September 2020 Volume: 2 Issue: 3
ISSN: 2690-0912

The Journal of *Psychedelic Psychiatry*

- The PSIP Model
- A Case Report of an Individual's Experience Participating in a Traditional Costa Rican Ayahuasca Ceremony
- Medicalization, Decriminalization, Legalization and the Path Forward for Psychedelics

THE JOURNAL OF PSYCHEDELIC PSYCHIATRY

Editorial Board

THE JOURNAL OF
PSYCHEDELIC
PSYCHIATRY

New Perceptions Podcast

Expand Your Knowledge by listening to the official podcast of The Journal of Psychedelic Psychiatry. Join us as we discuss the latest trends within the Psychedelics community with Clinicians, Advocates, and Policy Makers. We also explore the latest research in our author interviews and through our roundtable editors' discussions.

Subscribe

Spotify: Apple Podcast Google Play Overcast

Stitcher RadioPublic Breaker Anchor

Follow Us

Twitter Facebook Instagram

THE JOURNAL OF
PSYCHEDELIC
PSYCHIATRY

Articles:

- The PSIP Model
- A Case Report of an Individual's Experience Participating in a Traditional Costa Rican Ayahuasca Ceremony
- Medicalization, Decriminalization, Legalization and the Path Forward for Psychedelics

The PSIP Model

An Introduction to a Novel Method of Therapy: Psychedelic Somatic Interactional Psychotherapy

Saj Razvi, LPC, Steven Elfrink, Research Associate

INTRODUCTION

A New Model for Psychedelic Therapy

Research into psychedelic therapy was thriving from the 1950's until the late 1960's when cultural and political factors brought the field of study to an abrupt halt. With this rebirth of clinical research, there are new capacities in science that are yielding a better understanding of these remarkable therapeutic substances. However, one area that has remained constant from the '50s until now is the non-directive, non-interactional psychotherapy model that is used in clinical trials, and subsequently, in treatment. Here is an excerpt from an abstract that summarizes this approach:

> "The drug session itself is given in a room with soft ambient lighting and a comforting soundtrack (which may contribute to the therapeutic value as well). There are generally two therapists present in the room (ideally one male and one female) who are there to provide reassurance, medical cover, and care. They only talk with the patient if the patient wants them to, which they generally do not. It is important to note that there is no expectation of conversation during the "trip" and no direction by either therapist of the patient's speech or thought. It is the next day in the "integration" session that the content of the trip is discussed and interpreted and psychotherapeutic benefits derived [1]."

The assumption underpinning this approach is that the psychedelic substance provides a powerful experience that is later turned into therapeutic benefit during the integration phase. The therapists' main purpose is to create a safe, trusting, and supportive environment to allow the client to let go and enter into the psychedelic experience. The following day, participants gain insight into themselves and make meaning of the experience. What we know is that psychedelic therapy utilizing this approach does, in fact, reliably yield positive results. What we don't know is whether this is already the optimal approach or if and to what degree we can improve upon it. Are there certain populations or conditions that require a different modality? We also don't know how much this approach adds to or possibly even takes away from the beneficial outcomes. The non-directive, non-interactional model has been the default in psychedelic treatment because we speculate, interventions from traditional therapeutic modalities such as cognitive-behavioral therapy (CBT) or narrative-based talk therapies do not pair well with and can even interrupt the non-rational, non-linear, frequently non-verbal, and certainly non-ordinary states of consciousness generated by psychedelic substances. In the spirit of scientific progress, this paper explores the

possibility of developing a more therapeutically engaged modality that actively embraces the unique features of psychedelic consciousness, allowing more therapeutic processing during the actual therapy session. This White Paper will focus on the research and clinical foundations for a particular theoretical model, Psychedelic Somatic Interactional Psychotherapy (PSIP), that we feel provides deeper penetration into the core of anxiety, depression, dissociation, PTSD, and complex relational trauma. As renowned neuroscientist and psychedelic researcher, Robin Carhart-Harris, notes, "A future challenge will be to learn how psychological interventions can maximize the advantages of the psychedelic state."

Our goal is to provide an alternative option to the classic non-directive, non-interactive mode of psychedelic therapy. In this summary article, we will describe what is taking place neurologically during a psychedelic state as it relates to mental health treatment. We will also describe various PSIP interventions designed to target and support the inherent, self-correcting healing processes that arise within the altered state of psychedelic consciousness. Lastly, we will discuss a tiered approach, ranging from psychobiological to the transpersonal, that can serve as a possible road map addressing specific ailments of the Western psyche.

Modes of Human Consciousness

Human cognition can be divided into two distinct types that are each underpinned by two different ways the brain is able to operate. Primary consciousness is an evolutionarily early type of cognition. It does not conceive of time or think abstractly. It is based on body sensation, emotion, imagery, nondeclarative memory (i.e., non-verbal and non-conscious memory), and it is a more unconstrained, animalistic form of cognition. It is a fundamentally visceral, embodied type of awareness. There is a self here, but it is not conscious, rational, or verbal. It is what is known as an implicit self, meaning it is hidden and operates underneath your conscious awareness. It operates under your explicit conscious sense of identity. Think of your dog, or cat, or toddler: there is a self, a personality, there that operates and perceives the world very differently than your adult conscious mind does. There are a number of researchers (Porges, Panksepp, Damasio, Levine, Carhart-Harris, and Schore) whose work has independently led them to the conclusion that we have an unconscious, yet situationally and relationally sensitive self, with its own implicit cognition, implicit emotions, implicit communication, implicit homeostatic healing mechanisms, and implicit perceptions of the world [2].

The brain networks that make up primary consciousness and the implicit self are also evolutionarily old, and we share them with other animals such as fish, amphibians, reptiles, and mammals. Roughly speaking, the areas of the brain that make up this network are the brain stem (the earliest part of the brain), the limbic system (emotional centers), the emotional motor system, and the autonomic nervous system, to name just a few. The important thing to know is that even though your mind doesn't operate in this mode most of the time, it's still very much there under the surface. The processes and type of memory stored in primary consciousness are foundationally crucial to making you who you are. A great deal of your psychological functioning and core programming about yourself, your relationships, and the world is stored here.

Despite the designation of the verbal left hemisphere as "dominant" due to its capacities for explicitly processing language functions, it is the right hemisphere and its implicit homeostatic-survival and communication functions that is truly dominant in human existence.[2] *(Schore, 2003)*

In contrast, secondary consciousness is a mind operating in an ordinary, everyday, adult manner. It is capable of self-reflection, abstract meaning-making, cognitive thought, and goal orientation. It is verbal, rational, linear. It perceives time and generates a conscious, explicit sense of self that you identify as being you.

The brain regions that generate this type of consciousness consist of higher-order cortical networks (i.e., the more recently developed parts of the brain). In particular, the default mode network (DMN) is the central and hierarchically dominant system that organizes and synchronizes different parts of the brain to produce this secondary consciousness. The DMN is the conductor of an orchestra, and the music that orchestra makes is your ordinary, everyday consciousness. One of the ways the DMN achieves this organizing of experience is by suppressing the higher energy, more flexible, less stable, or, as Carhart-Harris notes, "higher entropy" order of primary consciousness, along with the activity of the brain networks that produce primary consciousness.

> *It is argued that this entropy suppression furnishes normal waking consciousness with a constrained quality and associated metacognitive functions, including reality-testing and self-awareness. Moreover, this leads to the proposal that the brain of modern adult humans differs from that of its closest evolutionary and developmental antecedents because of an extended capacity for entropy suppression.*[3] *(Carhart-Harris, 2014)*

The suppression of the more chaotic order of primary consciousness is what makes humans human. The purpose of secondary consciousness, and the unique evolutionary brain development that allows it, is to understand, predict, and manipulate the world around us. It is a survival mechanism that seeks to detail reality meticulously. Modern civilization, medicine, literature, engineering, physics, and landing on the moon are all thanks to the evolution of the DMN and movement into secondary consciousness from primary consciousness. The DMN and its subordinate cortical networks filter out information that is not filtered out of primary consciousness. The DMN deems this information as unnecessary noise in order to generate a stable, understandable, predictable, manipulatable reality.

Interruptive Mechanisms

Secondary consciousness is remarkable. More so than speed, armor, venom, camouflage, flight, or other evolutionary advantages, our ability to comprehend and manipulate nature has proven a very successful strategy. However, there is a heavy price to pay. *Secondary consciousness' suppression of primary consciousness means we lose access to the self-correcting, auto-regulatory mechanisms that are an inherent part of mammalian biology.* There are biological components involved in primary consciousness that can process anxiety, depression, PTSD, emotions, and traumatic memory far more effectively than the verbal, abstract cognitive processes of secondary consciousness. Consider that mammals in the wild frequently experience survival level threatening experiences that would qualify as traumatic. It is well documented that these animals, if they survive, involuntarily engage mechanisms that biologically process traumatic charge. Among others, these mechanisms are features of primary consciousness that get suppressed duringin secondary consciousness, and it is these mechanisms that PSIP targets during a psychedelic state.

In addition to suppressing the homeostatic functions just mentioned, we also lose connection with the emotional, sensory, and implicit self of primary consciousness—the sense of novelty, mystery, and awe that is not filtered out by the DMN. Research has found that an over-functioning DMN correlates

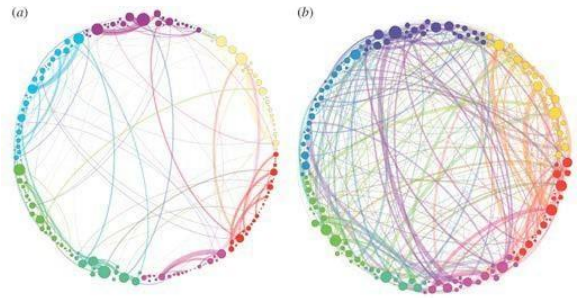
with a rigid, less permeable ego structure and a depressive personality [4]. We know that DMN activity is not detectable in infancy and so children having very little or no suppressive functioning are able to experience the world through primary consciousness as fresh, new, timeless with magical thinking [5]. *They are sensory beings learning about their environment by interacting with it viscerally. They are not outside of or removed from their environment through abstract cognitive processes. They are not chess players looking down upon the game, analyzing the game. They are fundamentally in the game, in flow.* Contrast that with an adult whose DMN has become overexpressed: this person is likely to experience the world as known, rutted, lacking in mystery. They are likely to experience themselves as separate from the world and their own experience, removed from it as an observer.

This, of course, leads us to speculate if having an overactive DMN is a random fact of maturation or if environmental factors such as traumatic life events can cause individuals to need more control, more boundaries, and seek more predictability in their environment, thereby creating a feed-forward loop that encourages the development of a more suppressive DMN as a defensive, safety mechanism.

The Effect of Psychedelic Substances on DMN & Consciousness

Carhart-Harris has noted that psychedelic substances desynchronize and disrupt the default mode network's smooth functioning, and the suppressive organization it exercises over consciousness. In fact, the serotonin 2A receptor upon which classic psychedelic substances such as psilocybin, mescaline, DMT, and LSD act is located primarily in the cortex. This receptor is most densely expressed in higher-level nodes of the DMN and is hardly found in subcortical regions such as the brainstem and motor (movement) cortex. *The effect of psychedelic substances is on the networks that generate secondary consciousness, not on subcortical networks that generate primary consciousness or on biological functioning.* We know that non-classic psychedelic substances such as cannabis and MDMA, while having different pathways of action, still have a disruptive influence on the DMN.

Imagine a spectrum where, on one side is a mind with a highly organized and filtered cognition, and on the other side is a mind with more unconstrained, unfiltered, more unstable cognition. Both sides taken to an extreme have their own pathology (psychosis is the extreme of an unconstrained mind, and ego rigidity, epileptic seizure, and depression are the extreme of an overly organized mind). Psychedelics temporarily disrupt the DMN and shift a highly organized mind towards disorganization (this is why it is not recommended for people with a history of psychosis to engage in this work). As the DMN disintegrates, we see an unconstrained form of cognition arise. We see a mind that has more communication or more activity between brain regions. When the DMN's management and filtration of reality has been disrupted, we see the rise of what is, in large part, a less curated, less managed, less filtered primary consciousness.



Simplified Illustration of Global Brain Connectivity while receiving Placebo (A) and Psilocybin (B) [6].

> *It is also proposed that entry into primary states depends on a collapse of the normally highly organized activity within the default-mode network (DMN) and a decoupling between the DMN and the medial temporal lobes (which are normally significantly coupled).*
>
> *These studies provide some useful clues about the mechanisms by which psychedelics alter brain function to alter consciousness. Although none of the analyses formally measured entropy, they spoke to a general principle that psychedelics alter consciousness by disorganizing brain activity.[3] (Carhart-Harris, 2014)*

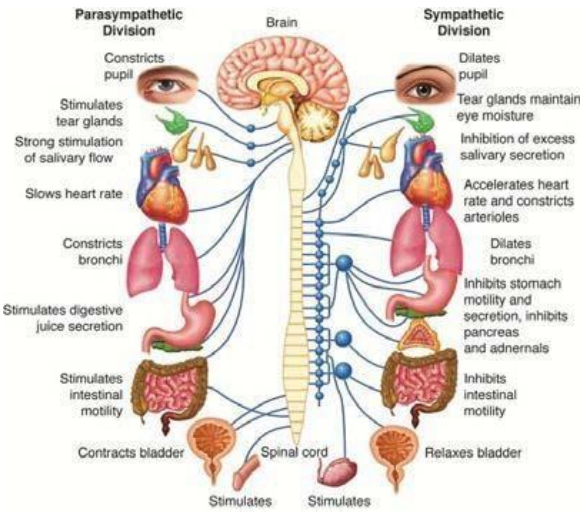
While there are significant questions about how psychedelic consciousness is generated, the prevailing therapeutic understanding is that psychedelic substances do not create anything new in a system. They provide deep access to what has been underneath the entire time: the implicit self and all the experiences that have gone into creating it. This is why we relate to psychedelics as a catalyst evoking a person's own internal world and engaging their own natural biological, psychological, and spiritual processes.

THE BODY

At the core of the PSIP model is the psychobiological intelligence of the autonomic nervous system. It is this ancient mammalian structure that activates during primary psychedelic consciousness and is a self-correcting foundation of transformation.

Defense Cascade and the Autonomic Foundations of Mental Health

The interactions between psychedelic substances, the DMN, and primary and secondary consciousness are an important foundational understanding. Now let's shift our attention to the psychotherapy modality that interfaces with these elements. If the purpose is to address mental health conditions, a psychotherapeutic process that embraces the non-rational, non-linear, non-verbal, implicit, embodied functioning of primary consciousness will be necessary. The dominant forms of psychotherapy, cognitive-behavioral therapy (CBT) or traditional talk therapy, were not designed to embrace such altered features of psychedelic consciousness. These modalities are primarily intended to manage symptoms through cognitive restructuring, reality testing, introspection, insight, or a verbal retelling of difficult or traumatic experiences. These interventions were designed to work within and strengthen secondary consciousness. They are seeking to ground the client in that stable reality to decrease symptoms. The DMN is deeply connected to the cortex's verbal processing areas and allows us to exert voluntary control over elements of primary consciousness [7]. *These processes of traditional psychotherapy run counter to the neurological direction psychedelic substances are taking the brain. Even as helpful as these traditional modalities can be under normal circumstances, the psychotherapy of ordinary, waking consciousness is not the psychotherapy of altered psychedelic consciousness.* We believe these substances require their own non-ordinary state psychotherapy (NOSP).



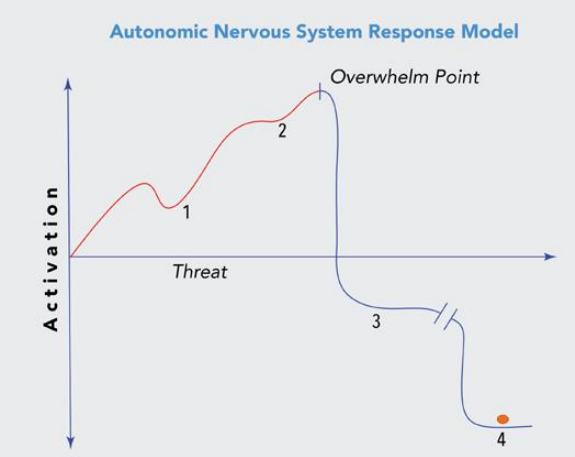
Psychedelic Somatic Interactional Psychotherapy is an autonomic nervous system based, body modality that speaks the language of primary consciousness, which is sensation, emotion, imagery, autonomic nervous reactivity (anxiety, panic, depression, dissociation), and operates within the vast world of implicit non-verbal memory. Of the various directions a psychedelic

substance can take an individual, the PSIP modality is designed to:

1. Keep the focus on the personal (versus mystical or transcendent) and relational aspects of a client's psychological functioning,
2. Activate psychobiological autonomic nervous system based, self-correcting mechanisms to process anxiety, stress, depression, dissociation, PTSD, and complex relational trauma, and
3. Establish a body-based processing pathway that is preferentially engaged by psychedelic medicines due to it being more robust than the cognitive processing channels of secondary consciousness.

While there are several different healing agents that we gain access to in primary consciousness, we focus on a particular system, the *defense cascade*, that generates many of the mental health symptoms that cause people to enter into psychotherapy. The defense cascade is a well-known phenomenon that scientists leading back to Darwin have documented by observing animal behavior. What we present here is our articulation of the defense cascade, enhanced to include other research on the mammalian autonomic nervous system (ANS) [8]. There is a series of escalating, involuntary defensive reactions an animal's nervous system engages when it is under real or perceived threat. As threat increases so does the organism's nervous system reaction to it. Given that we share the same basic mammalian ANS setup with other mammals (a system that evolved over millions of years in a state of nature with frequent threats), the defense cascade applies to humans as well.

The first ANS state is a condition of neutrality (State-0) that exists in the absence of threat. So, imagine you are a zebra on the African plains. You are with your herd eating grass. It's a nice sunny day. The physical, emotional, and mental conditions that accompany this state are warmth, ease, neutrality, and wakefulness. Now let's say there is some rustling in the tall grass. When you are in a state of nature, rustling grass can be the wind or a predator. We have an initial freeze, deer-in-the-headlights, response until we realize it's only the wind, and we go back to State-0. After some time, there is more rustling in the grass to which we have the same reaction, but now, we see a lion stalking us from a distance.



So, the threat has gone up, and the entire herd moves into a state of hypervigilant mild stress or State-1. This is a condition where danger is present, but not imminent. To put this in a human context, imagine walking down a dark ally in a city at night. There is no imminent danger, but you are on edge nevertheless: you're a little afraid, you feel some anxiety, your gut and breathing become tight, and you are very aware of any sounds and movement around you. Notice how you did not voluntarily choose any of these reactions; your ANS involuntarily activates these responses as they are appropriate to your situation. It is the same with the zebras.

Their movement into State-1 is involuntary. The symptoms of State-1 are:

Now, let's increase the threat level again and see what happens. Let's say that the lion has picked out the perfect zebra to hunt. When she finally positions herself and takes off, the zebras also take off. Everyone in the situation, the lion and the zebras, are now operating in high stress (State-2), defined as maximum fight or flight arousal or maximum activation of the sympathetic nervous system. This is a full survival level threat - the zebras run or fight or die. This is the realm of explosive energy, adrenaline, a sprint for life, a panic attack level of fear, or rage generated by the nervous system to help escape the threat.

In the human context, war zone experiences generate such levels of threat, but so do car accidents and events or family patterns in infancy where neglect or abuse is experienced. This is due to the very low capacity children have for defending themselves. The dynamic that we are pointing to here is that the level of threat an organism experiences is dependent on that organism's abilities (i.e., speed, strength, intelligence) to resolve that threat successfully. Schauer refers to these abilities as an organism's "battlesomeness" [9]. What is threatening to an adult is going to be very different than what is threatening to a child. Parental support and protection are a child's primary defense, and if it is lacking, otherwise mild threats can generate State-2 or stronger reactions in children. The physical and psychological reactions in this state include:

This nervous system state is relatively short-lived. It involves a high energy burst, a sprint versus a marathon. The lion will have gotten her prey, or she will not have, but either way-the chase is over relatively quickly. That is why we draw it as a flat line versus States 0, 1, 3, and 4, which we draw as troughs because they are stable nervous system states that we have the capacity to exist in for years.

If we add yet more threat to the system, we see a movement to the next stable state of moderate trauma (State-3) as denoted by depression. This is not the same type of depression we noted earlier that is related to an overactive DMN. This is threat induced depression, which based on large scale epidemiological research, may be a far more dominant causal factor in depression than previously imagined. The addition or continuation of a threat past State-2 means that an organism's maximum active efforts at escape or defense have failed. When active defenses fail, the nervous system recognizes this fact and engages passive defensive responses. Once the point of overwhelm is reached, the nervous system and brain release natural kappa opioids that generate a shutdown, collapsed, dissociative, depressive reaction [10]. "Non-opioid analgesia accompanies the 'active' defense responses (flight or fight), and opioid analgesia accompanies the 'passive' defense responses (freezing, tonic immobility, collapsed immobility, and quiescent immobility)" (Kozlowska K, Walker P, McLean L, Carrive P. Fear and the Defense Cascade). The result is the very

common condition of PTSD: a state characterized by both hyper and hypo-arousal, anxiety, and depression, feeling reactive and collapsed or hopeless at the same time. This is when the lion takes down the zebra, and this same animal that was full of fight, terror, and explosive reactivity moments ago is stunned, immobile, or numbed.

> *...A vast literature on combat trauma, crimes, rape, kidnapping, natural disasters, accidents, and imprisonment has shown that the trauma response is bimodal: hypermnesia, hyper-reactivity to stimuli, and traumatic re-experiencing coexist with psychic numbing, avoidance, amnesia, and anhedonia. These responses to extreme experiences are so consistent across the different forms of traumatic stimuli that this bimodal reaction appears to be the normative response to any overwhelming and uncontrollable experience.*[11] *(van der Kolk, 1994)*

Even though we are using a survival animal example to illustrate the defense cascade, State-3 responses are common for us. Excluding impulses to seek parental or group protection, dissociative collapse, or numbing is the very next defensive response for children. If threats come from a person's family of origin, overwhelm and subsequent depressive numbing are common. Even adults, after significant loss or shock, will exhibit dissociative symptoms. State-3 symptoms include:

State-3 Symptoms

- depression
- lethargy
- sleepiness
- feeling cold
- slowed speech
- suicidal thoughts
- psychological fragmentation of memory and experience
- dissociation (moderate)
- collapse
- sensations of weight
- slowed movement
- hopelessness
- visual distortion

There is a very good adaptive survival reason State-3 exists in the mammalian ANS. Carnivores frequently need to be stimulated by resistance to have a kill response, so the involuntary immobility of State-3 is still defensive in that 'playing dead' may just possibly lead to escape [7].

Furthermore, State-3 is defined by circumstances being dire, but there may yet be a possible solution, a lucky break. Let's say the lion, after tackling the zebra, is distracted by a threat to her cubs, or another predator wants to steal her catch. If a window of escape opens during this period of distraction, the zebra's ANS still has access to the explosive energy of State-2, which can quickly turn on. Placing this ANS state in a human context, consider the situation of a child who is being neglected or abused at home, but on some weekends, she gets to go to her grandma's house. Grandma's house is safe, it's comforting; it's a solution to what's happening at home. Unfortunately, she could not live with grandma or get to her house frequently enough to avoid the trauma. This situation will produce State-3 symptoms because a solution exists in the world of this child; it just was not achievable.

Finally, suppose we add yet more threat to the system. In that case, an organism's ANS will move to the final position of severe trauma (State-4) defined by a more thorough flattening of sensations, emotions, and reactivity. This is where the lion begins biting into the zebra or six other lions show up for the meal. There is no possible solution or lucky break that will rescue the zebra, so the ANS releases more internally generated opioids for a more profound dissociation. A complete lack of solution defines State-4, and the ANS reacts with a larger opioid dump leading to more profound numbing. It's a world in which there is no grandma's house; there is not solution to the threat. The symptoms of State-4 are:

State-4 Symptoms

- blank affect
- numbness
- larger endogenous
- opioid release body feels disintegrated
- body parts feel absent
- feeling disconnected
- vision changes feelings
- of unreality
- out of body experiences
- visual distortion floaty
- 3rd person perspective of events
- respite

We frequently see the client's cognitive abilities undisturbed in State-4, as this feature appears to be unencumbered by emotional or physical numbing. As you imagine this state, think about sitting with someone who under the influence of an opioid drug or pain medication. They might be talking to you, but they are not going to be feeling much or able to relate through the numbing reaction. It is common for clinicians to mistake ANS 4 for ANS 0 because, behaviorally, they are both identical in terms of appearing calm. However, the internal experience between these states could not be more different. State-0 is an associated calm where clients are able to describe their present moment experience even if it's neutral (a body in a neutral state still has sensation and feedback). State-4 is a dissociative calm where clients have an abstracted; one step removed idea of themselves or what they might be feeling. They will say, "I'm fine," but that is an abstracted thought versus an embodied reporting. State-4 is enacting the ultimate solution of non-existence, which is why suicidal thoughts and impulses are not a symptom of this state. The ANS at State-4 has already achieved non-existence, so there is no need to look for an end to the misery of State-3. The depressive numbing of State-3 is composed of difficult emotions and sensations that are still in the realm of feeling, whereas State-4 is outside of the feeling world.

While most animals in the wild do not survive State-4 threats, we frequently see clients in psychotherapy who have these deeply dissociative responses in their system either persistently or that turn on with common triggers such as intimacy or relationship. People with childhood abuse, neglect, insecure attachment, children who have been orphaned, people who have a parent with addiction or mental illness will almost certainly have some degree of state 4 in their system. More likely, they will have lived significant parts of their childhood inside of this state.

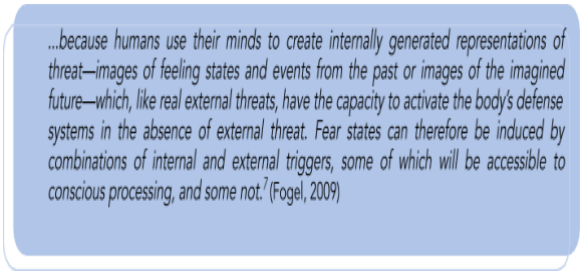
Van der Kolk described this phenomenon when he observed veterans dissociate twenty years after the Vietnam war when they were exposed to some echo (image, sound, smell) of the war. Van der Kolk's team found that these vets achieved the same level of numbing that is produced with an injection of 8mg of morphine [10]. Lesser doses of morphine are used in hospitals to treat severe breakthrough pain. It can be posited that our internal pharmacy is involuntarily secreting potent opioids to physically, emotionally, and psychologically numb us out even decades after a trauma occurs. This is true for war veterans; this is true for adults who grow up in stressful, neglectful, or chaotic families as children. *Dissociation is not mild; it's not invented, it's not a placebo. It is a very real neurochemical shift in the brain that can be measured. Yet, it is implicit: operating below your conscious awareness. The last person to know they have dissociation is the person who has dissociation.* It is one of the more complex phenomena in mental health, and it is one of the main factors leading to treatment resistance. This is all the more true if you spent an entire childhood in dissociative states. It becomes the water you swim in, and it can be challenging to know there is a feeling world outside of that protective layering.

There are no widely adopted modalities designed to notice, much less successfully address, dissociation. Neither your mind nor most therapists are trained to notice it (which is not a personal failing; the field of psychology is simply not prepared to work with such an implicit nervous system condition). You can see and feel stress; you can feel what is upsetting; it is much more challenging to see and feel blankness. We are not trained to look for what should be there but is oddly missing. Even psychedelics do not, by their own nature, crack the invisible,

highly resistant nut that is dissociation. Consider the scenario of someone seeking psychedelic treatment and who unknowingly also has State-4 symptoms from childhood: they will be taking a powerful psychedelic medicine to address the pain their life, and at the same time, their neurobiology will be releasing a large dose of numbing opioids specifically designed to protect them from their traumatic memory. *The mind is very well organized, not to see dissociation. Their system has been doing this for years (perhaps even from infancy). It's good at it, and it's not going to stop today. What might happen when a psychedelic response runs straight into an opioid response? Just like antipsychotic medication will shut down a psychedelic process, so will your natural opioids.*

People with significant State-4 may have very little or no response to substances as powerful as MDMA or psilocybin. They will feel sober, or bored or sleepy as if they could get up and go about their day. If a therapist wasn't in the room, they might fall asleep during the height of an MDMA session, which is a remarkable thing. The point here is that there are human psychobiological processes that can confound psychedelics medicines. These substances can significantly accelerate the clearing of dissociation, but they require individual focus and therapeutic guidance. This is not something that can be self-directed or happen in a group process.

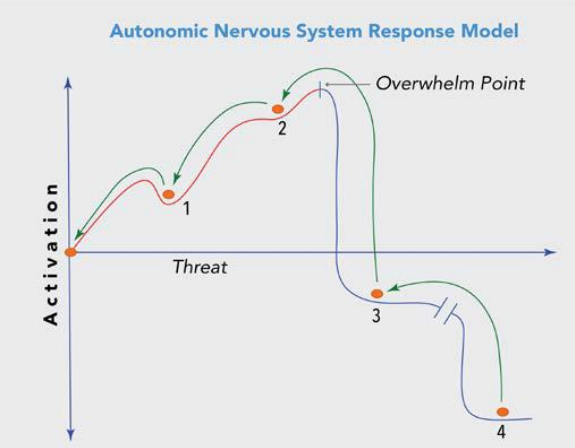
How does the defense cascade relate to psychedelic medicine, the DMN, primary consciousness, and overall mental health? It is evident from the symptoms that we see arise as part of the defense cascade that many of the conditions that cause people to enter into psychotherapy have a psychobiological basis as a response to a threat. These are not random reactions. Large scale, reputable research such as the Adverse Childhood Experiences study conducted by the Center for Disease Control shows that many significant adult mental health conditions do not take place in a vacuum.[8] They need a foundation of childhood stress and trauma to express later in life. We refer to the reactions in States 1 through 4 as symptoms you might get treatment for, but if you were actually under conditions of threat, these would be very sensical and welcomed reactions. You would want the explosive energy and adrenaline of State-2 if you were being assaulted. However, if you are not in danger, and this nervous system state emerges, it is considered a disorder to be managed. To a significant degree, many mental health symptoms are natural and involuntary responses to current or past events generated by the ANS.



The problem is not that these ANS states exist, remember they are adaptive. It's not necessarily even a problem that these states need to be invoked at different times in our lives. The problem is that we do not readily return to neutrality (State-0) from activation. Just as the ANS naturally shifts us into these states, the ANS also has the capacity to naturally shift us back to zero. This is a homeostatic function of your nervous system. Just as your body sweats to cool you down when you overheat or releases the right amount of insulin to balance your blood chemistry when you eat sugar, so it is that your body knows how to homeostatically return to State-0 after you have been stressed or traumatized. Many such self-correcting, homeostatic mechanisms are part of your intelligent, unconscious biological system that is constantly operating without your

volition or awareness. Even as you sleep, your autonomic nervous system is actively engaged. *It's not surprising to most people that these homeostatic mechanisms that run the body's machinery exist. What is surprising is that this same principle of homeostatic self-correction applies to our mental health.*

It is both biologically expensive and debilitating to maintain an organism in stress and trauma states, which is why the mammalian ANS has not only the capacity but also the impulse to return to State-0. We see this with wild mammals in nature: they move into an involuntary, visceral, non-verbal, and non-insight based processing mode after surviving a threat. Their nervous system is involuntarily shifting them back from State-4 to 3 to 2 to 1 to 0. We will not discuss details in this paper about the conditions necessary for this to happen or what the process entails. Just know that autonomic resolution operates on very different principles than modern psychology and the verbal, insight-based mechanisms of secondary consciousness. This ANS resolution pathway evolved over millions of years; it is an essential feature of our biology. It is an essential feature that is much more likely to activate during primary consciousness.



PRIMARY CONSCIOUSNESS

An exploration of PSIP interventions designed for altered states of psychedelic consciousness.

ANS Resolution Interruption, Selective Inhibition, and Waves

However, we don't see this autonomic resolution very easily in humans, or rather, we see it frequently interrupted. Our speculation based on observation is that interruption of this process takes place on two levels. The first interruptive source is our own voluntary avoidance. ANS resolution is not pleasant. It involves moving through the physical, emotional, imagery, thoughts, memories, and relational reactivity that has been trapped in each of the ANS states. We also tend to avoid the loss of voluntary control. Traumatized populations especially do not trust body processes of which they are not in charge. *Yet, allowing involuntary reactivity is a necessary component of ANS processing.* Moving through these nervous system states is an involuntary biological shift. It is not a choreographed or orchestrated action taken by your conscious, rational mind any more than you can direct the release of insulin. You also don't think, reason, understand or talk your way from one ANS state to another. You feel your way through these states; your body is able to negotiate its way through these states. The ANS is a concrete, biological mechanism generating much of the mental health that you can't purposefully interact with purely from secondary consciousness. It is relatively easy for secondary consciousness processes, such as cognitive appraisal, to be voluntarily used to interrupt autonomic processing.

PSIP session courtesy of Innate Path, Denver

The second major source of ANS interruption is the suppressive neurological action of the default mode network. We believe that ANS resolution is one of the subcortical features of primary consciousness suppressed by the DMN. *We say this because the somatic resolution pathway becomes far more available, fluid and responsive, during a psychedelic state than when secondary consciousness is dominant. As primary consciousness comes online, so does this resolution feature of the ANS.* This is inspiring news for us in the mental health world. Instead of the verbal, insight focused, thought-based management systems that we employ from the position of secondary consciousness to manage ANS reactivity, which we believe is the only option along with psychiatric medication, there is an actual biological, evolutionarily ancient, homeo-static, mammalian pathway. This ancient system for ANS resolution is potentiated by a psychedelic disruption of the DMN. In our estimation, this is a holy grail for mental health. What is emerging here are two systems, primary consciousness and ANS resolution, that are hard-wired into our evolutionary biology, ancient in origin, that potentiate one another's effectiveness and depth, and together address many symptoms of mental illness which are themselves biological in nature. *We are suggesting something fairly radical here based on sound information and reasoning: a good deal of mental health originates in and can be resolved through primary consciousness and the psychobiological brain networks that give rise to it.*

An essential difference between the PSIP model and the default non-directive approach mentioned at the beginning of this paper is when and how processing occurs in each model. In the non-directive, non-interactional system, the processing and therapeutic benefits are derived primarily during the integration session following the psychedelic session. The nature of the benefit is insight; long-held belief systems are challenged (cognitive restructuring), and new meaning is constructed here. These are all very useful in terms of mental health, and they are secondary consciousness processes. Hence, the integration phase is critical in this model to yield benefits.

In contrast, the majority of processing in the PSIP model happens during the psychedelic session through a biological process. The autonomic nervous system's processing of memory and the progression through the defense cascade to neutrality is not a function of insight that happens in integration. Rather it is a biological function that should occur during psychedelic use. *If this is handled well, integration is something that unfolds easily and naturally. The client is left with a much less reactive, much less symptomatic nervous system that requires much less management by secondary consciousness. We find that thoughts are much more easily shifted when the biological underpinning is neutral and fluid. The assumption here is that biology is foundational and thus primary to our systems, and meaning are secondary.*

In our clinical experience, the caveat to what we have described is that ANS resolution does not typically restart itself during a psychedelic state. There still needs to be a therapeutic interaction that activates this function. Consider that this feature has

been suppressed (voluntarily and involuntarily) and unknown for years if not an entire lifetime for many people. It's akin to a muscle that has atrophied from lack of use. However, it is readily available to most people once they uncover it, not cognitively but through experience and their felt sense of their own body. PSIP uses a process called *selective inhibition* (SI) to get the ANS resolution process restarted during a psychedelic therapy session (as well as during preparation sessions).

Selective Inhibition involves the suppression of voluntary distractions, avoidance or coping strategies to allow for the nascent involuntary autonomic nervous system responses to emerge and complete. Coping mechanisms yield short term relief and do not involve processing, whereas SI is designed to initiate autonomic resolution moving a person through ANS states. It involves associating a client to their experience, and is therefore a container for expressing the unconscious as much as it involves active inhibition. The different channels through which SI is used include physical, emotional, mental, and relational inhibition.

SI differentiates between and amplifies involuntary sensations, emotions, muscle contractions, and impulses for movement (ANS based reactions) over voluntarily directed signals, which are usually coming from our own desire to avoid, manage, or calm reactivity. For example, let's say you were in a PSIP session working through a particular traumatic memory: your gut might tighten, your breathing becomes short and fast, your neck is pulling you to the right, and you are feeling irritated (possibly the beginnings of a State-1 or State-2 resolution process). You have an impulse to take a few deep breaths or think about your upcoming vacation. Your PSIP therapist, using selective inhibition, would ask you to notice and inhibit the impulse for a deep breath and the mental escape while drawing further attention to your tight gut, shallow breathing, the details of the muscles in your neck pulling you, and the irritation. They might even ask if the irritation is directed at them to include a projective relational layer of processing if the original events were relational in nature. They would coach you to track these symptoms without altering them in any way. You would allow the autonomic sensations, contractions, emotions, thoughts, and relational projective signals to emerge, which they would of their own accord when distractive coping is inhibited. These elements would follow a wave pattern of growing symptom intensity, peaking, and then calming without any voluntary shaping of the response. Eventually, the autonomic signal would become louder and more apparent in the areas of the gut, breath, neck, irritation, and turn into a full autonomic expression appropriate to the original events. This unmanaged wave phenomenon is the natural resolution process of the ANS.

In contrast to the selective inhibition interventions, which is directive, the PSIP therapist is non-directive when it comes to the organic expression that emerges in that protected container. The PSIP therapist is non-directive and supportive when it comes to whatever autonomic; primary consciousness expression emerges in that space. The intelligent, healing response that arises is trusted and allowed to run its course. It's equivalent to creating certain conditions needed to fall asleep such as quiet, darkness, and no added stimulation that we can be directive about implementing. However, once the person has fallen asleep, the dream that arises has its own intelligence and internal logic that we can trust. Our clinical experience suggests that psychedelic therapy requires both a directive and non-directive component; the skill is knowing, which is appropriate when.

Another dynamic we have seen is that once this autonomic pathway has been uncovered and traversed a few times successfully by a client, it quickly becomes intuitive and one of the primary channels that psychedelic medicines will take through a person's psyche. The client becomes more trusting of their body and less avoidant of the reactivity it holds. Consider that many

therapy clients deeply distrust their own bodies and internal experience because this is where the lack of control, fear, pain, overwhelm, and trauma took place, and where this history expresses in the present moment as reactivity and symptoms. Once a pathway to resolution has been demonstrated, clients learn to trust strong reactivity, be it panic or deep dissociation, knowing that they are equipped to get to the other side. Their system is getting the signal that there is a solution that grandma's house exists, and avoidant coping mechanisms, such as addiction, can ease their grip simply by being much less necessary. *There is profound empowerment from knowing that not only are they not broken but in fact, possess remarkable innate healing intelligence that asks for more contact, more self-intimacy, more embodiment rather than self-avoidance or management to achieve stability*. Clients learn to differentiate between involuntary and voluntary impulses, and they become able to intuitively conduct their own selective inhibition. This pathway is certainly not exclusive: human psychological functioning is complex, and the psychedelic process will catalyze other healing tendencies. However, insofar as the defense cascade and mental health conditions are the focus, the ANS pathway is an essential feature in that system.

Training session courtesy of Trauma Dynamics

Dissociation, Selective Inhibition, & the Unique Potential of Cannabis

Concerning the complexities of dissociation that we outlined earlier, engaging selective inhibition involves accessing the dissociation by bringing blankness, flat affect, nothingness, boredom, sleepiness, or sobriety into focus. *The trick to working with dissociation is not to ignore the gold that is boredom in favor of other evocative pieces that are more interesting to the mind but may ultimately be distractions.* The client and the therapist will be tempted to provide something evocative to get the session going, but the blankness is incredibly valuable. *This seeming non-response is the response.* It is the 'here and now' visceral manifestation of the internal reality of dissociation, and an access point to go deeper. The blankness is what the psychedelic is revealing. Eventually, the dissociation will crack. In non-drug assisted therapy, this could take weeks or months of weekly sessions, or it might not happen at all. In a psychedelic-assisted session, it might take staying with it from minutes to a full day-long session, but it will crack. When it does, there is an entire universe underneath that was being hidden from awareness by the dissociation. This is the material that will begin to emerge to be processed. Remember, the dissociation became active in the first place because overwhelming, threatening, solutionless experiences were taking place. These overwhelming and impossible experiences are what the client will now begin to feel. The emergence of material from dissociation into association is frequently a significant, reactive experience. The merely stressful or panic-inducing events live in states 1 and 2, the much more formative and difficult to resolve sources of symptoms are the events that live in the numb regions of our body-mind. There is an old story of a man looking for his lost key under a streetlamp at night. Another man arrives and helps him

look. After some time of not finding it, the helper asks, “Are you sure this is where you lost it?” to which the first man replies, “no, I lost it in the dark, but the light is better over here.” To truly resolve symptoms, we have to look in the blank places where there are no words, sensations, hope, or light, not in the states the mind can see, feel, and is familiar operating within.

One fascinating finding that informs the PSIP protocol is that not all psychedelic medicines are equally effective at processing dissociation. We don’t know why this is the case. Different medications combined with psychotherapy have different responses to this defensive phenomenon. Psilocybin, for example, is not an ideal substance for resolving dissociation. Through our observations at our Amsterdam program and interviewing other researchers and clinicians who work with psilocybin, we discovered a minority of non-responders to this medicine (or mescaline and ayahuasca for that matter). For these non-responders, regardless of dose, psilocybin will provide prosaic images of water, flowers, some visual distortion perhaps, but nothing involving the client personally or connecting to their therapeutic process. This requires more investigation, but our best theory so far is that psilocybin is a more advanced psychedelic, and its action is more susceptible to being shut down by dissociation. Put in psychotherapeutic terms, the level of transformation psilocybin asks of the client is more profound than what the client is capable of if their nervous system is heavily compromised by dissociation. Psilocybin seems to simply pass over a person with this structure. We see this in individual psychotherapy settings as well as in group ceremonial settings.

PSIP session courtesy of Innate Path, Denver

In contrast, MDMA and cannabis, which do not act as potently on the 2A serotonin receptor, are much more effective at processing dissociation. Again, not inherently, but with an appropriate therapeutic focusing of the session, they can dissolve the dissociative defense. *Cannabis, in particular, more so than any medicine we have seen when combined with selective inhibition, changes its nature from a calming, symptom management experience to an excavating, nervous system response inducing treatment.* People begin to feel and have active defensive reactions to events that, under any other circumstance, would generate State-4 dissociative symptoms. The rapid clearing of psychological numbing is a remarkable therapeutic opportunity requiring significant therapeutic engagement since it is fundamentally destabilizing. It can also be a potential pitfall for the same reasons. Gaining conscious access to previously hidden material will be destabilizing and require varying levels of support outside of the session. In either case, cannabis is a fast track involving the emergence of powerful and frequently difficult sensations, imagery, emotions, and significant ANS processing with very little capacity for executive functioning or insight. We speculate that cannabis is such a thorough interrupter of executive control that any voluntary management capacity that might typically arise during a psychotherapy session is effectively disabled. Therapeutic guidance is essential when cannabis is being used in this capacity.

We realize this description of cannabis is quite alien to most people familiar with this

plant. As we noted earlier, it changes its nature drastically depending on the context. We see this excavating property arise most clearly when the autonomic processing channel has been established in a person's system. Based on these findings, the protocol that we've incorporated into working with psilocybin at PSI Amsterdam is to conduct three cannabis assisted SI sessions over two days as preparation for all of our clients prior to introducing psilocybin. This practice primes clients, regardless of whether they naturally would respond well to psilocybin or if they are non-responders, to make better use of the psilocybin when it is introduced on the third day.

Interactional Component

As we mentioned at the beginning of this paper, the default in psychedelic research, which has made its way into psychedelic therapy, has been the non-directive, non-interactional model where the therapeutic benefits are primarily derived during integration. The PSIP model articulated in this paper suggests a far more relational therapeutic engagement from the clinicians. What we have is the possibility of a therapist using interventions that are congruent with the psychedelic state, playing an active role in the client's relational psychedelic consciousness. Why is this relational part-icipation by the therapist important? When it comes to mental health, most of our wounding is relational in nature. We occasionally work with people whose symptoms come from non-relational events such as car accidents where you don't know the other people involved. You are not going to have an ongoing relationship with them. However, the vast majority of experiences that cause symptoms come from events or long-term, repeated patterns that have taken place in a person's family of origin. In other words, what is encoded as part of a traumatic memory is not just the events that happened, but your relationship with the people involved in those events. Your very definition of family, your sense of who a mother is, what she does, your sense of father, and what fathers do are formed by these experiences and encoded into memory. Your very definition of love, touch, intimacy, and relationship is encoded as part of traumatic memory since the events took place with the people closest to you on the planet, and these relationships give meaning to these concepts. This can be very positive programming that gets enacted later in life, or it can be encoded as part of traumatic memory leading to symptoms and relationship struggles. Attachment disorder, for example, is one of the most well-researched phenomena in all of psychology. Your attachment style is an implicit level of programming that determines a great deal about your life, your adult relationships, how you will parent, how you see the world, even your level of education and income. The bond between mother and infant completely relationally determines attachment style before the age of two [12]. Human relational wounding requires human relational engagement to be healed. Being a healthy human is not purely an internal intrapsychic or transcendent encounter with oneself or the greater world. Psychedelic medicines are

PSIP session courtesy of Innate Path, Denver

catalysts that support relational healing; they are not a substitute for it.

You need a responsive, attuned human being in that space with you to work through familial, relational material. What might this relational interaction look like in a psychedelic therapy session? The psychodynamic concept of transference is useful here. Simply put, transference is when the client places the perceptions, feelings, thoughts, sensations, or expectations of their unresolved relational past onto the therapist or other current relationships in their life. Think of it like an old film negative of the past laid on top of present moment reality. It becomes difficult for the client to discern what perception is coming from where. When that film negative is thick because it is a charged traumatic memory, you will be seeing and responding to more of the past than you are to the person in front of you in the present moment. Working with charged relational transference is both a difficult and necessary level of healing when it comes to psychological symptoms because, as we've noted, the vast majority of mental health disorders do not occur in a vacuum but are relationally derived. Stressful, chaotic, neglectful, traumatic early relationship patterns prime the pump for later physical and mental disease processes [13]. As such, processing relationships that we hold in memory is crucial to symptom resolution.

In the MAPS Phase 2 research trials for MDMA, the topic of relational transference, and the need for training around it came up very frequently in the clinical team meetings. Past relationships, good or bad, are held as part of the programming in primary consciousness that is expressed as transference when the door to primary consciousness is opened. It can arise slowly in traditional therapy but occurs more quickly and powerfully during and around the psychedelic session. Some interventions can decrease relational projection, and other interventions, such as SI, can evoke it. If this transference is traumatic in nature, and the therapeutic container allows for it, the client will begin to react towards their therapist as they had towards their parents or family members. This may be some version of a neglectful, incompetent caretaker whom the client believes is not capable of helping or holding them through their psychedelic session. The client may believe the therapist doesn't care about them or see what they are going through. As we saw in the clinical trials with male therapists and female clients who have had male perpetrators, a good deal of fear, anger, and reactivity can arise when perpetrator transference is manifested in the session. The client may see their therapist as dangerous, and all the ambivalence and complications of loving someone dangerous can arise. Again, if held well, working with transference in the psychedelic session is a profoundly valuable therapeutic opportunity.

Training Session courtesy of Trauma Dynamics Training

Alternatively, clients may have overly positive, idealized parental transference towards their therapist. The person sitting with them can do no wrong; they are the parent the client secretly wished they had. Even positive transference from client towards their therapist can be complicated and a double-edged sword especially if it fits into the unconscious psychological needs of the therapist. This is what frequently leads to boundary violations or inflated savior

complex in therapists. Crucially, even in this scenario, the negative transference is still in the client's system. Unless it is dealt with in the therapeutic relationship (and most non-psychodynamically trained therapists will not be comfortable being seen as incompetent, neglectful, or as perpetrator by the client), the client's primary consciousness will direct the negative transference towards their un-suspecting and ill-equipped spouse (or other significant relationship). Integration sessions in the PSIP model can often be couples or family therapy sessions, helping the system that is the client's relationship or their family prepare for significant changes and the possibility of transference expressing at home. Transference is a non-declarative, very implicit, very invisible feature of primary consciousness memory that will often be evoked with psychedelic therapy.

As much as possible, it is ideal if this transference layer is brought forth and dealt with in the session. Working with relational transference is more complex than dealing with the type of reactions we described in the defense cascade section, but it can still be processed through the same autonomic pathway. Instead of just involuntary body sensation, emotion, imagery, and thoughts being the focus of selective inhibition, the therapeutic relationship also becomes the focus. *If the therapist has an active, interactional role in the client's psychedelic session, the client's system will hand an internalized relational role or script to the therapist of whom the client needs them to be. Once this charged projection is active, the therapist works with it by not rejecting or correcting the projection but allowing it to be there, exploring the details of the relational memory, and responding as if it is true. The focus of psychedelic therapy is not the truth, but the processing of the client's truth. The processing of how memory, relationships, and the world lives in the client's system.* The projection is involuntarily emanating from the client's system, so we trust and support its expression. Having the client notice the relational transference while staying connected to the body will allow the ANS to enact defenses and process the relational memory.

These can be unpleasant, ugly relation-ships that the client is holding in their relational memory. It will not be easy for generally empathic therapists, helper types, to accept these roles from the client. This is all the more true if clinicians have not done their own work to achieve their ego fluidity and do not have experience working with transference. The charge of psychedelically uncensored negative transference is powerful. It is also a gift to the client that this relational aspect of their traumatic memory can be fully brought forth and held in the psychedelic session. As with other processes we've mentioned, the client's psyche will make an unconscious assessment of their environment and the person they are working with to judge the safety and appropriateness of expressing this relational layer. It will either not express or be muted and managed if the circumstances cannot hold the expression of the memory.

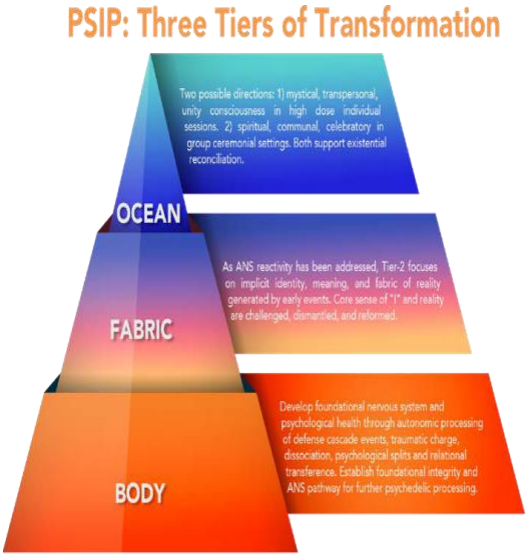
In addition to processing the charge of relational transference, the interactional therapist can provide positive corrective emotional and physical experiences. They can interact with you in a way that lets you know you are being attuned to, responded to, accepted, seen for who you are. Your therapist can be a source of warmth and love for you, or even physically hold you in your session. We have seen, for example, clients shift from insecure attachment styles to secure attachment through the relational psychedelic connection with their therapist. This is profound work because the parts of the client that need these experiences are at the surface and available to new learning during a psychedelic session. It is an opportunity and dynamic that calls for the

therapist to be well processed and not carry their own developmental wounds into psychedelic therapy where they will be glaringly apparent. The relational depth that the psychedelic will take the client and what their systems will ask of the therapeutic relationship means that therapists will need to be clear and available at those depths.

This is the relational, interactional opportunity that PSP seeks to address. *A human being stepping into a psychedelic session will naturally shift that session away from transcendent, mystical, and cosmic, to human and relational, which we believe is useful in terms of a tiered, graduated approach to working with psychedelic medicines.*

A Tiered Developmental Approach for the Western Psyche

We are developing a sense of how these medicines interact with the psyche and a possible recommended trajectory for people seeking to engage with them in a productive and integrable manner. We envision a three-tiered approach where the first tier involves psychobiological healing to develop a healthy, functioning ego structure. The focus here is nervous system health, the processing of traumatic memory, healing of psychological splits, processing of relational transference and the establishment of an ego that is not purely based in secondary consciousness repression but is permeable and informed by primary consciousness. The psychedelic substances at this level include cannabis, MDMA, and ketamine. These medicines typically have a smaller scope of focus insofar as they can be honed to work with the events in a person's life. These substances allow us to focus on events that have created defense cascade symptoms and biological compromise of the nervous system while avoiding deeper levels of personality change, mystical experiences, ego transcendence, and unity consciousness. Tier-1 work and medicines are not less powerful or relevant than Tier-2 or 3 work. Tier-1 work is more developmentally and psychobiologically appropriate for individuals at the start of their psychedelic healing work. Our experience, for example, is that cannabis is an equal partner to psilocybin in moving individuals through this tiered system.



The thinking behind this tiered structure is developmental in nature. Various models of human and spiritual progression suggest a movement from pre-egoic states to healthy egoic states prior to entering trans egoic states.[10] We are implying through this tiered model that attempting to manage ego dysfunction and suffering by transcending the ego is a spiritual bypass of a developmental process. In other words, you have to be someone before you can be no one and jumping ahead is not ideal. This bypassing of a wounded, underdeveloped ego into mystical states yields experiences that are difficult to integrate into that still unhealed ego. This can lead to peak experiences of liberation, peace, and beauty that are un-integrable into waking consciousness and lead to a need to repeatedly visit transpersonal states.

The focus of Tier-1 is psychobiological integrity, a foundational requirement for further stable, integrable psychological and spiritual development. Imagine a scenario where someone has very unhealthy eating habits: imagine they are eating mostly sugars and missing protein and fat from their diet. They are not making neurotransmitters, and their basic biology is not getting what it needs. Can this person conduct legitimate psychological or spiritual development on this foundation? Would it be appropriate for this person to try and resolve depression stemming from their lack of nutrition by having mystical experiences? Of course not, and the same is true of operating with a foundation compromised by a charged nervous system, unprocessed traumatic memory, dissociation, and split sub-personalities.

PSIP session courtesy of Innate Path, Denver

While the second tier is less about your biological foundation, Tier-2 is still focused on your autobiographical self. It is not a trans egoic phase. The depth of work that can occur at this level is a deeper cut than what is aimed at in Tier-1. Once you do not have a massive opioid release in response to the events in your life, the classic psychedelic substances like psilocybin can get traction in your system. Once you are much less biologically compromised by trauma, your system is far more capable of the shifts psilocybin beckons. Whereas Tier-1 deals with the events in your life, Tier-2 deals with the identity, the 'I' created in response to those events. There is dismantling and re-structuring of your very fabric of reality. This is a constructed level that you are not even aware you are operating within. It is truly the unseeable and therapeutically unchangeable water we swim in, yet, Tier-2 psychedelic work has the capacity to make this aspect of your mind visible and alterable. Of course, this is a very destabilizing phase as the reference points and touchstones of reality you once knew, even as problematic and symptom inducing as it was, fall apart. *A familiar reality, even a painful one, is something we will choose over ground-lessness.* This tier will typically be a months-long process that your system intelligently will not allow unless you have enough of a healthy and stable internal foundation and appropriate ongoing external support. Clients with mental health conditions short of a full Axis II personality disorder (i.e., borderline, narcissistic) can successfully engage this tier.

Even in clients with personality disorders, we have seen Tier-2 work be effective. These are diagnoses that the world of conventional treatment has very little to offer beyond symptom mitigation because the core personality kernel of the client was disrupted early on and is believed to be unchangeable. Noting that Tier-2 work can address personality disorders does not mean we have a protocol for this or even recommend it. The amount of internal and external resources needed to work with a person with this diagnosis through Tier-1 and contain the enormous reactivity unleashed in Tier-2 is profound. The point here is that Tier-2 has the capacity to operate in the realm of core structural, personality level change.

Tier-2 is becoming a full self in the world. It operates with an integrated primary and secondary consciousness, drawing on the strengths and intelligence inherent in each mode. It is embodied, fluid, relationally

present moment focused versus event memory-based. It is a state that is aware of the deliciousness of the world and our place in it: an embedded, alive, emotional, empathic, spiritual intelligence as a foundation through which secondary consciousness is engaged as the useful cognitive tool that it is. Putting this dynamic in more concrete terms, would you want your surgeon or airline pilot flying the plane you are on to be steeped in secondary consciousness, absolutely. Does that mean you should derive your core sense of meaning, identity, and worth from secondary consciousness? Our answer based on clinical experience is no. Meaning appears to be an emergent property of being in the world. It is something that arises out of direct contact with existence. Secondary consciousness is abstractly disconnected. It does not seem to naturally generate a sense of meaning, which leaves us struggling, working hard to find, invent, or construct meaning in a seemingly meaningless void. The Western psyche makes an art form out of this alienation from self and other inherent elements in primary consciousness. We undergo all sorts of secondary consciousness contortions in an attempt to create solutions for meaninglessness. In contrast, we see meaning and identity inextricably, organically arise in Tiers 2 and 3.

Tier-3 is composed of two different directions, neither of which are pointedly psychological or autobiographical in nature as the first two tiers were. This tier is essentially what is available today in terms of a group ceremonial, communal, spiritual experience conducted at retreat centers or an individual, high dose, ego transcending, unity consciousness inducing, mystical experience with non-directive, non-interventional facilitators. Which of these is engaged first seems a matter of preference. Still, either will be more accessible, navigable, sensical, and integratable if entered with a sound, foundationally stable self in place. Focusing on the high-dose, ego dissolution experience for a moment, we believe this is something that requires individual attention and significant integration afterward. It is the default approach at research settings using psilocybin to achieve benefit through contacting mystical states. As the ego entirely fades away, what is left is an ever-present sense of connection to everything. There is an existential reconciliation that can take place here. As many writers, mystics, and visionaries have stated, this experience is beyond words and is in the ineffable domain. We suspect the likelihood of challenging sessions is decreased if participants have completed Tier-1 and 2 work, but this remains to be seen.

> *[Mystical experiences are] those peculiar states of consciousness in which the individual discovers himself to be one continuous process with God, with the Universe, with the Ground of Being, or whatever name he may use by cultural conditioning or personal preference for the ultimate and eternal reality.*[14] *(Watts, 1970)*

The ceremonial groups are typically conducted with various psychedelic medicines. The traditional setting of the circle utilizing sacred plant medicines stretches back through eons of time throughout multiple cultures. The sharing of a psychedelic state in a highly relational, spiritual, community format can unite one with many. ‘It is not therapy; it’s worship’ is one way to conceive of this setting. Some psychological elements may emerge into this experience for people, especially if they have

not engaged tiers 1 and 2. Still, the setting is primarily designed for something quite different. It is intended to be a joyful experience in a sacred container - a collective movement towards wholeness, gratitude, awe, and love. For both of these higher tier states, there is a wordless, profound depth and transformation that can occur.

Our hope in constructing this tier system is to provide a map, as untested as it is, for the Western psyche to move through its unique illnesses and alienated sense of existence to successfully engage in core biological, psychological, existential, and spiritual transformation. While the PSIP model is mostly geared for tiers 1 and 2, it positions the individual to successfully navigate higher tiers.

CONCLUSION

As part of the scientific evolution of ideas, we proposed a new model of somatic, interactional psychotherapy designed to operate within and increase the inherent healing potential of the altered state of neurological functioning induced by psychedelic substances. *While the default non-directive, non-interactional model has proven a significant improvement over current psychiatric and psychotherapeutic interventions, we propose developing a therapeutic model that specifically targets psychobiological and relational factors involved in human well-being will yield an even more significant improvement in outcomes.* Psychedelic medicines being catalysts for a wide array of innate human healing tendencies coupled with psychotherapy that targets specific areas implicated in mental health such as defense cascade symptoms (anxiety, panic, depression, dissociation), developmental patterns, and relational family of origin-based trauma holds the potential for a more efficient, more thorough, more precise, more predictably repeatable, and ultimately more effective treatment.

The primary focus of psychedelic research has been on gaining governmental approval for the use of these substances. Focusing on improving the psychotherapy component, coupled with the psychedelic substance, is a relatively unexplored area and holds a great deal of potential for advancing the field. A significant example of this is the use of PSIP's selective inhibition with cannabis, which evokes a radical shift in its nature from being a calming agent to an excavation and somatic processing medicine. Cannabis is widely frowned upon by the mental health profession since it is counterproductive to generating insight, narrative storytelling, executive functioning, and can be used as an avoidance tool. Suppose we engage the same plant with psychotherapy that values a detailed felt sense contact with the body, that relies on interrupting higher-level coping strategies, and which supports autonomic processing. In that case, cannabis can yield an ideal therapeutic experience.

Furthermore, it is widely medicinally and recreationally available; it does not require FDA approval, nor does it require a medicalized treatment framework to be used. In other words, through the adoption of a therapy model designed explicitly for psychedelic use, we see a drug as common and available as cannabis become the accessible psychedelic medicine for private practice clinicians in the US. We see the possibility for cannabis assisted psychotherapy to have wide adoption and use in private practice psychotherapy settings, thus significantly expanding psychedelic therapy availability.

We also see the three-tiered approach to psychological and spiritual development successfully addressing one of the unique and primary ailments of the Western mind: an over-expression, an over-reliance, and

valuation, of secondary consciousness yielding alienation from emotional, psychological, spiritual, and natural phenomena we don't control. We suggest that the traditional use and practices of indigenous peoples using plant medicines evolved in the context of their societies and for their ailments. Some of these, of course, are generalizable to the human condition or overlap with conditions of the Western mind, but we have a unique scenario in how profoundly we have embraced secondary consciousness.

We have disavowed the value, reality, self-contact, and processes of primary consciousness in such a way that we have psychobiological deficits and egoic wounding that is perhaps unique to our culture. Individuals don't need much guidance, psychotherapy, or protocols at the higher end of the tiers. However, at the lower, foundational end of the tier spectrum, where we rely on human relational processes for health, we do. We believe our healing, the healing of Western culture, will require something different from what has evolved in other cultures. While the path we have suggested in this paper is more methodical and will take longer, our experience is that the foundational work allows the empathy, intelligence, gratitude, mystery, awe, and loving ground of psychedelic consciousness to abide, integrated into who we are as a people. What we see reliably arise from underneath the jagged, guarded, often hierarchically oriented, competitive and painful 'I' that we walk around with, identify with, and protect; is a much softer, much more alive existence of simply being in the world. We see the emergence of a self that is aware, appreciative, and loving of its own depth. We see a self that feels kinship and experiences empathy for the other. A being emerges that is part of the world, that gains meaning and inherent worth simply by participating in existence; a being that is existentially and viscerally reconciled with the mystery.

AUTHOR INFORMATION

Send correspondence to:
Saj Razvi (saj@psychedelicsomatic.org)
Steve Elfrink (steve@psychedelicsomatic.org)

DISCLOSURE

Saj Razvi and Steve Elfrink are the founders of PSIP and serve as directors of education and outreach at the Psychedelic Somatic Institute in Denver, Colorado. (https://www.psychedelicsomatic.org/)

Razvi, S., Elffink, S. (2020, June). The PSIP Model. *The Journal of Psychedelic Psychiatry*, *2*(3).

REFERENCES

1. Nutt D. Psychedelic drugs-a new era in psychiatry? Dialogues in Clinical Neuroscience. 2019 ;21(2):139-147. DOI: 10.31887/dcns.2019.21.2/dnutt.
2. Allan N. Schore Ph.D. (2011) The Right Brain Implicit Self Lies at the Core of Psychoanalysis, Psychoanalytic Dialogues, 21:1, 75-100, doi: 10.1080/10481885.2011.545329
3. Carhart-Harris RL, Leech R, Hellyer PJ, et al. The entropic brain: a theory of conscious states informed by neuroimaging research with psychedelic drugs. Front Hum Neurosci. 2014;8:20. Pub- lished 2014 Feb 3. doi:10.3389/fnhum.2014.00020
4. R. L. Carhart-Harris, K. J. Friston, The default-mode, ego-functions and free-energy: a neurobiological account of Freudian ideas, Brain, Volume 133, Issue 4, April 2010, Pages 1265–1283, https://doi.org/10.1093/brain/awq010
5. Peter Fransson, Beatrice Skiöld, et al. Resting-state networks in the infant brain. Pro- ceedings of the National Academy of Sciences Sep 2007, 104 (39) 15531-15536; doi: 10.1073/pnas.0704380104
6. Petri, G., Expert, P., Turkheimer, F., Carhart-Harris, R., Nutt, D., Hellyer, P. J., & Vaccarino, F. (2014). Homological scaffolds of brain functional networks. Journal of the Royal Society, Interface, 11(101), 20140873. https://doi.org/10.1098/rsif.2014.0873
7. Fogel, A. (2009). The Psychophysiology of Self-Awareness: Rediscovering the Lost Art of Body Sense, 1st Edn., New York, NY: W.W. Norton.
8. Kozlowska K, Walker P, McLean L, Carrive P. Fear and the Defense Cascade: Clini- cal Implications and Management. Harv Rev Psychiatry. 2015;23(4):263-287. doi:10.1097/HRP.0000000000000065

9. Schauer M., Elbert T. Dissociation following traumatic stress etiology and treatment. Journal of Psychology. 2010; 218(2): 109–127.
10. Lanius UF. Dissociation and endogenous opioids: a foundational role. In: Lanius UF, Paulsen SL, Corrigan FM, eds. Neurobiology and treatment of traumatic dissociation: toward an embodied self. New York: Springer, 2014: 81–104.
11. van der Kolk, BA: (1994) The Body Keeps the Score: Memory and Evolving Psychobiology of Posttraumatic Stress. Harvard Rev Psychiatry. Volume 1, Number 5
12. Ainsworth, M. D. S. (1973). The development of infant-mother attachment. In B. Cardwell & H. Ricciuti (Eds.), Review of child development research (Vol. 3, pp. 1-94) Chicago: University of Chicago Press.
13. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8
14. Watts A (1970). Psychedelics and Religious Experience In Aaronson B & Osmond H (Eds.), Psychedelics: The Uses and Implications of Hallucinogenic Drugs (pp. 131–144). New York: Anchor Books.

A Case Report of an Individual's Experience Participating in a Traditional Costa Rican Ayahuasca Ceremony

George T. Naratadam, BS; Jason Narikkattu, MS; Safeer Shah MD

Abstract:
Historical evidence has shown the potential efficacy of psychedelic drugs in the treatment of psychiatric diseases. Reporting psychedelic drug experiences in biomedical academic literature is critical to the progress of psychedelic psychiatry research and the potential implementation of psychedelics as therapeutics. Ayahuasca is a plant-based compound with hallucinogenic properties used by South American shamans to treat various psychological ailments. This report describes the case of a 25-year-old male's experience participating in a traditional Costa Rican ayahuasca ceremony and the immediate and long-term effects of the therapy on the participant.

Case Report

The participant (JN) was a 25-year-old male who had discovered Ayahuasca therapy through web research. His motivations for completing the therapy were to gain a deeper understanding of his psyche and to address tensions with his family. In the fall of 2017, JN personally funded a trip to the Rythmia Life Advancement Center in Guanacaste, Costa Rica where he participated in an ayahuasca ceremony. The ceremony lasted for four days during which ayahuasca therapy sessions were conducted at night and with recovery from the sessions during the day. The first three ayahuasca sessions began at sunset (6-7pm) and concluded around midnight with the last night beginning at sunset and continuing until sunrise. Each session was led by a ceremonial leader or shaman who would guide all the participants in one room (Figure 1).

Figure 1: Photograph of setting in which ceremony took place. Layout consisted of a bed for each participant, buckets for purging and a central area.

Prior to ingesting the ayahuasca brew, a rapé (pronounced ha-pay) ceremony occurs where a tobacco-like substance, known as the mapacho is inhaled to prepare for the ingestion of ayahuasca. This was said to be done to potentiate the effects of the ayahuasca. The mapacho is inhaled through a pipe that the shaman blows into. After the rapé ceremony, the ayahuasca brewed by the shamans was then served in a liquid form. The shamans serve each dose in a cup of approximately 1.5 ounces. They dispense dosages of the compound for each participant by assessing every participant's particular temperament as well as gauging the overall energy of the room. There are multiple opportunities for each participant to go up to receive the brew each night. Each participant is told that if they are situationally aware that an offering is occurring, even if he or she is feeling challenged, that they should go and receive the offering. The effects of the ceremony were described to the participant as wide-ranging. One shaman stated that ayahuasca has the ability to bridge both the physical and external and the mental and internal worlds. The goal of the ceremony is for each participant to achieve a "miracle", referenced as a supernatural-like experience that can be reflected and utilized in daily life. The first night was described as an adjustment period and a physical struggle. JN adjusted to the group setting and components of the ceremony itself, including entrusting

the shamans, tasting the brew, reflecting on the sacramental reverence given to the compound, and exploring the environment. There were three offerings and JN received all three doses during the first night. Within the first one to two hours of ingestion of his first dose of ayahuasca, JN began feeling incredibly uncomfortable. He experienced gastrointestinal distress describing that his "stomach was in knots", with associated nausea, and constipation. He recalls a shaman calming him down through the use of a song or chant which he found was very effective. He was able to lie down and noted the onset of visual hallucinations with periods of racing thoughts. He noted a loss of coordination and gait instability, particularly when going up to receive an additional dose.

The second night was described as more comfortable and personal, but with a much higher visual and physical intensity. There were two offerings and JN received both doses during the second night. After the ingestion of the first dose, he felt a sense of relaxation and had no major complications. However, after consumption of the second dose, he began to experience nausea and constipation.

A particular moment occurred during the second night of the ceremony that resonated with JN. He had gone to the bathroom and a female participant had fallen right outside. While deeply under the influence of the compound, he attempted to help the participant. He saw visual hallucinations and thought the experience was within his own psyche. He described seeing the other participant's body outlined by multiple layers in a spectrum of colors. Upon reflection, JN thought, at this moment, that the ayahuasca had bridged both the physical or external and mental or internal worlds. After calling for the shamans, they took care of the participant who had fallen, and a shaman helped him back to his station. The shaman began to perform a ritualistic blessing using rubbing oils and fanning with leaves which alleviated JN's tension from the incident.

Soon after this incident, he began having vivid hallucinations. A particular hallucination was a visualization of himself at the age of two to three. He saw his younger self running around the center area of the room. As he attempted to interact with the hallucination, geometric patterns began to appear. These geometric patterns were of a small circle within a larger circle and he felt as if the small circle were about to burst. He reported feeling anger and frustration while this was occurring and later felt the hallucination was a manifestation of his inner state. The night came to a close with JN beginning to reconcile the two worlds.

The third night was the greatest in terms of the intensity of the visual hallucinations and as well as the mood of the room. There were two offerings and he received both. He recalled extensive visual hallucinations with bright white and yellow flashing lights emanating from the distance followed by the presence of an entity. The entity was in a red and orange color gradient who resembled a samurai. He reports that the entity kept coming closer and closer towards him until it was right in front of him. After the ceremony, he sketched a portrait of the entity titled "Ribbon Lady" (Figure 2). As JN was attempting to calm himself down, the entity began to transform. It transformed into an object resembling an orange, longitudinal scrolling road with evenly spaced horizontal lines. This road began to move like a conveyor belt and was perceived by JN to be shoved down his throat. At this moment he was undergoing intense panic.

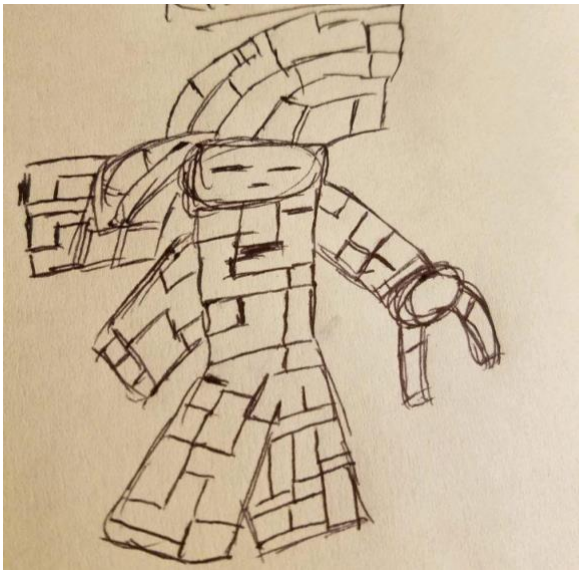


Figure 2: Ribbon Lady

The previous experiences subsided soon after and he received the second dose of the night. This led to the peak portion of the ceremony where JN felt like he had lost his mind. He was hyper attuned to the purging, the screaming, and the crying of the other participants in the room, but found it overwhelming to focus on himself. He described this as a psychological challenge of having to surrender to the chaos that developed within his mind and within the group. There was no relief until the shamans began to chant and play instruments, which gradually began to establish order out of the chaos.

The fourth night JN reported a milder reaction upon ingestion and became somnolent soon after without any other physical symptoms or hallucinations. He fell asleep and awoke the next morning well-rested. Upon waking, a particular observation was made. JN saw a scorpion crawling underneath his pillow and despite the close proximity, it did not sting him. While maintaining skepticism, he had a profound belief that a supernatural element of luck protected him from harm. Later that morning, the participant took part in a gathering with the other men of the group during which they were blessed as the ceremony concluded.

JN reports that his ayahuasca experience had many physical, spiritual, and emotional challenges. These challenges included physical symptoms upon ingesting the compound, the suspension of belief in how the treatment could cure illness, and the allowing of oneself to be vulnerable to the psychological effects of the compound. The participant believes that what had occurred upon completion of the ceremony was that he received a "miracle". His attitudes and comfort towards the unknown shifted favorably. He began welcoming new opportunities in his career and he changed how he spent his free time. He developed more meaningful and deeper personal relationships with his family members. He also shifted his perspective to seek out alternative ways of thinking (reiki, comedy, art and music performances, hypnosis, travel) to enhance his own well-being. The experiences and subsequent realizations that JN came to during his ayahuasca ceremony continue to positively impact the way he lives to this day.

AUTHOR INFORMATION

Send correspondence to George Naratadam, BS (naratadam@livemail.uthscsa.edu)

Naratadam, G, Narikkattu, J, Shah, S. (2020, September). Case Report of an Individual's Experience Participating in a Traditional Costa Rican Ayahuasca Ceremony. *The Journal of Psychedelic Psychiatry*, *2*(3).

ACKNOWLEDGEMENTS:

South Texas Medical Scientist Training Program

Medicalization, Decriminalization, Legalization and the Path Forward for Psychedelics

Tyler. Kjorvestad, M.D.

Since the passage of The Controlled Substances Act in 1970, psychedelic compounds have been classified as Schedule I Substances, meaning that:

1. The drug or other substance has a high potential for abuse.
2. The drug or other substance has no currently accepted medical use in treatment in the United States
3. There is a lack of accepted safety for use of the drug or other substance under medical supervision [1].

With the founding of the Multidisciplinary Association for Psychedelic Studies (MAPS) in 1986 came a slow but steady approach toward utilizing psychedelics within the current medical model[2]. This medicalization approach for all intents and purposes has been largely successful highlighted by the Federal Drug Administration (FDA) recently granting breakthrough therapy designations to both Psilocybin[3] and 3,4-Methylenedioxy-methamphetamine (MDMA) [4]. While these results are very encouraging and point toward the likely rescheduling of psychedelic substances in a way that is more consistent with their therapeutic potential, some localities across The United States have opted for an alternative approach.

States and localities have adopted different policies concerning drug criminalization compared to those issued by the federal government. As far back as the 1970s, multiple states and cities successfully decriminalized cannabis, but this was short-lived due in large part to the "war on drugs" in the 1980s. The increased efforts to combat drug use during the 1980s resulted in the re-criminalization of cannabis in many of these locations. The strong public sentiment even led Alaskans to vote to make cannabis illegal again in 1990, more than 15 years after the Alaskan State Supreme Court had declared it legal[5]. Starting in the early 2000s, the tides again changed, and decriminalization efforts cropped up across the country with the overwhelming majority of those being successful. As of this writing, 27 states have decriminalized cannabis, and of those 27, eleven have successfully legalized cannabis. Of the remaining 23 states, all but two allow for medical cannabis use in some capacity. While cannabis still remains illegal federally, the government has done little to counteract these laws [6].

Building off of the work done by the cannabis movement, some cities have sought to decriminalize psychedelic mushrooms. Denver became the first city to decriminalize psychedelic mushrooms in May 2019, with Oakland and Santa Cruz following soon after [7]. Efforts are currently ongoing in other cities across the country to adopt similar policies. Unlike with cannabis, there are currently no states that have legalized psychedelic mushrooms or other psychedelic substances, except for rare exemptions given to Ayahuasca for use in religious ceremonies. Given the marked success of the cannabis movement in obtaining legalization, it seems likely that this same strategy will be pursued for psychedelic mushrooms.

The Journal of Psychedelic Psychiatry completely supports and is committed to expanding the medicalization efforts currently being undertaken to bring psychedelic substances into the clinical realm. However, when it comes to discussing

decriminalization and legalization a cautious approach should be taken. The United States spends 47 billion dollars annually fighting the "war on drugs" [8]. It has not achieved anything close to a success insofar as the reported rates of use of illicit substances are concerned [9]. While arguments can be made for the full legalization and decriminalization of all substances, proponents of psychedelic decriminalization or legalization should be leery of joining these all-encompassing movements. Psychedelics are not addictive like heroin or methamphetamine, but they are still abusable and certain at-risk individuals should not take psychedelics. Giving opponents of drug decriminalization and legalization the capacity to conflate psychedelic use with other more addictive and dangerous drugs is counterproductive. By isolating the discussion to psychedelics, as has been done successfully in the aforementioned cities, nuanced conversations can be had about the positive benefits and compromises that can be made on how best to handle any adverse events that might arise. In general, *The Journal of Psychedelic Psychiatry* supports decriminalization efforts for psychedelic substances, particularly those that are naturally occurring. Prior to supporting legalization more research into psychedelics is necessary so as to better inform the public about the risks and precautions that should be taken prior to engaging in use. It is our belief that by taking the cautious and prudent medicalization approach, backlashes like those seen in the 1960s and 1970s can be avoided, and in time psychedelics can be more openly accepted within society at large. It is less ambitious than some would like, but it is imperative that this time science and medicine get this right. There is too much potential to have it wasted simply out of haste.

AUTHOR INFORMATION

Send correspondence to Dr. Tyler Kjorvestad (tkjorvestad@kumc.edu)

Kjorvestad, T (2020, September). Medicalization, Decriminalization, Legalization and the Path Forward for Psychedelics. *The Journal of Psychedelic Psychiatry, 2*(3).

REFERENCES

1. 21 U.S. Code § 812 - Schedules of controlled substances. (n.d.). Retrieved from https://www.law.cornell.edu/uscode/text/21/812
2. Multidisciplinary Association for Psychedelic Studies. (n.d.). Retrieved from https://maps.org/
3. FDA Grants Psilocybin Second Breakthrough Therapy Designation. (2019, November 25). Retrieved from https://www.medscape.com/viewarticle/921789
4. PRESS RELEASE: FDA Grants Breakthrough Therapy Designation for MDMA-Assisted Psychotherapy for PTSD, Agrees on Special Protocol Assessment for Phase 3 Trials. (n.d.). Retrieved from https://maps.org/news/media/6786-press-release-fda-grants-breakthrough-therapy-designation-for-mdma-assisted-psychotherapy-for-ptsd-agrees-on-special-protocol-assessment-for-phase-3-trials
5. Alaska Voters Approve Measure to Recriminalize Marijuana. (1990, November 07). Retrieved from https://apnews.com/article/4db1bf97a3d7c3a94c1d1e304f149c06
6. State Laws. (2020, June 23). Retrieved from https://norml.org/laws/
7. Kaur, H. (2020, February 04). Santa Cruz decriminalizes magic mushrooms and other natural psychedelics, making it the third US city to take such a step. Retrieved from https://www.cnn.com/2020/01/30/us/santa-cruz-mushrooms-psychedelics-trnd/index.html
8. Drug War Statistics. (n.d.). Retrieved from https://www.drugpolicy.org/issues/drug-war-statistics
9. Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health. (n.d.). Retrieved from https://store.samhsa.gov/product/key-substance-use-and-mental-health-indicators-in-the-united-states-results-from-the-2018-national-survey-on-Drug-Use-and-Health/PEP19-5068

Business Information

The Journal of Psychedelic Psychiatry LLC ISSN 2690-0912 is published quarterly. The views expressed in this journal are those of the authors and the editorial board that accepted them. This is an open access journal and no permission is required for the copying of isolated articles.

Contact:
journalofpsychedelicpsychiatry@gmail.com

Article Submissions:
https://www.journalofpsychedelicpsychiatry.org/contact-1