A Trip to Save a Life:
Psychedelics and the Untraveled Road to Recovery

For Bobes
(05.14.14)

Jessica Cadoch
Department of Anthropology
McGill University, Montreal
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Abstract/Résumé

Psychedelic-assisted therapy is a burgeoning approach to managing mental illnesses such as post-traumatic stress disorder, substance-use disorder, end-of-life anxiety, and treatment-resistant depression. This therapeutic approach is currently undergoing FDA-approved clinical trials in the United States and around the globe. The therapeutic practice involves the careful administration of a psychedelic-containing compound such as MDMA, psilocybin mushrooms, LSD, and ketamine, in conjunction with more traditional psychotherapies, including mindfulness and cognitive behavioral therapy.

In this thesis, I explore the shift in cultural and mental health narratives around psychedelic substances. This perceptual shift transforms significantly from their use in the 1960s, to their erasure and vilification in the 1970s, to their revival in the 2000s. I trace the historical integration of psychedelics in managing substance use disorders and also outline the controversies and conflicts with more traditional models like twelve-step programs. As psychedelic-assisted therapy shifts older structures in the medical management of addiction, I highlight that psychedelic-assisted-therapy in fact conserves many previous structures and bridges biomedical and spiritual methods in the management of addiction. By demonstrating how this new modality simultaneously displaces and conserves traditional approaches to managing addiction, the thesis argues that the introduction of psychedelic-assisted therapy elicits a paradigm shift in our cultural perspectives toward care and healing in contemporary mental health care.

La thérapie assistée par les psychédéliques est une approche en plein essor pour gérer les troubles de santé mentale tels que le syndrome de stress post-traumatique, les troubles de consommation, l'anxiété de fin de vie et la dépression résistante au traitement. Cette approche thérapeutique fait actuellement l'objet d'essais cliniques approuvés par la FDA aux États-Unis et à travers le monde. La pratique thérapeutique implique l'administration prudente d'un composé psychédélique tel que la MDMA, les champignons de psilocybine, la LSD et la kétamine, en conjonction avec des psychothérapies plus traditionnelles, y compris la thérapie cognitivo-comportementale et la pleine conscience.

Dans ce mémoire, j'explore le changement dans les récits culturels et de santé mentale autour des substances psychédéliques. Ce changement de perception se traduit par une transformation significative de leur consommation dans les années 1960, leur effacement et leur diffamation dans les années 1970, et leur renaissance dans les années 2000. Je retrace l'intégration historique des psychédéliques dans la gestion des troubles de consommation de substances psychédéliques et je souligne également les controverses et conflits avec des modèles plus traditionnels tels que les programmes en douze étapes. Comme la thérapie assistée par les psychédéliques modifie les structures plus anciennes de la gestion médicale de la dépendance, je souligne que la thérapie assistée par les psychédéliques conserve en fait de nombreuses structures antérieures et fait le pont entre les méthodes biomédicales et spirituelles dans la gestion de la dépendance. En démontrant comment cette nouvelle modalité déplace et conserve simultanément les approches traditionnelles de gestion de la dépendance, ce mémoire soutient que l'introduction de la thérapie assistée par les psychédéliques suscite un changement de paradigme dans nos perspectives culturelles en matière de soins et de guérison dans les soins de santé mentale contemporains.

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I thank you for helping me achieve this goal and supporting me all along my path toward achieving the rest of my dreams.

Acronym Legend

AA	Alcoholics Anonymous
BACP	Bay Area Community for Psychedelics
DNO	Decriminalize Nature Oakland
DSM-V	Diagnostic and Statistical Manual - V
DMT	Dimethyltryptamine
FDA	Food and Drug Administration
LSD	Lysergic Acid Diethylamide
MAT	Medication-Assisted Treatment
MAPS	Multidisciplinary Association for Psychedelic Studies
MDMA	3,4-Methylenedioxymethamphetamine
NA	Narcotics Anonymous
NYU	New York University
PTSD	Post-Traumatic Stress Disorder

Introduction

"Rising to a beautiful day, a new possibility, a new paradigm."
— Decriminalize Nature Oakland June 5th, 2019

"*You're not decriminalizing drugs; you're decriminalizing people."*
—Anonymous Oakland resident

I step out of the 12th St/Oakland City Centre Bart station in Oakland, California and see a large granite government building. That must be it, I think to myself, Oakland City Hall, complete with Romanesque pillars, bald eagle statues and a clock tower. The building rises three stories in front of me. As I approach, I see a few familiar faces, people milling about making signs and banners for the upcoming hearing. Steven, who has kind, wrinkly eyes, wears a black blazer with a t-shirt underneath that says, "Decriminalize Nature Oakland (DNO)". He is holding a sign with the heading *The Power of Words* (Figure 1). There are two columns below it. The first is a list of

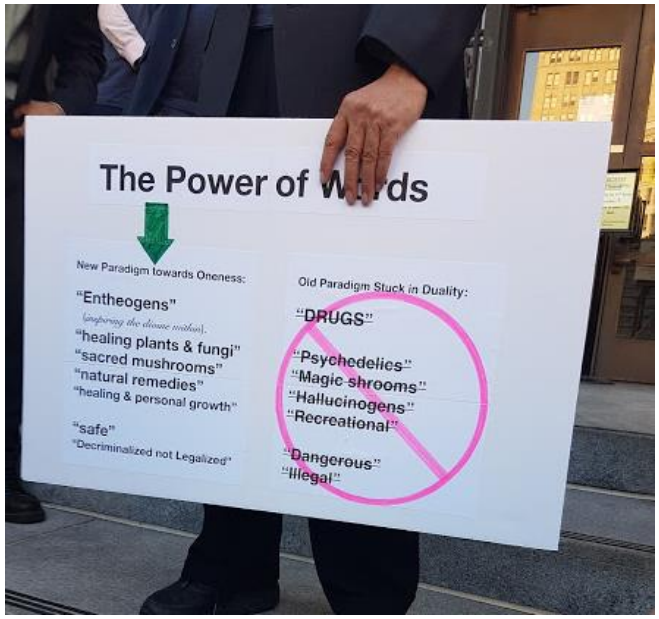

Figure 1: The Power of Words poster created by DNO organizer

words such as *Drugs*, *Magic-shrooms*, and *Recreational,* listed under the subtitle *Old Paradigm Stuck in Duality*, and the second column has the words *Entheogens*, *sacred mushrooms*, and *healing & personal growth,* listed under the subtitle *New Paradigm towards Oneness*. It is June 4th, 2019, day three of my fieldwork in the San Francisco Bay Area where I have come to learn about an ongoing shift in cultural narratives about psychedelic substances. I am attending an Oakland city council hearing to discuss the decriminalization of "all entheogenic plants and plant-based compounds listed on the Federal Controlled Substances Schedule 1"[1]. A motion has been advanced to decriminalize the possession and consumption of psilocybin-containing mushrooms, the peyote cactus, ayahuasca brews, dimethyltryptamine (DMT), and ibogaine.[2]

As we wait out front, Loren and Meadow, two of the leaders of the Decriminalize Nature movement, hand out pink slips to anyone who wants to speak at the hearing. Each pink slip grants the person 60 seconds to express their views and to try to convince board members that decriminalization is the best way forward. When those 60 seconds are up, it will be on to the next person.

[1] Oakland City Council - https://www.decriminalizenature.org/media/attachments/2019/11/20/decrim-resolution.pdf

[2] "Ibogaine is a psychoactive alkaloid naturally occurring in the West African shrub iboga. While ibogaine is a mild stimulant in small doses, in larger doses it induces a profound psychedelic state" (maps.org).

Now that we have our slips, close to 200 of us make our way up a grand marble staircase and into the pews and balconies of a large hearing room. A semi-circular wooden desk at the end of the room seats nine city council members who are discussing the previous motion on a bill to increase rent control rates in Oakland. Meadow, Loren and Steven, along with other DNO members, introduce the legislation they seek to pass. One of the city council members outlines the amendments requested at the first hearing a few weeks earlier:

> *These are 'whereas statements' that emphasize principals that, when adhered to, help ensure safe and responsible use of entheogenic plants. This was brought forth by the DNO team. The first is that entheogens are not for everyone; some people should not take entheogenic plants or fungi, including people with a personal or family history of schizophrenia or bipolar disorder or who are taking certain medications. Second is if someone has a serious condition like major depression or PTSD, they need to seek serious professional help before using an entheogen and ask their caregivers for advice. Third is, unless you have expert guidance through the process, it's best to start with really small amounts, potentially using more after you become familiar with the material and the terrain. Four, don't go solo; having at least one trusted friend be with you who is sober during the time of that journey and who has agreed in advance to honor that person, is a key and critical aspect of successful use. Fifth, the concept of reverence reduces risk and can help lead to a positive outcome. In cultures that have long used entheogenic substances, that use is approached with great respect, not haphazardly, and for life-enhancement purposes… These amendments are to ensure that this doesn't just become this thing that people do but that there is actual guidance behind this use.*

I recall feeling shocked to hear a city council member say the word ‘trip-sitter’ in the list of ways to ensure responsible and safe psychedelic use. A trip-sitter is a term that comes from harm reduction discourse and refers to a sober friend who stays by your side through a psychedelic experience to ensure your safety. It is not often that you hear a government official discuss the nuances of safe recreational psychedelic use. Was I was indeed participating in a hearing that would change municipal legislation around Schedule-1 psychedelic plant substances?

Attendees, most from Oakland and the greater Bay Area metropolitan region, start to share their stories. One man begins tearing up when telling the board that his children had slowly started speaking with him again after he successfully “kicked his opiate habit”. He explains that after years of repeated attempts at recovery in twelve-step rehabilitation clinics, he finally achieved sobriety at an ibogaine clinic in Mexico where this substance is legally provided in a biomedical setting. Next, a middle-aged woman addresses the audience and proclaims powerfully, “you are not decriminalizing plants; you are decriminalizing people,” while showing a photo of bruises and cuts on her face after being beaten up by local authorities for the possession of psilocybin-containing mushrooms. She explained that she was using mushrooms as a way to alleviate her treatment-resistant depression and that ingesting them was her way of self-medicating.

As I witness individuals, one after another, stand to share their stories, I see something more, the beauty of the Bay Area Community for Psychedelics (BACP)’s vision, and the moving power of their effort. Not only has a group of strangers united to work together collectively, not only have they provided a forum allowing individual voices to speak, the group has found a way make sure each one of those voices is fully heard. When someone does not have enough time to

finish telling their story, others stand up to shout, “they can have my minute!”, offering their own 60 seconds of microphone time. “Name please” the city council member asks, and the corresponding pink slip is removed from the pile and 60 more seconds are added to the clock. After one hour and seventeen minutes of community members coming together to share stories of the ways psychedelic-containing-plants and fungi had helped them, the motion to decriminalize passes unanimously.

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A new paradigm for the use of psychedelics is emerging in the United States, Canada and the United Kingdom. These substances are being recognized as having the potential to transform conventional methods for managing mental illness. We are seeing this happen in popular culture, Michael Pollan’s New York Times best seller *How to Change your Mind: What the New Science of Psychedelics Teaches Us About Consciousness, Dying, Addiction, Depression, and Transcendence (2018)* is changing the public discourse about the clinical use of psychedelic substances. Within the realm of public policy, Rick Doblin has founded the Multidisciplinary Association for Psychedelic Studies (hereafter, MAPS), a not-for-profit research and educational organization encouraging wide-scale acceptance of psychedelic-assisted therapy. And in the world of medical research, academic institutions, including Johns Hopkins and New York University, are conducting clinical trials demonstrating the efficacy of psychedelics for the treatment of multiple mental illnesses, including treatment-resistant post-traumatic stress disorder, anxiety, depression, end-of-life distress, and addiction. Psychedelic-assisted therapy is starting to be recognized as a revolutionary approach “to change the mind,” as Pollan (2018) has

put it. The shift in the narratives concerning psychedelic substances is thus three-fold. It is occurring in popular culture, in public policy and in medical research.

In *The Structure of Scientific Revolutions*, the philosopher of science, Thomas Kuhn (1962) coined the term 'paradigm shift', and permanently altered our understanding of how scientific discoveries come about. It should be no surprise, then, that the Stanford Encyclopedia of Philosophy, would list his treatise as "one of the most cited academic books of all time" (Bird 2018). Kuhn argued that instead of proceeding in an incremental and additive fashion—as scientific theory had previously been thought to be built—knowledge advances *episodically*. Conceptual continuity is periodically interrupted by revolutionary rethinking. Kuhn explained:

> …normal science repeatedly goes astray. And when it does—when, that is, the profession can no longer evade anomalies that subvert the existing tradition of scientific practice—then begin the extraordinary investigations that lead the profession at last to a new set of commitments, a new basis for the practice of science. The extraordinary episodes in which that shift of professional commitments occurs are the ones known in this essay as scientific revolutions. They are the tradition-shattering complements to the tradition-bound activity of normal science. (Kuhn 1970, 6)

In other words, a period of "normal science" ends when the prevailing paradigm is overturned or interrupted. This then creates a period of "revolutionary science" (Hedesan 2017, 10). Interruptions change the rules of the game by posing new questions of old scientific concepts, which leads to the creation of new paradigms (Kuhn 1970, 139). Vidya Hattangadi (2018) put it succinctly by defining Kuhn's notion of the paradigm shift as a "fundamental change in the basic concepts and experimental practices of a scientific discipline".

Questions: Using Kuhn's notion of a conceptual interruption, this project explores how psychedelic-assisted therapy *interrupts* the concept of recovery developed and promoted by Alcoholics Anonymous, and poses new questions of the prevailing paradigm. Echoing Kuhn, this thesis explores what rules of 'the existing game'—or treatment methods—are changed by the

introduction of psychedelic-assisted therapy. I investigate potential implications of the resultant paradigm shift should it become integrated into conventional modes of healing. More specifically, I ask, if psychedelic substances are reframed as medicinal rather than illicit substances, how will this change the way in which groups like Alcoholics Anonymous understand the term 'drug'?

Context: The current paradigm shift is happening amidst increasing interest in complementary and alternative medical treatments that emerged from a complex history of psychedelic-assisted therapy in the 1950s and 60s. It is occurring against a painful and difficult background of drug abuse, "America's deadly opioid crisis"[3]. Thousands of Americans are becoming addicted each year, and many are dying. In 2018 alone there were 128 opioid overdoses every day in the United States[4]. Some had succumbed to street heroin, others to prescription pain-relief medications.

This context, and the urgent need to find a way out of the crisis, has increased willingness to rethink the way prescription medications are being used, both in the field of medicine and in psychiatry. The opioid crisis is an indication that there has been a lack of effective and affordable non-medical treatments for anxiety, depression and pain. There has been widespread over-reliance on, and over prescription of, medications that result in dependency. Unfortunately, there has been little research on how to detoxify from such substances, resulting in a lack of proper protocols (Stone 2014; Cosci & Chouinard 2020; Nielsen, Hansen & Gøtzsche, 2012; Fava, Gatti, Belaise, Guidi & Offidani, 2015). At the same time, naturopathic and functional medicine approaches to healing are being embraced and accepted by an increasingly-wide segment of

[3] Gale, A. (2016). Drug Company Compensated Physicians Role in Causing America's Deadly Opioid Epidemic: When Will We Learn?" *Missouri Medicine. 114* (4). 244-246.
[4] National Institute of Health, May 27th 2020

society. The problem of prescription-medication dependency, accompanied by acceptance of alternative forms of healing on the part of the public, has made psychedelic-assisted therapy more palatable to the scientific community at the same time that psychedelics *re*-gain traction within the clinical community, and are coming to be seen as potentially legitimate treatments.

History: In the 1950s and 60s some psychiatrists, for instance Humphrey Osmond and Abram Hoffer, hailed psychedelic drugs as the 'silver bullet' needed to treat ostensibly untreatable conditions like addiction (Chwelos, Blewett, Smith & Hoffer, 1959). But then, following introduction of the Controlled Substances Act in the 1970s, psychiatrists and physicians began to fear using them. They worried that researching psychedelics had become disreputable. This, along with other factors that I explore in Chapter One, didn't eliminate the use of psychedelics altogether, but it did push their use into the underground. Now we are witnessing what is being called a *psychedelic renaissance* (Witt 2018). Popular culture, public policy, and medicine have all seen resurgent interest in the use of these substances. Critical and ethical anthropological research provides a powerful tool to explore how this shift is occurring, along with its broader effects. One of the most important of these has to do with the new paradigms of healing that are arising in accordance with psychedelic-assisted treatment. With a primary interest in addiction[5] and to twelve-step models of recovery, which involves submitting to a power greater than the self and working a series of steps while attending Alcoholic/Narcotics/Gamblers Anonymous meetings, this project investigates the potential incompatibilities of psychedelic-assisted therapy with conventional approaches to managing

[5] Addiction here is understood as a biopsychosocial disorder "defined as the continued use of mood-altering addicting substances or behaviors (e.g., gambling, compulsive sexual behaviors) despite adverse consequences" (Angres & Bettinardi-Angres 2008).

addiction. The goal is to contribute to an anthropology of the future.[6] I examine the potential of this new paradigm for healing and the repercussions that may ensue as it is adopted. Contextually, this study is inspired by and speaks to broader anthropological debates concerning the way scientific and cultural understanding of 'drugs' and 'addiction' are being maintained and/or overturned.[7]

The Existing Game: There are many paths that lead to recovery. In *Pharmaceutical Evangelism and Spiritual Capital,* Helena Hansen identifies two approaches based on neurochemical and faith-based understandings of addiction. "On the surface of it," Hansen explains, "they represent polar opposite models of what addiction is. They also invoke different images of who an addict is and lead to different responses to addiction as a society" (2013, 109). The biomedical approach assumes that addiction is a neurochemical disease in which the person has a reaction to substances that cause them to lose self-control.[8] This approach engages with medication-assisted treatment (MAT) techniques to help the person wean from the substances they are misusing. Twelve-step approaches to recovery have a faith-based orientation, in that addiction is framed as a spiritual problem and success relies on the acceptance of a higher power. This approach asserts that recovery requires abstinence from all mind-altering substances and broadly defines recovery as sobriety. Thus we can identify two main paradigms of recovery: an abstinence-based model and a harm-reduction one. Psychedelic-assisted therapy for the treatment of addiction muddies the separation between these categories. It offers an approach that is

[6] Bryant, R. & Knight, D. M (2019) *The Anthropology of the Future.* Cambridge University Press. Print.
[7] Nancy Campbell, Kelly Knight, Eugene Raikhel, William Garriott, Sandra Hyde, Helena Hansen among others.
[8] "Furthermore, individuals with lower levels of self-control, which may reflect impairments of brain inhibitory mechanisms, may be particularly predisposed to develop substance use disorders, suggesting that the roots of substance use disorders for some persons can be seen in behaviors long before the onset of actual substance use .itself (Moffitt et al. 2011)." (DSM-V https://dsm-psychiatryonline-org.proxy3.library.mcgill.ca/doi/full/10.1176/appi.books.9780890425596.dsm16)

biomedically-oriented as well as being based on a form of harm-reduction employing a spiritual discourse.

The prevalence of Alcoholics Anonymous programs around the globe[9], supports Erika Dyck's assertion that the twelve-step approach to recovery is the dominant approach to the self-management of addictive behaviors[10]. But participants in this study who engaged in psychedelic-assisted therapy to treat addictive behaviours felt that this new approach contrasted with the twelve-step model of recovery. For our purposes, I will refer to the twelve-step model as the dominant narrative within the recovery community. As I read the twelve-step literature, spoke with recovering drug users, and attended Alcoholics and Narcotics Anonymous meetings in the Bay Area of California, it became clear that psychedelic-assisted therapy generates tensions within the twelve-step community, and is viewed as incompatible with its principles. This tension provides a focus for further investigation, particularly for those who choose to traverse both the world of psychedelic-assisted therapy and the twelve-step approach to managing addiction. Following Kuhn, this project explores the way psychedelic-assisted therapy has come to represent a new paradigm. As such, I ask what this potentially revolutionary development does to current ways of thinking about, and managing, recovery, and explore the possible implications of integrating this new approach into existing methods for managing addiction.

Positionality: Naturally, my own personal experiences with these substances, and my confidence in their potential to treat mental illness, colors my ability to objectively study and report on this new paradigm. Although my analysis will include some critique of the twelve-step

[9] AA meetings are found in 180 nations with more than 125,000 groups worldwide. Although extremely difficult to monitor, the organization have estimated over 2 million active members (www.aa.org).

[10] "By providing peer-evaluated and empathetic therapy, AA had by the late 1940s become the most effective form of treatment and promised a 50 to 60 percent chance of recovery. This rate exceeded the medical rate, based on aversion therapy, or the use of chemical substances to suppress the desire to drink, by between 10 and 30 percent". (2006, 320)

model, this thesis does not aim to diminish the value or efficacy of the program itself. In an effort to echo self-reflective approaches to anthropology[11], I hold the twelve-step program close to my heart. I embark on this journey to explore the implications of having two seemingly-clashing-worlds work together. Indeed, I hope to illuminate the ways in which psychedelic-assisted healthcare practices are likely to conflict with current and conventional methods of managing addiction, and that this work sets the stage to mitigate such conflicts in the future.

My involvement with the community working towards the acceptance of psychedelic-assisted therapy provides me with a unique lens to anticipate the ways that it may clash with conventional healthcare practices. MDMA (3,4-Methylenedioxymethamphetamine), a psychedelic substance commonly referred to as ecstasy, is in the third phase of clinical trials with the FDA, and is expected to be prescribed for the treatment of post-traumatic stress disorder by 2021[12]. If this proves to be the case, it will be important as a social scientist to investigate the implications. As I examine differences between the prevailing and emerging treatment paradigms, I aim for objectivity and neutrality. This thesis lays out the ground from which this paradigm shift arises in order to provide a framework with which to ethically and critically examine it. My hope is that when psychedelic-assisted therapy becomes more acceptable, it will be integrated with grace and special attention to the ethical issues I highlight here.

Methods: I conducted three months of intensive ethnographic fieldwork in the Bay Area of California. The paradigm shift within which this work occurs goes beyond the Bay Area and

[11] Self-reflexive approaches to anthropology had been taken up my anthropologists like James Clifford, George Marcus, Clifford Geertz and Gregory Bateson.

[12] In MAPS' Phase 2 clinical trial to investigate the efficacy of using MDMA to treat PTSD, 68% of participants no longer qualified for PTSD at the 12-month follow-up mark. August 15th 2017 MDMA received breakthrough status (press release, August 26, 2017 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)

is occurring on several continents[13]. The Bay Area is unique, however, in that it provides a microcosm for investigating these shifting tides. Events and grassroots organizations here form an interconnected matrix that is leading the current psychedelic renaissance. Studying this renaissance has meant visiting a number of events in neighborhoods across the Bay Area.

The first day of my fieldwork takes place at the *Queering Psychedelics* conference which provides a platform for those whose voices often get relegated to the fringe. This is an opportunity for me to meet prominent members of the psychedelic renaissance. It is here that I meet Loren and Meadow. It turns out that on day three of my fieldwork, Oakland becomes the first city in North America to decriminalize all psychedelic-containing plants and fungi[14]. Soon enough, as if I am mimicking the mycelial network of fungi, I became deeply integrated within the psychedelic community of the Bay Area. My fieldwork comes to consist of attending various social events in a variety of organizations. I attend city council meetings, conferences at the *California Institute for Integral Studies*[15], and events held by *MAPS* and the *Chacruna Institute for Psychedelic Plant Medicines*. In doing so, I am able to explore the way in which institutions present this paradigm shift to the public.

As much as public reception is important, it is behind closed doors, in the grassroots non-for-profit organization called the *Bay Area Community for Psychedelics* (BACP), that I am able to understand the lived reality of this paradigm shift. With their help I conduct 22 interviews and enter into participant observation for three months in the summer of 2019. During the events that the BACP organize I am able to get a more nuanced understanding of the implications of having

[13] Research on psychedelic-assisted therapy for the treatment of mental illnesses is occurring in New Zealand, Israel, the UK, Switzerland, Canada, and all across the United States.
[14] Indeed, Denver, Colorado was the first city to decriminalize psilocybin-containing mushrooms, however, Oakland was the first city to decriminalize *all* psychedelic-containing plants and fungi.
[15] A college that specializes in transpersonal approaches to therapeutic disciplines, where they have designed a program to train therapists in psychedelic-assisted therapy.

psychedelic-assisted therapy become an accepted treatment for addiction and other mental illnesses.

Field: The BACP is a community-led organization with the goal of providing a safe space to connect people who use psychedelic substances. It was born of the need to de-stigmatize psychedelic use at a time when it was less acceptable. The BACP is part of an international effort to unite psychedelic-substance users. Compared to the New York, Montreal, and Vancouver psychedelic initiatives, however, it is clear that the BACP is, by far, the most active and engaged. For this reason, traveling to the Bay Area was crucial for the success of my project.

The mission of the BACP is to bring the underground psychedelic community together and educate the public about ways to safely participate in psychedelic-substance use. They host monthly conferences and workshops for those who want to learn more about psychedelic substances. They also provide a platform for influential figures in the subculture.[16] This encourages discussion and allows various approaches to using psychedelics to gain exposure. The BACP also hosts "integration circles" almost every week in different neighborhoods of the Bay Area. An integration circle is a support group helping people to 'make meaning'[17] of their psychedelic experiences. In the context of the integration circle participants gain insight by sharing their experience with their peers, and, if they wish, accepting feedback. Through integration, individuals may work to unravel the colourful experiences and often elusive threads of self-awareness that are woven into non-ordinary states of consciousness. Integration circles are the fruiting body of a valuable narrative repeated in psychedelic communities; "you get out of it, what you put into it." By showing up to a support group and discussing an experience with

[16] Influential figures in the field include researchers, therapists, journalists, and people who have successfully recovered from various mental illnesses via psychedelic-assisted therapy.

[17] 'Make meaning' is a term that many of my interlocuters would use to refer to the process of extracting meaningful lessons from a psychedelic experience.

others who might empathise, people can 'integrate' an often-elusive experience into their everyday life. It is in these spaces where one must 'put in' the hard work, in order to extract more significant lessons from a psychedelic experience.

The BACP has specialized integration circles geared towards participants' needs. They hold one group for people who use psychedelic substances to cope with mental health issues, one group for people who are using psychedelics while in recovery from addictive tendencies, a group that offers women a safe space to integrate their experiences, and finally, a standard integration circle that is open to all types of psychedelic-substance users. Between integration circles and other community events, the BACP hosts approximately 10-20 events per month[18], many of which sell out. These events support the organization in its NGO work. By contrast, the Montreal Community for Psychedelics holds one integration circle per month and one community potluck every two or three months. Alongside the larger-scale shift in cultural narratives around psychedelic substances that is occurring through public policy initiatives like Decriminalize Nature Oakland, the BACP provides a useful setting to explore the impact of the paradigm shift on people who are already making use of psychedelics.

By attending these events, I am able to build a network and connect with the diverse and prominent members of the field who are contributing to the shift in cultural, legal, and medical narratives around psychedelic substance use. I interview organizers of the BACP, participants who attend integration circles and events, administrative members of MAPS, therapists who are part of the psychedelic-assisted therapy clinical trials in association with the FDA, and general practitioners who understand the possible implications of integrating this approach into current modes of healing.

[18] Providing any further details on the types of events the BACP holds could put their privacy and pseudonym at risk. For this reason, the nature of these events will remain vague.

Ethics: One drawback of my method is that I do not get an opportunity to interact with people speaking out against psychedelic-assisted therapy. When I reached out to an ~~i~~llustrious psychologist, one who publicly expressed concern about introducing psychedelic-assisted therapy into biomedicine, he very quickly dismissed my interest in what is called the psychedelic renaissance. I had few opportunities to meet individuals that actively opposed, or were overtly concerned, with these new therapies for the treatment of mental illnesses[19].

As a result, I attended over a dozen Alcoholics and Narcotics Anonymous meetings in which I am provided with the conventional and dominant framework for recovery. These meetings were my attempt to gain exposure to a wide variety of perspectives regarding recovery. But as in all alternative and controversial therapies, treading these waters entailed a tremendous amount of grace and sensitivity.

Participating in these support groups, I make my presence as an addiction researcher known but omit giving information about my focus on psychedelic-assisted therapy. I feel that talking about this new and unconventional approach to treating addiction could negatively influence people in a vulnerable situation. Indeed, there is precarity in addressing psychedelic-assisted therapy among–newly sober individuals. Introducing this alternative and often taboo method for combating addiction can be suggestive of something that technically goes against twelve-step models of recovery. Many of those who are in AA or NA meetings have only recently turned to this traditional model of recovery. Presenting psilocybin mushrooms and

[19] In hindsight, I regret not having made a more thorough effort to reach out and expose opposing viewpoints. However, it is illuminating that throughout my entire three months traversing the Bay Area, along with attending AA and NA meetings, I did not naturally come into contact with anyone who overtly opposed the movement toward psychedelic-assisted therapy. This seems indicative and demonstrative of a truly widespread paradigm shift surrounding public perception toward psychedelic substances.

MDMA as *medicines* rather than *drugs* that leave users in a state of perpetual may lead to confusion.

As an ethnographer, I avoided being a source of confusion in discussing psychedelic-assisted therapy with my informants. For this reason, at AA and NA meetings, I introduce myself as an ally who has been in the passenger seat while assisting loved ones as they worked out their addictions and that I had dedicated my life to researching the best ways to combat and treat it. In the NA meetings, I make many friends, and people are interested in speaking with me about their experiences. However, I never feel comfortable taking out my recorder during these meetings, nor during any further conversations I have with people attending them. Doing so would make me feel like an 'extractivist' anthropologist, preying on the vulnerable for my own professional benefit (Burman 2018). For this reason, the method of data collection in these spaces is limited to participant observation and some notetaking.

I do not feel that same dilemma when I attend psychedelic integration circles. Although I don't record any of the sessions, I feel more comfortable overtly taking notes during the integration circles. There is more structure to integration circles than the AA and NA meetings. Before anyone can share their stories, we gather in a circle and introduce ourselves. At this point, the moderator or facilitator announces my presence as an anthropologist and asks participants for consent for me to attend and take notes. Having been part of the Montreal Community for Psychedelics, I feel closely connected with Meadow, one of the main organizers of the BACP. I also volunteer with the BACP. For this reason, I have more access to certain data than some researchers might. Considering that I only have three months to conduct my ethnographic research, it is challenging to get equally involved in the BACP and the Alcoholics Anonymous fellowships. Furthermore, the fact that I do not identify as a drug user in recovery makes it more

difficult to create rapport with participants at AA and NA meetings. Establishing a relationship with them would likely take longer than three months.

I realize that as a result of my personal involvement in the psychedelic renaissance, the data I collect may be slanted. I will attempt to correct this methodological setback by engaging with Alcoholics Anonymous literature[20]. However, I must acknowledge the impact that the imbalance has on my ability to conduct a comparative ethnography. For this reason, this project is not comparative; rather, I outline the current paradigm shift and investigate whether psychedelic-assisted therapy compromises, and therefore, interrupts prevailing and dominant notions of recovery. In the following chapter, I explore the history and the literature of how both psychedelic-assisted therapy and conventional models engaging with the concept of care. Next, I look at notions of agency and the will from their respective vantage points. Finally, I provide a framework for imagining how these two seemingly divergent approaches to managing addiction can converge to create a spiritual and biomedical fellowship.

[20] Albeit, the discourse and dogma of AA is likely different than the way in which it is practiced in reality.

1- Care: Paradigms of Recovery

"I can't listen to this because I had made a vow of not using anything"
—Roxanne

The anthropology of addiction has provided a scaffolding from which to critically examine a shift in the cultural narrative around psychedelic substances and the implications of their increasing approval by laypeople and government officials alike. Sandra Hyde explores the trajectory of care through the rise of humanistic therapy in drug rehabilitation centers (2011). Her ethnographic study of China's first residential community drug treatment center focuses on the implementation of humanistic therapy and how it came to replace punishment and

incarceration with an innovative form of psychological care. In *Discovering Addiction: The Science and Politics of Substance Abuse Research* (2007), Nancy Campbell investigates a paradigm shift in the role of the drug user in abuse research. She offers the term 'laboratory logics' to explain the change in "the pattern of beliefs that shape practical reasoning in science" (3). Helena Hansen investigates how different approaches to managing substance use disorder "invoke different images of who an addict is and lead to different responses to addiction as a society" (2013, 109). Finally, Eugene Raikhel and William Garriott have compiled a series of chapters outlining the changes in our understanding of addiction with their work *Addiction Trajectories* (2013). In their book, Raikhel and Garriott describe three types of trajectories;

> "(1) the *epistemic trajectories* traced by categories and concepts of addiction as they change over time and move across institutional domains; (2) the *therapeutic trajectories* of treatments as they move through distinct cultural and organizational settings; and (3) the *experiential and experimental trajectories* of lives constituted through the trains of addiction and subjectivity" (2)

In looking at the shift in the cultural narrative around psychedelic substances and exploring ways they are increasingly being understood as a form of treatment, this thesis moves psychedelic-assisted therapy into conversation with Raikhel and Garriott's notion of an addiction trajectory.

Building on concepts of care in addiction recovery discourse, this chapter looks at ways the term 'drugs' (as it pertained to psychedelics) is shifting in cultural and medical meaning. The discussion contributes to Raikhel and Garriott's *epistemic trajectory* in that it explores how psychedelic-assisted therapy affects categories and concepts to do with addiction. Ethnographic snippets are introduced throughout the chapter in order to demonstrate how new 'laboratory logics' are impacting dominant narratives around addiction, recovery, and care. This project is

inspired by broader anthropological debates concerning the politics of epistemology and historical shifts in scientific and cultural ontologies[21] to do with care.

First, the chapter outlines the long and complicated tale of psychedelic substance use in North America, and the variety of public opinions it has engendered. Second, I briefly investigate extant narratives and epistemic knowledge around recovery from substance misuse and ask how this relates to current ontologies of care. Third, looking into the emerging science about psychedelic-assisted therapy for the treatment of addiction, I argue that new laboratory logics play a significant role in the evolution of cultural narratives around drugs and the self. By exploring notions of 'care' in conventional approaches to managing addiction, and addressing the new science around psychedelic-assisted therapy, I show that the new approach troubles previous categories and ways of knowing drugs, medicine, and recovery.

A Brief Overview of Psychedelic-Assisted Therapy

From the beginning of the 1950s until the early 1970s, scientists from a range of disciplines saw potential for serotonin 2A receptor agonist (5-HT2AR) psychedelic compounds (i.e., classic hallucinogens) to accompany therapeutic engagements. The North American history of these substances dates to 1938 when Albert Hofmann synthesized LSD-25 with the intention of stimulating the human respiratory and circulatory systems (Shroder 2014, 3). Starting off with a bang, the tale of psychedelic-assisted therapy is a long and colorful one that has been told by

[21] Paolo Heywood distinguishes that "the 'ontological turn' in the discipline of anthropology is based on the notion that anthropologists are fundamentally concerned with alterity and that this is not a matter of 'culture,' 'representation,' 'epistemology,' or 'worldview,' but of being" (2012, 143). It is important to note that I am *not* using the term 'ontology' in the traditional anthropological sense. My use of the word ontology in this project is indeed a matter of culture, representation, epistemology, and worldview. In this project, I use 'ontology' to describe the way in which society perceives, understands, and represents psychedelic substances, and how the general worldview around these substances is changing.

many historians and journalists[22]. Nevertheless, before addressing the paradigm shift I observe in my fieldwork, it is important to briefly review the history of psychedelic substances in medicine and popular culture.

The first investigation into the efficacy of psychedelic substances for the treatment of various mental health disorders began in 1951, at the Weyburn Mental Hospital in Saskatchewan, Canada. Psychiatrists Humphry Osmond[23] and Abram Hoffer[24] initially tried to use LSD as a way to "understand psychosis from the inside" in hopes of pinpointing and reversing its root causes. However, personal experience led Osmond and Hoffer to note that the LSD experience resembled delirium tremens[25], a symptom that commonly accompanies alcohol withdrawal. The two psychiatrists wondered if the drug could "be a safe way to induce a delirium tremens-type event that might have a similar transformative effect" that it allegedly[26] has on one's personality and subsequent ability to attain lasting sobriety (Shroder 2014, 31). After undertaking fifteen years of study on the potential benefits of LSD, Osmond and Hoffer had promising success rates using it to treat alcohol-use disorder[27]. Furthermore, they noted that psychedelic substances are inherently non-addictive[28]. With the help of his dear friend Aldous

[22] Dyck, E. (2008), *Psychedelic Psychiatry: LSD from Clinic to Campus.* Johns Hopkins University Press.; Shroder, T., (2014). *Acid Test.* Blue Rider Press. New York.; Pollan, M. (2018) *How to Change Your Mind: What the New Science of Psychedelics Teaches Us About Consciousness, Dying, Addiction, Depression, and Transcendence.* Penguin Group.
[23] Humphrey Osmond was responsible for Aldous Huxley's first mescaline journey which culminated in Huxley's *The Doors of Perception (1954).*
[24] The director of research at the Weyburn mental hospital and Osmond's supervisor.
[25] Delirium tremens is a common symptom and reaction to alcohol withdrawal which includes shaking, shivering, irregular heart rate, and sweating (Healy 2008).
[26] It has been said that these symptoms are so enduring and emotionally taxing, that if someone survives them, they wind up quitting drinking in order to never experience those symptoms again.
[27] Upon treating over 700 patients, they found nearly 50% success rates with using LSD as a treatment for alcoholism (Chwelos et al., 1959 & Dyck 2006)
[28] The National Institute of Drug Abuse acknowledges that psychedelic substances tend not to induce "uncontrollable drug-seeking behavior" (https://www.drugabuse.gov/publications/drugfacts/hallucinogens) . Furthermore, researchers at Johns Hopkins University note that "no withdrawal was reported following chronic psilocybin use in humans in ARC studies including a study by Isbell et al. (1961) of 19 participants that included up

Huxley[29], Osmond coined the term psychedelic, meaning mind-manifesting, and scientists around the world took note of the staggering results.

Trailing not too far behind, in 1961 at Harvard University, Drs. Richard Alpert and Timothy Leary began investigating the effects of psychedelic substances as a means to explore the depths of the human psyche. The movement mushroomed, so to speak, and research expanded exponentially. Experiments were extensive and far reaching, and psychiatrists eagerly viewed these substances as a useful and legitimate tool for treating various mental illnesses such as alcohol use disorder (Chwelos, et al. 1959), depression (Abramson 1956), and trauma (Grof 1970). The scientific community increasingly came to revere psychedelic-assisted therapy. Psychedelic pioneer and transpersonal psychiatrist Stanislav Grof famously said that "the potential significance of LSD and other psychedelics for psychiatry and psychology was comparable to the value the microscope has for biology or the telescope for astronomy" (Grof in Hofmann 2009, 14). Psychedelic substances became venerated for their potential to help open the gates for the patient and therapist to peer into the subconscious mind, a phenomenon that had perplexed both scientists and philosophers for centuries.

More notably, in the public sphere, Leary became so enthralled with the potential of psychedelics that he felt they could alleviate broader socio-political issues. He became the public spokesperson for the hippie counter-culture movement of the 1960s, and encouraged everyone to

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to 12 days of psilocybin (ascending up to 0.15 mg/kg or0.21 mg/kg) followed by up to 13 days monitoring after termination of administration. With the exception of MDMA, which is distinct from classic psychedelics both in effects and primary pharmacological mechanism of action, the Fifth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM 5) does not include a diagnosis of withdrawal for 'hallucinogens' (American Psychiatric Association, 2013). As concluded by O'Brien (2011), 'Frequent, repeated use of psychedelic drugs is unusual, and thus tolerance is not commonly seen. Tolerance does develop to the behavioral effects of LSD after three or four daily doses, but no withdrawal syndrome has been observed" (O'Brien, 2011)'." (Johnson, Griffiths, Hendricks, Henningfield 2018).

[29] Author or *Brave New World* (1932) and *Doors of Perception* (1954).

"tune in, turn on, and drop-out" by using psychedelic substances. It was in this context that the reputation of psychedelic substances moved out of the sphere of clinical psychology and into the domain of sex, drugs, and music. Consequently, in 1971, US president Richard Nixon devised the Controlled Substances Act to legally incarcerate those who were participating in anti-Vietnam war demonstrations and the civil rights movement[30]. As a result, classical hallucinogens such as psilocybin, LSD, and marijuana were categorized as schedule 1 substances. "Schedule I drugs have no currently accepted medical use and aren't considered safe to use even under medical supervision. They have a high potential for abuse and dependency" (Robotti 2019). Thus began the war on drugs in the United States. Research came to a sudden halt and psychedelic substances gained a different reputation in popular culture. Anti-psychedelic propaganda became rampant in the 1970s, and psychedelic substances no longer were believed to hold the promise they'd once been seen to have. Indeed, they became feared enough that for the next twenty years no scientist dared tarnish his or her reputation by investigating their effects.

Then, in 1991, Rick Doblin, who received his Ph.D. in Public Policy at Harvard University, conducted a 25-year follow-up of Walter Pahnke's Good Friday Experiment from 1963[31]. The original study had set out to explore whether, if accompanied by the right set (mind-state) and setting (environment),[32] psychedelic substances such as LSD and psilocybin could

[30] "The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did." (Ehrlichman cited in Baum, 2016)

[31] Doblin, R. (1991). "Pahnke's "Good Friday Experiment": A long-term follow-up and methodological critique" (PDF). *Journal of Transpersonal Psychology. 23* (1): 1–28.

[32] 'Set and Setting' continue to hold an important role in the realm of psychedelic-assisted therapy. To this day, psychiatrists who are legally practicing PAT stress that taking psychedelics in the context of this protocol provides a completely different experience than taking these substances on the dancefloor of a music festival. For these

induce a mystical experience in religiously-inclined volunteers. Backed by the ground-breaking work of Rick Strassman, Stanislav Grof, and Roland Griffiths, Doblin's rigor and commitment to uncovering the long-term results of this study led to a resurgence of psychedelic science[33]. Doblin is the founder of MAPS. They are currently in the third phase of clinical trials[34] with the FDA to determine the efficacy of MDMA for the treatment of post-traumatic stress disorder in treatment-resistant veterans.

Today we are living amidst what is being called the *psychedelic renaissance*. This period encompasses a noticeable shift in a cultural[35], legal[36], and medical[37] narratives around psychedelic substances. Many people are enthralled and excited by their potential for healing. Doblin has estimated that by 2022, MDMA will be approved by the FDA as a treatment for PTSD. Once phase three[38] of these clinical trials has been successfully completed, MAPS will begin the *Expanded Access Program* – which has been systematically training psychiatrists in the psychedelic-assisted therapy protocol. This will allow them to start providing MDMA-assisted therapy for those with treatment-resistant PTSD. Furthermore, Johns Hopkins University recently received USD $17 million from private donors to open the Center for Psychedelic and Consciousness Research (CPCR). This center has been extensively investigating the efficacy of psilocybin-assisted therapy for treating tobacco and alcohol addiction and end-of-life distress. In

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reasons, doctors in the field argue that each experience is unique and cannot be re-emulated beyond the clinical space.

[33] Although 'Psychedelic Science' is a much larger genre than what I am tackling here, I am using this term in the way that many of my field respondents use it as a way to refer to new science and research on psychedelic substances

[34] Phase I of clinical trials includes "20 to 100 healthy volunteers or people with the disease/condition". Phase I seeks to determine a safe dose and protocol appropriate for this substance along with expected side-effects. Once a safe dose is found, the trial moves on to Phase II in which several hundred individuals participate in the study.

[35] With books such as Michael Pollan's (2018).

[36] As seen with the policy change in Oakland to decriminalize all natural psychedelic compounds (2019)

[37] Which can be found in looking at the MAPS, NYU and Johns Hopkins University clinical trials

[38] Phase III includes 300 - 3,000 individuals with the disease in question (Step 3: Clinical Research - United States Food and Drug Administration).

November 2020, researchers at the CPCR demonstrated substantial results for psilocybin-assisted therapy for the treatment of major depressive disorder (Davis, Barrett, May, Casimano 2020). In an interview with *New Atlas*, Alan Davis, from the Johns Hopkins University CPCR and corresponding author on the study said that "the magnitude of the effect [they] saw was about four times larger than what clinical trials have shown for traditional antidepressants on the market" (Haridy 2020). Other projects are also in the works: exploring psilocybin as a treatment for opiate use disorder, anorexia, Alzheimer's disease and Lyme disease[39].

Psychedelic substances have now come full circle in the cultural, legal, and medical domains, once more taking a revolutionary role. They are interrupting the continuity of scientific concepts and prevailing laboratory logics that both Kuhn (1962) and Campbell (2007) describe. But as we experience this psychedelic renaissance and psychedelic substances become more commonly used as treatments, it is important to address the ethical dimension *before* their use becomes normalized across the realms of biomedical science and popular culture. With an increasingly hopeful and expectant population[40] it is useful, and arguably crucial, to resist the temptation to treat these substances as a cure all. Integrating them into biomedicine will require thought and care. Thus, this project is an anticipatory endeavour, and can be considered part of an anthropology of the future. As such, it raises a key question: *what impacts do these findings have on current narratives around addiction, and how do they interrupt traditional trajectories of care?*

[39] See the Center for Psychedelic and Consciousness Research website for more information: https://hopkinspsychedelic.org/index/#research

[40] In referring to a 'starstruck' population, I am referring more to patients' who are venerating this type of therapy as their last hope for any sort of cure, and less so to the psychotherapists and researchers who are taking part in these clinical trials. The researchers on these teams are very careful not to engage in a panacea-like framework surrounding these substances – a narrative I will explore later on in the text.

Traditional Models of Recovery

Medication-Assisted Treatment (MAT) is one of the main methods currently in use to treat severe substance use disorder, primarily for people with acute opiate-use problems. MAT takes a harm reduction[41] approach to managing addiction and combines medications such as buprenorphine, naloxone, and methadone with counseling and behavioral therapies. Helena Hansen has dedicated much of her career to understanding current approaches to care in the realm of addiction. In her chapter in Eugene Raikhel and William Garriott's *Addiction Trajectories (2013),* she eloquently recounts the history of opiate-maintenance therapy and describes the evangelical nature of pharmaceutical approaches to managing addiction. She portrays them as 'medical evangelism' due to the way in which buprenorphine clinics enthusiastically advocate for their system. The way they promote its use "carries conviction of access to vital knowledge" (120). Compared to the ridicule many addiction patients receive in hospitals, these clinics offer their clients greater dignity. She concludes nevertheless that the "doctors are embroiled in a continual struggle to convince buprenorphine patients to stay on their medications for the long-term, to help them see that pharmaceuticals return patients to their natural state, to their true self, rather than pharmacologically maintain them in an artificial state... [and that] 'the 'bupe' is like insulin for a diabetic'" (119). Care, in this form, is provided by administering medicine regularly in an attempt to maintain a level of chemical homeostasis. While this approach will undoubtedly alleviate the patients' immediate addiction crisis, it involves coercive techniques that require consistent compliance. It also convinces patients that without this system, they are helpless and powerless over their addiction (see Knight 2015,

[41] Harm reduction is an approach to drug use which encourages the least amount of harm on the user. Often, harm reduction initiatives consist of drug education, clean needle exchanges, and supervised injection sites.

Hansen 2018, McLean 2015, Bourgois 2000, for a more in-depth critique of harm reduction approaches for managing addiction).

While MAT takes a more neurochemical approach to caring for those suffering with substance misuse, the twelve-step method for managing addiction offers a spiritual and communal dimension to care. Bill Wilson created Alcoholics Anonymous in 1935 after decades of repeated failure to end his own addiction to alcohol (Lattin 2012). Wilson had been approached by an old drinking companion who had found God and finally been able to renounce alcohol. The two men recognized that in order to dismantle ones' dependence on the bottle, they needed to surrender to a power greater than themselves. Wilson had come to see that an addicts' meager willpower was not enough to break the pattern of alcohol dependency. But having found strength by teaming up with another man who had suffered with, and then had a spiritual reprieve from drinking, Wilson wanted to replicate and formalise their approach. For this reason, in 1953, he wrote the *Twelve Steps and the Twelve Traditions* as a guide for those seeking to recover from addiction. Wilson defined addiction simply as "a seemingly hopeless state of mind and body" (Alcoholics Anonymous 2013, xiii).

Over time, the medical field reinforced the notion that the 'addict' is powerless against the bottle. At the beginning of the *Big Book* of Alcoholics Anonymous, before Chapter One, the segment titled "*The Doctors Opinion"* sets the authoritative tone of the AA canon. "In nearly all cases," Dr. William D. Silkworth writes, the alcoholic's "ideals must be grounded in a power greater than themselves, if they are to re-create their lives" (ibid., xxviii). In this way, by alluding to a 'doctor's opinion,' the AA approach to recovery utilizes the authority of biomedicine to pursue its spiritual agenda. Yet, medical historian Erika Dyck explains that at its core,

> [t]he principles of AA were not grounded in medical expertise but relied on fraternal support offered by members who shared experiences with one another. This approach

> created an alternative non-drinking society, which shaped its own rules to the needs of problem drinkers. The collegial function of the organisation continued to provide recovering alcoholics with a social outlet—an important aspect, as several members had highlighted the central role of shared activities surrounding drinking. (2006, 320)

Indeed, the twelve-step approach to recovery rests primarily on the strength of fellowship.

AA daily meetings were designed to provide support by gathering together people who had undergone similar tribulations and could honestly empathize with fellow members of the group. Having attended several Alcoholics and Narcotics Anonymous meetings, one slogan in particular stood out to me. It is said at the end of each meeting as, standing up in a circle, participants grab hands, shake them up and down, and chant, "keep coming back, it works if you work it and work it 'cause you're worth it". This motto implies that in order to remain sober, all one ought to do is work the steps and attend the meetings.

Based on the information above, it appears that both the MAT and AA models of recovery rely on coercive techniques that convince the 'addict'[42] that without working their respective programs continuously, they will fail at maintaining sobriety. Along with Hansen, Kelly Ray Knight brings discourses of coercion to anthropological investigations of care in addiction recovery. In her seminal ethnography, *Addicted, Pregnant, and Poor*, Knight explores how pregnant drug users are *entangled* "in carceral regimes in which the lines between care and coercion become significantly blurred" (2015, 13). Knight's ethnography investigates the carceral nature of government aid for homeless mothers who must simultaneously negotiate the temporality of addiction and ultimately find themselves in a liminal space of care and coercion.

[42] Throughout this text, I refrain from referring to people with substance use issues as addicts because this reinforces a pathologized notion of the substance user. My interlocutors felt triggered by this word and expressed that the word itself suggests a lack of power over the self. For this reason, I only use the term 'addict' when I am engaging in discourses that refer to the substance user as powerless.

While neither Hansen, nor Knight, focus specifically on coercion in twelve-step approaches to recovery, I use Knights' framework of entanglement and Hansen's investigation of diverse methods managing addiction as scaffolding to further explore the historical shifts in scientific and cultural ontologies around care in addiction recovery. As previously mentioned, I recognize that the currently dominant approach to managing addiction is through a twelve-step model of recovery. Dyck explains how AA quickly became the dominant method for combatting addiction:

> By providing peer-evaluated and empathetic therapy, AA had by the late 1940s become the most effective form of treatment and promised a 50 to 60 percent chance of recovery. This rate exceeded the medical rate, based on aversion therapy, or the use of chemical substances to suppress the desire to drink, by between 10 and 30 percent. (2006, 320)

For this reason, I pay particular attention to the potential incompatibilities between psychedelic-assisted therapy and the twelve-step model of care. Inspired by Knight's and Hansen's theoretical frameworks, and returning to Campbell's laboratory logics, as well as Kuhn's conception of a paradigm shift, the next section explores the epistemic impact that psychedelic-assisted therapy has had on conventional understandings of recovery.

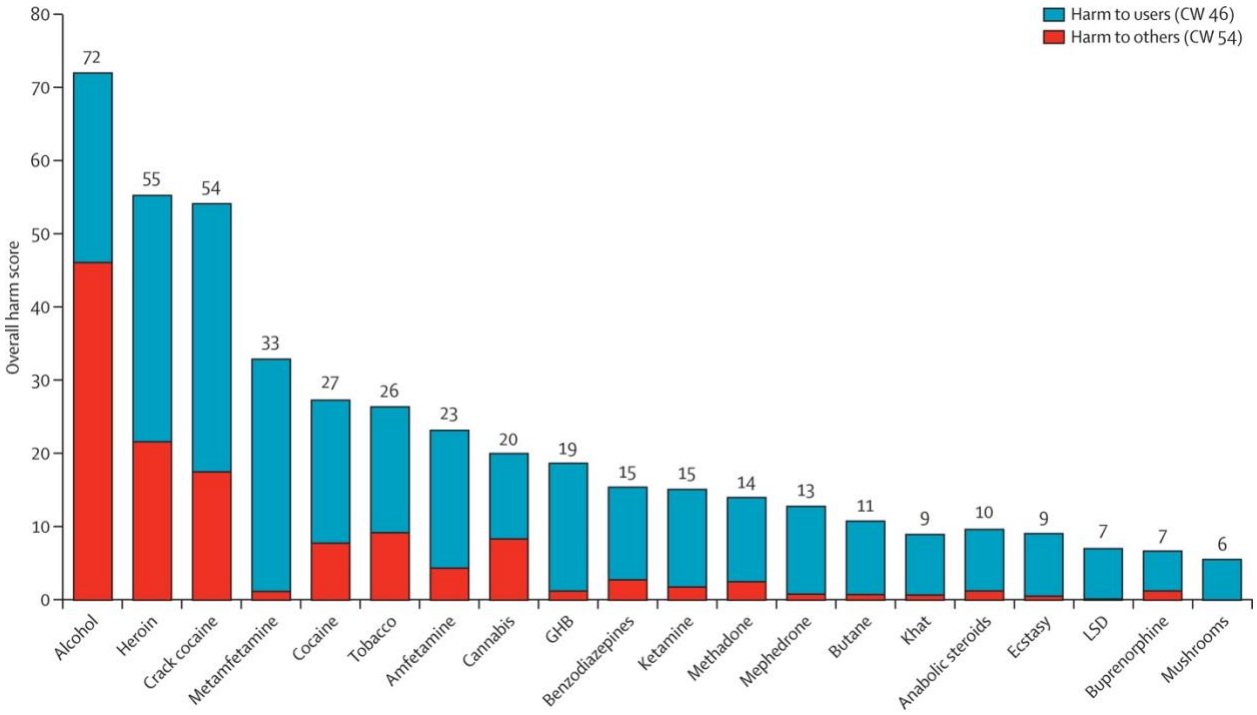
New Laboratory Logics and New Narratives

In 2012, neuroscientists Terri Krebs and Pål-Ørjan Johansen conducted a meta-analysis of studies from the late 1960's that successfully demonstrated the efficacy of LSD for the treatment of alcohol-use disorder. Their study addressed the positive and negative outcomes from six clinical trials involving more than 500 people suffering from alcoholism. They concluded that although the studies varied in their protocols and doses, "185 of 315 (59%) LSD patients and 73

of 191 (38%) control patients were improved at the first reported follow-up" (2012, 996)[43]. Furthermore, they claimed that "the effectiveness of a single dose of LSD compares well with the effectiveness of daily Naltrexone, Acamprosate, or Disulfiram" (ibid., 1000), all medications currently approved for reducing relapse from alcohol dependence. With this study, Krebs and Johansen led the legitimization of laboratory investigations into psychedelic-assisted therapy. Although they looked at work done before the *Controlled Substances Act* restricted access to psychedelic substances, they provide the framework for modern scientific endeavors to undertake further investigation.

More recently, research at Johns Hopkins University has revealed a significant success rate using psilocybin-assisted therapy for nicotine dependence, "demonstrating abstinence rates of 80% at six months follow-up and 67% at 12 months follow-up [dos Santos et al., 2016; Johnson, Garcia-Romeu, & Griffiths, 2017]—rates considerably higher than any documented in the tobacco cessation literature" (Argento, Tupper, Eugenia 2019, 80). Figure 1 demonstrates the abuse potential of psilocybin containing mushrooms. The negligible rates shown here contribute to Johnson, Griffiths, Hendricks and Henningfield's (2018) argument that psychedelic substances are non-addictive (see Johnson et al. 2018 for more information).

[43] To provide some perspective, between 22-37% of people in Alcoholics Anonymous programs remain abstinent. Furthermore, "studies generally show that other treatments might result in about 15 percent to 25 percent of people who remain abstinent" (Frakt & Carroll 2020).



Aiding this point, a recent US population study of 44,000 individuals found that psychedelic use was associated with a 40% reduction in the risk of opioid abuse, and 27% reduction in the risk of opioid dependence (Pisano, Putnam, Kramer, Franciotti 2017, 608). These are just some of the studies exploring the efficacy of psychedelic-assisted therapy contributing to the shift in understanding of psychedelic compounds and their place within contemporary drug narratives.

It is important to note, however, that each of the study protocols above varies. The timeline and the number of experimental sessions are not consistent. It would be helpful to have

Figure 2: "Normalized ratings of harm potential of psilocybin ("mushrooms") relative to other drugs as rated by experts in the United Kingdom using on a multidimensional scale. Drugs are ranked by overall harm from left (most harmful) to right (least harmful), with harm to users (blue) and harm to others (red) shown separately. Abbreviations: CW = cumulative weight, GHB = gamma-hydroxybutyric acid (Figure from Nutt et al., 2010, Fig. 2)" (Johnson et al. 2018).

a basic, standardized treatment protocol. This not only makes it possible to compare study results more accurately, it also offers a way to understand what is actually going on. The psychedelic healthcare industry is still in its early stages. Companies such as Maya PBC are building a software platform designed to help psychedelic practitioners manage their practice, measure progress, and illustrate health outcomes, so they can optimize their services, scale safely and effectively, and help advance psychedelic healthcare. Software such as these can lead to standardizing psychedelic-assisted therapy treatment protocols.

Below, in Figure 2, I show a generic representation of MAPS's protocol for phase three clinical trials created to explore the efficacy of MDMA for the treatment of PTSD. It requires roughly twelve weeks and fifteen sessions. Only three sessions involve the controlled, supervised

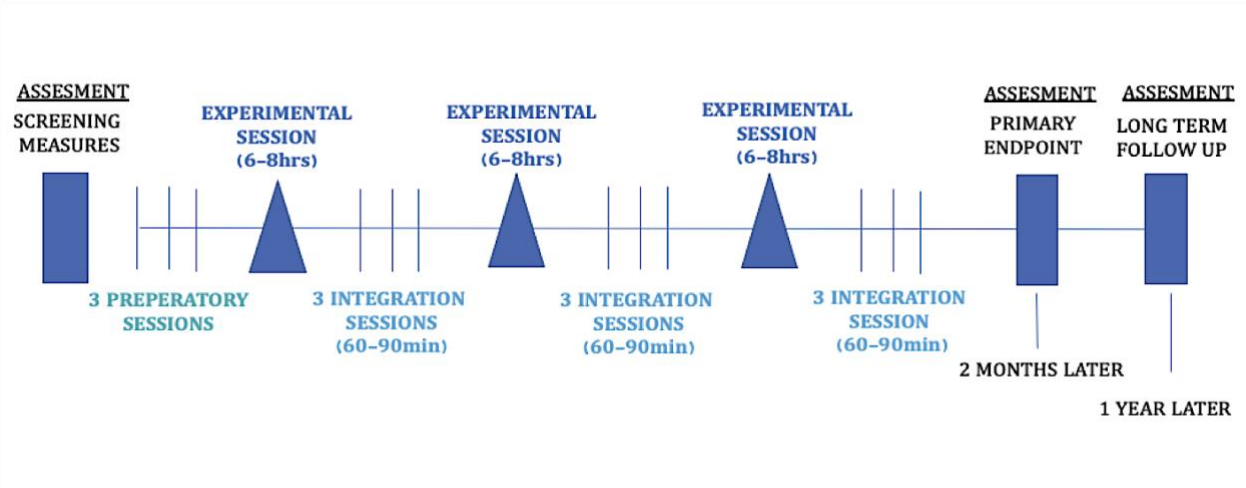


Figure 3: a generic depiction of the protocols used in MDMA-assisted therapy for the treatment of PTSD. Created by Jessica Cadoch based on Mithoefer 2015.

administration of a psychedelic substance. Two therapists (currently one male and one female[44]) attend each of the psychedelic sessions. Three integration meetings follow each treatment

[44] There is much debate over the necessity of having a male/female therapist dyad. They are meant to provide the patient a semblance of the paternal and maternal attachment figures. Speaking with private clinics waiting to join the MDMA expanded access program, I discovered that they are considering asking patients to specify the therapists they feel would be most beneficial (i.e.; people of color, someone who identifies as LGBTQ…etc.). The

session. The integration meetings are understood to be the most essential component to the success of the protocol. The objective of integration is to provide a platform for *making meaning* of the psychedelic experiences. In these sessions the same two therapists and patient meet to collectively discuss reasonable and pragmatic ways to integrate the experience into the patient's daily life. The initial integration session takes place the morning after the experimental session, and is followed by four phone check-ins over the next several days. The second integration session occurs two weeks later, and the third, four weeks later. These meetings create a space for the patient to decompress and process the psychedelic experience with the two therapists.

Integration sessions provide a foundation of a valuable narrative repeated in psychedelic communities; "you get out of it what you put into it". It is a phrase that was commonly heard during integration circles in which I participated, discussions with professionals, and at conferences. One research participant, whom I call Jen, and who works as a ketamine-assisted therapist, put it nicely:

> *People have this perspective that they're going to take a psychedelic and wake up the next day and never be depressed again. At the end of the day, the* dirty work *still needs to be done. And that's going to take time.*

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reason for this is that some patients might have trauma with a particular gender, and having that gender present during an experimental session could be triggering. The dyad itself is necessary in order to ensure best and ethical practice. Having another therapist present ensures that no lines are crossed in terms of consent. However, there was an incident in which the dyad did not protect the patient from therapist sexual misconduct – for more information on this, see the "Statement: Public Announcement of Ethical Violation by Former MAPS-Sponsored Investigators" here; https://maps.org/news/posts/7749-statement-public-announcement-of-ethical-violation-by-former-maps-sponsored-investigators .

Her approach implies that psychedelics are not a magic bullet. Indeed, Jen emphasizes that psychedelic-assisted therapy only functions *because* of the integration work that is fundamental to the protocol. Integration can, and is encouraged to, continue beyond the clinical trials with the help of the community through weekly meetups.

There are a number of studies exploring the efficacy of psychedelic-assisted therapy going on now, and the results look promising[45]. What I find intriguing is the way in which psychedelics are being transformed through this process from being illegal 'drugs' to pharmacological 'medicines'. This is occurring due to the fact that these studies alter the way we understand psychedelic substances themselves. I am interested in the role new laboratory findings have in creating the dominant narratives we have about healing and care. And I wonder how the ongoing paradigm shift impacts pre-existing notions of medicine, drugs, and care. Specifically, I ask how the very existence of this new paradigm affects those who are currently in long-term recovery using a traditional approach like the twelve steps.

Excerpts from the Field

During my last integration circle in Oakland, I met Roxanne and Jerry, a couple with 21 and 30 years of recovery respectively. I recall Jerry, a 73-year-old man with long silver hair, blue eyes, and the perfect smile of pearly white dentures, talking about using psychedelics in the 1970s. His eyes are closed, and he reminisces about feelings of elation and one-ness with himself and the universe. It seems something he's longed for. "I really appreciate being able to talk to a group about this that won't say 'you're not in recovery anymore' if I take psychedelics," he says. His

[45] Although the data from these studies are no doubt fascinating and pertinent, conducting an in-depth meta-analysis of these studies is outside of the purview of this thesis.

partner, Roxanne, a 53-year-old woman with sunken eyes and long dark hair, has a sweet and innocent air as she shares the guilt she feels for wanting to use psychedelics after 21 years of recovery. "We don't have anyone to talk to about this, it's toxic in the twelve-step fellowship," she confesses. I admit, I was eager to finally meet people who have more than one year of recovery in a psychedelic integration circle. This circle is a support group providing a safe space for people using psychedelics to help alleviate symptoms of mental illness.

Roxanne and Jerry live in the mountains along the coast about an hour-and-a-half drive from the Bay Area. Getting to them by public transit seems nearly impossible, so I opt to rent a car. I arrive at the car rental company to discover, however, that without any notice, my reservation has been cancelled because they are out of vehicles. The day is escaping me, and I'm beginning to get nervous that I will not get another chance to make the journey down to Roxanne and Jerry before I head back to Montreal. Turning to the sharing economy, I find a phone application that allows you to use other peoples' cars for short periods—what else ought one do in the tech capital of the continent? Since I am a Canadian citizen, they need a copy of my passport, which is back at the apartment where I am staying. Getting there is about a 25-minute trip from the car rental company. I walk back to the City Center Bart station and get no further than the next stop before a voice over the intercom lets the passengers know that there has been an electrical fire. We are asked to evacuate. All signs are pointing to failure; something does not want me to meet this couple. But I am relentless, decide this is a classic fieldwork hurdle, and decide to rise to the occasion to chase what turned out to be a rich experience, several hours of 'deep-hanging out' with Roxanne and Jerry.

It is 8:30 in the evening and I have been sitting with Jerry on the porch for three hours surrounded by 30-foot-tall sequoia trees amid the buzz of mosquitos. The interview concluded,

we head inside for a small bite to eat before Roxanne and I sit in the living room to discuss her story. After hearing her journey of substance misuse, I ask her, "what made you, after 21 years of abstinent sobriety, say 'I want to use psychedelics again'"?

> *Well, it happened on this funny whim, I have a two-hour commute, and I listen to a lot of books, and I'm still very inquisitive, and I always liked learning, learning, learning. Learning, about the brain, brain flexibility, and habits, there are all these books on habits. And I got a book* How to Change your Mind, *and I thought it was another book on habits or how the brain works or whatever. When I first started listening to it, I was like, oh my fucking god, I can't believe I got this book. This is so silly. I was like, I can't believe I got this book. I didn't know it was about psychedelics. I just thought it was another self-help book because I listen to a lot of those. And then I was like, you know, I'm not going to, I can't listen to this, because I had made a vow of not using anything. But then I listened to it a little bit more, and a little bit more and this guy was describing this trip. And I could understand the language. I totally knew exactly what he was saying, and I just listened to it more and more, and it just made a lot of sense. I mean, it was good to get all the history. And then he started talking about you know, how it was helpful for addiction, I was like...* (long pause) *I was like… this is making a lot of sense.*

Roxanne struggled with various substance misuse most of her life. She managed to quit things like cocaine, crank[46] and alcohol on her own. But she needed the twelve-step fellowship to quit marijuana, the substance with which she felt she'd had the most problems.

[46] Commonly used to refer to crystal meth, however we never specified what she meant.

I want to use psychedelics because I feel like they teach me a lot, you know, like I remember, always loving psychedelics. Like when I got sober, I said, I am not giving up psychedelics, I'll just not do them right now. I hope to reconnect.

What I liked about going [to the integration circles] was people that were saying, 'I got to reconnect with my spirituality,' or 'I got to reconnect with,' I don't know what they would call it, like spirit or power. I mean they say Higher Power in the program, and I have been struggling with finding a Higher Power, you know because in the program they act like he's Santa Claus, you know? And it's like "my Higher Power…", you know, and it's everything they make up, and I'm just like, you can't just make up something. Like a power of your own understanding is different than a power of your own creation, so what they're doing in the program is they're making a power of their own creation and saying this is my higher power, you know, like its…

So, I gave up, and I fluctuate throughout the years like I believe in a higher power, and then I don't believe in a higher power. But I feel like this will give me a connection, and right now with the times the way they are, with Trump in office, and all this craziness going on, I feel like this will give me peace, that I will be connected to the greater… the greater whole… and I just… I don't know what it is… and I really don't, you know.

Roxanne's story illustrates the way the lines between care and coercion are blurred in her twelve-step fellowship as she attempted to understand her identity as a 'recovering addict' amidst a paradigm shift.

When she had picked up Pollan's notorious book (2018), which the *New York Times* included in their 'Top 10 Books of 2018' list, Roxanne felt that her sobriety and her identity as an 'addict in recovery' were being threatened. Her experience suggests that the effects of scientific discoveries from clinical trials don't stay within the scientific realm. Michel Foucault's notion of 'biopower[47]' helps explain this by offering a logic of power that is capillary in nature. Power, according to Foucault, moves through cultural narratives in society similar to the way blood moves through capillaries in the body. As it spreads, it coheres in nodes that we recognize as pop-culture figures such as Pollan. A food writer and long-time journalist for the *New York Times*, Michael Pollan has had a significant ability to establish cultural narratives. His tone is authoritative but accessible. And his social status as a well-known and well-respected public intellectual prompts ordinary people to read about what I am calling a new laboratory logics[48] . Before Pollan's book, the vast majority of people living outside the underground psychedelic community knew very little about the studies taking place at Johns Hopkins University and New York University. His work disseminated these laboratory findings and brings them to the general public. In doing so, Pollan has systematically shifted normative conceptions of psychedelics, and accordingly, notions of drugs, care and healing. In this way, with the help of pop-culture figures, new laboratory logics are moving psychedelic substances from the category of illicit and hedonistic substances to the realm of healing and medicine.

[47] Contrary to a top-down conception of power that involves a single sovereign as the oppressor against the oppressed, biopower is a concept through which we can understand power as embodied and distributed by the 'capillaries' of society (Foucault 1978).

[48] As mentioned previously, Nancy Campbell uses to the term 'laboratory logics' to as a way to explain the change in "the pattern of beliefs that shape practical reasoning in science" (2007, 3). I use her term as a building block to demonstrate how new findings in the scientific setting impact the 'logics,' or epistemic knowledge, by which we understand recovery from addiction. In this setting of the *psychedelic renaissance,* the scientific discoveries around the efficacy of using psychedelic substances to alleviate mental illness change the "pattern of beliefs that shape practical reasoning in [the] science" (ibid.,) of addiction recovery.

In light of Roxanne's fear of returning to what she defines as a spiritual practice, I question the notion of care according to twelve-step models of recovery. In returning to Kuhn's paradigm shift, revolutionary science incites fundamental change in the basic concepts and experimental practices of a scientific discipline. However, when these laboratory logics permeate popular culture and effect legal change, as we have seen with Pollan's book and public policy (i.e., Oakland decriminalizing psychedelic-containing plants), fundamental shifts beyond the scientific disciplines begin to take place.

A change in the categories around drugs and medicines encourages us to reimagine fresh 'basic cultural concepts' around recovery itself. One of these, Roxanne exemplified with her insight that 'recovery' from addiction ought to be understood as a subjective experience. I recall a self-proclaimed love-addict, whom I call Lenore, explaining this when she recounted how recovery was subjective for her;

> *If I had been using my body to get crack cocaine my whole life and I decide I no longer want to use my body to get this substance, that could be my recovery – even if I am still using crack. Stopping to do anything is still recovering from a certain pattern of behaviors.*

Moving psychedelics from the realm of being a problematic and/or illicit drug into the category of medicine will certainly impact basic notions of recovery.

Roxanne's case demonstrates implications of this paradigm shift. Intrigued by modern science, she flirts with the idea of experimenting with psychedelics again. She yearns to reconnect to a power greater than herself, which she understands to be her spiritual self.

However, she is concerned about compromising her sobriety count, breaking her vow, and subsequently renouncing her identity as an ‘addict in recovery’.

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In the integration circle, both Roxanne and Jerry express their gratitude for having found this non-judgmental space to discuss their interest in using psychedelic substances. Speaking with Roxanne, I discovered that her Alcoholics Anonymous fellowship rejected her for suggesting she adhere to a 'singleness of purpose.' She explained to me that singleness of purpose implies that:

> *You are only dealing with the desire to stop drinking, that is the only requirement for membership. They were saying, well, you're not really sober if you're taking acid… these people have to hide what they do so that they can be accepted in the bigger group. And I think that's really cruel, you know because we're supposed to be honest. We're supposed to reach out, you know, we're supposed to be connected with other people, and they're creating an environment where we have to hide what we do. It's very painful, you know, because I know I won't be accepted if I spoke my mind*.

I recognize there is a difference between official and culturally interpreted ways of engaging in the twelve-step program. Often these seemingly rigid protocols take on meanings that are more malleable when they are lived and negotiated in reality. However, in Roxanne's case, her fellowship abandoned her for suggesting that abstinence from all mind-altering substances ought

not be required. As a result, we see her struggling with logics of the self, unable to understand where she stands amidst this paradigm shift during a previously-uninterrupted sobriety.

I am reminded of Knight's (2015) framework of entanglement between care and coercion in current attempts to alleviate addictive tendencies. In the discourse around the twelve-step model, it is recommended that members continuously identify as addicts in perpetual recovery, and not as 'recovered addicts.' According to this model, the ‘addict’ carries the same risk of relapse they had when they first entered the program. A popular slogan repeated in AA circles, and originally found in the *Big Book* of Alcoholics Anonymous, is "once an alcoholic, always an alcoholic" (2013, 33). The intentions are genuine and mean to foster the best recipe for success. The fellowship repeats this phrase to ensure its members attain recovery and avoid relapse. To safeguard success, twelve-step fellowships do not tolerate moderate substance use. It’s clear that the twelve-step approach to managing addiction was designed to provide care for its members, yet the lines between care and coercion are difficult to discern.

Within the twelve-step program, care is offered by providing community support. I am reminded of another slogan I often heard during A/NA meetings: “keep coming back, it works if you work it and work it 'cause you're worth it.” However, Roxanne and I noted that no one ever knows what happens to those who don’t “keep coming back,” and we wondered if it still does “work” for those people?

> *It's like an echo chamber, for the people who stay, it worked, so they say it works, the people who leave, oh they're going to go out into the world. And the only people the fellowship will see are the ones who come crawling back. So those other people who left,*

> *did they drink? Did they manage to not drink? Did they figure out how to use moderately? You never hear about them.*

Here, we can see how the twelve-step model of recovery blurs the lines between care and coercion. Based on my conversation with Roxanne and the Alcoholics Anonymous literature, it seems as though the twelve steps coerces its members into remaining abstinent out of *fear* that they will lose their community, and subsequently, their sobriety. By looking at Roxanne's story, which is just one among many, we see that the twelve steps invoke fear as a form of care.

It is in these instances that the introduction of psychedelic-assisted therapy muddies the distinction between drugs, medicine, and recovery. Is engaging with psychedelic substances considered a relapse? Or do clinical trials on psychedelic-assisted therapy move these substances into the realm of medicine, healing, and care? In the face of an emerging paradigm shift, members of the twelve-step fellowship will increasingly find themselves forced to navigate this unsettling territory, much as Roxanne is doing now. If psychedelic-assisted therapy is gradually being understood as a medicine rather than a hedonistic drug, how can people in recovery justify consistent abstinence? With this paradigm shift, conceptual continuity in conventional approaches to healing is interrupted by revolutionary science. More specifically, once the stigma around psychedelic substances is reduced —which occurs through the dissemination of laboratory logics —the dominant and widely accepted view that recovery demands abstinence from all mind-altering substances is interrupted. In this way, traditional approaches to care are reimagined. This paradigm shift, and the broader shift in the cultural, legal, and medical narrative around psychedelic substances, ultimately leads to ethical incompatibilities in the realm of care and in building personal narratives and conceptions of the self.

Even if we disregard the burgeoning science of psychedelic-assisted therapy for the treatment of addiction itself, this alternative approach is gaining traction as a viable form of personal deep healing. In this way, the investigation of psychedelic-assisted therapy falls under Raikhel and Garriott's first category of addiction trajectories; that is *epistemic trajectories*, demonstrating the new "categories and concepts of addiction" (2013, 2), and further impacting social and cultural ontologies of the self and recovery. Following their lead, this thesis builds on Raikhel and Garriott's third category of addiction trajectory; "the *experiential and experimental trajectories* of lives constituted through the trains of addiction and subjectivity" (2).

If the trajectory of psychedelic substances continues down this path towards large-scale acceptance, recovery will need to be redefined. In a world where psilocybin and MDMA are being reimagined as forms of care, Roxanne's example, attending to singleness of purpose becomes a more realistic avenue for establishing recovery. But how can the drug user make these decisions on their own if, according to the twelve-step model, they are 'powerless over their addiction'? Does the 'addict' have the capacity and agency to discern whether their psychedelic substance use is therapeutic as opposed to harmful and addictive?

2- Agency: The Gift of an Inner-Healer

"This is my story on how pharmaceuticals became harmaceuticals"
- Meadow, December 11th 2019

Thinking back to Roxanne's story, and her eagerness to reconnect with psychedelic substances, I wonder which aspects of the twelve steps will be abandoned in the next stage of her recovery and which will remain. Will Roxanne continue to attend AA or NA meetings? Indeed, it seems that she no longer subscribes to the abstinence model of recovery. By taking psilocybin-containing mushrooms Roxanne is not only resisting the dominant narrative that recovery be abstinence-based, she is actively reclaiming a level of agency and autonomy by making decisions about her own recovery.

I proceed next with my critical assessment of both this new paradigm and the conventional method of managing addiction, and investigate whether someone labelled an 'addict' has the ability to decide to experiment with alternative medicines like psychedelics. There are two layers to my inquiry. The first is an investigation of ways laboratory logics impact epistemic categories of drugs versus medicines. I consider what happens to pre-existing notions of recovery when psychedelic substances begin losing their taboo status. Looking into this question in Chapter One, I revealed the unsettling grounds on which a recovering drug user must walk in order to use this form of therapy to treat mental illness. But in Roxanne's case, we saw that she simply wanted to use these substances as a means to reconnect with the self, and potentially, a higher power—not necessarily to treat a mental illness. Thus, my second line of questioning—and possibly the more controversial one—is an effort to discern whether people who identify as addicts[49] can justify using recreational psychedelics as a therapeutic tool. To understand this I explore how laboratory logics impact epistemic understandings of the therapeutic versus the recreational.

Psychedelic-assisted therapy operates through the principle that one must be directed by an inner healer. This means that it validates, as well as prioritizes, patients' innate ability to heal themselves. I anticipate that assuming this stance will create another point of contention as the paradigm shift taking place with the adoption of psychedelic substances within the therapeutic sphere goes forward. It brings up the question of how prevailing conceptions of the 'addict's' mind will alter in response to the new framework that psychedelic therapeutics present. While Chapter One addressed larger cultural conceptions of care, this chapter explores the ways in

[49] As mentioned in Chapter One, throughout this thesis, I refrain from using the term addict. The very word 'addict' references the notion that the person who is using drugs is helpless. Thus, the only times that I do use this term is when referring to the idea of the drug user as lacking in agency.

which psychedelic-assisted therapy understands the role of the *individual* in contradistinction to the one espoused in the twelve-step model of recovery. Nancy Campbell explains that "the history of addiction science can… be narrated as a succession of thought styles that *displace* one another yet *conserve* some aspects of the previous structure of social and cultural constraints on cognition" (2007, 21). Returning to my central argument regarding the way diverging laboratory logics impact dominant narratives, this chapter explores the 'thought styles' that are being displaced regarding the 'individual'. I do so by looking at the current social and cultural understanding of the addict's ability to make decisions about his or her substance use and employ the term agency to refer to this ability to act autonomously and trust one's own inner voice.

By addressing the way in which the twelve-step model does not trust the 'individual,' or the agency of a recovering addict, this chapter examines the predicament of recovering addicts seeking moral and psychological healing with the aid of psychedelic substances. It investigates this predicament not only in terms of AA's policies and ontological conceptions of recovery, but also in regard to the lived reality of what it's like to use psychedelics *while in* a traditional form of recovery. Combining these two realities can occur during the treatment of substance use disorder via psychedelic-assisted therapy. However, what I find more interesting, and more relevant to the current reality of psychedelic healing, is combining twelve-step recovery with day-to-day recreational, albeit therapeutic, psychedelic use. In other words, I believe that the mingling of psychedelic substances and the twelve steps is likely to occur in the future when psychedelic-assisted therapy becomes legal and more acceptable. But today, this combination is happening in the realm of the 'recreational,' and thus 'non-legitimate,' engagement with psychedelic substances.

This chapter explores how the very existence of psychedelic-assisted therapy impacts on-the-ground understandings of psychedelic substances, and opens up possibilities for their capillary[50] expansion beyond the clinic. By focusing on everyday uses of psychedelic substances rather than clinical ones, I shed light on ways psychedelics are moving away from being considered illicit substances and towards being accepted as medicine in real-world, day-to-day experience. As the cultural narrative around psychedelic substances continues to move in a positive direction, people are growing curious and are testing laboratory findings in new settings. Furthermore, the dearth of treatment access we are faced with at the moment has meant that people are keen to explore them on their own and utilize psychedelic experiences to alleviate the often deeply-rooted causes of addiction (i.e., depression and trauma) may feel they have little choice but to explore these substances themselves. And here is the rub. It is in this instance that I question whether people who identify as 'addicts' can justify using recreational psychedelic as a therapeutic tool.

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The inspiration to ask these questions arises from a personal experience, one that I feel is necessary to share in order to show the genuine sense of curiosity from which this project arose. An old friend of mine, whom I'll call Dorian, struggled with cocaine and alcohol addiction. Afraid, and uneducated about the realities of addiction and the path to recovery, he and his family agreed that the best option would be to get clean at a private rehabilitation center. As

[50] As I mentioned earlier, in thinking through Michel Foucault's notion of 'biopower' as power that is capillary in nature, similar to the capillary veins in the body, these new logics permeate society in a capillary fashion through cultural narratives created by pop-culture figures such as Pollan.

someone who accompanied him during his journey to recovery, I watched my friend struggle to accept the twelve-step model of recovery. He was having difficulty making sense of himself. Having experimented extensively with psychedelic substances over the previous ten years, he felt connected to a power greater than himself. He felt uneasy giving up that connection to obtain complete abstinence. I recall him turning to me, his eyebrows raised and a look of concern in his eyes, asking: "Am I still considered sober if I occasionally take mushrooms in the forest with my friends, even if I am no longer using alcohol or cocaine?" I didn't have an answer for him. Having already lost a dear friend to a fentanyl overdose a few years earlier, I felt his predicament keenly, but didn't know how to address it. Upon completing the in-patient program, Dorian was expected to find a sponsor and attend 90 meetings in 90 days. However, his music career was taking off and he was set to play an upcoming music festival in Europe in two months time. The hedonistic nature of music festivals, with their free attitudes towards recreational drug use, meant potential sponsors were disinclined to take him on as a sponsee. Nor did he did find refuge in AA meetings. They offered Dorian no comfort, and subsequently, he dropped out of the twelve-step program altogether. Having never completed the twelve steps, riddled with guilt, he now worries that he shouldn't describe himself as an 'addict in recovery'.

As Dorian struggled, I was getting wind of the psychedelic renaissance. I learned about the importance of the integration stage after a psychedelic experience, and how, if used in a carefully orchestrated set and setting, psychedelic substances can indeed be regarded as a therapeutic intervention. It was at this point that I began to question the twelve-step approach to care and the very concept of abstinence-based recovery. Anthropologists, too, have questioned the nature of the twelve steps (Garcia 2010, Campbell 2007, Jamison 2018, Summerson Carr 2013) and asked if they are too coercive. Initiatives such as modified moderation and Mediation-

Assisted Therapy have been developed to find a possible middle zone between substance misuse and all-out abstinence. Indeed, many psychiatrists and social science researchers have noted the extreme nature of the twelve-step program.

Through my fieldwork I came to see that Dorian was not alone in his difficulty integrating the demands of twelve-step programs with the benefits of psychedelics. Meadow, my primary interlocutor, had a similar struggle. At a small conference on the (r)evolution of psychedelic substances in late November of 2019, Meadow eloquently tells her story:

> *I was initiated into the cult of big pharma at the young and impressionable age of 16 after I experienced several suicides of my friends jumping in front of trains in high school, and I was on one of the trains that my friend jumped in front of. And I really felt responsible for my friend's death and became severely depressed and anxious in high school. I looked towards psychedelics to heal my depression and anxiety, began going to raves and utilizing MDMA and working with psilocybin, and that just led my depression to get a lot worse at the time because I think that my brain was just so young and impressionable… At 16, I was sent to a psychiatrist and was put on one medication for depression which led to two, three, four, five. By the time I was graduating high school I was on a cocktail of 7 different medications and was basically prescribed a life-sentence of drug dependence. And I thought this was completely normal.*
>
> *Entering into my 20's, the doctors let me hopelessly depend on pharmaceuticals and the pharmaceuticals caused me to have a lot of side-effects and really caused my mood to go up and down in crazy ways and I started self-medicating with drugs like opiates and heroin and developed addictions to those and to cocaine... So, this was my*

> *normal. This is my story on how pharmaceuticals became harmaceuticals… By the age of 26 I had been prescribed over 100 different pharmaceuticals… And then I started realizing, well maybe I don't have any of these problems that they were telling me I had. And maybe the drugs that I was being prescribed were actually my problem. So, I started to slowly titrate off of them and it took me over two years to come off of 7 different medications, which left me in worse shape than I began. I lost my vision, I lost over 80lbs, I was completely debilitated, I couldn't function, I couldn't talk, I had cognitive impairment, and I was completely disabled and wanted commit suicide…*
>
> *By the grace of spirit and good will, I had a good friend recommend that I come to an indigenous ceremony of ayahuasca with him… And I started healing with ayahuasca… By working with ayahuasca, I really came home to my 'self', to who I really am, my body after being so disintegrated and lost for so long.*

Meadow is now thriving in her community and is a prominent member of multiple initiatives in the Bay Area focusing on the safe and ethical use of psychedelic substances.

Dorian and Meadow's stories have significant differences. Nevertheless, while hoping to adhere to biomedical and twelve-step approaches to recovery, they both yearned to continue engaging in psychedelic experiences while maintaining sobriety from the substance of abuse. This is something that Meadow termed *targeted sobriety*, which is similar to what Roxanne referred to as 'singleness of purpose', or what others call 'modified moderation'[51]. Dorian and

[51]Targeted sobriety, singleness of purpose and modified moderation are methods used in the world of recovery as alternatives to an abstinence-based approach. These methods offer legitimacy to the act of restraining from the substance of misuse while maintaining a relationship with other substances. With these methods, someone who is recovering from heroin addiction and still using marijuana is still considered to be in recovery by targeting a particular problematic substance and moderately using other substances.

Meadow are my inspiration for this project. All of the work that I have done in the movement to promote the acceptance of psychedelic-assisted therapy is in honor of these people and Bobes—who shall remain undiscussed but anchors my interest in this field. As I dove more deeply into the psychedelic community, I discovered that there is an element of their stories and experiences that I would encounter again and again.

With the increasing number of successful clinical trials and investigations demonstrating the efficacy of psychedelic substances to treat various mental illnesses, the taboo around psychedelic substances is fading. But this doesn't answer the question of what happens when people trying to recover from misusing substances maintain psychedelic use. I am not comfortable accepting the simplistic interpretation of the twelve steps that promotes a one-size-fits-all treatment for substance use disorder. And surely, I am not alone. Some of this unease has to do with the notion of powerlessness. As I mentioned in Chapter One, at the inception of the twelve-step program the field of medicine helped to authorize the notion that the 'addict' is powerless over the bottle by alluding to the brain disease model of addiction. Sociologist Scott Vrecko explores the politicized nature of the "birth of the addicted brain" (2010) and Nikolas Rose examines how patients have turned into "neurochemical selves" rather than seeing themselves as psychological and conscious beings (2003). There is indeed much to contend with in the disease model of addiction, and my arguments build upon previous social scientific critiques of a one-size-fits-all understanding of addiction and recovery.

Our cultural understanding of addiction has varied over time and has undergone a series of trajectories. From moral failing to neurochemical deficiency, descriptions of addiction have suggested little in the way of effective treatment. Against this miserable backdrop of historical failure, I acknowledge that the twelve-step program has been something of a success. And this

was achieved by advocating abstinence. I argue that it is possible, nevertheless, for someone to be in recovery from substance misuse and maintain a healthy relationship with psychedelic substances. Addiction functions on a spectrum. This means that there are people for whom these biomedical models are a good fit, and who very much need to rely on conventional models of recovery in order to break their habit. For such individuals, the only way out is through abstinence-based recovery. Indeed, there are many people who suffer from addiction who are not capable of staying in the grey zone of moderate substance use, and for whom modified use or targeted sobriety is not an option.

Alcoholics Anonymous has helped millions of people worldwide. We know that it is a viable and respectable method of managing addiction. However, "40% of people drop out of AA during the first year" and success rates vary between a mere 8 and 12% (Wagener 2020; Lilienfeld, & Arkowitz 2011; Stein & Forgione 2011). Unfortunately, one can only determine whether someone is 'treatment resistant' to current approaches once they have either tried everything and continue to suffer, or they pass away. In my ethnographic research, although I encountered many people who found comfort and solace in the twelve-step program, most of my interlocutors, having given themselves over to a highly restrictive system, found that it didn't actually relieve them of their compulsive relationship to substances. The solution, I suggest, is that we expand our view of addiction itself. We need to reassess what we mean by substance misuse and take a more fluid approach to examining its lived realities.

This chapter will focus on the incompatibility between conventional methods of managing addiction and psychedelic-assisted therapy. Later, in Chapter Three, I argue that these approaches are not so different from one another, and highlight the similarities between them. It is helpful, however, to demonstrate the differences between these methods before exploring the

similarities. In working with people in recovery who want to use psychedelic substances, one cannot avoid questions of agency and the capacity of the drug user to engage in decision-making. Even though more legitimacy is currently being accorded psychedelic substances, this doesn't guarantee that people in recovery can adequately discern, and objectively identify, what is healthy, as opposed to what is considered harmful, drug use.

Recreational Psychedelic Use

When I attended the BACP's addiction recovery circle, I felt like an outsider. I didn't see how I belonged in a support group that was created for people who use psychedelics to treat substance misuse. First of all, I did not identify as someone who struggles with addictive tendencies. Furthermore, I couldn't describe my psychedelic experiences as having treated any mental disturbances. When it was finally my turn to introduce myself and share, I explained that I used psychedelic substances in a recreational way. I justified my psychedelic practices by saying "recreational use is nevertheless healing as there is nothing non-therapeutic in seeking unity, oneness, and personal harmony in a world that encourages such toxic lifestyles as the one I currently feet subjected to". While I would receive a series of nods of agreement from the people around the room, acknowledging that recreational use can indeed fall under the category of therapeutic healing, I felt like an imposter nevertheless. I worried that the words I had come up with had somehow allowed me to improvise my way into gaining acceptance from the group. This was a typical anthropological moment in that I, the anthropologist, was trying to gain trust within the community with which I worked. But it provided me with an *ah-ha* moment with which to frame the rest of research. Having justified my recreational psychedelic practice as

therapeutic, I wondered what it would be like for a person who identifies as an 'addict' to engage in the same line of reasoning. Would he or she be met with the series of nods that I had received?

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Recreational substance use is commonly associated with hedonistic encounters and substances that have been made illicit. However, the first recorded example of the term came from the late-fourteenth century, when the word 'recreation' was used to describe the 'refreshment or curing of a person, refreshment by eating,' from Old French *recreacion* (13c.), and from Latin *recreationem* (nominative *recreatio*) 'recovery from illness,' a noun of action from past participle stem of *recreare* 'to refresh, restore, make anew, revive, invigorate,' from *re-* 'again' + *creare* 'create' (from PIE root *ker- (2) 'to grow')[52]. Thus, the term recreation was originally used to refer to a form of care and healing. It has since taken on a more negative connotation, implying that recreational use is a hedonistic undertaking. In October of 2018 I attended a workshop designed to train clinicians in psychedelic-assisted therapy. The speaker, an affiliated therapist working long-term on the NYU clinical trials to treat PTSD with MDMA, took a moment to describe the term 'recreational' to his audience:

> *'Recreation' literally means taking an intentional time for the sake of renewal. We have negative connotations around this type of use. However, it can be very healing to use drugs recreationally. Context and intention are extremely important in looking at the motivations for someone's use.*

[52] https://www.etymonline.com/word/recreation

If recreational engagements with psychedelic substances can be healing, what does this mean for the alleged 'addict'? If, according to the twelve-step program, 'once an addict always an addict', can someone who suffers from addictive tendencies adequately discern and objectively identify the intentions behind their psychedelic substance use? I wondered whether the paradigm shift occurring at the moment with psychedelic substances would impact these questions.

My own experience in the support group mentioned above provided me with the framework to understand the epistemic nature of creating one's own narrative. By not identifying as an addict, I am justified in adopting this particular way of describing my psychedelic substance use. It is in these very decisions that we, as autonomous individuals, can weave a personal interpretation of our relationship with our vices. However, in twelve-step discourse, the recovering 'addict' does not have the luxury, or ability, engage in this form of self-authorship.

According to twelve-step literature, the internal dialogue allowing me to rationalize recreational psychedelic substance use would be discredited due to the permanent nature of the addict's mind (Vrecko 2010; Bateson 1972; Garcia 2010). My interlocutors had had the phrase "once an addict, always an addict" ingrained in them, and didn't feel that they could safely rationalize using psychedelics. This narrative stems from the disease model of addiction in which there is a biological understanding of one's addiction. However, Raikhel and Garriott (2013) explain that:

> Even the ''disease model'' widely associated with AA and the twelve-step movement stands in an ambivalent relationship to the medicalization of alcoholism in that it uses the notion of disease instrumentally as a means to alleviate stigma and counter notions of moral responsibility while simultaneously espousing an understanding of alcoholism that places a much greater emphasis on psychosocial and spiritual frameworks. (2013, 33)

By adopting this model, the twelve-step approach proposes that an 'addict' will always be at the same risk of relapse that he or she suffered when first entering treatment due to being powerless over the substance of abuse.

But what if the narrative woven around drug use is what generates this sense of powerlessness? In his book, *Steps to an Ecology of Mind,* anthropologist and father of cybernetic thinking, Gregory Bateson, wrote a chapter titled "*The Cybernetics of "Self": A Theory of Alcoholism"*. In this chapter, Bateson investigates notions of the alcoholic self and notes that "drunk or sober, the total personality of an alcoholic is an alcoholic personality which cannot conceivably fight alcoholism" (1972, 318). Here, Bateson suggests that there is no escaping alcoholism, that indeed, the reality of alcoholism is chronic and unending.

I take Bateson's perception of 'the alcoholic self' as a rendition of 'the previous structure,' or the previous perception, of addiction. Returning again to Campbell's laboratory logics—which she offers as an alternative to the term 'paradigm shift', we revisit her explanation that "the history of addiction science can thus be narrated as a succession of thought styles that displace one another yet conserve some aspects of the previous structure of social and cultural constraints on cognition" (2007, 21). I suggest that the new laboratory logics exploring the efficacy around psychedelic-assisted therapy *displace* notions of powerlessness within "the previous structure of social and cultural constraints on cognition" (2007, 21), particularly regarding conceptions of agency in twelve-step models of recovery. In order to work through this line of thinking—that psychedelic-assisted therapy can be considered a new laboratory logic (or is causing a paradigm shift) due to the displacement of previous conceptions—it will be helpful to explore notions of agency in the 'previous structure,' which, in this case, is the twelve-step program.

The 'Addict' as Powerless

Medical anthropologist Angela Garcia takes note of the unendingness of the current narrative around addiction. In her follow-up with a patient called Alma in a rehabilitation clinic in Rio Grande, Mexico, Garcia observes how Alma must "prepare the grounds for her 'recovery,' even if the model of *chronicity,* on which the clinic's practices were based, alleged that her condition was by definition, *unending*" (2010, 72 my emphasis). What is interesting in Garcia's ethnographic depiction of these "opposing and conspiring worlds" is the way in which "Alma struggled to confirm her existence against their shared presupposition of *inevitable return*" (ibid. my emphasis) and the supposed 'endlessness' of her reality as an addict. Garcia explains that the recent biomedical interpretation of addiction has woven a dangerous ethos of suffering through technologies such as drug treatment centers, drug courts, AA and NA meetings. Garcia's depiction of Alma's struggle to understand her 'self,' within an interpretation of addiction as chronic and unending, inspires me to question notions of agency in traditional representations of substance abuse. I draw from, and build on, both Garcia's (2010) and Hansen's (2013) work, looking into the ways drug users adhere to notions of the 'self' in which the conception of addiction is inherently ongoing.

The basic premise of the twelve-step program is the idea that the alcoholic, or the 'addict', is powerless. The claims made in the first three steps of the program encapsulate this lack of agency: the first step requires that "we admitted we were powerless over alcohol—that our lives had become unmanageable" (Alcoholics Anonymous 2013, 59). The second step claims that "we came to believe that a Power greater than ourselves could restore us to sanity" (ibid.). And the third step says that, "we made a decision to turn our will and our lives over to the care of

God, *as we understood Him*" (ibid.). With this model, once you have accepted that you are powerless, you must then admit that only a power greater than yourself can save you. In Chapter Three of the handbook titled "There is a Solution" the *Big Book* insinuates that God "as you understand him,"[53] and God alone, has the capacity to change addictive behaviours. Bateson comments on the deconstruction of the myth of 'self-power' found throughout twelve-step depictions of addiction and recovery:

> Implicit in the combination of these two steps is an extraordinary —and I believe correct—idea: the experience of defeat not only serves to convince the alcoholic that change is necessary; it is the first step in that change. To be defeated by the bottle and to know it is the first 'spiritual experience.' The myth of self-power is thereby broken by the demonstration of a greater power. (1972, 319)

In this way, in order to successfully dismantle one's relationship to the drug they misuse, one must *externalize* his or her ability to take control of addiction and disregard notions of personal autonomy and will power.

I leaned more about this speaking with Ben, a young man in his fifth year of recovery from intravenous heroin use. We discussed the concept of the drug user's 'will' as it is understood in the *Big Book* of Alcoholics Anonymous.

> *Ben: So according to the Big Book, the alcoholic's will is the most dangerous thing that it possesses. So, the will to stop, according to the Big Book, the will to stop will never arrest the drinking*
>
> *Jessica: how come?*

[53] Adding "as you understand him" after the word God in AA discourse was a response to the critique of twelve steps being too Christian. This was AA's way of being more inclusive to alternate interpretations of the concept of 'God'.

Ben: because the nature of alcoholism is that it eradicates the ability for the will to function in a healthy and evolutionarily significant way.

Jessica: then how can you have the will to choose the path of AA?

Ben: yeah, it's the concept of removing one's will and surrendering the will to a higher power, it's not about using the will, and that is a choice that somebody makes but the idea behind it is that I'm not using my will, it's that I'm giving up *my will and that's where this dependence on a higher power comes in because that is their will, to turn their will, but it's not seen this way. Because the idea of removing the will is that if they're no longer in control then they went from feeling in control of their lives to deciding and admitting to themselves,* choosing *to admit that they're no longer in control. So, it's a conceptual surrendering and they have the will to do it but once they make that decision to turn their will and their lives over to the care of God as they understand it - which is the third step - from then on, they don't believe that it's their will, so it's a belief that the spiritual endeavour is going to alleviate it.*

We see here that the way in which traditional recovery models understand willpower is contradictory. Garcia points out the inconsistency by showing that the notion of *blame* underlies the conception of moral inventory because it requires *taking responsiblity,* but at the same time one surrenders to a higher power, which implies *giving over responsibility*. Garcia's analysis gives thoughtful attention to the 'addict's' innate capacity to reason in juridical recovery institutions (2008, 727). Building on her work, it appears that care in twelve-step models of recovery can not be separated from a belief in the perpetual and unending nature of addiction. In

these conventional approaches to recovery, care is offered upon accepting addiction as chronic, and in response, handing over ones' will to a higher, and external, power.

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Thinking through the way twelve-step programs provide care, I am drawn back to Roxanne's story. Roxanne was the woman that I met in a psychedelics-in-recovery support group who feared losing her fellowship if she experimented with psychedelic substances. In this narrative of chronic addiction, someone like Roxanne does not have the agentive capacity to discern the difference between healthy and risky substance use. Garcia notes that this biological depiction of addiction as chronic is not merely objective and scientific, that it also carries moral undertones. She discusses the ramifications of Alma's experience in a twelve-step- focused clinic;

> Alma's account of being "pushed" into remembering that she is at perpetual risk of relapsing into addictive behavior provides a powerful critique of contemporary medical and community models of drug treatment that liken addiction to chronic illness. Although this relatively new approach to drug dependence began as a well-meaning attempt to dispel the moral implications of being a drug addict—in other words, to not view drug addiction and relapse as a moral failing—Alma's framing suggests that there are, in fact, moral and psychological repercussions to approaching addiction as a chronic, unending process (2010, 87).

In this way, we see that describing the 'addict' as powerless has implications that go beyond the biomedical framework first created to make sense of the addicted brain.

In his exploration of the "birth of the brain disease" Scott Vrecko suggests that "addiction science is best analysed as a form of *ideology* that is essentially political in nature, and is best understood as the result of efforts to establish new programmes of social and medical discipline

over individuals' bodies and desires" (2010, 53, my emphasis). Garcia and Vrecko both point out that the idea of the addicted brain is not as neutral as had been initially intended. Indeed, in keeping with conventional approaches to recovery, a drug user lacks the moral ability to remain in control of his or her relationship with substances[54]. According to this model, and in thinking with Vrecko and Garcia, Roxanne does not possess the *moral* standing necessary to construct a justifiable narrative around recreational psychedelic use. The result of this moral construct is that Roxanne fears being judged by her community. And, her failure to remain abstinent means she fears losing access to the care she receives from her fellowship. By adopting an understanding of addiction through this construct of care, the drug user has been stripped of the essential human imperative, and right, to construct a narrative of the self.

Care has been a central point of contention in the world of medical anthropology over the past ten years. There are many different ways of understanding care being promulgated through the biomedical system. Medical anthropologist Sandra Hyde coined the term 'clashes in care' to allude to "the evolving societal understandings of what comprises the provision of care" (2017, 64). In discussing the clashes in care at a therapeutic community residential treatment center, Hyde suggests that care is never straightforward or clear-cut, that even within a certain approach to care there exist significant spaces of contention. Building on Hyde's concept of 'clashes in care,' I suggest that psychedelic-assisted therapy lies at the crux of a clash between abstinence and modified moderation[55] approaches of recovery. Since the definition of a successful recovery according to the twelve-step program rests upon complete abstinence from all mind-altering

[54] Again, it might be important to remind readers that indeed I understand, recognize and respect that there are many people who misuse substances who truly cannot maintain control over their relationship to substances and for them, the twelve-step program is very helpful.
[55] Modified moderation here being psychedelic-assisted therapy.

substances[56], the very introduction of psychedelic-assisted therapy into the treatment of mental illnesses (including addiction) establishes grounds for conflict. Ultimately, a person in a twelve-step recovery program does not possess the *moral* requisite to construct a narrative around recreational psychedelic use that can justify it. Thus, a clash arises.

To receive care through conventional approaches to recovery, one is expected to subscribe to belief in a self that has been rendered powerless. As we saw earlier, Bateson argues that the engineering of the alcoholic self creates a form of existence incapable of fighting alcoholism (1972, 318). The self gets lost in the logic that one is at a perpetual risk of relapse into addiction, and that only something external and greater than the self can alleviate the danger. Furthermore, Hansen notes that "the cultural work that [drug users] undertake is an attempt to craft and position to self. Addicts entering evangelical ministries and buprenorphine treatment are told that they are deficient, that their *shell* of their social existence needs filling, whether with neurotransmitters or spiritual power" (2008, 124, my emphasis). This is further reinforced in the *Big Book* which declares that "the central fact of our lives today is the absolute certainty that our Creator has entered into our hearts and lives in a way which is indeed miraculous. He has commenced to accomplish those things for us which we could never do by ourselves" (2013, 25). In this way, the addicted self is nothing more than an empty shell, incapable of self-healing. Indeed, according to these models, the only way to attain healing and recovery is by subscribing to an external power or system; whether that be through maintaining a biological homeostasis via MAT, or through a relationship with an *external* power higher than your own self. In this approach to care, one's inner self is not to be trusted. This idea is based on the rationale that "it

[56] Although coffee, cigarettes and sugar are highly encouraged and accepted in AA meetings.

was that same inner voice that got us here today"—as I remember hearing in an AA meeting—meaning that the inner voice led them down the road of addiction in the first place.

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This is very different from the way that, in the BACP addiction support group, I was able to describe my recreational psychedelic substance use as a therapeutic practice. I argued that recreational use is, nevertheless, healing. When looking at the original use of the term *recreation* as 'recovery from illness,' the noun of action from the past participle stem of *recreare* 'to refresh, restore, make anew, revive, invigorate,' my statement was accurate. However, not everyone would be able to make such a statement. In doing so, I exercised my capacity as someone who does not identify as an 'addict' to differentiate between problematic and therapeutic recreational psychedelic use, and demonstrated what it is to act as a free and autonomous agent. On the grounds of my stable mental health and the fact that I do not identify as an 'addict,' nor as an 'addict in recovery', I am permitted to make these distinctions on my own.

In contrast, in the twelve-step model of recovery, recovering drug users are believed to lack the capacity to make these types of judgements. Hansen explains that the biomedical understanding of addiction "implies that a person is unable to choose whether or not to use substances in a logical way. Evangelists see addiction as the outcome of choice—the *choice* of whether or not to accept the will of God" (2013, 111 my emphasis). The biomedical model implies that addiction is an illness of the brain, a gene that one can inherit, and thus, something

that one cannot control. It seems fair to conclude that traditional understandings of recovery do not grant the substance user the ability to make these decisions.

The concept of 'choice' here seems intriguing to me. The next section explores the politics involved in an 'addict' *choosing* to use other substances while remaining abstinent from their problematic substance (otherwise referred to as modified moderation or what Meadow and Roxanne term 'targeted abstinence' and 'singleness of purpose,' respectively). This makes me wonder how the twelve steps understand 'choice' and agency if the only way to successfully engage ones will is when handing it over to a higher power. I suggest that by not acknowledging the potential inner conflicts that the twelve-step models raise, the self gets lost in this traditional approach to recovery. Conversely, psychedelic-assisted therapy operates by an 'inner-healer directive' which prioritizes and empowers the patients' inner voice. I argue that this aspect of the new paradigm further disrupts categories of agency and care.

The Gift of the Inner-healer

The concept of an inner-healer is not new. Transcultural psychiatry specialist Dr. Laurence Kirmayer discusses the concept of an inner-healer as it appears throughout Asklepian Greek mythology, and argues for its integration into modern models of biomedical healing. He highlights the point that "the task of the healer then is to activate dormant or malfunctioning mechanisms of healing and resilience in the patient (which may be personified as an 'inner-healer')" (2003, 250). However, he explains that in the current paradigm of psychiatric healing, the therapist cannot successfully do so. The reason, he suggests, that the healer cannot activate the patients' inner-healer is due to the healer's inability to acknowledge his or her *own* wounds. This prevents the patient from connecting to their own inner-healer. Dr. Kirmayer posits that, in

order to optimize the patient-healer relationship, minimize imbalanced power dynamics, and reduce notions of healer authority, the healers ought to get in touch with their own wounds. What this achieves, Dr. Kirmayer argues, is that the "patients' own healing resources may be evoked by recognizing the healer's vulnerability" (ibid., 251). Dr. Kirmayer is suggesting that the therapist must contend with the idea of the "sufferer-as-healer".

The way in which psychedelic-assisted therapy utilizes the concept of an inner-healer is not that different from the way Dr. Kirmayer[57] does. The institutions that have created protocols for psychedelic-assisted therapy have built a model that centers on the patients' internal healing capacity. As part of my fieldwork, I interviewed a series of therapists and psychiatrists who are at the front line of this paradigm shift. Many of these therapists[58], even though they came from a number of different clinical traditions, felt there was a clear line between the conventional biomedical training they received in medical school, and the training they received for these protocols. Sacha, a psychiatrist who legally administers ketamine-assisted therapy, explains that it has been common for his colleagues to feel the need to 'unlearn' much of what they had been taught in medical school. Referring to the tradition of psychoanalysis, Sacha notes the power dynamics intrinsic to traditional forms of therapeutic training like the one he had received. They were brought about through seemingly-minor things such as feelings of authority and the caution against self-disclosure. Coming from such a background, psychedelic-assisted therapy felt revolutionary. I think that at the heart of Sacha's encounter with psychedelic-assisted therapy

[57] Indeed, more work to connect these two uses (Asklepian mythology and psychedelic-assisted therapeutic) of the inner-healer would be useful. However, this is not the purview of this thesis. The focus here rests on exploring how the protocols in psychedelic-assisted therapy operate on the premise that the patient must find the inner strength to heal themselves.

[58] I will simply refer to the various professionals I spoke with as 'therapists' as they were trained in a diversity of mental-health related disciplines including psychoanalysis, somatic therapy, social work, cognitive behavioral therapy, psychology, psychiatry,etc.

protocols, and what made the experience so different for him, was the protocols' reliance on an *inner-directed* therapeutic intervention.

The Multidisciplinary Association for Psychedelic Studies (MAPS), the leading organization running clinical trials to treat PTSD with MDMA, describes the inner directive as follows:

> *A non-directive approach to therapy based on empathetic rapport and empathetic presence should be used to support the participant's own unfolding experience and the body's own healing process. A non-directive approach emphasizes invitation rather than direction.* It is essential to encourage the participant to trust her/his inner healing intelligence, which is a person's innate capacity to heal the wounds of trauma. It is important to highlight the fact that the participant is the source of her/his own healing. The MDMA and the therapists are likely to facilitate access to, but are not the source of, the healing process.
>
> *(MDMA protocol 2015).*

Inviting the patients to take action rather than attempting to direct them, psychedelic-assisted therapy takes a new approach to healing and the treatment of mental illness. By taking this non-directive approach, psychedelic therapists are trained to operate under the premise that all patients have an "innate will to heal," and that *"the participant is the source of their own healing*," as one of the therapists put it.

Though therapists who use this approach believe it is non-directive, I would argue that there is actually an element of direction involved in this therapeutic mode. Medical anthropologist Cheryl Mattingly (1994) discusses the impact of therapeutic 'emplotment,' in

which the therapist weaves a narrative for the patient. She explains that "emplotment involves making a configuration in time, creating a whole out of a succession of events. What we call a story is this rendering and ordering of an event sequence into parts which belong to a larger temporal whole, one governed by a plot" (812). Mattingly suggests that one of the primary roles of a therapist is to 'emplot' a healing narrative, or story, onto a patient. By accepting this carefully woven narrative, the patient can begin the healing process. This method is certainly more directive than 'inviting'—as instructed by the protocol—in that it requires a certain amount of guidance on the part of the therapist.

Mattingly's concept of therapeutic emplotment is useful to think with in the context of an inner directive. By discussing the inner-healer directive, I am not suggesting that the therapist does not guide the patient. Indeed, the very act of telling the patient that they have an inner-healer is 'emploting' a narrative for the patient to take up and embody. This is also true in cases of more traditional uses of psychedelic substances. For example, French anthropologist David Dupuis discusses the socialization involved in a hallucinatory experience (2020). Looking at hallucinations induced by a psychedelic brew called ayahuasca in the Peruvian rainforest, Dupuis suggests that "verbal exchanges and ritual interactions shape hallucinations through the education of attention, expectation, and perception" (2020). It would be foolish of me to suggest that there is no guidance—or 'emplotment'—involved in the psychedelic-assisted therapy model. The act of telling the patient that they have an inner-healer will impact the outcome and experience of their psychedelic journey. These are themes that are planted in the mind of the patient, and they inadvertently drive the patient toward embodying a specific therapeutic narrative in which they become their own healers.

The inner-healer directive is nevertheless an important component of the psychedelic-assisted therapy model. It is this aspect of the protocol which makes psychedelic-assisted therapy unconventional. Sacha, the ketamine therapist, explains that the psychedelic-assisted therapy protocol is very much inspired by traditional Peruvian engagements with psychedelic substances:

> *Most good shamans never see themselves as having the answer, they are a vessel, a portal for the work to take place. But many of them will tell you 'I'm not the one doing the healing' so I kind of bring that in, even if I don't explicitly state that, that's always at the back of my mind. You know,* I don't have the answers here, I'm not the expert in the room. *This is your life that we're taking about, you are the expert on your life, much more than I am, and hopefully I can bring in some tools into the room to help you in whatever it is that you're seeking – psychedelics being part of those tools. So, when I begin to work with someone on intake, we'll talk about the collaborative nature of the way that I work and certainly, through working with psychedelics and the way that we use touch and touch being part of the therapy, much more than traditional psychotherapy, I think that very much helps level the playing field so to speak.*

By taking an inner-directive approach to healing, the therapist is stripped of the status of being an authority, and a level of autonomy is provided to the patient. It was here that my interlocutors differentiate between conventional and psychedelic methods of treatment. With an inner-directive approach to care, a certain level of 'personalized therapy' is achieved by allowing the patient to be his or her own healer.

Continuing his investigation of the 'healer-as-suffer,' Dr. Kirmayer argues that "in the context of professional training, this developmental model requires a setting that makes it safe for students to discuss their own emotional vulnerability and the resonance of patients' stories with their own wounds and conflicts" (2003, 268). Adding his thoughts to the ongoing discussions in modern psychiatry, however, he is often met with apprehension and skepticism. This is very different from the way that in psychedelic-assisted therapy protocols, roughly 90%[59] of therapists undergo their own psychedelic-assisted therapy and personal healing in order to shed light on the "dark side of [their] inner world," as Kirmayer puts it (ibid., 267).

Psychedelic-assisted therapy prioritizes connecting to people's inner-healers because it values the patients' innate will to heal themselves. But it also acknowledges the danger of engaging in a directive approach to healing while patients are under the influence of powerful psychedelic substances. In his discussion on the imbalance of power dynamics between the patient and therapist, Kirmayer explains that:

> Power disparities between clinician and patient are almost always present by the very nature of the clinical encounter. These may be exaggerated or intensified when differences convey larger social disparities rooted in social categories of race, ethnicity, and social class (Pinderhughes, 1989). Although the roles prescribed in biomedicine and psychiatry emphasize professional neutrality and focus on technical acts, neutrality itself requires a safe space and shared understanding of goals and procedure. When the wider social and historical context challenge the logic, authority and fidelity of the clinician, intercultural work may require modifications of the conventional roles and frames of clinical practice. (2003, 249)

The inevitable power disparities that Kirmayer discusses are addressed and acknowledged in psychedelic-assisted therapy training protocols. People are often highly impressionable in these altered states of consciousness. For this reason, therapists are trained to be mindful of the

[59] This is a rough estimate based on conversations I had with therapists who had been trained in psychedelic-assisted therapy.

questionable nature of consent in these environments, and are deliberately taught to be careful not to overstep their role. Peter, a therapist who works with MDMA to help treat veterans who suffer from PTSD, addressed the need for a passive role for the psychedelic therapist:

> *There's been a lot of discussion of what even to call ourselves; like therapist seems a little bit too, hierarchical. 'Guide' even seems too much. I like to say facilitator because I'm like facilitating the interaction between themselves. And then getting trained to do MDMA therapy, I admit that I rolled my eyes a little bit when I first started to hear it, but they would call the patient, the teacher, haha, but then having like done sessions with people I'm like oh my god yeah, it's really true*.

In order to understand their role as a mediator in the process of engaging the patients' innate will to heal themselves, the therapist seeks to redirect the ebb and flow of power relations in the therapeutic setting.

Thinking about the reduction of power differentials in this alternative therapeutic modality, I am reminded of the doctors at the MAT clinic where Helena Hansen conducted her ethnography. She suggested that these doctors were "embroiled in a continual struggle to *convince* buprenorphine patients to stay on their medications for the long-term, to help them see that pharmaceuticals return patients to their natural state, to their true self, rather than pharmacologically maintain them in an artificial state" (Hansen in Raikhel and Garriott 2013, 119, my emphasis). By engaging in an inner-healer directive, psychedelic-assisted therapists less often need to *convince* their patients to engage in their program. Indeed, in this new method of managing addiction, the goal is not to "return patients to their true self" via chemical

homeostasis, but instead to foster a connection and a dialogue between the self and one's inner-healer.

Rather than externalizing their ability to heal by finding a higher power (as proscribed in the twelve-step program), or using a medication to induce a level of homeostasis, psychedelic-assisted therapy revolutionizes care by honoring the inner-healer. In doing so, it provides the patient a level of agency that is not normally found in conventional approaches to care in recovery. Indeed, the model that psychedelic-assisted therapy operates with has the opposite effect. It reverses the traditional understanding of an addicted self, and encourages patients that only they, and they alone, can heal themselves. With this new paradigm in addiction recovery, it is neither the substance, nor the therapist, that offers care to the patient. In fact, it is a basic realization that the drug user possesses agency and the power to take care of one's own life. This is where the foundation for healing in psychedelic-assisted therapy lies.

Going back to Campbell and Kuhn, this approach to healing can be considered 'revolutionary' in that it poses new questions about old science, and changes the rules of the existing game. Psychedelic-assisted therapy ultimately achieves this by *displacing* previously accepted notions of the powerlessness of addicts, and reinstating a sense of self-power for those struggling with addiction. The emphasis on the patients' inner-healer offers a new approach to alleviating addictive behaviours. Based on the discrepancies found in conventional and psychedelic-assisted methods of managing addiction, it is fair to say that psychedelic-assisted therapy disrupts categories of recovery, agency and care, and can therefore be considered a revolutionary science that constructs a new paradigm around care.

Recreation as Therapeutic

If psychedelic-assisted therapy operates on the premise that the patients have the innate ability to heal themselves, perhaps we can begin to perceive recreational use as a therapeutic endeavor. The recategorization of psychedelic substances as a medicine, rather than an illicit substance, not only troubles conceptions of care, but it equally troubles conceptions of drugs. Thus, this new paradigm might actually legitimize personal and recreational explorations with the substance. If the protocol systematically dismantles hierarchical notions of authority in the therapeutic space, this leads individuals to take care into their own hands.

It is helpful to return to Roxanne's story. In this new paradigm, her eagerness to reconnect with the self through the use of psilocybin mushrooms would not be interpreted as a relapse. If, amidst this new paradigm of care, psychedelic substances help foster a connection to one's inner-healer, perhaps Roxanne can legitimize her psychedelic use. In doing so, she would be free to engage in the same level of agency that I had in the support group for addiction recovery. She would be able to weave a narrative of 'self' as an 'addict in recovery' while simultaneously engaging in psychedelic experiences.

Unfortunately, the paradigm has not yet shifted in AA meetings and these fellowships continue to operate on an abstinence-only model, maintaining that engaging with psychedelic substances would be considered a relapse. In this context, new laboratory findings have serious implications for the lives of those who must navigate between these two seemingly-disparate worlds. Indeed, they present troubling grounds to those who are in long-term recovery, but who are becoming curious about these new laboratory findings due to popular-culture figures like Michael Pollan. By suggesting there is an inner-healer, and providing the gift of agency, the very existence of psychedelic-assisted therapy prompts seekers to trust their inner voice. This very

idea inadvertently disrupts categories of care *beyond* the clinical and therapeutic milieu. With the help of books like Pollan's, *How to Change your Mind*, the results of psychedelic-assisted therapy clinical trials bleed into our daily lives. In a capillary fashion, new laboratory findings from Johns Hopkins and New York Universities move scientific discoveries beyond the clinic, and ultimately, impact the way categories of drugs, medicine, and care are conceptualized. It must be noted, though, that this paradigm shift has serious implications.

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In returning to Campbell, this section established the complex nature of the psychedelic-assisted therapy paradigm shift and demonstrated which "aspects of the previous system" (the twelve steps) have been displaced by this new approach to healing. I would like to remind readers of Kuhn's understanding of a paradigm shift. He suggested that the scientific discipline operates in episodes by which conceptual continuity in 'normal' science is periodically interrupted by 'revolutionary' science. These interruptions, he argued, create new paradigms which steadily pose new questions of old scientific concepts and change the rules of the existing game (Kuhn 1996, 40). Furthermore, Campbell notes that "the history of addiction science can … be narrated as a succession of thought styles that *displace* one another yet *conserve* some aspects of the previous structure of social and cultural constraints on cognition" (2007, 21). By identifying and utilizing the inner-healer, psychedelic-assisted therapy *displaces* notions of powerlessness. The gift of agency is granted to the patient, and as a result, the patient begins to assume new and more powerful conceptions of the self. Thus, psychedelic-assisted therapy is different than contemporary methods of managing addiction in that it *empowers* one's will.

I would like to clarify that I am saying 'different' and not 'better.' I do not claim that psychedelic-assisted therapy is *better* than current models of managing addiction. Indeed, I am simply laying out the grounds for, and explicating ways in which, these approaches are distinct. They operate through very different notions of care. It is due to this discrepancy that the very existence of psychedelic-assisted therapy can, ultimately, be troubling for people in conventional forms of recovery. It is *because* they use such different approaches to care.

The first chapter showed that the integration of psychedelic-assisted therapy in conventional models of treatment troubles categories of drugs and medicines. This process inspires us to reimagine the way we classify substances and encourages us to rethink prevailing epistemic drug categories. By looking at notions of agency within traditional approaches to recovery, I argued that this new healing paradigm disturbs conceptions of personal autonomy, and as a result, conventional approaches to care and healing. Returning to Kuhn and his definition of a paradigm shift, it is this gift of agency that interrupts conceptual continuity within traditional models of recovery, revolutionizes them, and subsequently qualifies psychedelic-assisted therapy as a paradigm shift. By identifying and reviving the patients' innate will to heal themselves, in psychedelic-assisted therapy drug users are no longer powerless over their addiction. Thus, the act of submitting either to a spiritual entity, a fellowship, or consistent MAT in traditional models of healing shifts from a 'power greater than themselves' to a 'greater power *within* themselves'.

Does this mean that psychedelic-assisted therapy cannot coexist with biomedical or spiritual approaches? Is this new paradigm too revolutionary to work alongside conventional models? To answer these questions the next chapter explores ways psychedelic-assisted therapy can work as a bridge to unite the spiritual and biomedical approaches to recovery.

3 – Cures? : The Convergence of a Biomedical and Spiritual Fellowship

"It was like that little seed had germinated during those few months…
and it's sort of, it… it… it sprouted
and even though I was in intense withdrawal misery,
I could feel this awareness growing in me that everything was going to be okay"
- Lazarus August 14th 2019

Having explored conventional approaches to providing care to addicted people with Medication-Assisted Treatment (MAT) and the twelve steps, Chapter One concluded that new laboratory

findings suggest psychedelic-assisted therapy works as a catalyst to shift paradigms about drugs and medicines. I noted that as popular culture figures like Michael Pollan disseminate recent findings about psychedelic-assisted therapy to the public, conventional practices of addiction management begin to be understood as treatment options rather than the entirety of treatment. Shifting psychedelics from the category of' illicit substance' to 'legally-recognized form of medicine' helps people in recovery to reconsider employing them for personal and therapeutic use. We saw this in Roxanne's case. There is a downside, though. Introducing psychedelic therapies into the social and cultural dynamics of recovery can be difficult, and even potentially unethical.

Delving into the protocols used in these novel approaches to managing addiction, Chapter Two concluded that by attending to the inner-healer, psychedelic-assisted therapy displaces conventional interpretations of agency in twelve-step and MAT-based approaches to recovery. As a result, conceptions of care in addiction recovery are being revolutionized. Chapter Three now focuses on how psychedelic-assisted therapy conserves "certain aspects of the previous structure" of managing addiction—as Campbell suggested (2007)—and concludes my investigation of the ethical integration of psychedelic-assisted therapy into current models of recovery. It demonstrates the unexpected compatibility of these seemingly disparate approaches to managing addiction.

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In Chapter One, I explored the two most common methods of managing addiction: twelve-step programs and MAT. I separated these methods into two categories: (1) the neurochemical

(hereafter referred to as biomedical) approach, and (2) the faith-based (hereafter referred to as spiritual) approach. The biomedical method of managing addiction, often taking the form of MAT, depends on harm-reduction. The harm reduction discourse suggests that reliance on substances like Suboxone and methadone is less harmful to the user than the illicit substances clients were misusing. By maintaining opiate users on weaker, regulated, and ultimately cleaner, opiates like Suboxone or methadone, MAT seeks to attain chemical homeostasis. Spiritual approaches, like the twelve-step programs, strives for abstinence from all mind-altering substances. Thus, these two categories of managing addiction can further be separated into two approaches. The biomedical method is oriented to harm reduction, and encourages use of certain substances, and the spiritual-based method encourages abstinence and discourages the use of mind-altering substances.

In “Pharmaceutical Evangelism and Spiritual Capital”, Helena Hansen (2008) identified two groups of people making choices about where and how to get treated. In one group they chose a buprenorphine clinic (using the biomedical/harm-reduction approach), in the other an evangelist fellowship (using the spiritual/abstinence approach). Each group took a specific approach to recovery. Even though she acknowledged that on first take these seemed very different undertakings, Hansen found that they had more in common than it might first appear. She eloquently described the way the two approaches "bridge the highly personal, individual states of possession, or neuroreceptor activation, with a view of themselves as part of a worldwide network sharing in a medium, whether of molecules or spirits" (2008, 124). Hansen showed that these approaches used a similar tack. They both provided the patient with a broader and more collective, personal narrative with which to identify and this gave them a means to recover. In both the biomedical and spiritual approaches participants joined a collective

project—either at the clinic or though AA fellowship. Thus, it appeared that both categories of recovering drug users found solace by joining a 'worldwide network'. The feeling of belonging and the act of viewing oneself as a part of a larger whole becomes the unifying factor between these two seemingly disparate approaches to recovery, as Hansen points out. Partaking in a collective identity is one of the cornerstones for successful recovery.

Although the larger part of this thesis has demonstrated that psychedelic-assisted therapy has been controversial, it is important to understand that this approach can work hand in hand with mainstream methods. Building on Hansen's framework, Chapter Three will look at the way these seemingly incompatible approaches are actually working in similar ways. Indeed, psychedelic-assisted therapy not only troubles the lines between drugs and medicines and forces us to rethink the agency of drug users, it further troubles the lines between biomedical and spiritual approaches. Psychedelic-assisted therapy brings these two treatment paradigms together.

A Scientific Mystical Experience

With the advent of MDMA and LSD molecules' synthesis in 1912 and 1938, psychedelic experiences became a biomedical and scientific matter that could be created by chemists in a laboratory. This was a very new way of thinking about psychedelic-induced states that, until this point, had been attained in the traditional way, by consuming mushrooms, peyote, and ayahuasca. If these states could be scientifically produced it challenged the notion of the unreproducible nature of the spiritual insights that naturally occurring psychedelic-induced states provide (see Taussig, 1986). This makes it challenging to assign psychedelic-assisted healing to either the scientific or the spiritual approach to healing.

Furthermore, beginning with the first scientific explorations of psychedelic-assisted therapy to treat alcoholism in the 1950s (Chwelos et al. 1959), faith-based approaches have been incorporated into the clinical protocol. Indeed, Alcoholics Anonymous was a crucial component and a major contributor to the long-term success of these clinical trials. In the *Quarterly Journal of Studies on Alcohol,* Abram Hoffer noted that "all the patients were encouraged to try the AA program. It was thought that the AA program and the learning gained under LSD were complementary" (Chwelos et al. 1959, 579, my emphasis). In this way, the lines between neurochemical and faith-based addiction treatment have been blurred since the earliest investigations looking into the efficacy of psychedelic-assisted therapy. This implies that the compatibility of neurochemical and faith-based approaches to managing addiction has been demonstrated since the genesis of their inclusion within the scientific realm.

Nevertheless, tracking and decoding the psychedelic experience within the biomedical framework has been no simple feat. The scientific model rests on observation of, and experimentation on, a theory or phenomenon. Objectively observing and testing subjective and subconscious experience presented researchers with a conundrum. In 1962, physician and psychiatrist Walter Pahnke edged towards a resolution to the problem. He conducted the *Good Friday Experiment* under the supervision of the notable author and counter-culture figure Timothy Leary, along with fellow researcher at Harvard University, Richard Alpert. As mentioned earlier, this experiment explored whether psilocybin-induced experiences could mimic religiously-induced mystical experiences. In 1963, Pahnke wrote his Ph.D. dissertation and devised the *Phenomenological Typology of Mystical States of Consciousness,* a system by which he measured and described religiously-inspired mystical experiences. The categories included: unity, objectivity and reality, transcendence of space and time, sense of sacredness,

deeply felt positivity, paradoxicality, alleged ineffability, transiency, and positive changes in attitude or behavior (Pahnke 1963, 46-84). Having taken this first step towards scientifically-defining mystical experience, Pahnke and his colleague William Richards organized experiments with psychedelics. Beginning with these categories, they devised the Mystical Experiences Questionnaire (MEQ43) questionnaire, which they then used to quantify the highly subjective and reflective experiences that the substances enabled them to have.

In 2015, researchers at Johns Hopkins University reviewed and revised the Pahnke-Richards 43-item questionnaire into what is now known as the MEQ30 (see Figure 4 below). This newer version is currently being used in clinical trials at Johns Hopkins University to test the efficiency of psilocybin-assisted therapy for alleviating tobacco addiction, depression, Alzheimer's disease, and anorexia nervosa[60]. These questionnaires aim to show that an experience that rates high enough on the mysticism scale provides "personal meaning and spiritual significance" to participants (Barrett, Johnson & Griffiths 2015, 7). This discovery is unique in that the team at Johns Hopkins has devised a way to demonstrate a spiritually significant experience quantifiably, proving that psychedelic-assisted therapy can provide people with a personally and spiritually significant experience. They found that in order for an experience to be deemed a 'complete' mystical experience and provide a significant change, the volunteers needed to score higher than 0.6 on the categories indicated above (2006, 272). The researchers then looked for long-lasting attitude and behavior changes in a 14-month follow-up study. Results demonstrated that, indeed, a psychedelic-induced experience that scores high

[60] On clinicaltrials.gov there are up to 280 clinical trials that are either completed, recruiting or in progress. The MEQ-30 has become a standard questionnaire that is being administered in order to understand the mystical experiences that patients are undergoing. The Johns Hopinks Center for Psychedelic Research and Consciousness has nine psychedelic-focused clinical trial studies currently underway. More can be found here https://hopkinspsychedelic.org/index/#research

enough on the mysticism scale could lead to long-term behavior changes (ibid.; MacLean, Johnson, Griffiths 2011; Millière et al. 2018). This research provides a profound bridge between the scientific and spiritual treatment methods that can be used to manage addiction going forward.

mystical experience questionnaire (meq30)

instructions: looking back on the entirety of your psychedelic session, please rate the degree to which at any time during that session you experienced the following phenomena. Answer each question according to your feelings, thoughts, and experiences at the time of the psychedelic session. In making each of your ratings, use the following scale: **0** none/not at all; **1** so slight cannot decide; **2** slight; **3** moderate; **4** strong (equivalent in degree to any other strong experience); **5** extreme (more than any other time in my life and stronger than **4)**. Feel free to use 'half-point in-between scores' if these are applicable.

		0	**1**	**2**	**3**	**4**	**5**
1	Loss of your usual sense of time. (T)						
2	Experience of amazement. (P)						
3	Sense that the experience cannot be described adequately in words. (I)						
4	Gain of insightful knowledge experienced at an intuitive level						
5	Feeling that you experienced eternity or infinity.						
6	Experience of oneness or unity with the objects and/or persons perceived in your surroundings.						
7	Loss of your usual sense of space. (T)						
8	Feelings of tenderness and gentleness. (P)						
9	Certainty of encounter with ultimate reality (in the sense of being able to 'know' and 'see' what is really real at some point during your experience).						
10	Feeling that you could not do justice to your experience by describing it in words. (I)						
11	Loss of your usual sense of where you were. (T)						
12	Feelings of peace and tranquillity. (P)						
13	Sense of being 'outside of' time, beyond past and future. (T)						
14	Freedom from the limitations of your personal self and feeling of unity or bond with what was felt to be greater than your personal self.						
15	Sense of being at a spiritual height.						
16	Experience of pure being and pure awareness (beyond the world of sense impressions).						
17	Experience of ecstasy. (P)						
18	Experience of the insight that "all is One".						
19	Being in a realm with no space boundaries. (T)						
20	Experience of oneness in relation to an "inner world" within.						
21	Sense of reverence.						
22	Experience of timelessness. (T)						
23	You are convinced now, as you look back on your experience, that in it you encountered ultimate reality (that you 'knew' and 'saw' what was really real).						
24	Feeling that you experienced something profoundly sacred and holy.						
25	Awareness of the life or living presence in all things.						
26	Experience of the fusion of your personal self into a larger whole.						
27	Sense of awe or awesomeness. (P)						
28	Experience of unity with ultimate reality.						
29	Feeling that it would be difficult to communicate your own experience to others who have not had similar experiences. (I)						
30	Feelings of joy. (P)						

scores/%'s: **transcendence (T) = /30 = %; positive mood (P) = /30 = % ineffability (I) = /15 = %; mystical = /75 = %; total score = /150 = %.**

Figure 4: Barrett, F. S., et al. (2015). "Validation of the revised Mystical Experience Questionnaire in experimental sessions with psilocybin." Journal of Psychopharmacology 29(11): 1182-1190.

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In light of these studies, Hansen's (2013) dichotomy between biomedical and spiritual methods can be approached in a new way. Psychedelic-assisted therapy does not belong exclusively to either category. Indeed, psychedelic-assisted therapy works within both the biomedical and the spiritual frameworks. It is inherently biomedical in that a chemical substance is carefully administered and monitored by a licensed therapist, as in the case of MAT. It is inherently spiritual because the main aim of these experiments is to induce a mystical experience. Psychedelic-assisted therapy belongs to the world of clinical trials, double-blind experiments, and testable protocols. And the scientific discipline has devised a way to quantify the long-lasting and positive effects of a psychedelic-substance-induced mystical experience with these studies. What was initially understood to be a subjective spiritual endeavor has crossed into the biomedical and scientific realm. Thus, the lines between biomedical and spiritual approaches to managing addiction are significantly blurred in the context of psychedelic-assisted therapy. This new method straddles both the world of biomedicine and spirituality.

Furthermore, by adopting a harm-reduction[61] model towards recovery, psychedelic-assisted therapy resembles the biomedical approach to maintaining abstinence. Similar to the way MAT assumes that substances like Suboxone and buprenorphine cause less harm than the illegal street substances, psychedelic-assisted therapy suggests that psychedelic substances cause less harm - both emotionally and physically - compared to a user's substance of abuse. Furthermore, in the integration circles that support people who are in recovery and are using psychedelic substances, the group adopts a nonjudgmental approach that does not encourage (but

[61] Harm reduction is an approach to drug use which encourages the least amount of harm on the user. Often, harm reduction initiatives consist of drug education, clean needle exchanges, and supervised injection sites

does not discourage) abstinence-based models of recovery. Psychedelic-assisted therapy aligns neatly with harm-reduction approaches to addiction management. The previous chapters have demonstrated the differences between psychedelic-assisted therapy models and conventional approaches to care, however, here, I suggest that this new method may not be as disruptive to the current healing landscape as one might suppose. In fact, psychedelic-assisted therapy bridges the gap between biomedical and spiritual approaches to recovery.

Psychedelics meet Alcoholics Anonymous

In an interesting twist on the fact that Hoffer and Osmond relied on the twelve-step program to carry out their studies on LSD and alcoholism, some recovering substance users have turned to psychedelic substances to better work the twelve-step program. After more than two decades of complete abstinence from all mind-altering substances, Bill Wilson, the co-founder of Alcoholics Anonymous, had his first LSD experience. It was 1956 when his "most-trusted spiritual advisor," Gerald Heard, a long-time friend of Aldous Huxley and Humphrey Osmond, facilitated Wilson's first psychedelic journey (Lattin 2012, 205). There is much debate over what Alcoholics Anonymous' official stance should be on this matter. Some say that Wilson felt no shame or guilt in his psychedelic experimentation and encouraged members to follow suit (Kurtz 1999). Others say that he took careful steps to avoid making it seem that AA endorsed psychedelic experimentation (Lattin 2012).

Wilson was fascinated by LSD and nurtured a relationship with the substance in order to foster a deeper connection with his higher power. Wilson's anonymously written biography mentions that he felt that LSD "helped him eliminate many barriers erected by the self, or ego, that stand in the way of one's direct experiences of the cosmos and of God. He thought he might

have found something that could make a big difference to the lives of many who still suffered." (Alcoholics Anonymous 1984, 371). Essentially, Wilson thought LSD "could help cynical alcoholics undergo the spiritual awakening that stands at the centre of twelve-step work" (Lattin 2012, 206). In that the twelve-step method encourages an abstinence-based model of recovery, one would be hard-pressed today to find someone in an AA meeting who holds this viewpoint.

In Alcoholics Anonymous' *Big Book*, "the terms 'spiritual experience' and 'spiritual awakening are used many times… which, upon careful reading, shows that the personality change sufficient to bring about recovery from alcoholism has manifested itself among us in many different forms" (2012, 567 my emphasis). A spiritual awakening can be achieved through various routes. However, seven of my interlocutors said they had trouble succeeding in AA because they could not connect to the required higher power, as we saw with Roxanne. Roland Griffiths, William Richards and Matthew Johnson (2008), three psychedelic research pioneers of the twenty-first century, and their colleagues discovered that "mystical-type experiences occasioned by psilocybin mediate the attribution of personal meaning and spiritual significance 14 months later". In their 2008 study, they concluded that psychedelic-experiences could induce a 'spiritual awakening' similar to the 'spiritual awakening' found in the *Big Book*. The *Big Book* of Alcoholics Anonymous looks to a 'spiritual awakening' to bring about successful recovery. During my research, I encountered one informant who wove the psychedelic-induced spiritual awakening into his recovery using the twelve steps. I call him Lazarus.

Lazarus' Story and the Challenges of AA

Although I met plenty of people on this journey, Lazarus stood out. He was so uninspired with the twelve-step program that he decided to adapt and adjust the program to better fit his needs. In

his eleventh year of recovery, he swore that without the help of ayahuasca he would still be "stabbing needles of heroin into [his] neck to this day" (August 14th, 2019). Throughout his journey through addiction, Lazarus had experimented with a substantial number of substances, including psychedelics such as LSD and psilocybin-containing mushrooms. When the opportunity for an ayahuasca experience arose, he was skeptical that anything meaningful would come of it.

> *Having had a lot of experience with psychedelics, I didn't honestly think it was going to change my life, but I thought, well, what the hell, at least it'll be like an interesting sort of an anthropological adventure or something, or whatever it was that I was thinking of it at the time. I knew I needed help, but I didn't know how it was going to come and I didn't really totally expect it, but it's kind of like… I think about like my inner – my higher self that was so obscured with problems, kind of knew that that's what I needed to do. So, I was going in spite of myself, kind of. So, during that initial experience, which was not overly powerful, even by the standards of my prior psychedelic experiences, it was not overly powerful, but I remember something beginning to happen and shift within me…*
>
> *So, I had my initial ceremony, and it got me thinking about some stuff. And I went back home to Missouri, began drinking alcohol again, up my dose of opiates again, and then three months afterward, I drank myself into jail for the last time. I was in opiate withdrawal one day; I would be dope sick, drinking heavily, blacked-out, and managed to get myself arrested. Came to the following morning in the drunk tank in all sorts of misery, but the good thing is, in my misery – because now I was in withdrawal sickness, from opiates and alcohol – I could feel that whatever happened in that ceremony was*

> *kind of like a little seed had been planted during that ceremony – and this is the analogy that I used: it was like that little seed had germinated during those few months in between the ceremony and my last trip to jail and it's sort of, it… it… it sprouted and even though I was in intense withdrawal misery, I could feel this awareness growing in me that everything was going to be okay and uhm, it showed me so many things about myself that I needed to see and it gave me directions too. I sat in jail for two weeks detoxing, got out of jail, and part of the (internal) directions that I was receiving while in jail was 'get out of jail, go to AA, learn to make your own Ayahuasca,' and that is what you're going to do.*

Today, Lazarus hosts online support groups for people who participate in a regular ayahuasca practice, inspired by the Santo Daime religion– while simultaneously working the twelve-step program. According to him, "one [approach] is a catalyst, [and] the other is a container. One is a seeker; the other is a map".

Lazarus continuously expressed that he would never have let his guard down or "surrendered" to a higher power without the experience with ayahuasca. Here I am reminded of something that Ben, a participant in his fifth year of recovery from intravenous heroin use, said about 'the will' in the twelve-step approach to recovery: "I'm not using my will, it's that I'm giving up my will [to a higher power]." Lazarus further spoke about how demanding the twelve-step program is and how much work it requires to genuinely surrender based on what AA was asking of him to accomplish.

> *Finding a sufficient amount of honesty, open-mindedness, and willingness to actually take these steps in their entirety is almost impossibly hard, even for those most*

> *desperately in need of them . . . I was drinking again, smoking crack again, and something had started to thaw after that ceremony. During that initial ceremony, it showed me things that I needed to address in a way that was very gentle and healing. So, during the four months of drinking again, it must have just been… the way I look at it… it was just germinating underground and when I came to in the jail cell, all of a sudden, it began to speak in very clear terms, and I was filled with hope – in spite of the fact that I was in extreme misery from withdrawal sickness – I had this sense of like it's going to be okay. It was like the plants, the experience from three months prior, were showing me things and giving me guidance on what to do and part of that was guidance to go back to AA, get a sponsor, work all the steps and learn to make Ayahuasca and use those experiences to continue excavating my soul on deeper and deeper levels . . . and so that's exactly what I did.*

Before his experience, Lazarus could not stay sober or abstinent for longer than four months. The only time he succeeded in doing so was when he went to a long-term in-patient treatment center. He had not aligned with the twelve-step program, and he had not felt that working the steps or attending meetings provided him with the tools he had needed to remain abstinent.

After using ayahuasca alongside working the twelve steps, Lazarus knew he was not alone in his struggle to surrender to a higher power within the twelve-step program. The twelfth step urges that "having had a spiritual awakening as the result of these steps, we tr[y] to carry this message to alcoholics, and to practice these principles in all our affairs." Lazarus felt it was part of his duty to bring this newfound approach to others who were struggling in the twelve-step program. He decided to build his own program to help guide others who are attempting to

combine these two approaches. His own experiences, and now, that of others he has helped, have led him to believe that the twelve-step program works much better with the help of a psychedelic substance. He believes psychedelics help foster a deeper connection to the self. It allows people to become more 'honest, open-minded, and willing' (the three cornerstones of the twelve steps which helps facilitate process of surrendering ones' will.

In discourses permeating both AA and psychedelic-assisted therapy, the notion of surrender comes up repeatedly. I see the state of surrender as a factor that both discourses have in common. In a meta-analysis of the scales used in psychedelic therapy clinical trials, researchers Raphaël Millière and Robin Carhart-Harris (2018) discussed variables indicating that a mystical experience had been achieved. Referring to the Tellegen Absoprtion Scale, they noted that experiences of absorption and surrender were two traits that subjects described when they were having stronger mystical experiences with psychedelic substances. Furthermore, they emphasize the importance of…

> the pre-experience state characterized by the disposition to "let-go" or "surrender" to whatever experience comes, sometimes called "surrender state" (Richards, 2015). This state is not only related to the subject's personality but also to interactions with the environment (e.g., trust toward the therapist). Higher ratings of willingness to surrender are associated with stronger mystical-type experience in both psychedelic experiences. (Millière et al 2018, 20)

In this meta-analysis of the many scales needed to quantifiably describe a mystical experience, these researchers established the correlation between a psychedelic-induced mystical experience and the ability to surrender. What I find interesting is that the ability to surrender is an essential component for successfully completing the twelve-step program. For this reason, I feel that psychedelic-assisted therapy can work in tandem with the twelve-step program.

In addition, in the first wave of scientific research on psychedelic-assisted therapy, Hoffer and Osmond concluded that "self-surrender and self-acceptance are more easily achieved in the LSD experience and . . . [that] the resolution of the problem of the alcoholic lies in this surrender" (Chwelos et al. 1959, 589). Similarly, as alluded to earlier, the *Big Book on Alcoholics Anonymous* clarifies that the terms 'spiritual experience' and 'spiritual awakening' are integral to an adequate 'personality change' (2012, 567). Psychedelic-induced mystical experiences offer an opportunity for this 'personality change' to occur.

According to Millière et al. (2018), ingesting psychedelic substances quiets the default-mode network (DMN). The DMN is responsible for the self-talk we experience throughout the day. In philosophy, they refer to these thoughts as *de se* (Garcìa-Carpeintero, 2015). Millière and his team of researchers infer that

> … *de se* thoughts themselves come in different flavors, which are more or less egocentric. Thus, one may explicitly reflect on one's personality traits or one's life trajectory, both of which are important elements of an individual's identity. This category of *de se* thought broadly pertains to the entertainment of core self-related beliefs, and is often linked to the notion of narrative selfhood—the stories we tell ourselves about the kind of person we are or want to be. (2018, 6)

The researchers explain that psychedelic substances decrease activity in these sections of the brain. As a result, by taking psychedelic substances, the DMN is quieted and *de se* thoughts that reinforce notions of identity and personality, are reduced. The researchers finally concluded that

> … narrative aspects of self-consciousness can be radically altered during a specific conscious episode in two ways: through a temporary cessation of self-referential thought and mental time travel, or more dramatically through a temporary loss of access to semantic autobiographical information, resulting in a complete breakdown of one's personal identity. (ibid., 7)

I take this conclusion to infer that psychedelic substances can induce a change in one's personal identity. Furthermore, in the Griffiths et al. (2008) 14-month follow up study, they concluded that

"mystical-type experiences occasioned by psilocybin mediate the attribution of personal meaning and spiritual significance" (Griffiths, Richards, Johnson, McCann et al. 2008).

These findings suggest that psychedelic-induced mystical experiences can induce the 'personality change' that the *Big Book* of Alcoholics Anonymous asks of its members. However, in order to achieve a substantial mystical experience with psychedelic substances, and the required long-lasting personality change, the patient ought to *surrender* (Millière, Carhart-Harris, Roseman, Trautwein et al. 2018, 20). From this perspective, the language used to talk about addiction-alleviating psychedelic substances is very similar to discourse found in Alcoholics Anonymous.

Earlier, I interpreted Gregory Bateson's understanding of 'the alcoholic self' to be an adequate description of 'the previous structure,' or the previous perception, of addiction. In his chapter titled "The Cybernetics of "Self": A Theory of Alcoholism*",* Bateson further discussed the importance and difficulty of surrendering in the twelve-step methods for managing addiction:

> The first step demands that the alcoholic agree that he is powerless over alcohol. This step is usually regarded as a "surrender" and many alcoholics are either unable to achieve it or achieve it only briefly during the period of remorse following a binge. AA does not regard these cases as promising: they have not yet "hit bottom". (1972, 318)

Here, Bateson has suggested that drug users must be at their absolute lowest in order to surrender. He noted that the "bottom is a spell of panic which provides a favorable moment for change, but not a moment which change is inevitable" (ibid., 336). He admitted that "only a deep unconscious epistemology- a spiritual experience – will make the lethal description irrelevant"

(ibid., 338). I contend that this concept of 'hitting bottom' is not so different from the spiritual experience one has under the influence of psychedelic substances.

In psychedelic-assisted therapy discourses, the psychedelic experience provides a “favorable moment for change, but not one in which change is inevitable" (ibid., 336), language similar to that which Bateson used to describe the twelve steps. The psychedelic experience induces a ‘bottom-like’ experience, where change can occur, however as the ketamine-assisted therapist, Jen mentioned, "the dirty work still needs to be done” in order to attain that change. Similar to the way a ‘spell of panic’ can encourage change in Bateson’s estimation, the mystical and psychedelic experience provides favorable opportunity for change too, *if* you do the corresponding work.

The parallels between psychedelic experiences and conventional methods for managing addiction do not end with bottom-like experiences. Similar to discourses in Alcoholics Anonymous about handing one's will over to God or a higher power, the patient continues to 'submit' to the experience. Suzanne Russ and Robin Carhart-Harris (2019,1) note that "a state of surrender at the start of the psilocybin session most strongly explained [mystical experiences]" The psychedelic experience can instigate getting to a 'bottom-like' state in which patients question their identity and sense of self, and this provides an opportunity for long-lasting personality change (Griffiths et al. 2008). In this way, psychedelics can provide the spiritual experience needed to attain the personality change discussed in the *Big Book* of Alcoholics Anonymous.

~ ◊ ~

I now want to return to Nancy Campbell (2007) and her term ‘laboratory logics’ that argues “the history of addiction science can. . . be narrated as a succession of thought styles that *displace* one another yet *conserve* some aspects of the previous structure of social and cultural constraints on cognition” (2007, 21). While Chapter Two addressed the way psychedelic-assisted therapy *displaces* old regimes of recovery, for example the twelve-step notions of the self and agency, I see three areas in which the ‘previous structure’ is indeed *conserved* in psychedelic-assisted therapy approaches to recovery.

First, in both psychedelic experiences and the twelve-step method of managing addiction, the patient must *surrender* and submit their will to something more meaningful. Second, similar to Bateson's view of the twelve steps, *changes to personality* that result from a psychedelic experience are *not inevitable* in that work needs to be done in order to prompt long-term recovery. Third, both psychedelic-assisted therapy and AA rely on a *spiritual experience* in order to bring about the required personality change. Indeed, a psychedelic mystical experience can be described as a window of opportunity for fostering a relationship with the inner self that helps those pursuing recovery to recognize and begin the 'dirty work' that lays ahead. These three 'aspects of the previous structure' conserved in psychedelic therapy indicate that psychedelic substances can help promote the work of Alcoholics Anonymous. However, the reverse also applies: Alcoholics Anonymous can be used as a tool to help patients integrate their psychedelic experiences.

Alcoholics Anonymous meets Psychedelics

Having had a number of sessions getting to know Lazarus, I learned that he had come to respect the role that both psychedelics and twelve-step programs can play in recovery. In fact, he

believed that an individual might have trouble extracting meaning and fundamental personality change from a psychedelic experience without twelve-step programs. As he put it so succinctly, "one is a catalyst; the other is a container. One is a seeker; the other is a map".

Lazarus was actively involved and familiar with the current psychedelic renaissance. I found him to be well-versed in the latest clinical-trial protocols around psychedelic-assisted therapy and able to integrate these models into his own personal practice. Having learned about the importance of integration sessions after psychedelic experiences, he put them at the center of his program for deep healing and personal transformation.

> *I mean, even though the term integration is constantly bandied about, what does that really mean? I see a lot of people want… they engage in magical thinking, 'the ceremony is going to change me, and I'll be forever okay.' The data do not show that that happens; the data show that people may get temporary benefits, but if they don't apply what they learned, they're probably going to return to their old behaviors… I mean, the ceremony gives the opportunity for all this to happen. So, if I can use my own case, I never would have gotten into recovery without it. It's just it would have been a non-start, I never would have gone to AA. I never would have been engaged in any kind of psychotherapeutic processes or spiritual development whatsoever. But I also know, by the same token, that those experiences really needed a very clear-cut, straightforward way to apply the lessons and the experiences that I learned so that I could truly learn to live differently and think differently.*

Lazarus's view was similar to therapists who practice psychedelic-assisted therapy. He did not believe that the psychedelic substance was a fix in and of itself. Indeed, there is much work to be done after a psychedelic experience and for Lazarus, that work took place by working the steps.

Lazarus eloquently explained a way of weaving together the protocols used in psychedelic-assisted therapy clinical trials with religious Santo Daime practices. He used the protocol's inner-directive approach and aligned it with the will of a divine higher power. He utilized the narrative of an inner-healer to help accelerate his, and his sponsees' success in the twelve-step program.

> *... you can call it Collective Shamanism in the sense that in the Santo Daime, there's not a shaman that leads everybody else. Everybody kind of works together even though there is a leader of the work. It's more like a communal group effort for the purposes of spiritual exaltation and communal healing. The Santo Daime emphasizes more, in terms of the healing part, it's not so much a shaman doing the healing like a Healer. In the Santo Daime each participant is considered to be their own healer they make contact with the higher powers, God if you will, that empowers you to heal yourself. (August 14th, 2019)*

Through this arguably 'recreational' (in the traditional use of the term) use of psychedelics, Lazarus sought to invoke a spiritual experience, and, much like psychedelic-assisted therapy protocols, fostered a connection with his inner healer. Again, I found that Lazarus's approach resonated with the AA spiritual fellowships in that he was submitting himself to a higher (albeit internal rather than external) power.

With this interpretation of a higher power and an inner-healer's strength, Lazarus blurred the lines between biomedical and spiritual approaches to managing his addiction. Indeed, by reverting to revolutionary scientific findings, or new laboratory logics, Lazarus "came to believe that a Power greater than [himself] could restore [him] to sanity" (step two of Alcoholics Anonymous). In this way, by considering his inner-healer as his higher power, he regained his own agency. By ensuring that he properly integrated his psychedelic experience with the twelve-step program, he maintained compliance with clinical trial processes of integration.

Lazarus presented a unique case that combined psychedelic-assisted therapy with twelve-step methods. I am inspired by his efforts to find compatibility in these two seemingly distinct worlds. Lazarus' endeavors act as a beacon of hope for psychedelic-assisted therapy's ethical integration into current recovery models. He provides a way to imagine how these two worlds can act as mutual supports.

For Lazarus, one recovery framework does not work without the other. His practice integrating psychedelic forms of therapeutic intervention with conventional twelve-step approaches offers a ground-breaking perspective through which to interpret the very question I set out to explore: does using psychedelics count as a relapse for those in recovery from other mind-altering substances? Lazarus demonstrated that the introduction of psychedelic-assisted therapy need not compromise using the traditional route towards recovery. A psychiatrist and leading physician in the recovery field, Ben Sessa, holds a similar view about utilizing psychedelic-assisted therapy within the biomedical delivery of care. In a conference on psychedelic-assisted therapy, Sessa asserted that "anyone who says that their method is better than another is speaking nonsense. This is mental health; it's very convoluted. They can work together".

Integration as Conservation

In light of Campbell's laboratory logics and how they conserve and displace old regimes of addiction recovery, Chapter Two concluded that psychedelic-assisted therapy displaces previously-accepted truths about recovery. By taking an inner-directed approach, psychedelic-assisted therapy displaces the fundamental principle that 'addicts' are powerless over their addiction. In Chapter Three, I've explored the ways psychedelic-assisted therapy conserves aspects of both the biomedical and spiritual approach to managing addiction, concluding that they can indeed work together. For this to occur, however, three key factors must be present: 1) a surrender state, 2) the continuation of post-surrender 'dirty work', and 3) a spiritual awakening leading to personality change. In the final section I expanded on psychedelic-assisted therapy's compatibility with Alcoholics Anonymous fellowships by demonstrating the similarities in their respective structures.

As previously discussed, integration is a powerful tool being used in psychedelic-assisted therapy. Many therapists and support-group facilitators emphasize that the substance itself will not 'heal' anything. Indeed, psychedelic substances are merely an opportunity to open a conversation with the inner healer. Sacha, a therapist who works in an above-ground ketamine clinic, shed light on the dangers of thinking that these substances offer a panacea for addiction:

> *They don't fix everything. For some people, when the ego dissolves, it's like a muscle. It just snaps back stronger than before. And so, if people aren't doing the work, they become even bigger assholes than they were before. And they're not a panacea... you might come away from that [experience] with insights and answers, you might come*

> *away from that feeling like your whole life is torn apart, and everything you thought you believed in is up for questioning. You realize you're working the wrong job, you don't know if you should be in this relationship, it can strip all this stuff away, and that's where the actual work begins, and that could go on for months or years. So, the period that you're high, you know, that's the easy part. You know, coming back and doing the work. If you're high, it's great you've got it all figured out, and you've seen God, and now you gotta come back and pay the mortgage and wash the dishes and put up with your grouchy spouse or whatever it is.*

In the psychedelic-assisted therapy protocol, much of the work is done in the integration sessions that follow the psychedelic session. The protocol used in psychedelic-assisted therapy only calls for three experimental sessions with the psychedelic substance. In contrast, the remainder of the protocol consists of integration sessions where patients and the therapists make meaning from the experience (see figure 2, page 21).

Integration circles hosted by the BACP are integral to the protocols' continuous integration process. They emulate the format of AA meetings. People sit in a circle, anonymity is paramount, people introduce themselves by their first name, and everyone has a 'check-in.' Furthermore, these circles provide people with a collective network with which they can identify. As Hansen noted in her assessment of the similarities between biomedical and spiritual approaches, these integration circles provide people "with a view of themselves as part of a worldwide network sharing in a medium, whether of molecules or spirits" (2008, 124). As I alluded earlier, establishing a collective identity with which individual substance users can identify can prove to be the cornerstone of successful recovery.

Although AA meetings happen in various places throughout a city, and many times a day, integration circles offered by the BACP (which have been taking place for three years or so) only happen weekly. The first time I attended a meeting to get a sense of what went on there it was a hot June day in the summer of 2019. Mid-circle on the floor a quartz crystal singing bowl had been laid on top of a white, faux-fur runner. Meadow read out the rules. They were:

1. We do not judge
2. We do not stigmatize any substance
3. We do not exclude anyone
4. We use psychedelics with reverence
5. We welcome *psychonauts*, newcomers and those still using with the desire to change
6. If you are in recovery, we'd love to hear how long
7. If you are still using substances and want to be in recovery, welcome, we are here for you.

Such integration circles, where I would spend the bulk of my time participating and observing, created a space in which people felt comfortable sharing difficult stories. Participants freely offered up information about their psychedelic substance use. It was a place where I heard some people say they felt understood "for the first time". Similar to AA meetings, these circles were incredibly diverse. A man in his 70s who was in recovery from opiates and used psilocybin-containing mushrooms to alleviate symptoms of depression, could relate to the 23-year-old girl who had just undergone her first MDMA-assisted therapy treatment in FDA clinical trials. These experiences became grounds for uniting everyone who wanted to use psychedelics for therapeutic purposes. I recall that participants like Roxanne expressed a deep appreciation for the acceptance and non-judgmental tone of the psychedelic support group. It was in marked contrast to the way she felt at her AA meetings.

In clinical trials, integration provides the basis for potential progress and success. Unfortunately, because these clinical trials are short-term, patients cannot maintain relationships

with the therapists involved. For this reason, the psychedelic-assisted therapy model not only values integration within the protocol and clinical setting, it also relies on community engagement. Once the trial is over therapists often direct patients toward the local psychedelic communities hosting integration circles so that they will not feel alienated.

It is important to note that protocols for integration are not limited to psychedelic-assisted therapy. Medical anthropologist Janelle Taylor (2014) explored the concept of care as it exists in actions of integration:

> …integration is an interesting provocation for thinking about care. Rooted etymologically in oneness (integer, integrity), the word posits it not as origin or essence, but as an outcome, an accomplishment, the end of a process. In this sense, integration resonates well with care, which—however we may define it, whatever specific forms it may take—is purposeful activity that seeks to restore wholeness in another. Care involves an act of reaching out, in a gesture that seeks to comfort, to connect, to heal—to make whole. To integrate. (culanth.org)[62]

I am reminded of AA's motto to "keep coming back; it works if you work it and work it 'cause you're worth it." I find that psychedelic-assisted models of recovery actually do conserve older regimes of care. By encouraging consistent integration and work, psychedelic-assisted therapy emulates twelve-step models of recovery. Throughout my fieldwork and having attended dozens of Alcoholics and Narcotics Anonymous meetings, I would often hear members of the fellowship say, "you have to work the steps, you can't just expect it to work like magic". Psychedelic-

[62]Janelle Taylor 2014 https://culanth.org/fieldsights/care-integration

assisted therapy offers a similar assessment in that it does not claim to offer a silver bullet. One does indeed need to do the dirty work.

In sum, psychedelic-assisted therapy not only emulates the twelve steps by helping to foster a connection to a higher, or internal, spiritual power, it emblemizes traditional models relying on integration within support groups created by a community-led organization like the BACP. By prioritizing the process of connecting to an inner healer, psychedelic-assisted therapy helps overcome the problem so many people have with the notion of powerlessness and displaces the previously accepted truth. It also conserves aspects of recovery involving spiritual significance, personal change, a surrender state, continuing to do the dirty work, and finally, maintaining fellowship. Following Campbell, one could say that psychedelic-assisted therapy qualifies as a new laboratory logic in that it simultaneously conserves and displaces aspects of the previous structure. This aligns well with Kuhn's notion of a paradigm shift in that psychedelic-assisted therapy interrupts the concepts of recovery developed and promoted by Alcoholics Anonymous at the same time that it poses fresh questions for that paradigm.

Psychedelics as a Bridge

By exploring how the current paradigm shift can pose new questions about extant understandings of recovery, this chapter has demonstrated the unexpected ways in which psychedelic-assisted therapy bridges the gap between biomedical and spiritual approaches to managing addiction. And, as psychedelic-assisted therapy goes through clinical trials with the FDA in order to be used in strictly therapeutic and clinical settings, what emerges will become a biomedical intervention. However, unlike MAT, psychedelic-assisted therapy does not seek chemical homeostasis. Instead it relies on the long-term personality changes induced by the psychedelic

mystical experience and integration sessions. In this way, what appears to be a biomedical intervention falls into the category of spiritual growth.

A second area of exploration in this chapter has been the way psychedelic-assisted therapy conserved aspects of both the biomedical and the spiritual approach, showing that they can work together. I found that they relied on four common factors: 1) a surrender state, 2) the continuation of post-surrender 'dirty work', 3) a spiritual awakening leading to personality change, and finally, (4) the communal fellowship provided by both AA and integration circles.

As we have seen, psychedelic-assisted therapy can not be considered simply a neurochemical/biomedical intervention. Nor can it be fully relegated to the category of faith-based/spiritual methods. It transgresses the boundary between them, and as a result, offers a bridge between the two approaches. In this way psychedelic-assisted therapy can act as an aid for working the steps and attaining the 'spiritual awakening' that the *Big Book* proscribes.

This chapter showed how psychedelic-assisted therapy can work hand-in-hand with the program of Alcoholics Anonymous. As Lazarus put it, the twelve steps provides a container for making meaning from the catalytic experience of a psychedelic journey. Lazarus' story illustrated that in a very practical way, psychedelic-assisted therapy and the twelve-step recovery model can be integrated. The resultant merger, is, in fact, more congruent with conventional approaches than one might first imagine.

Conclusion

"[T]he house of medicine is not cleaned up enough for the guest of psychedelics… or perhaps psychedelics would actually demand better of medicine and psychiatry" – Jesse
June 18th, 2019

As I reflect on all that I have learned in this research I return to a day in May of 2017, the moment when Dorian asked me, "can I still be considered to be 'in recovery' from alcohol and cocaine use if I occasionally ingest psilocybin-containing mushrooms?" I review the data I collected between June and August 2019 when I was conducting participant observation in San Francisco, California. At the Bay Area Community for Psychedelics and Alcoholics and Narcotics Anonymous meetings I conducted 38 interviews. Some were with therapists trained in various subdisciplines, others with people using psychedelics during recovery. Their insights led to this thesis and the answer to Dorian's question. Yes, there is an ethical way to integrate psychedelic-assisted therapy into prevailing forms of treatment. But when that occurs there is a paradigm shift. This shift maintains conventional methods for managing addiction and care at the

same time that it challenges them. As a result, we must be delicate in our attempt to bring these two healing modalities together.

Thomas Kuhn's notion of the paradigm shift was described as a "fundamental change in the basic concepts and experimental practices of a scientific discipline." He argued that the scientific discipline develops intermittently, exhibiting episodes of stability interrupted by revolutionary developments. These interruptions create new paradigms that pose novel questions of old scientific concepts and change the rules of the existing game (Kuhn 1996, 40). In accordance with Kuhn's notion of conceptual interruption, this project explored the current shift in the cultural narrative about psychedelic substances. It investigated the questions this new paradigm poses about old scientific concepts, and the rules it changes in the existing model for managing addiction.

This thesis has undergone many twists and turns. It started by exploring the ways cultural narratives around psychedelic substances shifted over the past century. Chapter One acknowledged how these laboratory logics move beyond the clinic into people's daily lives. Chapter Two focused on the paradigm of an inner-healer and how it impacted accepted notions of agency and care. Chapter Three argued that psychedelic-assisted therapy can act as a bridge between biomedical and spiritual approaches to managing addiction.

Ultimately, this thesis highlights the convoluted and difficult path that integrating psychedelic-assisted therapy into current addiction treatment narratives will require. I propose that as we embark on the integrative journey to include psychedelic substances in the armamentarium of modern psychotherapy and healing, we adopt it with care for and attention to those who will be impacted most. It is essential to acknowledge the profoundly intricate and complex nature of psychedelic-assisted therapy and the full implications of this paradigm shift.

Looking at policy changes involving psychedelic substances in cities across the United States, along with the surge in interest they have elicited, I argue that their use is undergoing a shift. And that shift impacts narratives of healing. Enthusiasm is running high. But I would urge psychedelic users to be cautious in the process of incorporating psychedelic-containing substances into the biomedical pharmacopeia. Psychedelics aren't ordinary drugs. They profoundly rework existing categories of drugs and care. It will take thought and effort to integrate them in a productive way. One way to do this is by shedding light on all this involves. Another is to honor what has been effective in previous approaches to treating addiction. I propose that the best way to do so is to listen to psychedelic-assisted therapy seekers and hear out their challenges and personal problems so that we may locate what is essential. This is the common ground of healing. From this ground we can grow together a new, and, agreed upon, narrative of agency, healing and care.

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