MDMA-Assisted Psychotherapy for the Treatment of PTSD in Europe

MAPS and MAPS Europe have completed key negotiations with the European Medicines Agency (EMA) to conduct an international multi-site Phase 3 clinical trial of MDMA-assisted psychotherapy for posttraumatic stress disorder (PTSD) in the Netherlands, Germany, Portugal, Norway, the United Kingdom, Finland, and the Czech Republic.

PTSD is a serious disorder that negatively impacts a person’s daily life, creates high-cost healthcare utilization, increased depression, and suicide risk. First line treatments of trauma-focused psychological therapies are either not effective or intolerable in up to half of patients. MAPS Europe aims to obtain approval for the prescription use of MDMA as an adjunct to psychotherapy in patients with PTSD.

Currently, MAPS seeks $9 million for EMA-regulated trials to supplement the data being gathered for the U.S. Food and Drug Administration (FDA). $897,735 is already raised and roughly $8.1 million is still needed.

In 2019, up to 40 participants will be enrolled in the Phase 2 open-label, two-dose lead-in study, the first multisite study of MDMA-assisted psychotherapy for PTSD in Europe. A brain imaging sub-study will explore possible biological correlates of treatment outcomes. The Phase 2 study will provide therapist supervision leading into the Phase 3 study at the same eight sites across seven European countries.

Enrollment will begin in 2020 for the Phase 3, randomized, double-blind, placebo-controlled study, which will enroll approximately 70 participants. The study will follow the same study design as Phase 3 studies currently underway in the United States, Canada, and Israel.

EU Phase 3 Study Sites

Phase 3 clinical trials of MDMA-assisted psychotherapy for PTSD will enroll 70 participants across 8 sites in 7 countries in Europe.

EU Phase 3 Study Design

Screen & Enroll ➔ 3 Prep Sessions ➔ 3 8-Hour Psychotherapy Sessions ➔ with MDMA or placebo ➔ and 9 Integrative Psychotherapy Sessions ➔ 2 Month Follow-up

60 Therapy Training participants from 14 countries gathered in Landgraaf, Netherlands from September 26 – October 3, 2018, to attend Part B of the MDMA Therapy Training Program, learning about “inner healing intelligence” and how the concept translates internationally.
Founded in 1986, the Multidisciplinary Association for Psychedelic Studies (MAPS) is a 501(c)(3) non-profit research and educational organization that develops medical, legal, and cultural contexts for people to benefit from the careful uses of psychedelics and marijuana.

MAPS furthers its mission by:
• Developing psychedelics and marijuana into prescription medicines.
• Training therapists and working to establish a network of treatment centers.
• Supporting scientific research into spirituality, creativity, and neuroscience.
• Educating the public honestly about the risks and benefits of psychedelics and marijuana.

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COVER ARTIST: AUTumn SkyE

Front cover: Secret Garden
21.5” x 25.5”
acrylic and gold-leaf on panel
2018

Back cover: Our Mother of Invention
16” x 20”
adrylic on panel with mixed media
(buttons, pennies, antique key,
chain, clock parts, lightbulb,
and antique frame)
2013

“Each canvas takes me on a journey, and as my paintbrush follows,
each time I am led back to my centre.

I believe that the role of the artist is especially crucial at this challenging
and exciting time. While the world is at the precipice of momentous
change, artworks have the potential to be maps, and these maps can
help guide humanity forward into new and positive ways of seeing
and being. Through creativity we have the opportunity to transmute
shadow and pain into visions of healing and wholeness.

And so, I offer my artwork as a mirror, both an intimate personal reflec-
tion and a grand archetypical revelation. Within these visions, may
each viewer recognize their own sacred heart and cosmic divinity.
And, through this recognition, may we remember the innate grace that
dwells within.”

Autumn Skye’s childhood was spent traveling the boundlessly majestic
landscapes of North America, developing a deep wonder for nature
and the diversity of humanity. She’s been translating this inspiration
through artwork since she was old enough to hold a pencil. Recogniz-
ing her curious imagination, creativity was always supported by her
family.

Autumn Skye’s meticulous and poignant paintings continue to gain
expanding recognition, attracting collectors and students from around
the globe. As a self-taught artist, she has dedicated innumerable hours
in creative exploration. Her style gracefully weaves together refined
realism, iconic imagery, profound symbolism, and subtle geometries.

She teaches and exhibits worldwide, and otherwise now lives and
paints on the beautiful Sunshine Coast of BC, Canada. Considering
herself immensely blessed, Autumn Skye strives to support others
through inspiration and creative empowerment.

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Introductory Note from Guest Editor
Bia Labate, Ph.D.

As MDMA and psilocybin have recently received FDA
breakthrough therapy designation for the treatment of PTSD
and depression, and we advance towards regulation and main-
streaming of psychedelics, we are especially happy to present
Unfortunately, women’s role in the field of psychedelic science,
and in psychedelic culture in general, has been historically se-
verely diminished and misrepresented. Women have frequently
been central to clinical experiments and to healing as therapists,
sitters, and caretakers in diverse contexts, but often have not
figured as authors of research papers, or had their presence even
acknowledged. However, the winds of change are in motion.

We are proud to unite here an amazing group of female
researchers, therapists, healers, community leaders, and drug
reform activists to help rewrite this narrative and call our at-
tention to the need to reshape gender balance in the field of
psychedelics. This edition covers an array of relevant topics in
psychedelic science and culture, such as the role of women in
ceremonial practices of indigenous traditions; the hidden his-
tory of women in early psychedelic research; women’s leader-
ship in the drug reform movement, in training and integration
programs, and in initiating community-based harm reduction
initiatives. Contributors also reflect on the influence of the
therapist’s gender in MDMA-assisted psychotherapy and the
special needs of women, transgender people and gender-diverse
populations in psychedelic healing. They argue that psychedel-
ic-assisted therapy has incredible potential for the treatment of
these populations.

This special edition presents MAPS’ pioneering and unique
MDMA-assisted psychotherapy code of ethics, and further ex-
woods into ethical considerations for psychedelic work with
women. This publication also risks navigating into controversial
waters, addressing other topics generally left off the menu, such
as sexual abuse, consent, accountability, and community build-
ing in the underground field of psychedelics. Finally, equity and
access for people of color to psychedelic medicines is included;
first step solutions to address health disparities are offered. We
hope that this edition contributes to making both psychedelic
therapy and underground psychedelic communities safer for
women, genderqueer individuals, and people of color. We also
hope that this effort helps honor our special contribution as
women, and recognize the feminine as essential to the health,
welfare, and spirituality of our communities. In sum, if you want
to know more about what women bring to the field of psyche-
delic science that has been missing, read on and find out!

Bia Labate, Ph.D.
Public Education and Culture Specialist,
MAPS
From the Desk of Rick Doblin, Ph.D.

At this time of spring and new life, MAPS, and guest editor Bia Labate, are bringing forth this special theme issue of the MAPS Bulletin focusing on Women and Psychedelics. We’re glad to bring to the fore a series of articles all authored by women addressing a wide range of issues of concern to them relating to psychedelics and the psychedelic community. These concerns relate to matters of equity, ethics, consent, integration, and training in this psychedelic community we are in the midst of building. While none of these matters are inherently women’s issues, reading about all of them from a woman’s perspective can better educate all people. The Women’s Visionary Congress, co-founded by Annie Oak, an author of an article in this Bulletin, has done and continues to do pioneering work in bringing forth women’s voices in psychedelic conferences and other settings. This issue of the MAPS Bulletin was inspired in large part by their work.

For historical and cultural reasons, the most visible people and voices of the psychedelic community in the U.S. and Europe have been predominantly male. Working toward more gender balance and actively amplifying marginalized voices in the psychedelic community is crucial so we can more effectively and gracefully mainstream the use of psychedelics and their widely varied applications in medicine, spirituality, creativity and culture.

Similarly, the psychedelic community in the U.S. and Europe has been predominantly white. In our community, over time, we can rectify these gender and racial imbalances, as well as sexual orientation and other sorts of imbalances. We can integrate lessons from unitive states into our daily lives by welcoming, celebrating and honoring diversity of all kinds.

One of the ways MAPS has tried to positively create gender balance has been implementing our therapeutic model of a two-person co-therapist team, one male and one female. Using male/female co-therapist teams has contributed in a positive way to our treatment outcomes and to the growth of our community of therapists. However, we’re not rigid about this. Transgender and non-binary therapists are most welcome and bring their own unique contributions, and the article in this issue by therapists Anne Wagner, Annie Mithoefer, and Candice Monson discusses same-gender teams.

In terms of MAPS staff, we have 8 men and 16 women. For the MAPS Public Benefit Corporation, we have 10 men and 20 women. In terms of the Board of Directors, MAPS has 5 men and 1 woman. The Board of Directors of MPBC includes 3 men and 1 woman. We are going to be adding at least one more woman to both boards, although we are still searching for the right fit for each.

We’re currently in the midst of an incredible renaissance in psychedelic research around the world. Psychedelics are being used with psychotherapy to treat posttraumatic stress disorder (PTSD), depression, drug dependence and alcoholism, anxiety and other mental health conditions, to study spiritual and mystical experiences and their connection to meditation and mindfulness, and as neuroscientific tools to explore brain function and the enduring mystery of human consciousness.

MAPS has started FDA-approved Phase 3 research into MDMA-assisted psychotherapy for PTSD, with approval anticipated at the end of 2021, though of course nothing can be taken for granted. MAPS is about a year behind in starting Phase 3 research in Europe compared to the U.S., and needs to raise another $8.1 million to fund that research. Other groups are laying the groundwork for Phase 3 research with psilocybin for treatment-resistant depression and for major depression (Penny Patterson wrote an article in this issue about the psilocybin research plans of the non-profit organization, Usona).

At a time of rising nationalism, tribalism, fundamentalism, and authoritarianism, the world needs more people to experience our fundamental unity and shared humanity, a spiritual/mystical experience that psychedelics, when used wisely and with support, can help to catalyze, and the world needs more people to overcome trauma and multigenerational trauma, so we can work together to resolve our differences in a peaceful manner.

As the psychedelic renaissance continues to gather momentum, the perspectives of all people need to be taken into account. Our goal for this special issue of the MAPS Bulletin is to bring forth the views of women on psychedelics for the benefit of men, women, those who don’t identify with either gender, and those who associate with all genders to ponder. It’s only together that we can experience and implement the full flowering of the psychedelic renaissance.

Psychedelically yours,

Rick Doblin, Ph.D.
MAPS Founder & Executive Director
Phase 3 Trials: Nine Sites Screening Participants

Our FDA-regulated Phase 3 clinical trials of MDMA-assisted psychotherapy for PTSD are taking place at 15 locations across the United States, Canada, and Israel. Nine study sites are currently recruiting participants.

The Phase 3 clinical trials are assessing the efficacy and safety of MDMA-assisted psychotherapy in adult participants with severe PTSD. Over a 12-week treatment period, participants will be randomized to receive twelve non-drug preparatory and integration sessions lasting 90 minutes each along with three day-long sessions about a month apart of either MDMA or placebo in conjunction with psychotherapy. The primary endpoint will be the Clinician Administered PTSD Scale (CAPS-5), as assessed by a blinded pool of independent raters.

The trials are the final phase of research required by the FDA before deciding whether to approve MDMA as a legal prescription treatment for PTSD. If approved, MDMA will be required to be used in conjunction with psychotherapy in an outpatient setting.

The Phase 3 trials will be conducted at the following study sites:

- Los Angeles, CA | private practice
- San Francisco, CA | research institution
- San Francisco, CA | private practice
- Boulder, CO | private practice
- Fort Collins, CO | private practice
- New Orleans, LA | private practice
- New York, NY | research institution
- New York, NY | private practice
- Charleston, SC | private practice
- Madison, WI | research institution
- Boston, MA | private practice
- Montreal, Canada | private practice
- Vancouver, Canada | research institution
- Be’er Ya’akov, Israel | research institution
- Tel HaShomer, Israel | research institution

In MAPS’ completed Phase 2 trials with 107 participants, 56% no longer qualified for PTSD after treatment with MDMA-assisted psychotherapy, measured two months following treatment. At the 12-month follow-up, 68% no longer had PTSD. Most subjects received just 2–3 sessions of MDMA-assisted psychotherapy. All participants had chronic, treatment-resistant PTSD, and had suffered from PTSD for an average of 17.8 years.

On August 16, 2017, the FDA granted Breakthrough Therapy Designation to MDMA for the treatment of PTSD. The FDA grants this designation for treatments that (1) are intended alone or in combination with one or more other drugs to treat a serious or life-threatening disease or condition; and (2) if preliminary clinical evidence indicates it may demonstrate substantial improvement over existing therapies.

There is now a clear path ahead to make MDMA a legal medicine for millions of people suffering from PTSD. Help us heal trauma: maps.org/donate.

Israel Approves Compassionate Use of MDMA-Assisted Psychotherapy for PTSD

On February 3, 2019, the Israeli Ministry of Health announced the approval of compassionate use for MDMA-assisted psychotherapy for posttraumatic stress disorder (PTSD), which will allow 50 patients to receive the therapy within a treatment protocol. Patients with PTSD will be eligible to receive treatment at four sites throughout Israel, including Rambam Medical Center in Haifa and psychiatric hospitals in Be’er Yaakov, Lev Hasharon, and Be’er Sheva.

“The ministry is taking this seriously and with appropriate caution, an in-depth investigation has been carried out. There is a considerable population in Israel of people suffering from PTSD that is resistant to other treatment,” Bella Ben-Gershon of Israel’s Ministry of Health said to Haaretz News.

Open-Label Lead-In Study of MDMA-Assisted Psychotherapy for PTSD: 31st Participant Completes Treatment

The 31st participant has completed treatment in our Phase 2 open-label lead-in study of MDMA-assisted psychotherapy for posttraumatic stress disorder (PTSD) at planned Phase 3 sites across the United States and Canada. The purpose of this study is to provide the final training and supervision for our co-therapy teams as they each work with one subject with PTSD using the same treatment approach as in Phase 3. All study sites are now fully enrolled. The study is expected to be completed in mid-2019.

Participate in Research

MAPS sponsors clinical trials around the world that require human participants. Our studies have strict enrollment criteria based on the goal of the study and the condition the study is investigating.

Phase 3 trial participant enrollment is open at multiple sites. Please bookmark our Participate in Research page and check it frequently for updates.

maps.org/participate/participate-in-research
Therapist Training Study Enrolls 74th Participant

**Ongoing study**

**Location:** Charleston, South Carolina, and Boulder, Colorado

**Principal Investigator:** Michael Mithoefer, M.D., (Charleston); Marcela Ota’lora, M.A., L.P.C., and Wael Garas, M.D., (Boulder)

**Sub-Investigator:** Annie Mithoefer, B.S.N., (Charleston)

On January 15, 2019, the 74th participant officially enrolled in our ongoing Phase 1 study of the psychological effects of MDMA when used in a therapeutic setting by healthy volunteers. Enrollment in this multi-site study is limited by invitation only to therapists in training to work on MAPS-sponsored clinical trials of MDMA-assisted psychotherapy for PTSD. Principal Investigators Marcela O’tala’ora, M.A., L.P.C., and Wael Garas, M.D., lead the Boulder, Colorado study site and Zhenya Gelfand, M.D. is serving as Principal Investigator at the site in Charleston, South Carolina with Sub-Investigator Annie Mithoefer, B.S.N.

Cognitive Behavioral Conjoint Therapy for PTSD: Study Close-Out Completed

**Completed Study**

**Location:** Charleston, South Carolina

**Principal Investigator:** Michael Mithoefer, M.D.

**Sub-Investigator:** Candice Monson, Ph.D.

In July 2018, the study close-out was completed for our study of MDMA combined with Cognitive Behavioral Conjoint Therapy (CBCT) for posttraumatic stress disorder (PTSD) at our Charleston, South Carolina site led by Principal Investigator, Michael Mithoefer, M.D., and Sub-Investigator, Candice Monson, Ph.D. This study enrolled six dyads with one participant diagnosed with PTSD and one concerned significant other who does not have PTSD but does experience psychosocial distress. MDMA was administered to both participants to help facilitate communication and connection between participants and therapists.

The primary goal of this study is to develop a combined method of MDMA with CBCT for PTSD. This is the first MAPS-sponsored MDMA study conducted with VA-affiliated researchers and the first to employ measures developed for the DSM-5. There are several important reasons to include significant others in PTSD treatment, in addition to the data supporting the efficacy of CBCT for PTSD.

Startle Testing with MDMA: 12th Participant Receives Experimental Treatment

**Ongoing study**

**Location:** Emory University in Atlanta, Georgia

**Principal Investigator:** Barbara Rothbaum, Ph.D.

On February 20, 2019, the 12th participant completed experimental treatment in our ongoing study of the effect of MDMA on startle testing in healthy volunteers. Led by Principal Investigator Barbara Rothbaum, Ph.D., this study is being conducted at Emory University in Atlanta, Georgia. This research group is planning a subsequent study exploring the combination of MDMA with Prolonged Exposure in people with PTSD.

MDMA Therapy Training Program: Expanded Access Update

**MDMA Therapy Training Program**

**Training Program**

**Therapy Training Team:** Michael Mithoefer, M.D., Annie Mithoefer, B.S.N., Marcela Ota’lora, G., M.A., L.P.C.

The MDMA Therapy Training Program has launched a new round of trainings in the U.S., with a special focus on sites interested in offering MDMA-assisted psychotherapy for PTSD in an Expanded Access (compassionate use) protocol. MAPS Public Benefit Corporation (MAPS PBC) submitted the protocol to the FDA in January and is awaiting approval.

Interested and qualified sites may now apply with MAPS PBC to assess eligibility and obtain the required training to administer MDMA-assisted psychotherapy for PTSD under an approved protocol. The basic requirements of a qualified site are (1) a treatment facility conducive to MDMA-assisted psychotherapy; (2) a therapy team, qualified and able to complete MDMA Therapy Training Program; and (3) a prescribing physician who can obtain a DEA Schedule 1 license for MDMA. Only sites in the U.S. and U.S. territories may participate in a U.S. FDA Expanded Access program.

To support the development of compassionate use internationally, from January 27–February 1, 2019, the MDMA Therapy Training Program delivered an MDMA-assisted psychotherapy for PTSD training to 47 therapists, doctors, and counselors in Israel. The event was hosted by the community of Neve Shalom/Wahat al-Salama, “Oasis of Peace,” an intentional village co-founded by Israelis and Palestinians. The training was led by Annie Mithoefer, B.S.N., and Michael Mithoefer, M.D., and Israeli Phase 3 clinical investigators Keren Tzarfaty, Ph.D., MFT, and Ido Siemion, Ph.D. This training event prepared therapy providers to work on a compassionate use protocol in Israel, with approval by the Israeli Ministry of Health to treat 50 participants.

The first U.S. training primarily for Expanded Access therapists took place from March 4–10 in Asheville, North Carolina, and was led by the Mithoefer families. Notably, most therapists paid for their own training.

More information on therapy training requirements and application procedures for Expanded Access sites and therapy providers can be found at maps.org/training. Each site must submit one site questionnaire. Additionally, each therapy provider must submit a MDMA Therapy Training Program Application for Therapy Providers. Only applicants affiliated with a qualifying site can be considered for training at this time. MAPS PBC will review applications on an ongoing basis as they are received. Applicants can expect a response 3–6 weeks after submitting a complete application. Interested applicants should be familiar with the Treatment Manual (maps.org/treatment-manual), which describes the MDMA-assisted psychotherapy modality, before submitting an application.

Throughout this year and the coming years, the MDMA Therapy Training Program will host training retreats at various locations across the U.S. On May 4–11, 2019, Marcela Ota’lora, M.A., L.P.C., and Bruce Poulter, R.N., will lead a training...
event outside Fort Collins, Colorado. Additionally, MDMA Therapy Training for Communities of Color, led by Marcela O’C líora MA, L.P.C., and Monnica Williams, Ph.D., A.B.P.P., with support from additional trainers, will take place August 10–17 in Louisville, Kentucky. Additional training retreats, once scheduled, will be announced via the MDMA Therapy Training Newsletter (maps.org/training).

**MDMA-Assisted Therapy for Social Anxiety in Autistic Adults**

Results Published in *Psychopharmacology*

**Completed study**

**Location:** Los Angeles, California

**Principal Investigators:** Charles Grob, M.D. and Alicia Danforth, Ph.D.

On September 8, 2018, the results of the first clinical trial of MDMA-assisted psychotherapy for the treatment of social anxiety were published in the peer-reviewed journal *Psychopharmacology*. All 12 participants in the small pilot study were adults on the autism spectrum, a population that commonly experiences severe social anxiety. The research was conducted by Charles Grob, M.D., and Alicia Danforth, Ph.D., at the Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center.

The study found reductions in the social anxiety that were significantly greater for participants who received MDMA-assisted psychotherapy than for those who received placebo (psychotherapy without MDMA). On average, participants in the placebo group experienced reductions of 19.3 points on the Liebowitz Social Anxiety Scale (LSAS), compared to 44.1 reductions in the MDMA group. Goals for this study included (1) gathering evidence for the safety and effectiveness of MDMA-assisted therapy for adults with autism and diagnosed with social anxiety, (2) determining if additional studies in this area are warranted, and (3) initiating a new program of research into the possible beneficial use of MDMA building on collected case accounts.

**MDMA-Assisted Psychotherapy for Anxiety Associated with Life-Threatening Illness**

**Marin: Study Closeout Completed in June 2018**

**Completed study**

**Location:** Marin, California

**Principal Investigator:** Phil Wolfson, M.D.

**Co-Therapist:** Julane Andries, LMFT

A close-out visit of MAPS’ Phase 2 clinical trial of MDMA-assisted psychotherapy for anxiety associated with life-threatening illness in Marin, Calif., took place on June 20–21, 2018. Led by Principal Investigator Phil Wolfson, M.D., with Co-Therapist Julane Andries, LMFT, this study gathered preliminary data about the safety and efficacy of MDMA-assisted psychotherapy for anxiety associated with a diagnosis of a life-threatening illness. Goals for this study included (1) gathering data on the safety and effectiveness of MDMA-assisted psychotherapy for participants with anxiety associated with life-threatening illness; (2) determining if additional studies are warranted; and (3) initiating MDMA-assisted psychotherapy research for a new clinical indication.

**Medical Marijuana Research**

**76th and Final Participant Completes Treatment**

**Ongoing study**

**Location:** Phoenix, Ariz.

**Coordinating Principal Investigator:** Marcel Bonn-Miller, Ph.D. (University of Pennsylvania)

**Co-Investigator/Site Principal Investigator:** Sue Sisley, M.D. (private practice) and Trainee Investigators: Thomas Kingsley Brown, Ph.D. (Mexico), and Geoff Noller, Ph.D. (New Zealand)

On February 8, 2019, MAPS-sponsored researchers officially completed the first-ever clinical trial of smoked marijuana (cannabis) as a treatment for PTSD symptoms, with all 76 veterans enrolled and treated. The data from the study are now being analyzed and prepared for publication later this year in a peer-reviewed biomedical journal.

“We are thrilled to finally be at the finish line of this nearly 10-year saga trying to get this crucial clinical trial completed,” said Site Principal Investigator Sue Sisley, M.D. “We are immensely grateful to all of the study’s supporters, especially the veteran service organizations who helped us with patient recruitment.”

**Ayahuasca Research**

**Data Collection Survey Continues**

**Ongoing study**

**Principal Investigator:** Jessica Nielson, Ph.D.

We are currently collecting responses for the revised version of our anonymous questionnaire about the potential risks and benefits associated with using ayahuasca in treatment for PTSD. The data collection is sponsored by MAPS, with Jessica Nielson, Ph.D., as Principal Investigator. We welcome participation from anyone that has tried ayahuasca in any context or setting, including those who took the first version of the survey. To participate in the survey, visit surveymonkey.com/r/AyaPTSD.

**Ibogaine-Assisted Therapy for Drug Addiction**

**Observational Research Published in *American Journal of Drug and Alcohol Abuse***

**Study completed**

**Locations:** Mexico and New Zealand

**Principal Investigators:** Thomas Kingsley Brown, Ph.D. (Mexico), and Geoff Noller, Ph.D. (New Zealand)

On May 25 and April 12, 2017, the promising results of MAPS-sponsored observational studies of treating opioid dependence with ibogaine-assisted therapy were published in the peer-reviewed *American Journal of Drug and Alcohol Abuse*. Download both articles for free at maps.org/ibogaine.
MAPS in the Media

Inc.
The Insane Cure for PTSD That’s About to Be a Billion-Dollar Industry
January 14, 2019. In a recently released video from Inc., MAPS Founder Rick Doblin, Ph.D., speaks about MAPS’ progress towards the goal of legalizing MDMA-assisted psychotherapy for the treatment of PTSD and other mental health conditions. In 1986, shortly after MDMA was criminalized, Doblin began a battle against the federal government to reverse the decision. His goal was to legalize the drug for therapeutic use. Right now, he’s very close to crossing the finish line.

Haaretz
Party Drug or Breakthrough Treatment?
Israel Approves Compassionate Use of MDMA to Treat PTSD
by Ido Efrati on February 10, 2019. Recreational use of MDMA, also known as ecstasy, is forbidden in Israel where the drug is considered dangerous. But a trial treatment may soon change that, Haaretz reports. “Emerging research has shown promising results in using this ‘party drug’ to treat patients suffering from post-traumatic stress disorder, and Israel’s Health Ministry has just approved the use of MDMA to treat dozens of patients.”

CBC
The Big Trip: How Psychedelic Drugs Are Changing Lives and Transforming Psychiatry
by Deanne Bender on December 28, 2018. CBC Radio’s Day 6 reports on the therapeutic use of psychedelics. On a recent podcast, three people share their personal experiences undergoing psychedelic-assisted therapy in clinical trials, including Army SGT (R) Jon Lubecky, who shares his experience of participating in a MAPS-sponsored clinical trial of MDMA-assisted psychotherapy for the treatment of PTSD.

Newsweek
Small Study Shows More Promise for MDMA Therapy in Treatment of Chronic PTSD
by Aristos Georgiou on November 1, 2018. Newsweek reviews the promising results of MAPS-sponsored Phase 2 clinical trials of MDMA-assisted psychotherapy for PTSD.

NPQ
Free Your Mind, and Your Nonprofit Will Follow: Racial Equity in Psychedelic Research
by Cyni Suarez on November 8, 2018. NonProfit Quarterly explores the lack of racial diversity amongst therapists and participants within the field of psychedelic research.

Good Times.
Can MDMA Research Change Mental Health?
by Wallace Baine on January 8, 2019. Santa Cruz Good Times features an overview of MAPS.

Stars and Stripes
Long Trip: Psychedelic Advocate Nears Goal of Legal Ecstasy
by Matthew Perrone on November 1, 2018. The Associated Press profiles MAPS Founder Rick Doblin, Ph.D., highlighting decades of work to legalize psychedelic medicine and Doblin’s goal to receive FDA approval for MDMA-assisted psychotherapy as a treatment for PTSD by 2021.

AP
Marijuana-PTSD Study Reaches Target Enrollment of 76 Veterans
by Nikki Wentling on November 14, 2018. Stars and Stripes reports that the MAPS-sponsored clinical trial of medical marijuana for treating symptoms of PTSD in veterans has recently reached the enrollment goal of 76 participants.
The focus of this article is to elucidate the unique roles women have in peyote religious practices of the Wixárika (Huichol Indians) of Mexico and the Native American Church (NAC) in North America and Canada. Special consideration is given to the meanings associated with these female practitioners/participants in spiritual terms and physical experiences. In Wixárika thought, flowers symbolize both women and peyote (*Lophophora williamsii*, a small spineless cactus which contains mescaline) (Figure 1). Flowers exude beauty, are indicators of fertility, and, through their reproductive anatomy, give new life via seeds. Women, likewise, have the wondrous ability to bring new life into the world. Akin to Wixárika notions of femaleness, women in NAC traditions personify the feminine essence in NAC peyote ceremonies. I will emphasize Wixárika peyote traditions because of my extensive fieldwork among women in that culture.1 My intention is to bring awareness about entheogens in women’s lives. Based on my own and other women’s experiences I also briefly explore the interaction of peyote with female physiology, which is fundamental to this relationship.

**Women and Peyote Origin Myths**

Wixárika myths lay the foundation for beliefs about women and their roles in the culture. One origin myth of the pilgrimage to the Peyote Desert in San Luis Potosí, tells of the Earth Goddess, Utüanaka, and how she manifested the path to Wirikuta through the designs she wove on her loom. She, and two other goddesses, Yuawime and Wiri’uwi, traveled far from their Sierra homelands to the desert.2 Upon arriving, Yuawime stayed behind while...

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1 I have been carrying out fieldwork since 1979 among the Wixárika people of the Sierra community of San Andrés Cohamita, Jalisco. During my doctoral research on Wixárika women I lived in this community with Wixárika families for a total of three years. I also spent significant time in the Sierra over two sabbatical periods as well. In total, I have gone on four pilgrimages with Wixárika to Wirikuta. Every year I visit the community and families and continue to learn more about Wixárika culture (See Schaefer 2015a).

2 Anthropologists in the 1890s through the 1930s indicate that Wixárika women may not have gone on the pilgrimage to Wirikuta (Lumholtz 1900, 1902; Zingg 1938). Instead, they stayed in the Sierra with the children, praying for a successful pilgrimage and the safe return of their men. As is customary in present times, upon the arrival of the pilgrims, the women and families who stayed behind most likely were given peyote collected specifically for them to eat. Now women go on pilgrimages, often with their husbands and a few of their children. Some women go to learn from the peyote how to become shamans.
Wiri’uwi accompanied the Earth Goddess into Wirikuta where they encountered peyote (Figure 2). They ingested this little grey-green cactus and learned of its psychoactive powers. The Earth Goddess traveled back to her Sierra homelands to share this remarkable cactus with her community. Wiri’uwi remained in Wirikuta and became the “Mother of Peyote.” Thus began the Wixárika peyote traditions; every year Wixáritari (plural) make the pilgrimage to Wirikuta to relive their history, leave offerings, commune with the gods and goddesses, and harvest peyote to share with their communities back home (Figure 3).

There are various versions of the peyote origin myth recounted by NAC members. In times past a Native American woman wandered through unknown lands. In some accounts she was looking for her lost brothers; in other versions she had a daughter or a little boy with her and they were lost trying find and rejoin their tribe (Perez 2009). Exhaustion overcame the woman and she lay down on the ground. She saw a peyote plant in a dream and it spoke to her. When she awoke she discovered the plant and ate it. The spirit of the peyote told her how to find her lost relatives and she shared peyote with them. After they had eaten, “the peyote told them how to run a meeting, told what things to use, and how to do it” (Parsons 1936:64). This heroine is known as Peyote Woman.

In both origin myths the main actor is a woman; she is searching, and her personal quest enables her to have a supernatural encounter with the peyote plant. Realizing its powerful, beneficial qualities, she takes peyote back to share with her community, initiating the rituals and ceremonies revolving around this psychoactive plant that exist today.

**WOMEN’S ROLES IN PEYOTE CEREMONIES**

Among the Wixárika, the ceremony that begins the series of rituals that pertain to the pilgrimage to the peyote desert involves weaving a small bag (waiinuri) in the native temple to carry the first leaves harvested from the sacred tobacco. This ritual recreates the event of the Earth Goddess materializing (on her loom) the path to Wirikuta. The last peyote ceremony of the season, called “Dance of the Peyote,” also takes place in the temple. Adorned with a shaman’s plume secured with a woven band around their heads, women toast corn as ceremonial food and grind dried peyote plants, which they mix together with water into a frothy ritual beverage.

Women exchange food, drink, and peyote with their female companions and dance together, arms around each other’s shoulders, while the men dance with their companions in a long line that moves around the sacred fire where the shaman and his assistants sing (Figure 4). Women who have gone on the pilgrimage paint designs on each other’s faces with yellow paint made from the ground root of the desert plant ‘uxa. This is so the gods can easily recognize them by their designs. Peyote visions women experience are understood to be communications from the gods, and women are encouraged to duplicate these in embroidered and woven designs to visually share with
their families and community (Figure 5). Some women under the effect of peyote break into spontaneous song and are highly esteemed; it is well understood that peyote has facilitated the creative link for them to receive these songs from the gods and share them with their families and temple members.

In NAC meetings the ritual role of Water Woman is fundamental to the ceremony; she is the embodiment of Peyote Woman (Figures 6 and 7). Oftentimes the Water Woman is the wife of the roadman who runs the ceremony, or a female relative. Dressed in her finest with her shawl gracefully draped over her shoulders, the Water Woman brings sacred water at midnight and again in the morning. At that time, the woman enters the teepee, kneels before the fire, takes a ritual smoke from a hand-rolled tobacco cigarette, and prays out loud. The thoughts she expresses are eloquent, heart-felt, and full of wisdom. She is like a moral compass, sharing good thoughts and inspiration on how to live an honorable, meaningful life. Food prepared by the Water Woman and her female assistants is then brought in, and the participants eat this ritual food that nourishes their bodies after fasting and wakefulness for the all-night ceremony.

In both peyote traditions, women are nurturers, providing food and drink, prayer and song to their families and community members. They are highly regarded for their creativity, which is shared publicly in the peyote-inspired imagery with which Wixárika women adorn the textiles they create and the songs they sing. The Water Woman in the NAC ceremony shares wisdom and moral teachings in her inspiring oratory on how to live an honorable life following the Peyote Road.

PEYOTE AND WOMEN’S BODIES
As we have seen through these peyote myths, ritual roles, art, song, and prayers, the female archetypal themes of community, nurturing, and creativity, are ever present. These concepts are also deeply intertwined when examining the physiological level of women, their bodies, and the ingestion of peyote. In these indigenous peyote traditions, many women consume peyote throughout the various stages of their life cycle. Some even consume peyote during their pregnancies, a practice that I have discussed in various publications (Schaefer 1996b, 2011, 2017). The following paragraphs provide a very preliminary look into how peyote seems to interact with the female reproductive system.

In the Wixárika myth, the Earth Goddess and her two female companions traveled to Wirikuta. As they were about to enter the Peyote Desert, the Earth Goddess and the woman who became the Mother of Peyote began to menstruate indicating that they were fertile. The third goddess, Yuawime, had a barren womb and was forbidden from entering Wirikuta. Instead she turned into a rock in the desert landscape. After the Earth Goddess and her companion entered Wirikuta and consumed peyote, they both became pregnant.

3 In the past, most NAC meetings excluded women. Over time they were allowed to attend. (La Barre 1989: 41, 46, 55, 60).
4 It appears that in the early years of the NAC religion if women attended meetings they did not sing. Nowadays in NAC meeting some women will sing. (Maroukis 210:178) Like men, they hold the roadman’s staff and sage, shake the gourd rattle as they sing and are accompanied at their side by the drummer on the water drum. At the meetings I attended it was not uncommon for participants to be from various tribes and peyote traditions, and inevitably the make up of the people in the meeting was predominately roadmen and their wives. In this setting a few women would sing; other times singing by women was discouraged. A few NAC women told me that at their NAC meetings back home it was more common for women to sing.
heat emanates from menstruating women, and that could spoil peyote plants. Women who menstruate while in Wirikuta undergo a ritual in which a lock of hair at the crown of the head is cut by the shaman to “calm the heat from the menstrual blood.” I learned of this practice because on several occasions when I went on the pilgrimage, some Wixárika women began to menstruate. I was surprised that this also occurred to me on a few pilgrimages; I began my menstrual cycle earlier than anticipated. I underwent the hair cutting ritual along with these women. The officiating shaman specialized in fertility; later she told me this was a good sign for preparing a woman to become pregnant. I also found that consuming peyote during ceremonies in the Wixárika Sierra frequently caused me to get my period, even when it was out-of-sync with my cycle (Schaefer 2017:228).

NAC taboo prohibits menstruating women from participating in the tipi meetings. At times, when I attended these meetings and consumed peyote, I would unexpectedly get my period. I learned from other women who were in the meeting that they had also begun to menstruate (Schaefer ibid:229). No formal scientific research has been conducted on the effects of peyote, or even mescaline, on human female hormones. However, professional midwives, Juanita Nelson and Maria Victoria Mangini, who participate in peyote ceremonies and attend to mothers who also ingest peyote, shared with me their empirically informed thoughts on this phenomenon. They both believe that peyote alkaloids activate the release of progesterone. Synthetic progesterone has been used to treat menstrual problems and difficult pregnancies. (Redig 2003, Hahnet.al. 2009). Juanita Nelson confirmed that if a woman eats peyote and is close to menstruating, she will get her period. Similarly, if a woman is off-cycle, she can also get her period. Based on her experiences at NAC meetings, she also explains that “pregnant women who eat peyote have very little problem with miscarriage,” and that “it helps establish the placenta and maturation of the fetus” (Schaefer ibid:229).

One version of the NAC Peyote Woman story tells that the

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5 Juanita Nelson, L.M., R.M., C.P.M., is a certified professional midwife who is director of Community Midwives in Durango, Colorado which serves the Four Corners Region. She has been involved with the NAC for more than 30 years, during many of which she was the wife of a prominent roadman.

Maria Vittoria Mangini, Ph.D., FNP, is an Associate Professor at Holy Names University and a Nurse Practitioner and Advanced Practice Midwife. She practices in the San Francisco Bay area of California and is very knowledgeable about peyote.
woman who was lost in the desert was pregnant and starving. As she goes into labor, “something tells her to eat peyote. She then delivers a child easily.” (Mount 1987:14 in Perez 2009:3).

Scientific research has revealed that the mescaline in peyote interacts with serotonin receptors in the human body, particularly 5HT2A (Nichols 2012:566). Stimulation of these receptors induces vasoconstriction in the uterus. Serotonin also interfaces with the smooth muscle in the uterus and can induce contractions (Lychkova, et. al. 2014; Nandkumar et. al. 1972; Dyer and Gant 1973).

After Peyote Woman eats peyote and delivers her baby, her hunger is gone and her breasts are full of milk. Prolactin, a hormone that promotes the production of breast milk, is also found to be stimulated with the ingestion of mescaline. (Demisch and Neubauer 1979) According to the scientific studies, the oral administration of mescaline also affected the 5HT2A serotonin receptors and triggered the secretion of prolactin more than four-fold above base level. (Smith accessed 7/20/17).

Some Wixárika women tell me that eating peyote when nursing increases the amount of breast milk they have for their children (Figure 8).

CONCLUSION

In conclusion, women in Wixárika and NAC cultures are central to their peyote traditions. The eminent females who discovered peyote and initiated the ceremonies, Utüanaka the Earth goddess and her companion Wiri’uwi for the Wixárika, and Peyote Woman for the NAC reflect the beliefs that connect peyote and feminine principals. The actual roles women have in these religious traditions reinforce the ideas of women as essential to the welfare of their communities. Women are also recognized for their creative endeavors be it art, song, or oratory; on a biological level they are esteemed for their reproductive abilities. Flowering peyote produce a fleshy pink sack (fruit) in the center of the plant6 (Figure 9). Like peyote, women are seen in Wixárika ideology as beautiful flowers; the fruit of the peyote metaphorically represents the human female uterus. The mysteries of how peyote interacts with the female body and hormone system is worthy of further study; what little we know points to a synergy between the plant and women, one that promotes fertility and well-being for mothers and their ability to bring healthy babies into the world.

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6 Peyote flowers played a pivotal role in my learning about this psychoactive cactus. On my first pilgrimage, I was unsure how to find peyote. An old wise shaman with the group explained to me "sometimes it is not so easy to find peyote when it is not flowering. If one finds a few with flowers he is very lucky." He taught me how to look for this reclusive little cactus. He harvested several peyote and, one of the plants had a little pinkish-lavender flower blooming on top. He picked the flower, pressed it to my eyes, put it in my mouth and told me in a soft but sure voice, "eat this flower of the peyote...it will help you, it will guide you to find many beautiful peyotes." Within minutes I miraculously began to see peyote all around me (Schaefer 1996:147–148).
Schaefer, S. B., 2002, with a second edition of the book in 2015 titled Huichol Women, Weavers and Shamans, 2002, with a second edition of the book in 2015 titled Huichol Women, Weavers and Shamans. From 1991 to 1999 she was Assistant and Associate professor at University of Texas Pan American along the Texas/Mexico border during which time she conducted extensive fieldwork research among federally licensed Mexican-American peyote dealers and members of the Native American Church (NAC). This work continued through 2015, culminating in Amada’s Blessings From the Peyote Gardens of South Texas, published in 2015 by the University of New Mexico Press, a winner of three literary awards in 2016. Her current research examines the relationship between peyote and the human reproductive system. She has also initiated a research project on the Cannabis Culture of Humboldt County.
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Stacy B. Schaefer, Ph.D., is Professor Emerita in the Department of Anthropology, California State University, Chico (CSUC) and former Co-Director of the Museum of Anthropology (CSUC). Dr. Schaefer has been carrying out ethnographic field research with the Huichol Indians of Mexico since 1976 and members of the Native American Church in the United States from 1993–2015. Her research has focused on traditional beliefs and practices that revolve around the use of the mind-altering peyote cactus (Lophophora williamsii). She is co-editor with Peter T. Furst, and contributor to the book People of the Peyote, Huichol Indian History, Religion and Survival. Dr. Schaefer also published the book To Think With a Good Heart: Wixárika Women, Weavers and Shamans, 2002, with a second edition of the book in 2015 titled Huichol Women, Weavers and Shamans. From 1991 to 1999 she was Assistant and Associate professor at University of Texas Pan American along the Texas/Mexico border during which time she conducted extensive fieldwork research among federally licensed Mexican-American peyote dealers and members of the Native American Church (NAC). This work continued through 2015, culminating in Amada’s Blessings From the Peyote Gardens of South Texas, published in 2015 by the University of New Mexico Press, a winner of three literary awards in 2016. Her current research examines the relationship between peyote and the human reproductive system. She has also initiated a research project on the Cannabis Culture of Humboldt County.
There is plenty of writing about women and drugs, but the discourse around psychedelics has historically been dominated by men. The drug experiences of women have been both sensationalized for their scandalous aspects and sterilized in clinical reports, but the role of women in the investigation of psychedelics prior to criminalization is obscure, and the identities of early women experimenters are often unknown.

Discourse, in critical analytic terms, is larger, more complex and more formal than conversation. It includes complex systems of rules, roles, rituals, goals, professional credentials, customs, habits, combinations of words, and patterns of thought. These complex systems were described as “games” by Timothy Leary, and were what his famous (or infamous) slogan “Turn On, Tune In, Drop Out” urged people to leave behind in seeking new forms of consciousness. In medicine, law, teaching, and the ministry, professional language and restrictive credentialing processes continue to shape candidates into recognizable members of these elite groups, legitimating their ideas and opinions and delegitimizing those of outsiders.

The discourse around psychedelics has tended to neglect the contributions of women, but courageous and determined female scholars, artists, and therapists have earned and demanded full participation in programs of research, professional forums, and educational efforts, and are now changing this field. Philanthropy is a bit further behind, but has always been a bastion of relative conservatism. As a consequence of historic gender imbalance, there are a number of women whose significant role in the exploration and employment of psychedelics for spiritual development, personal discovery, and therapeutic impact has not been well recorded or reported. Three representatives of this group are discussed in this article.

**MABEL LUHAN**

In 1914, Mabel Evans Dodge Sterne Luhan, who was a wealthy American patron of the arts, and member of the Greenwich Village avant garde, became interested in peyote. Her four volumes of memoirs describe her several marriages, her many affairs with both men and women, and her ultimate feeling of “being nobody in [her]self,” despite years of psychoanalysis and a luxurious lifestyle on two continents among the leading literary, art, political and intellectual personalities of the day (Palmer & Horowitz 2000). In Movers and Shakers (Luhan 1936), she describes her life in Greenwich Village at the beginning of the 20th century, and the many scholars, artists, and radicals who frequented her social salons, including John Reed, Walter Lippman, Isadora Duncan, Emma Goldman, and Margaret Sanger. She also gives the first account of a peyote experience in white America.

Luhan persuaded a friend, the ethnographer Raymond Harrington, who had lived in Oklahoma and was familiar with the rudiments of Native American ceremonies, to help Luhan and several friends to try to replicate a peyote ceremony in her apartment on West 9th Street in New York. Harrington had described the benefits of the peyote religion for his Native contacts, whom he pronounced were sober, industrious, and inspired to produce more beautiful craft work due to their recovery of inspired designs under the influence of peyote. His description, that peyote conferred the ability “to pass beyond ordinary consciousness and see things as they are in Reality,” excited Mabel’s adventurous spirit, and when she discovered that Harrington actually had a supply of peyote she was determined to try it. Harrington warned her that peyote was not to be taken lightly and insisted that there was a correct procedure for its use. Mable and her friends agreed to take it according to his instructions.
one meal) and then set up her drawing room with a simulated fire and a folded sheet standing in for the peyote altar. Luhan later wrote about this event.

Her trip, with nine friends, was not a pleasant experience for Luhan, who became frightened that the police would be called after one of the participants left the apartment in a frenzy (Elcock 2018). She was reluctant to use peyote again, but in 1917, bored with her society life and weary of the focus on military mobilization and of the propaganda related to the world war, she moved to Taos, New Mexico. Luhan found her home and her mate in Taos. She described her simple life there in Winter in Taos (Luhan 1935).

She married Tony Lujan, a Taos Pueblo man, who was a peyote leader in the pueblo. He gave his wife (who changed her spelling of their name to make it easier for her Anglo friends to pronounce) peyote medicine when she was very ill, and she had a classic transformative vision (Allen 2016). She wrote a poetic and evocative account of her experience, in which she said that the whole universe fell into place for her (Luhan 1937). Mabel Luhan used the term “expansion of consciousness” long before it was to become idiomatic some 40 years later (Palmer & Horowitz 2000).

Peyote, however, became a contentious issue in her marriage to Tony Lujan. Although she had directly experienced healing and deep insight under its influence, she insisted the Lujan give up the use of peyote, and opposed the inclusion of peyote leaders in the pueblo government. Along with other instances of meddling in pueblo affairs, Mabel Luhan encouraged religious persecution of peyote users, whom she described as “drug addicts,” and supported the enactment of a federal law prohibiting peyote use. A wealth of expert knowledge from both anthropologists and peyote users from Oklahoma to Montana opposed this legislation, and it was quietly dropped (Stewart 1987).

GERTRUDE PALTIN

A scholar who knew Gertrude Paltin’s daughter Sharon found a rare 1971 reference book, co-authored by her mother and Oscar Janiger, and brought it to her attention in 2005. Sharon Paltin, M.D., had not previously known of her mother’s contribution psychedelic research, although she knew that Gertrude Paltin had had some kind of professional link to Janiger. Sharon Paltin distributed the book, A Bibliography of LSD & Mescaline: From the Earliest Researches to the Beginnings of Suppression by Oscar Janiger, M.D., & Gertrude Paltin, M.S., to researchers and libraries, who discovered that it includes reference entries previously unfamiliar to most scholars (Janiger & Paltin 1971).

Janiger is a well-known figure in early psychedelic therapy, but Gertrude Paltin, is almost completely unknown. Ms. Paltin was trained as a biochemist, and encountered Dr. Janiger when he lectured to the osteopathic college that her husband attended. She became one of his clients, and later an assistant and the co-author of this work. This extensive annotated bibliography includes works in Italian, German, and French as well as in English, and subdivides these into 18 major areas of focus, including publications on Administration-Dosage-Tolerance, Psychological Studies, Behavioral Studies, and Popular and Creative works, among others. The bibliography also provides the first names of the cited authors, making it possible to glimpse the genders of papers’ authors,
which is interesting to consider for that era of research (Sylvia Thyssen, private communication, 2009). The references compiled by Ms. Paltin and Janiger, although not focused on therapeutic applications and complete only to 1963, provide recoverable links to otherwise unrecorded parts of the early body of knowledge and research which might otherwise be forgotten (Passie 1997).

A short biography of Gertrude Paltin is found in the Vaults of Erowid (Erowid Crew 2009). She was daughter of Jewish Russian immigrants, who received her M.S. in biochemistry from Temple University. Her first husband, a physician who was an early Janiger LSD subject, reports that Gertrude Paltin worked closely with Janiger as his executive secretary and participated in his early work with LSD (Samuel Paltin, private communication, 1998). Samuel Paltin’s own LSD experiences took place during a normal clinic day, with Janiger seeing other patients while the LSD user sat out on the porch under an oak tree, unaccompanied except for periodic checks by Janiger. Samuel Paltin believes that the bibliography was completed some years prior its 1971 date, and the most recent reference cited is almost a decade older. Ms. Paltin, who was raising small children during the preparation of the bibliography, later died of a cerebral hemorrhage at an early age. Acknowledged in this publication as the co-author, Ms. Paltin’s contribution to Dr. Janiger’s work is otherwise unknown (Sharon Paltin, private communication, 2019). She is emblematic of the hidden history of women in psychedelic research who often supported the work of their male partners and colleagues, provided comfort to participants, were involved as sitters in psychedelic sessions and helped write up reports, but were very rarely identified as co-equal participants in published work (Dyck 2018).

MARY BARNARD

The poet Mary Barnard (1909–2001) is the author of an elegantly written and perceptive essay about magical and sacred plants, which appeared in The American Scholar, the magazine of the Phi Beta Kappa Society. Barnard was a student of the origins of myth. In 1958, she published a “clear and elegant” translation of the poems of Sappho that has never been out of print, and permanently changed the way that scholars approached the poetic forms of Sappho’s verse. Her research on Sappho sparked an interest in folklore, and in 1963 Barnard published “The God in the Flowerpot” with the assistance of R. Gordon Wasson. In 1966 this essay was reprinted in a collection of essays about the origins of myth entitled The Mythmakers. In it, Barnard discusses the relationship between folklore and sacred mind-changing plants including peyote, varieties of Datura, Texas mountain laurel “mescal beans,” South American lianas, kava, soma, haoma, coca, opium poppies, mushrooms, marijuana and hashish, the Delphic oracle’s chewing of laurel leaves, bufotenine, and Taoist hermits’ use of the “divine fungus” lingchih.

According to Barnard: “Half a dozen important mythological themes—the shaman’s journey, the food of immortal life, the food of occult knowledge, the fate of the disembodied soul, the communication with the dead, plant-deities—all converge on this point: on some actual food, (usually a drug plant) ritually consumed, not symbolically, but for the experience it confers” (Barnard 1966).

Barnard believed that the magic plants in many myths are not imaginary, and that the food of occult knowledge is not a fiction. She pointed out that the characteristic descriptions of the disembodied soul in may shamanic narratives are not just a cultural or psychological phenomenon. In many of these narratives, and in first hand descriptions of shamanic performances, we are told that the shaman “takes something” to encourage or facilitate healing, divination or prophecy, but we are not told not what it is that s/he takes. Barnard suggests that this gap in understanding is due to a mixture of the shaman’s reluctance to reveal sacred and secret knowledge; and to early observ-
ers’ tendencies to see shamanic practice as satanic if they were religious people, and as theatrical hokum if they were skeptics. On the contrary, she says the mythological golden apples and other elixirs, barks, root, leaves, and ambrosias have their origins in real plants, and that “talking” plants really do impart occult knowledge.

Barnard was prescient and accurate. When she published her essay about peyote, she imagined the development of a field which she called “theo-botany,” which would be the study of magic plants as “vehicles for a special kind of experience adaptable to the use of most religions that acknowledge an otherworld and permit its exploration.” At the end of her essay, Barnard makes a prophecy: “that theo-botanists working for fifty years would make the then-current theories of the origins of mythology and religion as out of date as pre-Copernican astronomy.” That was 1963. She has not been proved wrong.

The lives and achievements of the remarkable women discussed here represent only a tiny fraction of the many women researchers, healers, artists, scholars and visionaries whose contributions to the history of psychedelics remain to be explored and revealed.

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Mariavittoria Mangini, Ph.D., FNP has written extensively on the impact of psychedelic experiences in shaping the lives of her contemporaries, and has worked closely with many of the most distinguished investigators in this field. She is one of the founders of the Women’s Visionary Council, a nonprofit organization that supports investigations into non-ordinary forms of consciousness and organizes gatherings of researchers, healers, artists, and activists whose work explores these states. Her current project is the development of a Thanatology program for the study of death and dying.
Archetypes of the Feminine in Psychedelic Peer Support

BROOKE BALLIETT, LMFT
SARA GAEL, M.A.

The Zendo Project (zendoproject.org) has provided specialized harm reduction services for those experiencing psychedelic and emotional crises at events in the U.S., Europe, Central America, and Africa. The project has grown into a unique pioneer in on-site peer support services and provision of a safe space for attendees to receive compassionate care.

Inherent in the Zendo Project’s approach to psychedelic support is the co-creation of communities of compassionate care. It is historically females who teach the lessons of attending to emotional experience, healing and spirit: our mothers, nurses, and teachers. When guests receive support in the Zendo they are not simply receiving a quiet place to reflect; they are also experiencing, in the midst of an awakened brain, direct interaction with these feminine archetypes. This experience, in itself, can be enough to minimize potential trauma from a difficult psychedelic experience. The presence of a loving figure softens the emotional impact of difficult experiences.

The Zendo Project’s approach to psychedelic harm reduction prioritizes compassion, safety and human dignity, as well as the basic elements of psychological and emotional first aid. The project’s values and practices are unique in their matriarchal approach, an approach that is seldom considered at large events where many people use psychedelics and risk arrest, psychiatric hospitalization, or other potentially harmful consequences. Most common is the “sedate and restrain” approach, which predates psychedelic peer support and continues to be the status quo in crisis response for emotional and psychedelic crises that do not require medical intervention. This approach focuses on convenience and resource maximization, unfortunately also resulting in loss of the opportunities for growth and insight that psychedelics can offer, even in the midst of difficulty, and potentially increasing traumatic outcomes.

The Zendo Project’s dedication to an alternative approach extends not only to its programming, but also to its staffing. MAPS began offering peer support services at events in 2001. From 2001–2008, peer support services offered by MAPS were pioneered by Rick Doblin and Valerie Mojeiko. In 2012, the department took on the name the Zendo Project and came under the direction of Linnae Ponté. Now directed by Sara Gael, the project continues to maintain a legacy of female leadership. Leadership roles have been occupied by women who’ve created and sustained an inclusive, collaborative model that both informs and reflect the Zendo Project’s approach. Deep presence, nurturing, unconditional acceptance, and cooperation are foundations of the support strategies utilized in the Zendo and the Project’s contributions to the psychedelic harm reduction movement.

ARCHETYPES AND PSYCHEDELICS

Archetype, in its most literal sense means the original model of something, deriving from the ancient Greek root words archē meaning “beginning or original” and typos, meaning “pattern or model.” Historically, archetypes are considered representations of the collective human experience that we can all relate to, even if it contains qualities that we do not consciously identify as part of our individual selves. The term was first coined by Plato to name the replicated essence of the true form of actions, things and characters which we carry within ourselves. Centuries later, Carl Jung re-invigorated the term as an expression of the collective human experience, both conscious and un-
conscious. Today, archetypes can be understood as thematic, collectively understood expressions of the human condition. Jung proposed that recognition of archetypes within and around us can serve to provide a greater sense of connection among us and subsequently, influence our psychological health. Indeed, throughout history across the planet, universal archetypes have permeated the mind in relationship, art, spirituality, entertainment, and nearly every other aspect of society.

In psychedelic experiences, not unlike the dream state, an ideal setting for working with archetypes emerges: perspective widens, interconnectedness deepens, and the ego leaves space for direct access to experiences we may not otherwise allow or understand. Over the years, thousands of guests have used the Zendo Project’s peer support services. Spend enough time in the Zendo, and it becomes clear that encountering archetypes is inherent to the psychedelic experience and perhaps even essential during a difficult psychedelic experience. Therefore, the project’s matriarchal approach offers a vital resource—archetypal femininity—as a response to the guest’s basic needs for familiarity, nurturing comfort, and emotional support in order to avoid escalation of difficulty or potentially harmful behavior. Responding with unconditional receptivity and calmness, as the Zendo Project’s peer support volunteers are trained to do, is an invitation to embody the archetypally feminine qualities of selflessness, compassion, and surrender while still allowing the guest to remain engaged in their own process.

Though common archetypal experiences seen in the Zendo can include what is commonly referred to as light aspects of the feminine, feminine archetypes can also illuminate the shadow aspects of the feminine—wrathful and unloving. Difficult psychedelic experiences frequently encountered in the Zendo can feature frightening aspects of the feminine, such the frigidity of the queen and the deceitfulness of the lover. In the psychedelic, as well as in the archetypal, both light and shadow
exist. The project’s response to all archetypal symbolism, dark or light, is to remain focused on the core values of unconditional presence and acceptance. Approach whatever presents itself as a common collective experience—and an opportunity for connection and psychological growth.

**COMPASSIONATE CARE AND THE GODDESS ARCHETYPE**

If in psychology the Mother is the most beloved and most fraught of the feminine archetypes, than in non-ordinary states of consciousness the most potent feminine archetype is the Goddess. As the individual mind expands into the collective with psychedelic assistance, the individual experience of the mother transforms into the Goddess. Both the positive and the negative aspects of the Goddess exist across a range of cultures, including in pre-monotheistic, animistic earth-based cultures, as well as in Hinduism, Buddhism, Egyptian, Western Grecian, and Roman traditions. The ferocious Kali Ma, wise Sophia, lusty Aphrodite, mother Mary, and compassionate Quan Yin are some examples of well-known and widely worshipped Goddesses. These last two representations could be said to embody the qualities of the Goddess of Compassion. Ariel Spilsbury, author of *Alchemy of Ecstasy*, describes the Goddess of Compassion archetype as:

> She who unfolds in mercy, forgiveness, and compassion.  
> Like a Divine Mother who loves all in an impersonal way (rather than a personalized human mother), the Goddess of Compassion represents the benevolent heart that assists all beings in channeling the love of creation into manifest form. She acknowledges and empowers by seeing the potential of each being beyond the limitation of ego, from the perspective of the oversoul rather than the personality (Spilsbury, 1999).

It should be noted that despite the importance of the feminine elements present in the Zendo Project’s approach to care, gender identity and expression of the sitter are inconsequential when providing compassionate care. All genders can embody the Goddess archetype in service to attending to challenging experiences. Compassionate care results in the gift of unconditional acceptance. Unconditional love is frequently a major feature of the enlightened state, a common theme of the psychedelic experience. Zendo Project guests often report that despite being disoriented or uncomfortable due to experiencing difficulties they didn’t expect, this spirit of compassion remains cognizant in the following days. The archetype of the Goddess supports the offering of compassionate care in the midst of psychedelic emergencies.

In the psychedelic field, largely occupied by the voices and bodies of white cis-gendered men, the Zendo Project stands in contrast. Though male researchers continue to dominate the field of psychedelic science and research, women are at the forefront of providing care to the thousands of individuals who find themselves lost in distress and confusion in the environ-

ments where psychedelics are used most often: mass gatherings, festivals, and concerts. The receptive, collaborative, and unconditionally accepting elements of femininity are amplified and put into practice when women hold positions of leadership and when the feminine archetype is valued and acknowledged in organizations, independent of the gender identity of staff and volunteers.

In the spirit of collaboration, providing training and supporting others in utilizing the Zendo Project’s approach is the focus of the future. The Zendo Project has responded to the growing recognition of its innovative model by increasing training and consultation services offered to event producers, promoters, venues, and emergency service providers. The Zendo Project also supports grassroots organizations in providing similar services in their geographic locations. The continued growth of safe and compassionate psychedelic peer support communities around the world where people feel capable of caring for one another and for themselves is the goal of the Zendo Project, and together with our growing community of supporters, we will continue to make outstanding progress—Goddess willing.

**REFERENCES**


**Brooke Balliett, LMFT**, is a licensed psychotherapist in Los Angeles, CA. With over a decade of clinical experience in trauma, developmental and depth psychology, Brooke has a passion for treating psychological, spiritual, emotional, and relationship challenges through the development of self-awareness, emotional intelligence, and recognition of the healing power we each inherently hold inside of us. Brooke is the Co-Founder and Clinical Director of the California Center for Psychedelic Therapy; a therapist on the Los Angeles MAPS Phase 3 clinical trial of MDMA-assisted psychotherapy for the treatment of PTSD; maintains a clinical practice specializing in emotional intelligence, Ketamine-Assisted Psychotherapy and Jungian psychotherapy; and also provides direct service, supervision, and training in harm reduction services at events worldwide with the Zendo Project, Kosmicare, and RGX Medical. Additionally, she provides clinical supervision in depth psychotherapy, ketamine-assisted psychotherapy, and psychedelic integration for early career psychotherapists.

**Sara Gael, M.A.**, received her Master’s degree in Transpersonal Counseling Psychology at Naropa University. She began working with MAPS in 2012, coordinating psychedelic harm reduction services at festivals and events worldwide with the Zendo Project. Sara was an Intern Therapist for the recently completed MAPS Phase 2 clinical trial of MDMA-assisted psychotherapy for PTSD in Boulder, CO. She maintains a private practice as a psychotherapist specializing in trauma and non-ordinary states of consciousness. Sara believes that developing a comprehensive understanding of psychedelic medicines through research and education is essential for the health and well being of individuals, communities, and the planet.
Breaking the Mold: 
Reflecting on Our Experiences in Same-Gender Therapist Teams with MDMA-Assisted Psychotherapy

ANNE WAGNER, PH.D., C.PSYCH.
ANNIE MITHOEFER, BSN
CANDICE MONSON, PH.D., C.PSYCH.

What started for us as a pragmatic decision to have same-gender therapist teams in our pilot study of MDMA-assisted Cognitive-Behavioral Conjoint Therapy (CBCT) for posttraumatic stress disorder (PTSD) has now resulted in a larger discussion of the need for mixed gender therapists in providing MDMA-assisted psychotherapy. We contend that, for philosophical, theoretical, and scientific reasons, it is important to question this precedence in psychedelic research. The issue of gender in this line of research is an important one, from many different angles, and we are pleased to bring these issues to the forefront of research and practice.

Historically, the majority of clinical studies of psychedelic-assisted psychotherapy have used male-female co-therapist teams to support people through their psychedelic experience. This tradition flowed largely from the influence of Stanislav and Christina Grof, Bill Richards, George Greer, Requa Tolbert, and other early psychedelic researchers and practitioners. Much of the reasoning for this practice in more recent clinical trials has been that for many people, especially those with a history of sexual abuse, having a male-female co-therapy team can add to the participant’s sense of safety; however, this is based on assumptions about gender that do not apply for many people. In addition, from the Jungian perspective, the experience of a non-ordinary state of consciousness could elicit strong autobiographical, as well as more universal experiences, of the mother and father. This perspective holds that having a male-female co-therapist team facilitates these experiences by having the therapists symbolically represent the mother and father roles, with the potential of having new, corrective, positive, and supportive interactions with these archetypes.

We question these positions on sociopolitical and theoretical grounds. Philosophically, they inherently assume gender is a reality as opposed to a social construct, and privilege a heteronormative and essentialist male/female parental experience. In reality, therapists can elicit a wide range of reactions from clients due to their individual per-
sonality characteristics, alongside their age, ethnicity, nationality, perceived level of experience, and many other characteristics, in addition to their gender. We believe that to choose co-therapist teams based on their genders unnecessarily emphasizes this particular set of stereotypes. Our team provided a therapy grounded in cognitive-behavioral theory, which does not assume a universal archetype of stereotypical mother-father roles.

Also inherent in our philosophical stance (from an anti-oppressive perspective) is that we want to be embracing of all gender identities, including transgender and non-binary identities, by setting a precedent both for other therapy teams and for clients. Specifically requiring a male–female co-therapist team inadvertently excludes non-binary or transgender therapists, as well as separating out the experience of clients who do not identify as cis-gender.

Our pilot study combining CBCT, an empirically-supported protocol for PTSD that demonstrates strong evidence for both decreases in PTSD symptoms and improvements in relationship satisfaction, with MDMA included four therapists. Two of us were experts in MDMA-assisted psychotherapy (Annie Mithoefer and Michael Mithoefer), and two of us were experts in CBCT (Candice Monson and Anne Wagner). In our work, we privileged expertise in the two interventions in determining the therapist teams. There was always one therapist per team who was an expert in MDMA, and one expert in CBCT. It happened to be that both of our CBCT experts were female. We encountered no issues in having female–female co-therapist teams; rather, what participants appeared to be interested in (from comments and conversation) was the respective expertise of each of the therapists, and participants would often ask each of us about either MDMA work or CBCT.

Scientifically, we do not yet know the impact of having male–female, same-gender, or multi-gender co-therapist teams. To our knowledge, there have not yet been same-gender therapist teams in psychedelic-assisted psychotherapy studies prior to ours. Thus, we do not have evidence that they are not as effective, or that male–female co-therapist teams are preferred. We do not yet have empirical data to test this assumption. Rather, going forward, it would be ideal to have a variety of different therapist pairings, or even solo therapists, to determine the comparative effect of having different therapist team constellations. Having a choice of therapist team would also be useful and important to explore, since clients often have preferences for therapist gender (as evidenced by clients in private practice actively seeking out and requesting therapists of a particular gender). We also do not know, however, the impact of having a therapist of a gender that does not match your initial preference—it is possible that this could be hindering to the therapeutic process, or useful, by giving opportunity to work through dynamics with the therapist.

We encourage others to consider this approach going forward, which involves questioning assumptions: a fitting perspective when working with psychedelics. Going forward, our next study, which will combine Cognitive Processing Therapy, an individual, evidence-based therapy for PTSD, with MDMA, also will not require male–female co-therapist teams. In order to make psychedelic psychotherapy accessible to more people, having a requirement of male–female teams may limit the opportunities people have by limiting who can provide treatment, and does not capture the lived experiences of many people who may inadvertently not be included in this process (e.g., gender non-binary therapists).

Although the utility of working through family-of-origin archetypes in different treatment models should not be dismissed, we do not actually know if it is the gender of the therapists that elicits these archetypes, or rather other therapist characteristics, which anyone could hold. For example, a father figure for a given client may be quiet and warm, and a mother figure louder and brusque, or vice versa. If we are assuming the usefulness of a male–female co-therapist team for what they potentially elicit, we should actually be testing what they do indeed elicit, gender notwithstanding.

In an era where women are increasing in leadership roles within psychedelics, as well as being the majority of practicing therapists in many areas of the world, it is important to examine how a gendered lens of psychology, psychiatry, and the therapeutic professions may have created our understandings and the teachings of the past, and to approach these assumptions now with curiosity. An open-minded perspective, that can be tested empirically, can help us support our clients in the best way possible today.

On a personal note, the three of us have each been able to work as co-therapists together over the years, and in this particular study, Anne and Annie were paired together, as were Candice and Annie, and both Anne and Candice also saw cases with Michael Mithoefer, the fourth member of the study investigator team. We each had incredible learning experiences from our co-therapists, developed excellent rapport with our clients, and helped the clients move toward healing. In our opinion,
the greatest differences were in our different backgrounds of expertise, not in our genders, and we found that working together was incredibly useful, enriching and productive. We hope to demonstrate that working in same-gender or multi-gender teams can yield results, and offers new opportunities for bringing different backgrounds of expertise and therapeutic minds together. We encourage others to consider this approach going forward, which involves questioning assumptions: a fitting perspective when working with psychedelics.

Dr. Anne Wagner, C.Psych., is a clinical psychologist and researcher who is committed to helping understand and improve trauma recovery. She is the founder of Remedy, a mental health innovation community. She is an Adjunct Professor in the Department of Psychology and an Associate Member of the Yeates School of Graduate Studies at Ryerson University, in Toronto, Canada. She completed a Canadian Institutes of Health Research Postdoctoral Fellowship at Ryerson University. She is the Chair of the Traumatic Stress Section of the Canadian Psychological Association, and sits on the Quality Committee of Casey House (Toronto’s HIV/AIDS Hospital). She is a trainer for Cognitive Behavioral Conjoint Therapy for PTSD and a consultant for Cognitive Processing Therapy, and has mentored dozens of clinicians in each of these treatments. She has presented and published extensively in the use of trauma-informed care, trauma treatment, stigma and interpersonal factors. Her work has been funded by the Canadian Institutes of Health Research, the Ontario Trillium Foundation, the Canadian Foundation for AIDS Research, and the Canadian Armed Forces. Dr. Wagner is one of the investigators of the MAPS funded pilot study of Cognitive Behavioral Conjoint Therapy for PTSD + MDMA.

Annie Mithoefer, BSN is a Grof certified Holotropic Breathwork Practitioner and is trained in Hakomi Therapy. Since 2004 she has been a co-therapist for a series of MAPS-sponsored clinical trials. She and her husband, Michael, completed the first phase 2 clinical trial of MDMA-assisted psychotherapy for PTSD in 2009, a subsequent study of MDMA-assisted psychotherapy for PTSD in military veterans, firefighters and police officers, and, in collaboration with Candice Monson, Ph.D. and Anne Wagner, Ph.D., a recently completed study with couples receiving MDMA-assisted psychotherapy in conjunction with Cognitive Behavioral Conjoint Therapy for PTSD. She and Michael are now leading trainings in MDMA-assisted psychotherapy for therapists, supervising MAPS Phase 3 therapists and providing FDA-approved MDMA sessions for research therapists.

Candice M. Monson, Ph.D., is Professor of Psychology and Director of Clinical Training at Ryerson University and Co-Founder of Evidence-based Therapy, Training and Testing (EBT3) in Toronto, ON. Dr. Monson is one of the foremost experts on traumatic stress and the use of individual and conjoint therapies to treat PTSD. She has published extensively on the development, evaluation, and dissemination of PTSD treatments more generally. She has been funded by the U.S. Department of Veterans’ Affairs, U.S. National Institute of Mental Health, U.S. Centers for Disease Control and Prevention, U.S. Department of Defense, and the Canadian Institutes of Health for her research on interpersonal factors in traumatization and individual- and conjoint-based interventions for PTSD. Recognizing her distinguished contributions as a clinical psychologist and educator, she is a Fellow of both the American and Canadian Psychological Associations, a Beck Institute Scholar, received the Canadian Psychological Association Trauma Psychologist of the Year Award in 2013, was named the Outstanding Mentor by the International Society of Traumatic Stress Studies in 2014, and was inducted into the Royal Society of Canada in 2016. She has co-authored 7 books, including Cognitive Processing Therapy: A Comprehensive Manual and Cognitive-Behavioral Conjoint Therapy for PTSD, and has published over 100 peer-reviewed publications. Dr. Monson is well-known for her efforts in training clinicians in evidence-based assessments and interventions for PTSD.

Begin with the end in mind
then work backward to plan for reaching ambitious goals
—Ashawna Hailey, who left $5.5 million to MAPS in her will

Help create a world where psychedelics are integrated into society by including MAPS in your end of life plans.

Please contact MAPS Development Officer & Connector Jade Netanya Ullmann to discuss your plans. jade@maps.org
The practice of MDMA-assisted psychotherapy aims to provide an environment of safety and support for a person to engage with their own inner healing intelligence, one's innate wisdom and ability to move towards wholeness and well-being. We act in the spirit of service to support each participant's connection to their own inner healing intelligence. We devote ourselves to establishing therapeutic relationships based on trust, care, and attunement, and to support the participant's own unfolding experience.

This modality involves deep work with trauma and attachment, as well as non-ordinary states of consciousness; therefore, MDMA-assisted psychotherapy carries unique ethical considerations. These considerations include the potential for greater participant suggestibility, the particular need for sensitivity regarding consent, and the likelihood of stronger and more complex transference and countertransference. Given the special considerations of this modality, we take seriously our obligation to participant safety. This work requires an elevated quality of presence, tending to the process consistently throughout long MDMA-assisted psychotherapy sessions, as well as during the phases of preparation and integration.

In order to provide impeccable care and to evolve ethically, we engage in practices of self-care, self-growth, and self-examination, aligning with our own inner healing intelligence. We give and receive feedback from mentors and colleagues, and participate in continuing education.

This modality is founded on the practices of healers, explorers, researchers, and indigenous traditions which stretch back centuries. We honor these contributions and recognize the privilege of working with non-ordinary states of consciousness. The ability to participate in these healing practices, as ancient as they are innovative, is both a gift and a responsibility.

Ultimately, we envision a world where all people can access healing. We view our participants’ challenges, as well as their growth, within a greater web of relationships, acknowledging that trauma, as well as healing, is passed between people, across
cultures, and through generations. We aim to validate and support the intrinsic wisdom and healing intelligence in others as well as in ourselves, in service to collective healing, liberation, and greater engagement in the fullness of life.

CODE OF ETHICS

1. Safety
We commit to the safety of our study participants, patients, and clients.
• We ensure that a person is an eligible candidate for treatment before enrolling them, both medically and psychologically. An eligible candidate has the resources necessary to engage in treatment, ideally including supportive people in their life and a stable and safe living environment.
• We conduct thorough and comprehensive preliminary screening and preparation.
• Prior to initiating treatment, we provide participants with clear information about our availability, backup support, and emergency contacts.
• We take measures to prevent physical and psychological harm. We ask participants not to leave during medicine sessions. We inform participants that we will take precautions to ensure their safety, such as preventing falls or injuries.
• We immediately address medical emergencies.
• We have a crisis plan prepared, where a qualified professional is available in the event of participant crisis or medical complications. We maintain responsibility for addressing crises as long as the participant is under our professional care.
• We provide thorough post-session integration with participants.
• We never abandon a participant. We conduct appropriate termination, with preparation when possible, and provide referrals to other providers.
• We adhere to laws and guidelines regarding storage and security of psychedelic medicines.

2. Confidentiality and Privacy
We commit to the privacy of our participants and uphold professional standards of confidentiality.
• We adhere to applicable patient privacy laws and regulations, such as the HIPAA Act, and other local, State, and Federal statutes.
• We discuss the limitations of confidentiality with our participants during the informed consent process and before initiating treatment. Depending on the licensing agency and the law, exceptions to confidentiality may include mandated reporting if there is reason to believe that a child, elderly person, or dependent adult is being abused or has been abused, if there is a serious threat to harm an identifiable victim, including oneself or another, and when required by a court order. Under these conditions, we release the minimum amount of participant information required.
• We may occasionally discuss cases as part of professional consultation and supervision, in which our consultants and supervisors are also obligated to respect participant privacy, and we will provide the minimum amount of identifying information.
• Outside of these limitations in confidentiality, we never release personal information about participants without their explicit permission.
• We make agreements with our participants about acceptable and preferred means of communication, such as leaving voicemails, sending text messages, hours of contact, and response time.
• We securely store treatment records and session recordings. We promptly respond to breaches in confidentiality.
• We seek legal counsel as needed to maintain participant confidentiality.

3. Transparency
We respect participants’ autonomy and informed choice.
• We include our participants in treatment decisions.
• We obtain informed consent before conducting treatment and when introducing a new intervention or technique. We honor the participant’s option to withhold or withdraw consent at any time.
• We inform participants of all treatment procedures, including an accurate description of medicines used, potential risks and benefits, as well as alternative treatment options.
• We discuss the process of termination with our participants at intake.
• We inform participants if we have significant reason to believe they may not be benefitting from treatment.
• We accurately represent our background and training using appropriate terms according to applicable laws and professional code.
• In advance of treatment, we inform participants of any fees and the process for collecting payment.
• We obtain consent to record sessions when applicable and to use recordings solely for purposes explicitly agreed upon by the participant, such as for training and supervision, or for the participant’s personal use.
• We obtain informed consent for any physical touch by describing the type of therapeutic touch. Physical touch is never sexual and we make agreements about how the participant can stop touch at any time.
• We inform participants in advance about the possible or scheduled presence of assistants, providers, observers, or any other staff who may be a part of treatment and/or have access to patient-identifying information.
• We provide consistent care to our participants and arrange...
backup and emergency contact when we are unavailable to participants.

4. Therapeutic Alliance and Trust
We act in accordance with the trust placed in us by participants.

- We aspire to create and maintain therapeutic alliances built on trust, safety, and clear agreements, so that participants can engage in inner explorations.
- We respect the inner healing intelligence of our participants to guide their experience.
- We understand that the healing process is deeply personal; each participant has different needs for support.
- We set our participants’ best interest above our own interests, within the bounds of our therapeutic relationship.
- We treat people receiving services or reaching out for services with respect and compassion.
- We acknowledge the inherent power differential between therapy providers and participants and act conscientiously in the service of participants’ self-empowerment.
- We avoid entering into dual relationships that are likely to lead to impaired professional judgment or exploitation. In cases where there is a dual relationship, we give special attention to issues of confidentiality, trust, communication, and boundaries, and seek supervision as needed.
- We use careful judgment about any continuing interaction with existing or previous participants outside of treatment.
- When treating couples or families, we always consider potential conflicts of interest, disclose policies on communicating information between family members, and discuss continued care and treatment plan.
- When working with participants in a research study, we strive to deliver therapeutic benefit while following scientific protocol.

5. Use of Touch
When using touch as part of our practice, we commit to obtaining consent and offering touch only for therapeutic purposes.

- We only offer techniques, such as touch, if they fall within our scope of practice and competence.
- When touch is part of our practice, we discuss consent for touch during intake, detailing the purpose of therapeutic touch, how and when touch might be used and where on the body, the potential risks and benefits of therapeutic touch, and that there will be no sexual touch.
- We obtain consent for touch prior to the participant ingesting medicine, as well as in the therapeutic moment. Aside from protecting a person’s body from imminent harm, such as catching them from falling, the use of touch is always optional, according to the consent of the participant.
- We discuss in advance simple and specific words and gestures the participant is willing to use to communicate about touch during therapy sessions. For example, participants may use the word “stop,” or a hand gesture indicating stop, and touch will stop.
- We practice discernment with touch, using clinical judgment and assessing our own motivation when considering if touching a participant is appropriate.

6. Sexual Boundaries
We do not initiate, respond to, or allow any sexual touch with participants.

- While we respect the sexual identities and expression of our participants, and validate participants’ processes that might relate to sexuality and sexual healing, we firmly maintain the responsibility as providers of upholding clear professional boundaries.
- We do not engage in sexual intercourse, sexual contact, or sexual intimacy with a participant, or a participant’s spouse or partner, or immediate family member, during the therapeutic relationship or after termination. While we believe this guideline applies indefinitely to former participants, in the rare case in which a therapy provider and participant might be considering engaging in such activities, there must be a period of years since last professional contact, and the therapy provider is responsible for assuring that there has been no exploitation in light of factors including: time passed since termination, the nature, duration, and intensity of the therapy, the circumstances of termination, the participant’s personal history and current mental and emotional health, and the likelihood of harm to the participant. If a therapy provider has a licensure board with more restrictive regulations, these regulations take precedence.
- We commit to examining our own sexual countertransference, to not act in ways that create ambiguity or confusion about sexual boundaries, and to seek supervision as needed.
- As representatives of this work, we aim to uphold clear sexual boundaries and ethics in our daily lives.

7. Diversity
We respect the value of diversity, as it is expressed in the various identities and experiences of our participants.

- We do not condone or knowingly engage in discrimination. We do not refuse professional service to anyone on the basis of race, gender, gender identity, gender expression, religion, national origin, age, sexual orientation, or socioeconomic status.
- We take steps to examine unconscious biases that we may hold and commit to ongoing self-reflection to unlearn oppressive patterns.
- We make every effort to include people living with physical, mental, and cognitive disabilities.
- We respect the unique experiences of our participants, and
practice openness towards different peoples’ values, belief systems, and ways of healing.

• We are attentive to the impact of power dynamics in our relationships with participants, particularly where there are differences in privilege, gender, race, age, culture, education, and/or socioeconomic status.

• We strive to be honest with ourselves and with our participants about the limits of our understanding, and to hold genuine curiosity and interest as we relate to our participants’ experiences.

• We aim to provide culturally-informed care, and seek education in support of greater cultural understanding. We refer participants to other providers as appropriate.

8. Special Considerations for Non-Ordinary States of Consciousness

We tend to special considerations when working therapeutically with participants in non-ordinary states of consciousness.

• Participants in non-ordinary states of consciousness may be especially open to suggestion, manipulation, and exploitation; therefore, we acknowledge the need for increased attention to safety and issues of consent.

• We examine our own actions and do not engage in coercive behavior.

• In working with non-ordinary states that can evoke unconscious material for both the participant and therapy provider, we acknowledge the potential for stronger, more subtle, and more complicated transference and countertransference, and, with that in mind, we practice self-awareness and self-examination, and seek supervision as needed.

• We respect the spiritual autonomy of our participants. We practice vigilance in not letting our own attitudes or beliefs discount or pathologize our participants’ unique experiences. We hold and cultivate an expanded paradigm, which includes the experiences people have in extraordinary states.

• We protect our participants’ health and safety through careful preparation and orientation to the therapy, as well as thorough integration.

• We support participants who may experience crisis or spiritual emergency related to psychedelic experiences with appropriate medical and psychological care, engaging the support of outside resources as needed.

9. Finances

We maintain clear communication with participants about fees and aspire to increase financial access to services.

• We disclose our fees and payment procedures before enrolling a participant in treatment.

• We advocate for our participants with third party payers, including health insurance reimbursement, sponsors, and donors when appropriate.

• We create opportunities for participants who are unable to afford the full cost up-front to engage in treatment, by considering income-based fees, sliding scale, pro-bono work, scholarship, sponsorship, and donor-supported services.

• We do not take on or continue treating a participant solely for financial gain; we only take on or continue to treat a participant if we believe our services will have therapeutic value.

• We do not accept payment or charge money for referrals.

• We establish and maintain clear and honest business practices.

10. Competence

We agree to practice within our scope of competence, training, and experience specific to the populations we are working with and the modalities we offer.

• We agree to represent our work honestly and accurately.

• We assess at intake whether a potential participant’s needs can be addressed within our scope of competence and, if not, make informed referrals to other providers and services.

• We commit to ongoing professional development, seeking supervision and continuing education to further our therapeutic skills and presence.

• We agree to maintaining our licensure and certification in good standing, including re-certification as required.

11. Relationship to Colleagues and the Profession

We establish and maintain compassionate and positive working relationships with colleagues, in a spirit of mutual respect and collaboration.

• To maintain the highest integrity in our practice, we agree to seek counsel with our fellow practitioners and colleagues, being open to feedback when given, and offering feedback when it may be needed.

• As practitioners of this modality, we are mindful of how we represent this work to the public, including through the media, social media, and public presentations.

12. Relationship to Self

We commit to ongoing personal and professional self-reflection regarding ethics and integrity.

• We adhere to an ongoing practice of self-compassion and self-inquiry.

• We agree to seek professional assistance and community support for our own emotional challenges or personal conflicts, especially when, in our view or in the view of colleagues, they affect our capacity to provide ethical care to participants.

• We subscribe to the value of humility, out of respect for the transformative power of the experiences we have the privilege to witness and support, and out of respect for human dignity.
The basis of professional ethics is to act always in the best interests of the client. Yet in our work using psychedelics, what is best for the client is not always simple to discern, especially when we have unconscious assumptions or motivations. Unexamined attitudes from mainstream culture may influence our interactions with women clients.

**Why do we want to do psychedelic work with clients?**

Our very first self-reflection must be on our reasons for choosing the professional role of psychedelic facilitator. Do we want to be this client’s true well-wisher? Even if the answer is yes, most people in a helping role also have more shadowed motivations. Examples of these are: wanting to be seen as the healer, the guide through mystical new territories, or the catalyst for a client’s transformation. These desires are not in themselves wrong or bad, unless we don’t recognize them. If we are not conscious of these motivations, we can be driven by them unconsciously, to a client’s detriment. Once we are aware of the complexity of our motivations, we are one step closer to getting clear about what truly serves our client, and choosing to refrain from what does not.

There are always differences between the culture, gender, and life experience of the client and those of the professional. (I am using the word “professional” here to mean “responsible party.”) There are subtleties to ethical right relationship that inevitably involve the present fears, desires, and longings of both professional and client. This is particularly true when the client is female (and/or belongs to any other group that has experienced discrimination.)

Often when clients experience profound, extraordinary states of consciousness, their unconscious tendencies are amplified. When professionals sit in the field of a client taking psychedelic medicine, they may experience this same amplification of their own fears, desires, and longings. It is not uncommon for everyone in the room to have surprising emotions and content emerge from their unconscious.

Sometimes these take the form of “healing impulses.” These are usually inclinations to help in some way, perhaps to try to address some old wounding. Healing impulses are usually well-motivated in that the impulse has identified a real need, either in oneself or the client. However, they also can be projections of our own needs, even if they seem initially, to be for the client. Even if a proposed intervention is examined and feels right, we could still be unclear about the best timing for it. All unconsidered interventions have greater potential for ethical missteps.

When we want to intervene in a client’s process, we can ask ourselves, “Who is this for?” (Taylor, 2017, p.176). We can look more closely at the healing impulse we may mistakenly determined is on behalf of the client. We can ask ourselves whether this intervention, at this time, with this client, is really helpful. Awareness about our own motivations is important. “In almost all cases where we…have caused harm to those in our professional charge, it was because we just didn’t know better or because we weren’t able to look at ourselves” (p. 35).

Michael Pollan (2018) chose a wonderful title for his book *How to Change Your Mind*, because a precipitating factor for what I call a “personal paradigm shift” is a deep, non-ordinary state of consciousness. As Pollan demonstrated with accounts of his personal psychedelic experiments, we really do have the opportunity to change our minds and shift our personal paradigms by using methods like breathwork and psychedelic medicines.

**How do we bring meta-awareness to cultural paradigms?**

How can the fish be aware of the water in which they are swimming? How can we humans have a meta-awareness of the paradigms in which we exist and interact with others? We can do our best with self-supervision, but we cannot entirely avoid inhaling and exhaling from the cultures in which we live.

We professionals are a combination of our cultural programming and the deep, self-reflective work we have done to discard whatever of the mainstream culture is not consonant.
with our authentic selves. When our client takes a psychedelic, we are challenged to refrain from interfering with the transformational trajectory that the psychedelic has initiated.

The professional and the client approach the client’s psychedelic work when they are both still in an ordinary state of consciousness. The ordinary state holds embedded programming from the established assumptions we all learned in nuclear families, in school, at work, in religion, and with friends. These patterns are comprised of beliefs, habits, language, trends, and prejudices. These are “engendered,” so to speak, because of our identities (gender, sexual, ethnic, socio-economic, religious, racial, and others).

Women of color, for example, in addition to the prejudice they experience as females, experience racial prejudice. During one of his last speeches Martin Luther King, Jr. (1967) gave us an example of prejudice embedded in mainstream use of language, when he pointed out that at least half the thesaurus meanings for the word “black” were offensive and all meanings of the word “white” were favorable. A psychedelic therapist could unwittingly use language to allow a mainstream pattern to influence a client’s self-esteem or her own way of holding an important step in her transformative process. Monnica T. Williams (2018) names other factors which might exclude people of color altogether from access to psychedelics as legal medicine including, “prohibitive costs and lack of access to substances, negative stereotypes about people of color and drug use, and criminalization of people of color through the War on Drugs” (para. 3).

We make meaning for ourselves by seeing our reflection in the mirrors the cultural paradigm holds up for us. We do not always question the images in those mirrors. It is difficult to be a human in need of community and at the same time question everything in every sphere of life. But when the professional and the woman client draw near the moment when the woman will take the medicine, it is important for both to understand the need to protect her from the mainstream programming that remains in each of them and to provide permission for her to connect with and follow the guidance of her own inner wisdom.

Protection, Permission, and Connection is a concept that Dr. Ingrid Pacey, Mary-Louise Gould, and I originated for a teaching syllabus on trauma for the Grof Transpersonal Training. Each of us had worked for years, independently, using the Holotropic Breathwork® method of working in non-ordinary states with women healing from the childhood trauma of emotional, sexual, and physical abuse. The three of us realized that every successful treatment container has found a balance of Protection, Permission, and Connection, a balance that served the specific safety, encouragement, validation, and caring needs of the particular client. Protection, Permission, and Connection elements in right proportion result in trust and right relationship between professional and client so that the client can move freely towards authenticity (Taylor, 2017, pp. 58–60).

While Protection, Permission, and Connection applies to all clients in therapeutic settings, it is crucial for professionals to pay extra attention to balancing these three elements with women in psychedelic treatment. Too much protection, for example, may keep someone from venturing into new territory. Not enough protection may prevent a corrective, healing, or transformative experience and possibly, instead, set up a client for a re-traumatizing experience or one that reinforces a limiting self-definition.

The InnerEthics™ model of ethics education described in my book The Ethics of Caring: Finding Right Relationship with Clients has a foundation of self-compassionate, ongoing self-reflection. When we are in continuous self-reflection about our desires, fears, and longings, we can understand better what is “ours.” Then we can do a better job supporting the client in discovering what is “theirs.”

I am a strong advocate of peer supervision: small groups of professionals who commit, in an on-going way, to willingness to explore ethical issues and their own fears and desires with trusted peers, calling on formal supervision when necessary.
Today’s video conferencing makes it easy to form and nurture groups that establish a regular practice of self-discovery.

What ethical differences arise in working with psychedelics?

Ethical issues are quantitatively and qualitatively different with clients when using psychedelic medicine. I use “quantitative differences” to mean that the usual ethical issues need more attention in more ways when working with clients in non-ordinary states. In my decades working as a trainer and facilitator using the method of Holotropic Breathwork®, it became evident to me that there is increased need for physical, mental, emotional, and spiritual safety when working with clients with non-ordinary states. More information needs to be provided for informed consent, especially if a client has no prior experience in a non-ordinary state. There is potential for stronger transference and countertransference—projections that come from both the client and the professional. Clients in non-ordinary states, as in hypnosis, have increased vulnerability and are less defended against a professional’s suggestions, so there is a greater than usual necessity for caution in offering verbal direction (Taylor, pp. 159–176).

There are also qualitative differences in ethical issues that require professional knowledge and attention. For example, the requirements of set and setting differ. The definitions of ethical touch may be different. Cognitive dissonance, an internal clash of old and new understandings about self and world, occurs, sometimes abruptly, when a client discovers that her previous personal paradigm is too small. A different perspective of self, world, and the cartography of the psyche may be needed to hold what she is experiencing. Clients often need gentle assistance with re-entry back into an ordinary state of consciousness, a state which historically incorporated their old way of perceiving things, but one to which they are now bringing new awareness of how things are. Most importantly, the psychedelic professional must have garnered competencies from his or her own personal psychedelic and other deep experiential work.

What helps women clients in psychedelic work?

The principal protection that women need going into psychedelic treatment is non-interference—protection from the lingering mainstream paradigm that holds women as inferior in some way, role-defined, and role-limited. The psychedelic is the transformational ticket out of a limiting pattern for the female client. In any session the doors of the psyche may swing open. She may feel free to experience her authentic self, understand how roles have been defined for her. She may be ready to confront self-doubt. She may be able to see beyond externally and internally imposed limitations and find confidence in her unique gifts.

Leo Zeff, a psychologist and famous psychedelic therapist described his work in an interview with Myron Stolaroff (2004) which was published in The Secret Chief Revealed. Zeff gave psychedelic medicine to 3,000 people starting in the 1950s. He describes his own journey as a therapist, as he gained more experience with medicine work, moving from doing and interfering to trusting the innate healing force in the psyche which is liberated by the psychedelic medicine:

I very soon learned that my traditional techniques of helping people in therapy do not work, they just don’t work. Just leave ‘em alone! They know what the hell’s wrong with them or the God within them knows what’s wrong with them and provides them with whatever they need, which I don’t know anything about and they don’t even know anything about. (as cited in Stolaroff, 2004, p. 50)

What happens when you leave women alone (within, of course, a balanced container of Protection, Permission, and Connection they can trust) is that they source their inner wisdom, their inner healer, and find their own way to a place they self-define as “home,” where they recognize and empower their authentic selves.

Erica Avey reported on the 2018 Women and Psychedelics conference, presented by Chacruna Institute of Psychedelic Plant Medicine and held at CIHS in San Francisco. Avey quoted speaker Sara Reed, who told the group the story of her MDMA experience in a clinical research setting. Reed concluded, “I finally had a place where I belonged; I felt free.” Avey reported, “Those words hit the room. Most people were crying or on the verge of tears from her retelling.” Clearly, most of the women in that room related to Reed’s finally finding “a place where I belonged.” They had experienced and empathized with Reed’s journey of starting from a limited or incomplete identity to “coming home.”

Zoe Helene (2018), founder of Cosmic Sister, concurred that healing is part of what psychedelic therapy for women is about, but it is not the whole story. She wrote, "I really think self-liberation is a big one, especially for women" (para. 5).

As psychedelics are poised to become prescribed medicines, we would do well in psychedelic community to promote an ethos valuing self-reflection, particularly regarding the needs of women clients. Each of us who is holding space for psychedelic transformation must find right relationship with each person for whom we are in a responsible role. Community helps us with this. We can use both external and internal ethical guidelines. We can learn from self-examination and ethical mistakes. We can seek supervision and course-correct in a moment-by-moment way in every client relationship as it unfolds.

Only courageous soul-searching, especially in regular sessions of peer or facilitated supervision, can bring consciousness to the fears, desires, and spiritual longings hidden in each of us. Our willingness to face our unconscious programming, our vulnerabilities, and our hidden motivations will enable us to make choices that are truly in the best interests of our clients.
A woman in psychedelic treatment needs...

1. Money

2. Sex

3. Power

4. Love

5. Truth

6. Insight

7. Oneness

To be able to share stories with other women about their healing and transformative journeys, and not feel alone

To be honored for knowing her own way forward before, during, and after the medicine session

To be listened to and helped to discover her own meaning from her own words

To have a woman as a psychedelic therapist, psychedelic therapy assistant, or sitter—one who is confident and self-compassionate and trusts that her client can be too

To be encouraged to believe that finding her way home to herself is possible and that she can do it herself

To be protected from touching and verbal interventions that are not in her best interests

To be protected from cultural assumptions and expectations about the roles of women

The full and original Chart of Vulnerabilities to Ethical Misconduct (Taylor, 1995, 2017) is a guide to motivations—our personal and transpersonal desires, fears, and longings—that occur in these seven areas of relationship.

REFERENCES


Kylea Taylor, M.S., LMFT is grateful to MDMA for the biggest personal paradigm shift of her life. She is a Holotropic Breathwork® Facilitator, a Senior Trainer for the Grof Transpersonal Training and a SoulCollage® Trainer. She teaches InnerEthics™ and consults on ethical issues related to work in non-ordinary states of consciousness and community. She wrote The Ethics of Caring: Finding Right Relationship with Clients, The Breathwork Experience, Considering Holotropic Breathwork®, and edited Exploring Holotropic Breathwork®. She has a therapy practice in Santa Cruz, California, specializing in the integration of profound experiences into everyday life. She may be reached at KyleaTaylor.com.
Women in communities that use psychedelics have been talking about sexual assault and sexual harassment long before #MeToo. In these conversations, it’s not uncommon for women to recall incidents of unwanted and inappropriate sexual contact—and express frustration that these violations are often never addressed. While the initial focus of #MeToo encouraged victims to tell their stories about abuses in the workplace, these discussions have expanded to include sexual violence and coercion in therapeutic and social settings. Under these circumstances, there is the same need to stand in solidarity with people of all genders who have been harmed, and to educate everyone that they have a right to say no to sexual advances. While legal and corporate protocols in some workplaces offer ways for victims to come forward and file a complaint, this is more difficult in non-professional environments. This challenge has sparked much discussion about how to intervene when witnessing abusive behavior and take a stand against sexual violence.

Almost two years after the emergence of #MeToo, communities of all types are looking for ways to address consent violations and end impunity for perpetrators. In settings where psychedelics are used, the need for restorative justice is especially pressing as victims may be less likely to trust the criminal justice system. Within communities that I am part of, thoughtful people have put forward some useful ideas about upholding a culture of consent when participants may be exploring altered states of consciousness.

SAFETY WHILE HEALING WITH PSYCHEDELICS

In 2007, some friends and I organized an annual gathering where women who worked with non-ordinary states of consciousness could present their work. The Women’s Visionary Congress (visionarycongress.org) and its nonprofit sponsor the Women’s Visionary Council (WVC), were created to overcome the historical exclusion of women in public conversations about psychedelics. The event features women activists, healers, researchers, and artists, and hosts frank conversations about safety and ethics.

Shortly after we launched the Women’s Visionary Congress, women began sharing stories about sexual assault and harassment in ceremonies that used psychoactive substances, especially ayahuasca. These ceremonies offer opportunities for deep healing and self-knowledge when led by facilitators who maintain impeccable ethics, but some participants have the mistaken impression that people who lead psychedelic ceremonies can always be trusted and that ritual spaces are inherently safe. Sexual violence carried out by people who present themselves as spiritual leaders is an old problem that impacts people of all genders. But these accounts of sexual coercion during and after these rituals were so troubling that in 2014, the WVC published a series of Safety Tips for people participating in psychedelic ceremonies (visionarycongress.org/safety-tips-for-participating-in-psychedelic-ceremonies).

Drafted by a group of WVC elders, these Safety Tips have been widely shared and have inspired other organizations to produce their own versions. These recommendations include conducting due diligence before the ceremony and checking out the reputation of the ayahuasquero, shaman, or healer with whom one is considering working. Participants are advised to attend ceremonies with friends, develop a safety plan, and carefully evaluate how they are touched during the ritual to determine if this contact feels sexual or non-consensual. Extra caution is recommended when offered individual healing sessions, especially if the participant is asked to remove clothing.

The Safety Tips also note that entering into consensual sexual relationships with ceremonial leaders, while possibly making the participant feel special, can expose them to an imbalance of power that has the potential to be coercive and abusive. They include a reminder that the professional ethical standard for therapists in the U.S. is a complete ban on intimate relationships with former clients for at least two years after the conclusion of their therapeutic work together. Finally, participants in psychedelic ceremonies are encouraged to determine prior to the ritual what forms of accountability exist for the shaman or healer. If that person harms or disrespects you in some way, how will they be held accountable? Will the ceremony take place in a country where it may be difficult for women to file a sexual assault complaint within the local justice system? Is the healer part of a larger community of practitioners that hold them to a standard of care? Should participants consider taking part in ceremonies within their own local legal jurisdictions where they can file sexual assault charges against facilitators who violate them?
These same questions are also worth asking when working with therapists and counselors who offer psychedelic-assisted therapies. The rapidly growing number of people now being trained as psychedelic therapists creates an even greater need for professional associations that hold these practitioners accountable to a code of professional ethics and a standard of care. The psychedelic community should watch carefully to ensure that such developing regulatory bodies are not compromised by conflicts of interest, and that they oversee both licensed and unlicensed therapists. Licensing and professional organizations should be independent of commercial drug developers such as COMPASS Pathways, educational institutions, and nonprofits such as the Usona Institute and MAPS. As MAPS will hold a five to six year exclusive right to market the therapeutic use of MDMA and will train many therapists, it will hold a temporary monopoly on these services. As with large pharmaceutical companies or monopoly players in any market, consumers should insist on independent oversight and not self-regulation of these groups which could lead to concealment of abuses.

BEST PRACTICES FOR CREATORS OF SOCIAL EVENTS

Commercial markets for psychedelic services can include different forms of accountability, but what about social communities where people participating in immersive experiences may also use psychedelics? People who organize social gatherings from private parties to large festivals also have an ethical duty to help safeguard participants from consent violations and take action when people are harmed. The process of creating safety systems encourages both event producers and the communities they serve to reflect on their collective values and how to uphold them. If volunteers are involved in providing health and safety services at events, determining how to best support these people is also an important consideration.

In 2013, I co-founded an event production company called Take 3 Presents, which seeks to catalyze personal and societal evolution through private, immersive art and music events. When we first began producing these gatherings, we made a decision to create groups of volunteers from our own community to uphold a culture of consent. The first group of safety volunteers we created were a team of rangers who roam the event site in pairs around the clock. Trained in conflict resolution, the rangers provide support for participants who need assistance or wish to report a safety issue. The rangers intervene in situations when a consent violation takes place. They work directly with a group of onsite medics and a rapid response team made up of professional counselors. If someone is violated during a Take 3 event, the rangers take action to secure the safety of the victim and document their account of the incident. This information is kept confidential as is the identity of the victim if they request. Ranger leadership also locates the person accused of the violation and collects information from them. In some cases, perpetrators have been escorted out of the event to secure the safety of other participants.

Participants who need focused care during a Take 3 event can also visit the onsite quiet space (much like the Zendo Project) which is staffed by specially trained rangers. If they wish to leave the event, the rangers help ensure that they get safely home. After the event, a separate aftercare team of volunteers with counseling and mediation training examines the incident. Using a series of set protocols, they determine if the person who instigated the consent violation represents a threat to community safety. Being in an altered state of consciousness is not an excuse for sexual assault or harassment. The aftercare team conducts follow-up meetings with all parties. They also provide referrals to the victim for professional counseling and advise Take 3 leadership as to whether the person who committed the consent violation should be invited back to the event. If the person who violated consent is invited back, certain conditions for counseling, education, and mediation—if requested by the victim—are set as a condition of return. The people responsible for managing the cases of these returning participants are ideally not the same people making the decision about their inclusion or exclusion. Attempting to do both risks burning out this team—which also considers safety concerns from participants between events. They are a precious community resource and should be treated as such.

Take 3 also takes other actions to discourage consent violations. In particular, it does not sell alcohol or allow any participant to run a bar. Events instead feature a tea house which serves as a social center for rest and hydration. Participants can bring alcohol for personal consumption, but the elimination of served alcohol reduces conflict and injuries of all types. The invitation structure of Take 3 events also requires that participants be invited by a sponsor who are then responsible for them during the gathering. Finally, all artists who create immersive art during Take 3 parties are expected to uphold the culture of consent and treat participants with respect.

CREATING SYSTEMS OF ACCOUNTABILITY AND RISK REDUCTION

Risk reduction (visionarycongress.org/manual-of-best-practices-for-risk-reduction) is arguably an art form in itself. Communities should develop their own protocols for upholding a culture of consent that reflects their values. They should also share information with each other to develop collective knowledge and best practices (visionarycongress.org/risk-reduction-for-community-and-event-organizers) that can evolve over time. No system will be perfect, but each effort advances the basic human rights of all people to be treated with dignity and respect.

Annie Oak is the founder of the Women’s Visionary Congress (visionarycongress.org) and co-founder of the nonprofit Women’s Visionary Council. Annie is also the co-founder of Take 3 Presents (take3presents.com) which produces private, immersive art and music events. She is especially interested in risk reduction and collaborative community art, such as the Full Circle Tea House which she created in 2009. A former science reporter, Annie now works as a researcher for a human rights organization.
Ayahuasca Community Guide for the Awareness of Sexual Abuse

EMILY SINCLAIR, PH.D. (C)
BEATRIZ LABATE, PH.D.

Many individuals participate in ayahuasca ceremonies for healing purposes, sometimes specifically to heal trauma caused by sexual abuse. Considering this, it is especially disturbing to discover that sexual abuse is also quite prevalent in ayahuasca and shamanic healing contexts. Several cases, some quite high profile, have come to light in recent years spanning different kinds of abuse across diverse ayahuasca ceremonial contexts. Yet, despite sexual abuse and harassment being prevalent within ayahuasca circles, many participants seeking ayahuasca healing are still unaware of the problem and can unknowingly end up in a vulnerable situation. Indeed, one of the first obstacles we face in attempting to address sexual abuse in the ayahuasca community is the widespread disbelief that sexual abuse is indeed a problem. The Chacruna Institute for Psychedelic Plant Medicines believes that the more people learn about past and potential sexual abuse, the greater the chances to combat it. Sexual assault is always the fault of the perpetrator, and it is the responsibility of all individuals within the community to come forward and speak about this. While we have no control over the perpetrators of these acts, we hope that the experiences of others can be useful in raising awareness about the typical contexts in which past abuse has occurred.

Motivated by a desire to raise awareness and to help safeguard individuals and groups in ayahuasca healing contexts, Chacruna produced the Ayahuasca Community Guide for the Awareness of Sexual Abuse, (chacruna.net/community/ayahuasca-community-guide-for-the-awareness-of-sexual-abuse) an initiative of Chacruna’s Ayahuasca Community Committee (chacruna.net/community). We chose to craft the guidelines to focus on women, since it is mostly female participants being abused by male shamans that comprise the bulk of sexual abuse occurrences. Yet, our hope is that they are of value to all. Attempting to cover diverse social and cultural settings where ayahuasca healing takes place, the guidelines have been created through a collaborative process with many experienced individuals in a wide range of ayahuasca settings across different cultural contexts and continents. This shared process has included indigenous as well as Western victims and survivors of abuse, ayahuasca healers and ceremonial facilitators, and anthropologists who, like ourselves, have conducted long term fieldwork in lowland South America and have longstanding experience with ayahuasca communities. We also have tried to make these guidelines relevant across the spectrum of potential abuse that can occur in ayahuasca settings, including verbal persuasion, invasive touching, “consensual” sex between healer and participant, and rape.

In forming the guidelines, we began by asking, “why is sexual abuse so prevalent in ayahuasca circles?” Apart from acknowledging that sexual abuse is an abuse of power, which occurs broadly across diverse contexts in diverse societies, we were interested
in better understanding what elements or conditions can specifically be linked to ayahuasca healing contexts. One issue is the undue romanticism that can surround expectations about ayahuasca and ayahuasqueros, and the assumed position of trust a healer or ceremonial facilitator inhabits in the imagination of participants. When entering into ayahuasca healing circles, one may assume and expect to be entering a safe space. One may assume or expect to be able to trust the people calling themselves healers, “shamans,” leaders, and facilitators of this space. The guidelines hope to shed light on the context of typical ayahuasca scenarios and what some of the associated assumptions and expectations surrounding these might be. For instance, the guidelines hope to demystify the position of the ayahuasca healer, as well as to draw attention to multicultural issues within ayahuasca community contexts that are not immediately understood or applicable outside of such settings. The guidelines present a series of cultural differences that have typically created confusion, miscommunication, and conflict in ayahuasca healing settings. It is important to note that sexual abuse of women in the ayahuasca community occurs across and within cultures, between indigenous healers and participants, and between Western healers and participants. Moreover, research and experience indicate that the potential for abuse is further exacerbated by cultural differences in the current context of the increasing globalization of ayahuasca, whereby many Western people now partake in ayahuasca ceremonies in South American contexts, or whereby South American healers travel to the West. A main aim of our guidelines is to empower women in these culturally unfamiliar contexts where ayahuasca ceremonies often take place.

Mutual cross-cultural misunderstandings and misconceptions between healers and participants create confusion at least and can be brutally manipulated at worst.

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and have no regrets. Some individuals are attracted to the possibility of having sex with a shaman or ceremonial leader, and may pursue sexual relations with them. Of course, it is also possible that loving and sexual relationships can be established between ceremonial facilitators and participants in ayahuasca circles. However, as with doctors and patients, it is widely agreed that this is a transgression in the healing context.

The importance of integration is also emphasized in ayahuasca circles, after allowing time for the effects of the medicine to wear off with its ensuing sense of empowerment and after waiting to “come back down to earth” so that a woman can apply clear judgement. It is the healer or facilitator’s responsibility to resist entering into relationships with ceremonial participants within the healing space and context.

There is no common rule of how long afterward parties should wait outside the healing context if they are considering initiating a relationship. Indeed, this topic generates heated arguments in the ayahuasca community. Chacruna’s purpose with the guidelines is to raise awareness about the complexities of “consensual” sex with an ayahuasca healer so that women can be informed and thus empowered by this knowledge to make their own choices. Further discussion is needed across the ayahuasca community and wider psychedelic circles to better establish where the boundaries might lie between consensual and non-consensual sexual relations, a conversation that should be ongoing.

Finally, it is important to emphasize that there are many male healers and ceremonial facilitators working with ayahuasca with great integrity who are outraged by sexual abuse in ayahuasca settings. We hope that, in addition to helping to safeguard women, the guidelines will help to inspire constructive dialogue around sexual misconduct and its elimination. We do not intend to alienate men from this conversation; indeed, they form part of our committee. In fact, we believe it is crucial to our communal efforts toward healing that this conversation extends across gender as well as cultural boundaries.

Emily Sinclair is a social anthropology Ph.D. candidate with Durham University, UK. Her research focuses on the globalization of ayahuasca in the context of the Iquitos region in Peru, where she was based between 2014 and 2018. Before beginning anthropological fieldwork, Emily lived and worked with a local healer and his family with whom she ran an ayahuasca healing center for over two years. She has also worked as a facilitator in other centers in the Iquitos region. Her interests include the contemporary revival of shamanic practice, the use of plant medicines for spiritual exploration and healing, and the study of human potentials and evolution. Emily is a member of the Ayahuasca Community Committee at Chacruna (chacruna.net), and is involved in Chacruna’s initiative on preventing sexual abuse.

Beatriz Caiuby Labate has a Ph.D. in social anthropology from the State University of Campinas (UNICAMP), Brazil. Her main areas of interest are the study of plant medicines, drug policy, shamanism, ritual, and religion. She is Executive Director of the Chacruna Institute for Psychedelic Plant Medicines (chacruna.net), an organization that provides public education about psychedelic plant medicines and promotes a bridge between the ceremonial use of sacred plants and psychedelic science. She is Adjunct Faculty at the East-West Psychology Program at the California Institute of Integral Studies (CIIS) in San Francisco, and Visiting Professor at the Center for Research and Post Graduate Studies in Social Anthropology (CIESAS) in Guadalajara. She is also Public Education and Culture Specialist at the Multidisciplinary Association for Psychedelic Studies (MAPS). She is co-founder of the Interdisciplinary Group for Psychoactive Studies (NEIP) in Brazil, and editor of NEIP’s website (neip.info), as well as editor of the Mexican blog Drugs, Politics, and Culture (drogaspolitica-cultura.net). She is author, co-author, and co-editor of twenty books, one special-edition journal, and several peer-reviewed articles (bialabate.net).

RESOURCES
Council for the Protection of Sacred Plants chacruna.net/council-for-the-protection-of-sacred-plants
Legal resources for victims of sexual abuse, a project of the Council for the Protection of Sacred Plants chacruna.net/community/ayahuasca-community-guide-for-the-awareness-of-sexual-abuse

Peyote Files, an educational project to raise awareness for conservation issues around peyote vimeo.com/301667934
Psychedelic-Assisted Therapy Music Forum chacruna.net/psychedelic-therapy-music-forum
Queering Psychedelics Conference, June 1-2, 2019, San Francisco, CA. chacruna.net/queering-psychedelics
Retreat for health care professionals in Costa Rica soltara.co/healthcare-practitioner-retreat
What can we learn from studying psychedelics in special populations?

CLANCY CAVNAR, PSY.D.

In the contemporary psychedelic sciences, what is the purpose of singling out certain groups for research, treatment, or conferences? Are gay people, women, and people of color so different that psychedelics would have such dissimilar action on them that it would warrant separate research on their effects?

An announcement for the upcoming conference, Queering Psychedelics, planned for June 1–2, 2019, presented by the Chacruna Institute of Psychedelic Plant Medicines, and co-sponsored by the Multidisciplinary Association for Psychedelic Studies (MAPS), focusing on LGBTIQ (lesbian, gay, bisexual, transgender, queer, and intersex people) and psychedelics, was met with posts on social media calling the idea “ridiculous” or asking “why?” The search for inner peace, self-acceptance, and self-love is complicated by societal disregard, religious censure, and patriarchal structures that hinder this quest, with barriers and judgments that are different for each population.

Higher rates of trauma exist for people of color and LG-BTQI (Ellis 2016), and women are more likely than men to experience PTSD, depression, and anxiety (Olff 2017). If we are looking at psychedelics as treatment for mental health symptoms, it makes sense to especially focus on these groups. Beyond this, though, are differences in the nature of the trauma, abuse, or rejection that each group has experienced that necessitate different approaches and emphases.

When I proposed my dissertation research on gay people and ayahuasca, several people, including some prominent researchers in the field, also reacted with confusion. Although a focus on women and psychedelics might incite a less confused response, I propose the dominant culture has trouble conceiving that the psychedelic experience of minority groups might be different and may open other, important doors of perception for stigmatized individuals. It is a credit to MAPS for recognizing this in their trainings and proposed trials of MDMA-assisted psychotherapy for people of color who have suffered racial trauma. The issues for each group may be different, but the end goal might be said to be the healing of the relationship with the world through an unassailable love for the self, achieved by the understanding of one’s true identity.

As psychedelic therapies have become more discussed as a possible treatment approach for various mental health issues, including addictions and depression, their capacity to influence self-esteem has been featured. Self-esteem can also be characterized as self-worth and self-love, and is the most fundamental basis upon which progress in psychotherapy proceeds. Healthy self-esteem includes a beneficent and forgiving inner voice that encourages rather than judges. The more one comes to know oneself, the greater the chance to love all the parts of oneself; the journey of self-discovery is inevitably a journey of self-acceptance. This self-acceptance and self-esteem have the power to overcome all the negative judgments of the world.

Parenting styles and culture strongly influence the way we see ourselves and what type of voice is given space in our heads. Women are taught to modify their self-concept, minimizing themselves to fit in with a patriarchal culture and, for many LG-BTQI people, the voice is shaming, impacting self-esteem in a negative way. Psychedelics can allow us to observe the messages we repeat about ourselves and follow their origins to discern their validity. It is possible to understand psychedelics as a tool to achieving the goal of liberation: women’s liberation, gay liberation, trans liberation, black liberation, and liberation from the illusion that we are unequal in any meaningful way.

Women’s roles are inscribed in popular sacred texts, reminding them to obey and serve in secondary roles. Slowly, women are gaining agency and representation, but their work is consistently undervalued, they can still be sold into marriage as children, and they are trafficked for sex worldwide (Lewis 2019). Women have been relegated to subordinate status and an accomplished woman will rank lower than the lowest man in many cultures. How satisfied and content can someone be acting in subservience while denying their true nature and potential? Everyone is familiar with the loving sacrifice of mothers for their children and families, but is it fair that the burden should fall so disproportionately on the shoulders of women? Unequal pay, limited civil rights, being treated as chattel, and sexual abuse characterize the lives of many women around the world. These factors will all impact self-esteem.
Psychedelics may be used to show women who have been oppressed the full range of their capacities; women can have experiences with psychedelics that reveal a self that is beyond the roles foist upon them, and they may come to see the power that they have as divine beings on earth. This is the spiritual truth that lies at the heart of the mystical experience; an understanding of the limitless and absolute nature of the self. A recent event in November of 2018, the Women and Psychedelics Forum, also presented by the Chacruna Institute for Psychedelic Plant Medicines and co-sponsored by MAPS, took on some of the issues relevant to women both as researchers and consumers of psychedelics. Psychedelic treatments focused on women’s needs and differences will be appropriate for this population and more conferences and discussions related to this topic will be generated, if psychedelic science continues on its current trajectory.

In my own research (Cavnar 2018), I discovered that some gay and lesbian people have used ayahuasca to come to terms with their orientation and accept themselves, even within religious paradigms that criticize and reject orientations. Beyond the social and cultural messages, and for some people I spoke to, beyond ideas of gay or straight and male and female, was the truth of who they really were. Their ideas of themselves had expanded through the use of ayahuasca and they found it hard to accept or understand ideas critical to the expression of that self in all its desired manifestations.

Owning an LGBTQI identity is typified by the act of “coming out of the closet,” telling others of our minority orientation and bracing for the response, which can be one of complete rejection, often with religious implications; a rejection extending from the parents to the family to the deity, all in agreement on the wrongness of the revelation. A strong sense of self-esteem, found in people with healthy egos, is the best defense against the assault from heaven and earth that can be the response to coming out. As culture changes and benefits from the greater numbers of people coming out, rejection is becoming somewhat less likely, but continues to be the dominant response, also codified in religious texts common worldwide. “Reparative” therapy to change sexual orientation has been outlawed in several states and has been found to be more damaging than useful (Hicks 1999), but it continues to be promoted by some therapists and has support among current administration officials (Stack 2016; Nutt 2016). This level of rejection of the sexual self is deeply disturbing to the soul, and is an area especially in need of attention and healing in gay, lesbian, and trans people. Psychedelics may be useful in this regard. Conferences and forums to explore this potential can be expected to be relevant to this population and researchers working with them.

I hope in this short text to have explained to those who are perplexed the purpose and justification for focusing on groups outside white, heterosexual, male paradigms. That so many in the dominant culture find it confounding that other groups have other ways of understanding and benefiting from their psychedelic experiences speaks to the dominance of their viewpoint and the lack of input that has reached them. And this is only to speak of healing psychedelic treatments in the West, let alone the indigenous use of plant medicines and their justifications: The study of those different from ourselves can only increase our appreciation of the diversity of options to draw on when formulating our world view. Psychedelics, used carefully, can for some people provide a path past the external limits that fate has meted out, and their radical truths have represented a threat to the status quo since they were first used in modern times. If we could all see the truth about ourselves, our equality would be apparent, and hierarchies based on external accumulations would be ruined. This is the threat and the promise of psychedelics.

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MDMA-assisted psychotherapy has demonstrated tremendous promise in the treatment of posttraumatic stress disorder (PTSD). Extreme disparities exist in rates of PTSD, with people of color and transgender (“trans”) and gender diverse people experiencing particularly high rates of trauma compared to white and cisgender people. However, the number of trans and gender diverse participants in clinical trials of MDMA-assisted psychotherapy for PTSD remains unknown, primarily because this information has not been collected and/or reported, but anecdotal estimates are very low. If we are to ensure access to the most cutting-edge psychedelic therapies for the communities that need them the most, we must continue to educate ourselves and evolve our therapeutic approaches to address their unique yet pervasive experiences of trauma.

Introduction to trans and gender diverse people

Broadly speaking, trans and gender diverse people are those whose gender identity and/or gender expression do not align in conventional ways with the sex they were assigned at birth. The United States does not collect data on gender identity at a federal level, so population estimates are approximate; researchers estimate that about 0.5–3% of the U.S. population identify as trans or gender diverse (Meerwijk & Sevelius, 2017)—somewhere between one and nine million people. Throughout history, diversity in gender identities, expressions, and roles have been documented in societies around the world. In Western cultures, trans and gender diverse people are often socially marginalized for not conforming to rigid binary expectations of gender identity and expression. Rates of trauma due to stigma and discrimination are high in these communities as a result, and this is compounded even further for trans and gender diverse people of color.

The promise of psychedelic-assisted therapy to address trauma may represent a unique hope for trans and gender diverse individuals. However, trans and gender diverse people are vastly underrepresented in clinical research, and trials of psychedelic-assisted therapy have been no different. Generally speaking, data on gender identity beyond “male/female” is not collected in these studies. Even if a participant does identify
as trans or gender diverse, they may not feel safe disclosing that information if they sense that the therapists are not familiar with gender diverse people, issues that face trans people, and/or that their identity may be an exclusion criterion.

Foundational considerations for working with gender diverse clients

To increase the participation of trans and gender diverse people in clinical trials and to prepare therapists for practice with these communities, it is essential to start with some foundational concepts. When working with trans and gender diverse people, language is critical to rapport building. Many trans and gender diverse people use names and pronouns different from that on their legal and/or medical documentation—often referred to as a person’s “preferred name and pronoun.” When a client introduces themselves, be sure to listen to the language they use, the name and pronouns they use, and mirror this language carefully. If you are unsure, it is better to ask directly than to guess and get it wrong. Language about gender is constantly evolving and varies by age, region, and race/ethnicity, as well as other factors, so we will always be learning from our clients about the language they use to describe themselves.

Even when working with “cisgender” (a term for someone whose gender identity corresponds with their assigned sex at birth) clients, it is important to refrain from imposing a binary lens on clients’ identities and self-expression. As in all aspects of therapeutic work, it is imperative for therapists to do personal work in terms of their own gender identity. It is exceptionally easy for therapists’ unexamined assumptions about gender to reveal themselves in their language without their awareness.

It is also important to examine the impact of the institutional barriers that may be present in your setting. For example, how do you ask about gender in your screening tool? Are binary male/female options the only ones offered? You may not think you are screening enough trans people to warrant updating this tool, but you cannot know unless you ask, and you communicate your values with the types of questions you do and do not ask.

Therapeutic issues unique to gender diverse clients

While there are several presenting issues that may be unique to working with trans and gender diverse clients, the issues that a client is bringing to psychedelic therapy may or may not be related to a person’s gender identity. Trans and gender diverse people experience the same life struggles and traumas as cisgender people, but there are unique themes that trans and gender diverse people may be working with, many of which may be especially amenable to psychedelic therapy.

Many trans and gender diverse people experience bullying, rejection, victimization—often by family members, peers, medical care providers—people who they should be able to rely on for support. They also experience higher rates of childhood sexual abuse than the general population. Studies have shown that experiences of discrimination among transgender people are associated with increased rates of depression, suicide attempts, and PTSD symptoms (Haas, Rodgers, & Herman, 2014; Jefferson, Nietland, & Sevelius, 2014; Reisner et al., 2016).

Trans and gender diverse people often express distrust of medical and mental health professionals for several reasons. Standards of care guidelines for providing healthcare to trans and gender diverse have historically required trans people to obtain psychological evaluation prior to undergoing gender-affirming surgery. Due to this history, many trans people have experienced healthcare professionals, including therapists, as “gatekeepers” or people who can prevent or delay them from accessing necessary treatments.

Further, many trans and gender diverse people report that they must educate their healthcare providers about their healthcare needs, because so few providers are adequately trained to work with them. In addition, some trans people have a history of conversion therapy experiences, or therapy that aims to change a person’s gender identity to conform to a cisgender, heterosexual concept of gender. Conversion therapy has been shown to be unsuccessful and extremely damaging. Trans and gender diverse people of color may be especially wary of medical professionals due to extensive history of medical abuse in communities of color. For these reasons, be aware that trans and gender diverse people may enter clinical settings with higher levels of distrust than other clients.

As in all aspects of therapeutic work, it is imperative for therapists to do personal work in terms of their own gender identity.

A conceptual framework for addressing unique therapeutic issues among trans and gender diverse people: The model of gender affirmation

Research overwhelmingly demonstrates that gender diverse people are more likely to have positive outcomes when their treatment is gender-affirming. Our culture produces overt and covert negative messages about trans and gender diverse

The promise of psychedelic-assisted therapy to address trauma may represent a unique hope for trans and gender diverse individuals.
people almost constantly, even shaming cisgender people for not adequately conforming to strict (and unrealistic) binary notions of gender. It is nearly impossible for trans people not to internalize these messages, resulting in low self-esteem, even suicidality. When our self-concepts are disaffirmed by others, it can result in what social psychologists call “identity threat.” Identity threat can result in negative coping behavior such as substance use, self-isolation, and seeking out affirmation in unhealthy ways. When transgender people face constant identity threat through violence, discrimination, and microaggressions, the trauma of such experiences leads to hypervigilance, distrust of others, and avoidance behavior, including avoidance of physical and mental healthcare.

Psychedelic therapy can reduce identity threat and decrease its negative impact by allowing the client to heal and release internalized transphobia. MDMA is thought to support clients in working through traumatic content by increasing one’s ability to process using the prefrontal cortex, the part of the brain that produces higher level reasoning. Simultaneously, MDMA suppresses activity in the amygdala, the fear center of the brain, which is overly activated in people suffering from PTSD. Psychologically, the Model of Gender Affirmation is a framework for conceptualizing transgender people’s experiences of this healing process and its psychological and behavioral consequences (Sevelius, 2013). According to the theory, we can improve health outcomes for transgender people by increasing access to gender affirmation and/or reducing the need for gender affirmation from others, thereby decreasing identity threat. Psychedelic therapy has the potential to do both.

With psychedelic therapy, we can increase access to gender affirmation in multiple ways. Ideally, the client experiences connection and affirmation from the therapists. The client may experience affirmation of themselves, as MDMA is known to increase one’s self-compassion and unconditional self-love. Psychedelic therapy that results in a mystical or unity experience can result in a sense of “divine blessing”, described as the experience of having God or one’s higher power communicate affirmation of the highest order (Eichenbaum, 2018). Overall, MDMA-assisted therapy can increase one’s sense of trust and connection, and for trans and gender diverse people who describe experiences of feeling like an outsider, these medicines may provide a pathway for reconnecting with oneself and others. In addition to increasing access to gender affirmation, psychedelic therapy may also reduce the need for gender affirmation from others. As a client experiences renewed connection with their body and self-compassion, they often come away with a visceral understanding that true affirmation must first come from within.

Even cisgender people often report openness to a broader conceptualization of gender after psychedelic experiences, and trans people who have spent a lot of energy trying to conform to binary notions of gender may feel relief in the experience of this type of openness. Psychedelic therapy, particularly MDMA-assisted psychotherapy for PTSD, offers deep healing that has the potential translate into true resilience for trans and gender diverse people when supported by trained, culturally humble therapists. 😊

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I am delighted to be a part of the rapidly growing field of psychedelic therapy and research. In this paper I share my personal experiences as a participant in a psychedelic therapy training program, discuss the possible benefit of direct experience with psychedelic medicine, and touch on some of the challenges of being a woman on this path.

**Wedging Open Doors:**
**The MAPS MDMA-Assisted Psychotherapy Protocol and Expanded Access**

With the successful completion of the Phase 2 clinical trials for MDMA-assisted psychotherapy for the treatment of Posttraumatic Stress Disorder (PTSD), the start of the Phase 3, and the highly-anticipated rolling out of the FDA Expanded Access program to provide MDMA outside of the trial, historical restrictions on the clinical uses of psychedelics, along with dynamics of privilege and power that have traditionally favored white male researchers (Tolbert, 2003), are shifting. We are seeing the emergence of greater opportunities for women to be equally included in the field as researchers and to hold leadership roles. Additionally, study participants are increasingly able to work directly with female researchers.

The protocol for the MDMA study is a remarkable example of how this landscape is changing. The condition of male-female co-therapy pairs as a part of the study design was developed by Annie and Michael Mithoefer, and informed by the work of Stanislav and Christina Grof, Leo Zeff, George Greer and Requa Tolbert, Ralph Metzner and others (MAPS, 2017) to promote a sense of safety for some participants and to create the setting for potentially emotionally reparative experiences of parental care. However, this was based on assumptions about gender that do not apply for many people. Therefore, the male-female therapy pair requirement will probably not be enforced going forward in Expanded Access, although the protocol will likely continue to mandate the provision of co-therapy, and ideally expand to include non-heteronormative female-female, male-male, transgender and non-binary therapist pairs (Wagner, Mithoefer, & Monson., 2019 [this edition, page 21]).

**Psychedelic Therapy Training**

As a female psychotherapist deeply interested in the healing and transformational potential of non-ordinary states of consciousness (NOSC), I have for many years closely followed developments in psychedelic research. While waiting for an opportunity to enter the field, I focused on developing my skills in trauma therapy, becoming a Somatic Experiencing practitioner, EMDR therapist, consultant, and facilitator, and Realization Process Teacher, and deepening my knowledge and practice in contemplative traditions.
It was a life changing moment when I got an email from MAPS accepting my application and inviting me to the MAPS MDMA-assisted psychotherapy training. Not only was I able to step into working with NOSC in treatment and engage in furthering the decades of work that have been spent developing the trial, I was also given an opportunity to grow as a therapist and further my personal healing. Moreover, my relationships with members of my training cohort became an integral part of my life. Our bonds deepened and strengthened as we shared in the collective inspiration and purposefulness of doing profound transformative work together.

For those unfamiliar with the components of the MAPS MDMA Therapy Training Program, I will briefly summarize the stages of training. It consists of several mandatory parts: theoretical preparation through an online course, residential retreat covering topics from the MAPS treatment manual and watching videos of sessions, role-play of sessions, and working with a clinical case in close supervision. Didactic training during the retreat is provided to describe and highlight important concepts of the MDMA-assisted psychotherapy, such as acknowledgement of different ways of knowing and healing, focus on safety and wellbeing of the participant, preparation and orientation to the therapy, creating the appropriate set, setting, and support system for the participant, developing therapeutic alliance and trust, and using an inner-directive approach to treatment guided by the inner healing intelligence (our innate capacity to heal), and the importance of ongoing integration (MAPS, 2017). Finally, there is an optional component of experiential learning, where MDMA-assisted psychotherapy is provided to the therapists in training under the MT1 protocol (MAPS, 2016).

**Personal Experience with MT1**

I have been in favor of therapists who work with MDMA (or other psychedelics) having direct experiences with psychedelic therapy, or at least with NOSC. I have personally experienced a variety of non-drug-induced NOSC, including many Holotropic Breathwork sessions. These experiences, in conjunction with more traditional psychotherapy, have been the key component of my own healing of personal and generational trauma and created the foundation of my integral and transpersonal approach to psychotherapy. I have been opened to new ways of knowing, via body wisdom, inner healing intelligence, and non-local consciousness, that have shown me the limitations of talk-therapy, discursive thought and the conventions of language. In MT1 I was finally able to compare the therapeutic value of non-drug- and drug-assisted-therapy sessions on an experiential level.

Therefore, not surprisingly, my participation in MT1 turned out to be a priceless therapeutic opportunity. I gained a new appreciation of the importance of principles I had previ-
ously only known as a study therapist: encouragement of inner focus, emphasis on listening to the inner healing intelligence, allowing for plenty of time and space for the processing and integrating material during and after the session, working with uncomfortable and challenging material, and the guiding role of music. Additionally, I was able to first-hand experience the variety of physical and emotional effects of the medicine itself.

Furthermore, I directly experienced the potential value of the male-female co-therapy team from a participant perspective. Gender, I came to understand, even though only one of several variables (Wagner, Mithoefer, & Monson., 2019), is an important factor in the treatment. For example, depending on the gender of my therapist, I observed a difference in my level of comfort and capacity to ask for and accept support. I cherished the emerging balance that their collective presence provided. Receiving the full, undivided attention of the male and female energies and being witnessed, non-judgmentally supported, and cared for was for me healing in itself.

With regard to my own healing journey, the MT1 session provided me an opportunity to look back on my life and revisit painful experiences that have not been fully resolved, seen, and healed, to continue to engage with them, to watch them transform, and to integrate them in new ways. Since emerging from this experience, I have been able to relate to my past with more empathy and to extend more compassion towards myself and my family. As a result, I believe it made me a better co-therapist and sub-investigator in the study and helped engender a deeper trust for the MDMA-assisted psychotherapy process. I now understand the principles of this type of therapy at an experiential level, and I believe I can relate to my past with more empathy and an unbiased way to my participants’ experiences.

**Contemporary Challenges for Women in the Field of Psychedelic Research**

As a female, I have been particularly attuned to the social, cultural, and political factors that have deterred women and other marginalized groups from entering the field of psychedelic research. I believe that due to privilege—a built-in advantage distinct from level of effort—white men have been spared from the damaging consequences of racial profiling, stereotyping, and other trends of marginalization and have enjoyed being perceived by and large as the leading authorities in the field. In my own experience, when speaking about psychedelic work alongside male colleagues, people will regularly pay more attention to my male counterpart, regardless of what is being shared and by whom. I would like to see more men being aware of these dynamics and proactively assuming the roles of allies for women and other marginalized groups in the field.

Furthermore, I think that the looming threat of legal repercussions involved in working with Schedule I substances and the consequences of the War on Drugs has also deterred many women from entering the field or becoming visible and has greatly limited diversification of the field. As an example, just within the past year, I have invited two female colleagues providing ketamine psychotherapy to present with me at a conference and write an article on the topic, and both declined due to being mothers and fearing the possible detrimental consequences that presenting publicly could have on their children.

On the other hand, I have been pleasantly surprised by, and deeply appreciative of, the great support of many men as well as women in the field. I have regularly observed my colleagues helping and encouraging each other, exhibiting principles of inclusion, sharing resources, providing each other with opportunities to write and talk at events, and creating space to discuss and process experiences. I am grateful for the ongoing support of Annie and Michael Mithoefer, Rick Doblin, Marcela Ot’Alora, Rita Kocarova, Gregory Wells, Phil Wolfson, Harvey Schwartz, Eric Sienknecht, Kevin Parker, Raquel Bennett, Bia Labate, Sylvë Quevedo, Jessica Katzman, Debbie McDivitt, Genese Herzberg, Julie Megler, Karen Peoples, Cristie Strongman and others. Inclusion of diverse perspectives, mutual support, and sharing are essential and imperative principles of this new emerging stage of the field of psychedelic research and psychotherapy.

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**Veronika Gold, MFT,** is a psychotherapist with an expertise in the treatment of trauma. She is a co-therapist and sub-investigator at San Francisco Insight and Integration Center, a site for MAPS sponsored Phase 3 Clinical Trial for MDMA-assisted psychotherapy for the treatment of PTSD. Veronika is a co-founder of Polaris Insight Center, where she provides Ketamine Assisted Psychotherapy. Previously she served as a consultant for a Ketamine Assisted Psychotherapy Program and Ketamine Infusion Center in San Francisco. She is a Czech Republic native and holds an M.A. in Clinical Psychology from the Charles University; inspired by her passion about the work of Dr. Stanislav Grof she moved to San Francisco, California in 2003 to pursue her M.A. in Integral Counseling Psychology at California Institute of Integral Studies.
My client Joel came for an integration session after three weeks alone in a cabin in total silence. He reported that it had been challenging. He had felt fidgety at times, and peaceful and still at other times. By the end of the retreat, he had connected with a gentle sense of equanimity, toward himself and the external world. He had revisited many relationships in his life, which revealed insights. He came to see me to receive support for the integration phase following his retreat. It was important to him to somehow express the emotions he had felt, the many insights he had received, and his renewed feeling of serenity.

As we explored the ways he could express himself, he came up with the idea of writing a song, recording it, and sending it out to the people who had “visited” him during his retreat. He was a guitar player but singing was new to him. This felt like a sweet way to honor his connection with them, as well as a creative endeavor. He came back the following week with his guitar and sang his song to me; it was a delightful distillation of his heartfelt feelings. He sent his song out and surprised his family members and friends who got to see a part of Joel they had not seen before.

Expanded state experiences such as Joel’s have the power to initiate growth in our life and expose us to new possibilities. While a journey can shift internal patterns and belief systems, this does not necessarily mean one’s external reality is transformed. More lasting effects appear during and by virtue of the integration process.

In indigenous cultures, because ritual is woven in with day-to-day life, there is less of a need for intentional integration practices. The community often engages in ritual as a group, and each person is likely to receive support from friends and family. The person facilitating the ritual, the local curandera or shaman, often lives in the village and can keep an eye on those who were present. In our modern industrialized world, while rituals and ceremonies are gaining popularity in many communities and cultures, many journeys return to their family, work, or school, after an extraordinary experience and find there is minimal appreciation or understanding from others. This leaves many journeys with few people to connect with and a potential sense of isolation. Thus, the integration process is something we must intentionally create in order to honor these experiences in the best way.

An extraordinary experience, whether through a ritual with a psychedelic sacrament, a ceremony, a vision quest, or a retreat, can stand alone as a treasured event.
There is something inherently valuable in surrendering to spirit, being one with the cosmos, and understanding the patterns of the universe. But the real question is: what does it contribute to our daily life? How does it make us more whole, balanced, and awake? What is the use of seeing God if you cannot be kind to your partner? What is the point of realizing that all beings are connected if you are unable to look a homeless person in the eye?

My background as a somatic counselor has taught me the importance of expressing the invisible dimensions in tangible ways. I believe that the gifts of our consciousness exploration can add value to our daily life and should be expressed through real life actions.

Integration is the process of bringing separate elements together into a whole. For our purposes, it is the art of weaving the extraordinary into the ordinary—interpreting a journey’s mythical and symbolic layers, revealing its gifts and treasures, and anchoring them into our lives. If we do not commit to tending the living, evolving process that is our life, no one will. When we commit to the process of integration, we honor the transformation that has occurred.

The phase of integration may last a few days, a few months, or a lifetime, depending on the content of the journey and the magnitude of what has been revealed. Memories, glimpses, or moments can visit us years down the road and finally give us the aha moment of why a certain vision or insight appeared and how it fits into the overall scheme of our lives. But because we are more psychologically adaptable for the days and weeks following a journey into an expanded state, this is the best time to introduce practical changes and anchor new insights into our lives.

What happens without integration? Most of the time, what may have seemed clear during the journey slowly fades like a dream, as old habits and tendencies return. Occasionally, the absence of integration can result in disorientation, as expanded states of consciousness can expose previously unknown and possibly painful layers of the psyche. People have come to my office in severe states of disorientation after having powerful expanded state experiences they were not able to process. Their intention to access the transpersonal realm brought them face-to-face with complex parts of themselves. Without the necessary support and integration skills to make sense of these inner states, they were frightened, had nightmares, or found themselves becoming anxious or depressed and unable to function in their everyday lives. What could have been a significant inner transformation instead resulted in a destabilized state.

It is an insult to the potency of this inner work to not take the time to integrate what has been revealed. Without proper follow-through, the journey becomes another fleeting experience and loses its power. It is a tragedy to squander such potential for healing and growth. As the experience fades from the journeyer’s immediate memory, it is the commitment to integration that will keep the teachings and insights continuing to inform all aspects of their life.

**Creation and Application of Integration Practices**

Taking the intention and the narrative of the journey into consideration, the guide and journeyer can create integration practices that will sustain the development of the themes that have emerged. Although one or a few obvious themes will be revealed in a journeyer’s experience, it is most important to remember that a holistic integration requires involvement of all aspects of one’s life. By overemphasizing one aspect of life in an integration process, the risk is of unintentionally creating an imbalance the journeyer’s life. A new passionate commitment...
can create new imbalance. A guide should keep an eye on the whole gestalt of the journeyer during the integration process, spreading the healing intention into all the facets of their life.

As with this entire approach, the phase of creating integrative practices should engage the qualities of wisdom, creativity, and love as the guide helps the journeyer discern their most potent course of action. This discernment calls forth wisdom. The practices should be designed creatively. But the most fundamental quality to draw upon during the phase of integration is love. By love, I mean a posture of compassion and tenderness. Sometimes the most compassionate way to support someone is to tell the truth in a direct manner. Regardless, love and support should remain at the core of a guide’s motivation.

Integration suggestions should be doable and feel good. They should not feel like a burden, or induce intense stress, although they will likely feel new at first. If meditating every day is not something a journeyer is realistically capable of doing or has resistance to, then maybe meditation could be done every other day or once a week. A guide should be realistic so that the journeyer can honor whatever practice is decided upon. Start small. Practices can be increased after a week or two if they are easily incorporated into daily life. A walk in the park once a week, drinking a cup of herbal tea in the afternoon, or writing in a journal every few days are easy to implement. If the journeyer is able to stabilize their new practices and feel enriched by them, they can take them further.

After a post-journey integration meeting with me, one of my clients flew to Florida to confront her abusive father. During her experience, she had physically felt the body of her father on her small child’s body. She had felt physically suffocated and enraged. She had been estranged from him for seven years. He was now dying, and she felt that time was of the essence. She reported back to me that once she arrived in Florida, she found him weak and bedridden. She stood at the foot of his bed and asked him what he had to say. When he said nothing, she stood there, staring at him in silence. She could feel the strength flowing through her veins, the strength she had repressed as a child. She was free of the secret, the “not telling” he had insisted on when she was small and frightened. Facing him now she felt free from his intimidation. She asked him again if he had anything to say to her. He lowered his eyes and shamefully answered, “No.” She walked away. She told me that she finally felt complete.

They can be joyful—painting, singing, or simply spending time with our loved ones.

A guide doesn’t need to argue if there is resistance. If there is resistance to suggested changes, then explore the resistance. Work with the journeyer’s fear of what will happen if I change? The theme of resistance is real. We have all studied something and then dropped it. We thought it was fabulous and then we found ourselves not doing it anymore. We want to establish an engaged dialogue with the journeyer so that they do not feel isolated or discouraged. They might find they dislike the practice or need to be more creative and do something that supports them in a different way. Stay with the aspects touched during the experience and create integration practices appropriate to the specific content of the journey.

Our culture teaches us to be consumers of all things, including experiences. However, a journeyer’s active involvement in the integration process creates a different kind of relationship to the experience. There is an arc of transformation, which includes all of the journeyer’s preparation, the actual journey, and finally the integration process, which invites the journeyer to engage with their own healing process. As a client of mine said about this work of personal exploration, “There is nobody out there; we are it. It is me with me, facing me, talking to me, healing me.”

We are creatures of habit, and our habits are often stronger than our insights. If we do not actively commit to ways of dismantling our unhealthy habitual ways of being, our old physical tensions, behaviors, and tendencies will likely reassert themselves. Integration includes supporting and reinforcing new healthy brain pathways and neural networks through committed intentions and practical actions. Furthermore, by embodying and grounding these sometimes abstract or obscure experiences into everyday reality, we deepen our experience of the sacred in the everyday, and we bring a different vibration to the world. Not only will the integration work affect the journeyer, but it will ripple out to touch their family, friends, and community.

In the end, the commitment to sustain integration practices is not only to ourselves, but to all those we love as well.

Françoise Bourzat holds a M.A. in Somatic Psychology from New College of California (San Francisco, 1990). She is a certified Hakomi Therapist (1991). She is an adjunct faculty in the East West Psychology Program at CIIS. Since 1987, Françoise has apprenticed with shamans and healers in the U.S. and Mexico. In the last 20 years, she has traveled with groups to Mexico, incorporating her counseling practice experience with her knowledge of expanded states of consciousness where she partners with Mazatec healers in Sacred Mushrooms ceremonies. She also leads workshops in the U.S, France, Lebanon, and Israel.
Dedicated to ET & FB, who saved my life with ketamine treatment.

Ketamine is a unique and beautiful medicine. It is used all over the world as a surgical and procedural anesthetic. Ketamine was first synthesized in a laboratory in the mid-1960s, and has been FDA-approved in the United States for anesthesia and analgesia since the early 1970s. Recently, an enantiomer of ketamine called esketamine was approved by the FDA for the treatment of refractory depression, which is a game-changer in psychiatry and psychotherapy. Interestingly, ketamine is a highly psychedelic medicine, but not in the classical sense. It is a dissociative medicine that quiets sensory input and can launch people into an expansive, transpersonal space.

For many years, ketamine was overlooked as a therapeutic agent because of the bias in Western medicine against psychedelic or psychospiritual experiences. However, in recent years, there has been a resurgence of interest in the therapeutic properties of ketamine as a tool for the treatment of severe and refractory (treatment-resistant) depression, and other psychiatric disorders such as bipolar depression, ruminative suicidal ideation, obsessive-compulsive disorder (OCD), and pain with depression. Clinicians and researchers are also currently investigating ketamine as a possible treatment for post-traumatic stress disorder (PTSD), substance use disorders, anxiety associated with death, anorexia, and chronic relational problems (personality disorders). One of the most interesting questions in the field at this time is whether it is useful and legally defensible to use ketamine as an adjunct for psychotherapy, i.e., for the purpose of spiritual exploration, in the absence of a psychiatric disorder that causes profound functional impairment?

Ketamine is a tiny, chiral molecule that easily passes through the blood-brain barrier. It primarily is a glutamate modulator that acts on the NMDA receptors in the glutamate pathway. There are many different ways to get ketamine into the human body, and each route has a different amount of bioavailability (the amount of medicine that effectively reaches the brain). The neuroscience of ketamine is beyond the scope of this article, and will be covered in a separate publication.

Ketamine is a delicate and flexible tool. There are many different ways of working therapeutically with ketamine. Clinicians and researchers disagree about the optimal way to work with it. One well-known way of working with ketamine is to administer 0.5 mg/kg of ketamine with normal saline solution via intravenous infusion (IV) based on the weight of the patient. The actual infusion typically takes 40 minutes, and the entire appointment takes about two hours. Patients frequently need a series of six infusions clustered together over the course of two or three weeks to induce a robust antidepressant effect using this dosing strategy. This approach to ketamine treatment has been endorsed by the National Institute of Mental Health (NIMH) and the American Psychiatric Association (APA).

The new nasal spray containing esketamine will be used in a similar way. It is interesting to note that these protocols were specifically designed not to induce psychedelic experiences in any single treatment session. In this paradigm, the psychedelic properties of ketamine are generally considered to be a problematic (“psychotomimetic”) side effect that needs to be avoided or medicated. This approach to ketamine treatment is fundamentally a Western medical or a surgical model, where the antidepressant or therapeutic effects of ketamine are attributed to its biochemical properties, and the benefits are explained in terms of molecules, receptors, neurotransmitters, and the like. While there is no doubt that ketamine does something helpful on a chemical level, this may not be the whole story. The problem with this paradigm of treatment is that it puts the patient in a passive position; the patient is not called upon to participate in their own treatment (except to show up for the appointment), and all of the “magic” is attributed to the chemical action of the medication.

A different way of working with ketamine is to use it as a lubricant in the psychotherapy process. The basic idea here is to offer the ketamine session(s) in the context of an ongoing psychotherapy relationship, in order to help the patient talk about material that is too painful or shameful to discuss otherwise. In
this approach to ketamine treatment, the medicine is typically administered via a lozenge (transbuccal and/or sublingual absorption) or intramuscular injection (IM) in the 0.3–0.8 mg/kg range, and the session takes 1.5–3 hours, depending on the dose. (Note that you have to know the bioavailability of each route of administration to do the calculation correctly). Often, what we see clinically is the “consolidation” of psychological material. This is not the time to go searching for new memories. Instead, patients convey that their understanding or resolution of a difficult issue moves from being intellectualized into an embodied way of knowing. This way of working with ketamine fits into a psychological and relational paradigm, where the beneficial effects of ketamine treatment are attributed to the metabolism of psychological material, and the emphasis is on the psychotherapy process. Note that this kind of work can only truly be done by a trained psychotherapist embedded within the context of regular talk therapy sessions (which is conceptually similar to the MDMA-assisted psychotherapy protocol for treating PTSD); any other kind of provider in any other context is offering pseudo-therapy.

Another way of working with therapeutic ketamine is to use it to purposefully induce mystical and psychedelic experiences. Patients must be carefully selected and prepared for this kind of experience, as it can get very weird or be frightening in the absence of adequate preparation. To induce a psychedelic ketamine journey, 1.0–2.0 mg/kg of ketamine is administered by intramuscular injection (IM) by a medical professional in a safe and supervised environment. This typically causes the patient to temporarily enter into a state of conscious sedation or a special level of altered consciousness that precedes full anesthesia, and may include temporary partial paralysis. Patients report having vivid dream-like visions during the active medicine phase, which can begin a few minutes post-injection, and which may last approximately 75 minutes on average (depending on the dose), followed by several more hours of sedated recovery. Patients often have the experience of being “dissolved” as they enter into the dissociative and transpersonal space, and it is not uncommon for patients to report that they were in communication with a “divine energy” or “being” during their disembodied travels. When clinicians choose to work in this way, they are working in a psychedelic and shamanic paradigm, in which the mystical visions are valued. (Note that in the previous two paradigms, the mystical visions are avoided.) The role of the clinician is to ensure the physical and psychological safety of the traveler, and then later, to help the patient construct meaning from their visions and identify the action(s) that the patient can take to move toward wellness.

So which of these treatment paradigms works the best? In other words, what is the “right” way to use ketamine therapeutically? The answer is that all of the paradigms are useful. In my 17 years of experience to date, it is clear that different things work well for different people: Some patients are excellent candidates for a series of low-dose ketamine infusions or nasal spray; some patients are tied up in emotional knots on the inside and truly benefit from ketamine-facilitated psychotherapy; and a tiny fraction of clinical patients are actually good candidates for a full psychedelic ketamine journey. Learning how to distinguish which patients are likely to benefit from each strategy is beyond the scope of this article and the subject of much active debate in the clinical ketamine community. My goal is to educate patients about the variety of therapeutic ketamine services that are available, and to educate providers about how to work with various routes of administration and different dosing strategies for ketamine. Also, in reality, the different ways of thinking about ketamine treatment actually overlap and blend together. For example, when we offer a psychedelic ketamine journey to a patient, we are attentive to the therapeutic relationship, we are interested in the content of the visions, and of course the ketamine is affecting the brain on a chemical level, all at the same time.

Because of its importance in medical and surgical settings, ketamine is uniquely positioned as a highly hallucinogenic agent which is legal to prescribe and administer. Ketamine offers us the valuable opportunity to study psychedelic, transpersonal, and dissociative experiences without all of the bureaucratic red tape associated with studying other Sacred medicines. I think we are currently under-utilizing ketamine as a research tool for expanded mental states, mood modulation, and the possible connection between them. However, the easy access to ketamine creates another clinical dilemma, namely that ketamine in the transpersonal dose range is a terrible place to begin psychedelic exploration, because the dissociative experience can be so strange. What does adequate preparation look like? Also, is it psychologically safe for patients to do this kind of exploration on their own? These questions are actively being discussed within the clinical ketamine community.

Ultimately, the availability of therapeutic ketamine invites us to return to several essential questions. Is there any value in having psychedelic experience (in a contained medical environment)? I think that there is. Some people report that their psychedelic ketamine journeys were some of the most meaningful and educational experiences of their entire lives, while psychedelic ketamine experience would be extremely inappropriate for other people. Are the visions an annoying side effect, or are they a beneficial (or essential) component of the treatment? Finally, what are the implications for the broader field of medicine if we embrace the psychedelic component of ketamine treatment, instead of turning away from it?

Raquel Bennett, Psy.D. is a psychologist and ketamine specialist from Berkeley, CA. She has been studying the therapeutic properties of ketamine since 2002. Dr. Bennett is the founder of KRIYA Institute (kriyainstitute.com) and the organizer of KRIYA Conference, which is an annual and international event devoted to the use of ketamine in psychiatry and psychotherapy. Dr. Bennett has a long-standing interest in the relationship between mood modulation and psychedelic experience.
Health Equity In Psychedelic Medicine: Advancing Practices for People of Color
SARA REED, M.S.

“Coming home, coming home; Nevermore to roam; Open wide Thine arms of love; Lord, I’m coming home.”
—Pastor Henry's Church Choir

“I feel like I’m dying but it’s okay,” I say with a smile on my face. As I lie on the couch with two therapists by my side, I feel safe, grounded, and ready to explore deeper truths of my inner world. With my eye shades on, I follow the rhythm of the music and begin my ascend to a peculiar liminal space. Soon enough the drug sneaks past my ego defenses, past my reflexive tendency towards control and protection, and catapults me to a place of dissolution. Defenses down, I am raw and open, experiencing the world in its Divine essence, and for the first time in my life I felt free. Me—a young, black woman, free. No longer bound by the constraints of my political realities, I set sail on a journey that allowed me to reconnect and rest in a place saturated by grace, mercy, and love; I call that place home.

As a therapist in training for the Phase 3 MDMA-assisted psychotherapy clinical trials, I had the opportunity to take MDMA in a one-time clinical trial as part of the Multidisciplinary Association for Psychedelic Studies (MAPS) therapist training program (maps.org/training). This week-long study allowed me to experience the therapy treatment from the perspective of the participant, gaining somatic insight on the subjective effects of the drug and how to maximize the potential therapeutic benefits of those effects within psychotherapy. I was thrilled to complete this part of the therapy training program and became curious about the ways sociocultural variables—like race, gender, and other social markers—would show up in treatment. I researched the literature to learn whatever I could about the drug and its origin story. I asked psychonauts to share their experience, fascinated by their mysterious, untethered storytelling. However, no amount of research prepared me for the stories this black, femme body carried from my past and ancestral lineage.

“Color is not a human or a personal reality; it is a political reality.”
—James Baldwin, The Fire Next Time

I grew up in the countryside of Kentucky, where most days are like the day before and you can usually find someone who knows how to make a mean chess pie. As a Kentucky native, I was forced to learn how to navigate a world outside of my own, an unusual political world filled with hierarchy, bigotry, and hate. Although the terminology was unfamiliar to me at the time, I recognized the difference between my personal and political realities at an early age. My social networks revealed subtle differences in my behavior in interracial and intraracial relationships. There were unspoken rules and social cues I had to be sensitive to for survival. I remember questioning the reasons to justify the difference in those behaviors, but was left with the explanation “because you’re black.”

Because you’re black.

Those racial wounds from my past resurfaced during my MDMA-assisted psychotherapy experience and I had to learn how to sit with these stories in an unfiltered way. So, there I was, with my two therapists, the drug, and my wounds, trying to make sense of a new reality; a culture my body knew in a language my mind did not. As a black woman, I have had to learn the language of this White American world, the mannerisms, and the performance. I’ve straightened the coils from my hair and denied parts of myself just to feel like I belonged. Those defenses that became a necessary part of my social development and helped me survive in the only world I knew no
longer worked. With my mind attempting to translate these embodied-stories, I felt lost, confused, and despondent, not having the skill set to process such complexities. My personal reality told me that I was beyond my race, gender, and traumas from the past, but my political reality demonstrated something different. These moments were difficult for me and my therapists to process. Strict adherence to the protocol, and limited cultural sensitivity, hindered my ability to process my personal and political realities. This experience ultimately led me to think more critically about how to advance health equity for people of color in this clinical research.

The motion to divorce race and culture from scientific and clinical inquiry is one that “is not practicable, possible or even desirable” when “race and ethnic classification are embedded in the routine collection and analysis of data” (Duster, 2003, p. 263).

It is essential for clinicians to be culturally competent while working with people of color, considering the ways race organizes our perceptions about the world and the social realities in which we exist (Duster, 2003). Inadequate training on the subject could harm participants and widen that gap for health disparities among people of color (POC). Cultural incompetence has significant ramifications not only for participants but for the efficacy and integrity of clinical research. In psychedelic-assisted research trials, participants are required to be in very vulnerable states as they attempt to process some of the most difficult memories of their past. If clinicians are not sensitive to the landscape of a participant’s cultural experience, they can easily misinterpret, dismiss, or ignore critical information that is necessary for a participant’s therapeutic process.

So how do we create health equity in psychedelic medicine? MAPS is taking action to answer this question. As a study coordinator and co-therapist for the open-label clinical trials at the University of Connecticut Health Center, I had the unique opportunity to work with closely with Monnica Williams, Ph.D., and MAPS staff to provide feedback and advocate for culturally informed practices within this research. MAPS now includes screening questions that assess for trauma from any discriminatory incident. They also trained independent raters to be more culturally competent in assessments and are co-sponsoring a training for therapists of color and clinicians who work in marginalized communities in August 2019. Although MAPS is taking steps to provide more inclusive treatments for people of color, more work is needed to make treatments like MDMA-assisted psychotherapy more accessible and sensitive to the needs of this marginalized group. Our site at UConn fought to provide culturally informed treatment for participants of color during this research trial but had to shut down before moving on to the Phase 3 clinical trial due to a variety of barriers.

We, as a research team, are continuing the mission of advancing health equity for people of color in psychedelic research through joining MAPS’ Expanded Access program, contingent FDA approval of the program, and will continue to provide solutions that address health disparities for people of color. Some of these solutions that foster health equity include:

- Recruiting a diverse group of researchers and scientists during the development of treatment protocols. If not, we run the risk of harming vulnerable groups, unintentionally
- Acknowledging the stigma that plagues communities of color for seeking treatment for mental health ailments and applying practical solutions to help overcome that stigma
- Developing recruitment and outreach strategies that validate the historical harm on POC in research (ex. Tuskegee Syphilis Experiment, an unethical study that harmed black men) and psychotherapy (ex. Drapetomania, a pseudo mental illness that pathologized slaves for running away)
- Educating communities about psychedelic therapy, harm reduction, and how these treatments intersect
- Presenting research on how drugs disproportionately affect communities of color and how we address that issue in psychedelic medicine
- Creating community-based solutions for addressing intersectional issues that affect POC, and put people in those communities in positions of power to develop interventions that are relevant and sensitive to their needs

As I close, clinical research and culture are not mutually exclusive; they actually inform each other (Goodman, Heath, & Lindee, 2003). In order for psychedelic medicine to advance health equity for all groups, we must think intersectionally about how to address systemic issues and not perpetuate them in practice. People of color are not represented equitably as therapists or participants in the current MDMA-assisted psychotherapy research trials, and luckily there are a group of people trying to change that. Going through my MDMA-assisted psychotherapy experience showed me many things about the world we live in and my position in it. It showed me the damage from colonialism and the residue from my past traumas. It also, however, gave me a glimpse of what lies beyond the political realities of this life. And that, my friend, is freedom.

REFERENCES


Sara Reed is a Marriage and Family Therapist at Behavioral Wellness Clinic in Tolland, CT. She is also a Study Therapist on the Psilocybin-Assisted Therapy research study for Major Depression at Yale University. As a socially-minded therapist, Sara works to advance health equity and upward social mobility for Black Americans.
In her decades of experience as a clinical psychologist, Magaly Mauer, Ph.D., has drawn from a wide variety of therapeutic orientations and techniques, from clinical hypnosis and EMDR (Eye Movement Desensitization and Reprocessing), to cognitive-behavioral methodologies and humanistic psychology. Her core belief as a therapist is that everyone has an innate ability to heal themselves. Over the past few years of learning about psychedelic medicine, she has come to champion the unique ability of psychedelics to catalyze this self-healing capacity. A former research faculty at the University of Miami School of Medicine who has been in private practice since 1994, Mauer became a Multidisciplinary Association for Psychedelic Studies (MAPS) supporter in 2014.

Dr. Mauer, tell us a little about your personal and professional background.

I was born in Colombia and came to the United States when I was 21. I’ve been here ever since, living almost the entire time in Miami. When I was 40, I was doing human resources for a medical company and realized that the only aspect of my job that I enjoyed was the counseling. So I went back to school and got my Ph.D. in psychology. I’m now 70.

What elements of psychology have most influenced you?

From the beginning, I was interested in what the client is able to find within themselves. I was lucky to learn a lot about Carl Rogers, a psychologist who came away from traditional psychoanalysis into a whole other way of listening to people. He believed that we all have a drive toward health, and that the job of the therapist is to remove the obstacles so that drive can reengage. The healing is not done by the therapist—the healing is always done by the person. The therapist is a facilitator of that force of self-healing that we all have.

What has your experience been as a psychologist of color?

Miami is a haven for people of color, especially Latin American people. It’s not like the rest of America. I never feel that I’m in a minority. However, when I’m traveling in other parts of the country—teaching somewhere or attending a conference—then I can tell that there’s a difference in how a brown person is seen. People have acted surprised that I have a Ph.D., for example. I think if you’re going to be a brown anything, be it in Miami! Even in the Florida chapter of the American Psychological Association, there’s a very big group of Hispanic therapists and psychiatrists. We’re not marginalized here.

Are there mental health needs specific to the Latin American community?

I can only speak about what I see here in South Florida. When you look at mental health needs in this area, you have to look at socioeconomic status. In Miami, any needs of someone who is Latin with high socioeconomic status are met. When you’re talking about someone who doesn’t have economic power, there is a lack, plus there might be a language barrier that makes it more difficult to get help. The other thing I see related to mental health needs is that Latina females with anxiety go to the doctor, and they are given Xanax or another benzo, and they can stay on it for years. This is at all levels—working class, middle class, upper class. It’s like a way of shutting them up instead of helping them feel negative emotions and work through all the difficulties that led them to be anxious in the first place. Psychiatrists put women on these drugs for years, when they’re supposed to be used for no more than three weeks.
How did you become interested in psychedelics?

Several years ago, I was exposed to ayahuasca. I had a series of experiences with maestros from the Shipibo tribe in the jungle of Peru. I was there for 12 days or so. Each experience was powerful in itself, and at the end when I came back, I could see how different I was in my ability to see that there is a bigger picture than my everyday life, and really having a sense that we’re in this together. We’re not so separate, we’re not so isolated. I think the emphasis on individuality is how Western civilization lies to us. When you have an experience with ayahuasca or mushrooms or any other psychedelic, what you experience is unity, and that we’re one not just with each other but with the plants, the animals, the stars, and the moon. It’s an experience that changes your perspective. That was the start of my exploration.

How did you become involved with MAPS?

Somebody told me about MAPS, and that they were doing dinners around the country to raise funds for psychedelic research, so I offered to host a dinner. There I met Rick Doblin and really, really liked him. When I learned more about his story and all the work he’s done, I thought: I want to help. I want to participate in this. Because as a psychologist, I’m amazed at the transformational power of psychedelics. You have a couple of sessions and you’re able to see what has happened to you from a different perspective, and something changes. The obstacles that prevent the inner drive toward health are removed, so the drive can re-engage. How? I don’t think we know the mechanism of action, how MDMA does what it does, or mushrooms or ayahuasca or even cannabis. But something happens when these substances are used with the intention of healing. We don’t know exactly how, but that understanding will come.

Do you foresee receptivity to psychedelic medicine in the Latin American community?

Well, the public has to be educated. In most Latin American communities that I’m familiar with, there’s a belief that psychedelics are party drugs. I think education to the public, not just professionals, about the benefits of psychedelic medicine has to happen now for people to feel comfortable when they become legally available.

How do you hope to see MAPS make its work more accessible to and inclusive of the Latin American community?

I think MAPS should train more therapists of color. Communities with a high concentration of Latin Americans need to have therapists who understand their culture and speak their language. So there should be a concentrated effort to train people who can do that.

What’s your vision for the future of psychedelic medicine?

I’m waiting with bated breath for 2021! With the proper education of professionals and the public, people will surge for legal MDMA-assisted psychotherapy. If we have enough therapists and psychiatrists who are well trained, then we can really change the way we treat PTSD, of course, but also other anxiety disorders that are so disabbling. People walk around with so much anxiety, and their quality of life really suffers. I think that psychedelic medicine is going to help not just with big trauma, for which it’s very much needed, but with everyday anxiety also. I have high hopes!

At the first national cannabis industry conference in 2012, I was invited to present on a marketing panel where I addressed the role of women in cannabis. We had just won Colorado’s Amendment 64 to regulate marijuana like alcohol, a campaign that relied heavily on converting women from opponents to supporters of cannabis policy reform. Leading a dedicated and brave group of activists, we brought our message of justice and safety to PTAs, places of worship, suburban living rooms, and boardrooms alike. In the years that followed, we have pressed for women, trans folk, people of color, and other marginalized or targeted communities to hold space in the cannabis and drug policy ecosystems. Regardless of that work, I recognize that what follows is an analysis of gender norms based in a false binary, written with the privilege of a white cisgendered woman which is by its nature reductive. I warmly invite feedback from community members who feel resourced to provide it, and I hope to initiate a more rigorous dialogue that incorporates a broader view.

“Women and cannabis” has been a hot topic, a conundrum, a focus of special interest in the cannabis industry since there was a licit cannabis industry. Born out of the efforts of Brownie Mary and her cohort, legal medical cannabis has always been, to some degree, the domain of women just as caretaking and nursing so often are. Since those early days, though, women and people who identify as women have always been relegated to gender-specific roles in cannabis culture and community: caretaker, baker, bikini-clad bong holder, exploited migrant trimmer. For decades, nearly every major drug policy reform organization was led by cis-gendered men and the trend was replicated in the cannabis industry, where few large companies had any women or people who identify as women in the C-suite, much less serving as President or CEO.

Men and boys, generally, are socialized as risk-takers. They are encouraged to test the boundaries and expected to carve out a legacy while holding limited responsibility for their actions—boys will be boys, after all. Women and girls, of course, are encouraged to hold boundaries, both expected to create an environment from which exploring and adventurous men can find the support to achieve greatness and, especially as young women, protect their own virtue and keep boys safe from themselves—they must be good girls, and if they aren’t they are shamed and stigmatized.

As young people, this creates an environment in which boys are more free to experiment with psychoactive substances and girls are less so. The 2017 National Survey on Drug Use and Health shows that 53.7% of American men and 45.7% of American women have ever used illicit drugs, with past-month and past-year use rates demonstrating larger gaps in regular or continued use. This is a trend that carries across all illicit substances, and is clearly attributable to socialized norms which require girls to be chaste and controlled but permit boys to experiment much more freely. (Unfortunately, these data sets do not address use rates among people who do not identify as male or female, though we know that young people who identify as LGBTQI+ are more likely to engage in problematic drug use due to social isolation.)

In adulthood, these trends are manifest in cis-gendered male-female partnerships across socio-economic demographics, with women still carrying the primary burden of caregiver for offspring and maintenance of the household despite growing equalization of expectations in the workplace, and as a result have less free time. Additionally, the dangers of losing our children, losing our freedom, losing hard-won opportunity, losing control, or losing bodily autonomy lend us to be more protective and risk-averse in professional and personal activities. The inevitable result has been that men have been the dominant
force in the early development of the cannabis consumer community, cannabis advocacy community, and cannabis industry.

Early efforts to carve out a place for women and people who identify as women in the cannabis industry were remarkably promising, with 36% of businesses reporting employing us in the C-suite in 2013 and vibrant conversation at every industry conference regarding the role of women in the industry. However, the social norms combined with the norms of broader business—where there are more men named John in America’s C-suite than there are women—have combined to replicate the dominant status of men in business.

These same trends are evident in the world of psychedelics, where women are a majority in the roles of therapist, sitter, caretaker—but the organizations and companies leading the vanguard are represented by high-profile men, with notable exceptions such as the MAPS Benefit Corporation. Pre-existing gender norms which contribute to such trends are remarkably similar to those in cannabis and are equally worthy of deconstruction.

Women outnumber men in the psychology workforce by two to one and make up 75% of the educational pipeline, yet The American Psychological Association reports that gender gaps in research and high-status positions are pervasive. Men make higher salaries, are more likely to be in tenured or tenure-track positions, lead more research, and have less debt when they leave college.

The previously cited 2017 National Survey on Drug Use and Health shows that fewer than 12% of women have ever used hallucinogens, whereas nearly 20% of men have. Early research on the use of psychedelics to treat trauma has focused primarily on combat veterans, a vast majority of whom are men. Without careful attention paid to make psychedelic therapy safe and inviting for women and people who are genderqueer or transgender, norms which make it safer for cisgendered men to participate in such healing will only intensify.

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Betty Aldworth is the Executive Director of Students for Sensible Drug Policy and since 2014 has led the organization through its most substantial growth: the member base and campuses on which SSDP is present have doubled; staff and offices supporting those members have tripled; global presence has quadrupled; and as a result the policy change present have doubled; staff and offices supporting those members have tripled; global presence has quadrupled; and as a result the policy change enacted. Jason Ortiz, Rachelle Yeung, Scott Cecil, Ismail Ali, Jake Plowden, Monique Chavez, Kevin W Cranford Jr. and Nelson Guerrero helped shape the Minority Cannabis Business Association. Amanda Reiman and I, alongside countless other alumni, have contributed to gender equity efforts in cannabis. Our continuing work is generating relevant practices which should ultimately inform equity and inclusion work for influencers in psychedelics.

In that ecosystem, SSDPers are already shaping the dialogue around inclusion and diversity. As the next generation of therapists, researchers, and advocates is developed within our ranks, we can expect them to understand that the pervasive and destructive harms of the War of Drugs will only be ameliorated through reparative activities which are driven by and centered around the needs of the most marginalized. They will drive policies from government and practices in business which generate real investment in the health and well being of communities and individuals targeted by the drug war, ensuring that people who use highly stigmatized drugs are not left behind. They will ensure that in the future, questions about the sometimes helpful, sometimes harmful, and always inevitable presence of drugs in our communities will be answered with policies rooted in safety, education, and true justice.

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Usona Institute: The Path Toward Psilocybin and Depression Clinical Trials

PENNY PATTERSON

As winter snow blankets Usona Institute’s headquarters here in Madison, Wisconsin, it has been a pleasure to pause and reflect upon our work and growth over the past few years. Throughout the hum of activity involved in establishing our programs, we have seen a steady rise in the interest in our work. We would like to extend our sincere appreciation to our friends at MAPS, who have supported our efforts in so many ways, for the opportunity to share a bit of our story with you in this issue of the MAPS Bulletin.

Usona Institute is poised to launch its first clinical trials researching the potential of psilocybin as a treatment for major depressive disorder. With clearance from the U.S. Food and Drug Administration (FDA) to proceed, approval from a central Institutional Review Board (IRB), investigational drug in the final stages of preparation, and thousands of people expressing interest in being a part of this research, Usona anticipates the first clinical sites for these trials to be fully operational by fall 2019. The objective of Usona’s psilocybin research program, if the clinical trials are positive, is to receive a new drug approval from the FDA.

As a nonprofit Medical Research Organization (MRO) founded in 2014 by scientist/entrepreneur Bill Linton and physician Malynn Utzinger, Usona’s mission is to conduct and support pre-clinical and clinical research to further the understanding of the therapeutic effects of psilocybin and other consciousness-expanding medicines. The inspiration to establish the Institute was sparked by the promising findings of prior academic research on psilocybin’s effect on anxiety and depression in people with life-threatening cancer.

It is due to the dedicated teams at institutions like Johns Hopkins University, New York University, the University of California-Los Angeles, and others who have advanced contemporary psilocybin research that this next phase of clinical trials and engagement with the FDA is made possible.

UNDERSTANDING MAJOR DEPRESSIVE DISORDER

As Usona began to focus on the development of its clinical development program, major depressive disorder (MDD) emerged as the most compelling indication to study in its first Phase 2 psilocybin trial.

The World Health Organization lists MDD as the leading cause of disability worldwide, with more than 300 million people struggling with this complex disease. The intensity of emotional and psychological suffering can be immense and can lead those suffering to attempt or commit suicide, of which 800,000 people are victims each year.

Usona’s Director of Clinical and Translational Research, Dr. Charles Raison, notes that there have been few significant breakthroughs in the field of depression for over a decade while the need for more effective and fast-acting antidepressant treatments continues to grow. Dr. Raison’s expertise is in examining emerging pathways through which major depression evolves and novel mechanisms through which it might be treated. He is leading the development of Usona’s study design and protocols in collaboration with other researchers in the field. “The academic findings in this area give us something that we haven’t had for some time—they give us hope that entirely new ways to treat depression are on the horizon” says Raison. “We are eager to learn from the larger studies. No matter the outcomes, they will advance our understanding.”

THE USONA TEAM

Embracing the challenge of embarking on clinical trials as a non-profit, the Usona team has been developing the robust capabilities and infrastructure required to carry out an FDA-regulated, multi-site clinical program.

Since 2014, Usona’s team has grown to 18 employees plus consultants with expertise in clinical research, mental health, pharmacology, medicinal chemistry, regulatory affairs, and others. The organization’s internal capabilities are bolstered by additional support coming from the dedicated groups at our Contract Research Organizations (CRO).

In recognition of the theme of this Bulletin issue, “Women in Psychedelics,” we’d like to note that Usona is fortunate to have many women on its team, serving all areas of expertise—from the founding of the Institution, to leading roles in clinical operations, quality and compliance, drug development, chemis-
try laboratory management, scientific collaboration, communications, and organizational operations. As of late March 2019, of our 18 employees, 13 (72%) are women.

**Clinical Operations:** Usona’s clinical operations include developing the study protocol, a clinical facilitator (“guide”) manual, and training protocol; creating and maintaining the Investigator’s Brochure for psilocybin; coordinating with CROs for the onboarding and management of clinical research sites; developing quality control systems; and carrying out related nonclinical studies.

**Chemistry Manufacturing and Controls:** Our initial current Good Manufacturing Practice (cGMP) production of psilocybin was completed in late 2018. With Usona’s commitment to “Open Science” and advancing scientific knowledge, psilocybin is being offered to qualified researchers at no cost.

**Regulatory Compliance:** Usona’s study of psilocybin for MDD received central IRB approval and has been cleared to proceed by the FDA under Usona’s active Investigational New Drug Application (IND). These approvals represent a major milestone in the research program, enabling Usona to move ahead toward the start of trials later this year at five to seven research sites across the United States.

**Medicinal Chemistry:** Usona has two chemistry laboratories—one based in Madison, WI and one in San Luis Obispo, CA—each staffed with dedicated Usona medicinal chemists. Both labs have full synthetic and analytical capabilities as well as DEA licenses. While the primary focus is currently on clinical trials for the psilocybin and MDD study, on a separate track there are initiatives to explore the therapeutic potential of new and underexamined molecules.

**COLLABORATIONS**

In both clinical trials and medicinal chemistry work, Usona has been fortunate to partner with experts within the fields of psychiatry, pharmacology, biology, and neuroscience. Knowledge-sharing and collaboration have been cornerstones of the development of the many dynamic branches of Usona’s work. The team is grateful to the researchers at the Johns Hopkins School of Medicine, New York University School of Medicine, Yale School of Medicine, the University of California San Francisco School of Medicine, the University of Wisconsin-Madison School of Pharmacology, the University of Zurich Center for Psychiatric Research, the Multidisciplinary Association for Psychedelic Studies, the Heffter Research Institute, the D’Or Institute for Research and Education, the Hans Knöll Institute, Imperial College London, and many others for their collaborations and mutual dedication to expanding the field of psychedelic science.

**NON-PROFIT WORK AND OPEN SCIENCE COMMITMENT**

As a non-profit MRO, Usona is committed to serving the public good. The Institute’s Open Science model means that it aims to share its discoveries and work within the public domain so that medical and scientific advancements can be made as quickly as possible.

Part of Usona’s commitment as a non-profit includes grants and scholarships to projects, academic work, and events that advance knowledge about the potential therapeutic effects of consciousness-expanding medicines.

Of timely note, Usona continues its support to the annual International Forum on Consciousness held in Madison, Wisconsin. This May, thought leaders such as Robin Carhart-Harris and Jack Henningfield among others will lead two days of presentations and discussion on “Psychedelic Therapy in Society: Exploring the Mechanisms of Action and Delivery of Care.”

**CLINICAL TRIALS INFORMATION**

Although Usona is not yet actively recruiting for the MDD and psilocybin trials, those interested in learning more are encouraged to visit the Usona clinical trials website, usonaclinicaltrials.org. On the site, those interested in volunteering for this trial may elect to receive updates on study-specific information and recruitment activities. A clinical trial pre-screening tool will be released in the coming months as an initial step in assessing an individual’s eligibility to participate in our upcoming study.

**OUR GRATITUDE**

Usona is supported by the generosity of individuals, families, and organizations who are motivated by the story and the possibilities of this research. There is a high degree of complexity around the needs in regulation, drug development, training, and organizational growth to conduct this phase of sponsored clinical trials. We could not do this work without the intention, trust, and enduring commitment of supporters who share in our dedication to making a positive impact on society and human well-being.

Usona is part of a mosaic of individuals and organizations that have devoted themselves to finding ways to promote healing and meaningful change. Each has an important role to play in this collective vision to reduce suffering. We honor those people who have paved the way for this work and who have committed themselves to creating a more peaceful and resilient world. We thank you for your interest and look forward to sharing more with you as our path unfolds.

A special thanks to the Usona team for contributing their expertise and review to this article.

**Penny Patterson** has been the Director of Communications for Usona since its inception, providing consulting and management of the organization’s communications, media, and public relations policies and engagements. Penny brings her depth of experience in broadcast journalism, public relations, and marketing communications to the Usona team.
Founded in 1986, the Multidisciplinary Association for Psychedelic Studies (MAPS) is a 501(c)(3) non-profit research and educational organization that develops medical, legal, and cultural contexts for people to benefit from the careful uses of psychedelics and marijuana.

MAPS furthers its mission by:

- Developing psychedelics and marijuana into prescription medicines.
- Training therapists and establishing a network of treatment centers.
- Supporting scientific research into spirituality, creativity, and neuroscience.
- Educating the public honestly about the risks and benefits of psychedelics and marijuana.

MAPS envisions a world where psychedelics and marijuana are safely and legally available for beneficial uses, and where research is governed by rigorous scientific evaluation of their risks and benefits.

MAPS relies on the generosity of individual donors to achieve our mission. Now that research into the beneficial potential of psychedelics is again being conducted under federal guidelines, the challenge has become one of funding. No funding is currently available for this research from pharmaceutical companies or major foundations. That means that the future of psychedelic and marijuana research is in the hands of individual donors. Please consider making a donation today. maps.org/donate
MAPS Public Benefit Corporation (MAPS PBC) catalyzes healing and well-being through psychedelic drug development, therapist training programs, and sales of prescription psychedelics prioritizing public benefit above profit. Founded in 2014, MAPS PBC is a wholly-owned subsidiary of the Multidisciplinary Association for Psychedelic Studies (MAPS) a 501(c)(3) nonprofit.
YES, I would like to join MAPS and support this important research.

Please accept my tax-deductible gift (USD):

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Featuring books, DVDs, art prints, clothing and accessories, historical artifacts, and back issues of the MAPS Bulletin. All proceeds support psychedelic and medical marijuana research and education.

Zendo Project Eco-Fleece Hoodie $90
Support the Zendo Project while staying warm and cozy with these Eco-Fleece hoodies! Each hoodie is sustainably-produced with recycled and organic materials and low-impact dyes. Screen printed in Santa Cruz, California.

MAPS T-Shirts $30
Show your support for psychedelic science with MAPS t-shirts! Our fitted ladies’ scoop-neck shirt is a very soft blend of 50% polyester, 25% combed ringspun cotton, 25% rayon, by Next Level Apparel. Navy shirts are 100% organic cotton, made in the USA, by Royal Apparel. Our t-shirts are screen printed by hand in Santa Cruz by The Print Gallery.

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