.

As the drugged yet wretchedly insomniac gatekeeper of incarcerated trauma — both on personal *and* collective scales — depression asks not for further drugging (except under extreme conditions), but for a compassionately integral exploration.

And depression is spreading like a plague: Its incidence has reportedly increased tenfold since the late 1940s. Before then there was no threat of nuclear war, no obvious ecological crisis; in the face of such overwhelming concerns, the intensity of which has accelerated in the last few decades, depression or “psychic numbing” is quite understandable.

However, in numbing and turning away from our own pain, we’re also turning away from our collective pain, too dulled, overloaded, or uncaring to take necessary action, our mantra being something like, “I can’t be bothered.” (No wonder so many teens say “whatever” when pain gets too close for comfort.) Unfortunately, DSM-IV only reinforces such numbing, both by ignoring (or only very superficially considering) its originating contexts, and by all too readily drugging it — *numbing the numbness*. As helpful and necessary as antidepressants are in some cases, their prolonged use may only postpone

our entry into the very depths that could, if skillfully worked with, fuel our shift to a more Life-giving course.

The holism suggested by DSM-IV's format (which pays lip service to psychosocial and environmental problems) cannot hide its fragmented, reductionist nature — its labels and exclusion/inclusion criteria for so-called disorders do not include the *person* being diagnosed, nor do they necessarily accurately describe that person's condition.

By paying so much attention to surface phenomena and their categorization, and so little attention to actual human development and psychodynamics — let alone the spiritual dimensions of patients — DSM-IV simply perpetuates its psycho-ecological blindness. In its obsessively standardized approach to diversity and anomaly, DSM-IV displays a *monocultural* bias, in which the unusual all too easily becomes an endangered species.

The neatly partitioned categories packing the pages of DSM-IV may appear to be simply guideposts for mental health professionals, but they carry far too much authority (being, after all, psychiatry's "law of the land") to be given the benefit of the same logic that the National Rifle Association employs regarding gun possession — namely that guns aren't the problem, people are (thereby conveniently bypassing *the actual relationship* between people and guns, not to mention the ways in which the actual presence of a gun can affect or modify human behavior).

Yes, in the right hands DSM-IV can be a useful tool, but it is *more* than a tool, carrying in its very structuring and languaging a powerful operational bias that is going to be very appealing to clinicians who have put themselves in a position to be overly committed to cookie-cutter diagnosis.

So should we get rid of DSM-IV? Not necessarily, but neither should we keep it as it is. First of all, it needs to be reworked so that it does not pathologize unusual behavior, and secondly, it needs to be given a less central consideration in diagnosis. That is, as much as it can be a factor in arriving at a diagnosis, it needs to be kept in much the same position as would one's left-brain notions in attempting to get to the heart of the matter in a personally crucial situation. This is not to suggest a right-brain bias in diagnosis, but rather a practice wherein left and right hemispheric input, rational and intuitive modes, cognition and emotion, scientific and poetic stances, are synergistically combined.

Then the "gnosis" — the knowledge-transcending knowingness innate to us all — can be put back in "diagnosis."

BREAKTHROUGH

DEEP HEALING & AWAKENING

AUGUST 15th-17th, in ASHLAND, OREGON

Deep, efficient, highly effective breakthrough work for those who want to make wise use of their difficulties, and who are ready to work through whatever is obstructing their liberation.

LOCATION: 483 E. Hersey Street, Ashland.

TUITION & LOGISTICS: A special reduced rate of \$495. A nonrefundable deposit of \$200 is required. The group goes from 3pm to 6:30pm Friday, 10am to 6pm Saturday & Sunday. Limited to **14 participants only**.

NOTE: Private sessions will be available August 19th, 20th, & 21st. Both Robert and Diane will be present at each session. To schedule sessions, contact info@robertmasters.com.

FREEDOM THROUGH INTIMACY

A Transformational Intensive For Couples

AUGUST 23rd-24th in ASHLAND, OREGON

OR

SEPTEMBER 13th-14th in BOULDER

Intimate relationship has immense transformational possibility, especially when we approach its difficulties as opportunities instead of as problems. Opportunities for what? To know ourselves more deeply, to love and live

more fully, to become intimate with *all* that we are — in short, to be freed from our suffering.

This group is for couples who want a more conscious, loving, and liberating relationship with each other, and are ready to cut through whatever's in the way.

Even if you already have a good relationship, consider coming, and taking your relationship from good to great to what it *really* can be.

Individual work will be given as much emphasis as couples work, using a spontaneously structured approach that creatively mixes psychotherapy, bodywork, dream exploration, spiritual practices, and dyadic deepenings.

LOCATION: ASHLAND: TBA

BOULDER: Boulder Center for Integral Living, 2819
Broadway Street.

TUITION & LOGISTICS: 10am to 6pm both days. Limited to **6** couples only. A special reduced rate of \$475 per person (or \$950 per couple). A nonrefundable deposit of \$300 is required from each couple.

BREAKTHROUGH

DEEP HEALING & AWAKENING

SEPTEMBER 20th-21st in BOULDER

Deep, efficient, highly effective breakthrough work for those who want to make wise use of their difficulties, and who are ready to work through whatever is obstructing their liberation.

LOCATION: Solstice Center, 302 Pearl Street. The group will begin Saturday, Sept. 20th at 10am and end Sunday, Sept. 21st at approximately 5:30pm.

TUITION & LOGISTICS: CAD\$550. A nonrefundable deposit of \$250 CAD is required. Limited to **12 participants only**.

EVENING TALK/EVENT: Friday September 12th at 7:30pm at the Boulder Center for Integral Living, 2819 Broadway, Boulder.

NOTE: Private sessions will be available September 16th-18th. Both Robert and Diane will be present at each session. To schedule sessions, contact info@robertmasters.com.

HEALING & INTEGRATION

A THREE-DAY GROUP IN ENGLAND

October 3rd-5th, 2008

Deep, efficient, highly effective breakthrough work for those who want to make wise use of their difficulties, and who are ready to work through whatever is obstructing their liberation.

Everything can serve our healing and awakening. Especially the difficult stuff. Going toward, into, and through whatever is troubling us, rather than just rising above or otherwise avoiding it, is a deeply liberating journey. Along the way we learn, firsthand, to be intimate with all that we are: high and low, dark and light, dying and undying.

This group will be both a catalyst and sanctuary for such deeply transformative work, providing a safe place to let go of playing it safe. The work will be not be prestructured, but rather structured in fitting accord with group and individual needs and energies.

All kinds of issues and concerns — from the deepest trauma to the seemingly trivial — will be dealt with, through a dynamic, creative mix of psychotherapy, bodywork, spiritual disciplines, dreamwork, and group practices.

And the group will be small, being limited to **14** participants only, so that there will be enough time for everyone to receive in-depth attention.

LOCATION: Integral College, 2 Wilbury Crescent, Brighton, UK BN3 6FL

TUITION: CAD \$750 (or approx. £380). A deposit of CAD \$375 is required, nonrefundable after August 1, 2008. Accommodation and meals are not included. (The group is now over half full.)

PAYMENT: In Canadian funds either by bank draft (payable to Robert Masters at 16133 9th Avenue, Surrey, BC V4A 1A5) or by credit card online through the STORE page at <http://www.robertmasters.com>. Full payment is due August 15, 2008.

Man Unbound

A GROUP FOR MEN IN ENGLAND

OCTOBER 11th-12th, 2008

Man Unbound is about doing what's necessary to reclaim our balls without armoring or numbing ourselves, becoming warriors who, finding a source of strength in their vulnerability, can take needed stands with both heart and full-blooded power.

To enter our true manhood, we need to stop turning away from the wounded boy in us, both protecting him and giving him what he needs to heal. We also need to become more emotionally literate, not turning our anger into aggression, nor our shame into guilt, nor our hurt into an excuse to shut down or get heady.

As we assume our real power, we must at the same time step more fully into our heart; otherwise, we won't be capable of real intimacy. No more hiding out in cognitive strongholds, no more avoidance of our raw strength, no more bypassing of our wounds, no more avoidance of our depths.

Tuition: CAD \$595 (or approx. £300). A deposit of CAD \$250 (or approx. £125) is required, nonrefundable after August 8, 2008. Accommodation and meals are not included.

PAYMENT: In Canadian funds either by bank draft (payable to Robert Masters at 16133 9th Avenue, Surrey, BC V4A 1A5) or by credit card online through the STORE page at <http://www.robertmasters.com>. Full payment is due by September 1, 2008.

LOCATION: Brighton, TBA

Maximum number of participants: **12**

“I have facilitated hundreds of groups for men, for professionals, for youth, for parents, and for couples over the last dozen years. I have attended dozens of workshops, learning about working with anger and many other aspects of counselling/therapy. I have never attended anything that moved me in the manner that Robert’s groups have. Each and every man in the three groups that I attended gained profound insights into their lives. Men from all over the U.S. and B.C. and Alberta attended. We all deeply gained from each other and Robert’s skillful facilitation. For those who want to face their fear and gain from their experience, this is the way to go.”

— Alistair Moes

An opportunity to learn from a master integral psychotherapist and groupleader (1) unique, exceptionally effective psychotherapeutic, spiritual, and bodywork/energywork skills; and (2) how to creatively and effectively integrate these in counseling work.

Masters Integral Psychotherapy Practicum

2008/2009 UNITED STATES APPRENTICESHIP PROGRAM

5 Four-Day Modules in Ashland/Boulder

The purpose of this training is to deepen the capacity of participants to effectively counsel others through a dynamic, intuitively structured approach that integrates body, mind, emotion, and spirit.

To this end, the training will blend deep work on oneself and equally deep work with others, in personal, social, and spiritual contexts. Healing will be the primary intention and activity. Approaches that are taught and practised will be held, as much as possible, in a perspective that transcends them.

You'll learn to not rely upon nor necessarily impose structure, but rather to let it naturally arise from your relationship and interaction with those you're counselling. Working this way weans us from the security — the eventually deadening security — of operating from behind a preset structure or methodology, leaving us in a position that requires an appropriately creative response from us. Such creativity keeps us fresh, open, and alert.

Throughout the training we will be working in great depth with body, mind, emotion, and spirit. Love, integrity, and presence will be the cornerstones of our practice. **We will only be taking 12 participants.**

NOTE: The Practicum is not just for therapists who want to learn a more intuitive, integral, and bodywork-including approach to their practice, nor just for those who are wanting to work in the counselling/psychotherapy field, but also for those who want to participate with kindred spirits in a year of exceptionally deep personal (and interpersonal and transpersonal) work, during which they will learn skills that will serve them in every area of their life.

Graduates of previous practicums have not only found themselves at home with new skills (sufficient enough to begin working as an integral counsellor), but have also done work of such depth — and not just a few times, but many times — during the practicum that they invariably emerge more grounded, open, intuitive, and confident about both themselves and their ability to effectively guide others.

Much of the depth and quality of the work done has to do with being with a group of individuals who are all deeply committed to their own healing and awakening. In such a setting, there's not only more than enough safety and

The Crucible of Awakening

trust, but also a rare intimacy, generated by sharing such deep work both as a participant and as a counsellor-to-be.

LOCATION & STRUCTURE:

The Practicum will take place over 5 four-day modules. Some of the modules will be held in Ashland, Oregon, and some in Boulder, Colorado.

Each module will include individual and group work, plus facilitation by participants of each other's work (with fitting feedback and guidance from Robert).

After the training concludes, participants who have attended it in its entirety will receive a diploma indicating that they have completed a one-year training in Masters Integral Psychotherapy with Robert Augustus Masters.

PREREQUISITE: Previous work with Robert.

TUITION: CAD\$6800. A nonrefundable deposit of CAD\$1000 is required. Half of the tuition is due at the start of the first module; the rest is due by the start of the third module (unless other arrangements have been made with us). Lodging and meals will be extra. Contact info@robertmasters.com to arrange payment.

SCHEDULE:

November 13-16, January 8-11, March 12-15, May 28-31, July 23-26. If we begin in January (which will happen if we don't have 12 fully committed participants by November), our final module will be September 10-13.

There is considerable interest in the Practicum. If you are interested, please contact Robert.

Masters Integral Psychotherapy Practicum

2009 APPRENTICESHIP PROGRAM in England

The training will take place over 4 five-day modules. Tuition £4000. A nonrefundable deposit of £500 is required. The training is limited to **12** participants. For a description of the Practicum, see the write-up for the US Practicum on the preceding three pages.

Previous work with Robert required.

The training will begin as soon as there are 12 registered participants. We are hoping to begin by May 2009.

For more information regarding groups and trainings, or to register for them, contact info@RobertMasters.com.

All cheques, deposit and otherwise, should be mailed to Robert Masters, 16133 9th Avenue, Surrey, BC V4A 1A5.

Payments for groups (and my books and Diane's new CD) can also be made by credit card online at our new Store; simply go to www.RobertMasters.com and click on STORE.

To view previous newsletters, click on the NEWSLETTER button at www.RobertMasters.com.

To view Robert's blog, go to www.RobertMasters.com and click on the BLOG button.

2008 WORK SCHEDULE

- August 15-17 Breakthrough: Ashland, OR
August 18-21 Private sessions in Ashland, OR
August 23-24 Freedom Through Intimacy: Ashland, OR
September 12 Evening Event in Boulder, CO
September 13-14 Freedom Through Intimacy: Boulder, CO
September 16-18 Private sessions in Boulder, CO
September 18 Man Unbound Evening Group: Boulder, CO
September 20-21 Breakthrough: Boulder, CO
October 3-5 Healing & Integration: Brighton, UK
October 7-9 Private sessions in Brighton, UK
October 11-12 Man Unbound: Brighton, UK
October 25-26 Women's Intensive: White Rock, BC
November 13-16 Integral Psychotherapy Practicum: TBA
November 26-30 Bodywork/Energywork Practicum: White Rock