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Personal Psychedelic Use Is Common Among a Sample of Psychedelic Therapists: Implications for Research and Practice

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Abstract

Background: An emerging controversy in psychedelic therapy regards the appropriateness or necessity of psychedelic therapists having personal experience using psychedelics themselves. Although there are a number of potential advantages and disadvantages to personal use among psychedelic therapists, no studies to date have measured their use or other aspects of their training.

Materials and Methods: First, we broadly review the literature on experiential learning in psychotherapy and psychiatry as well as the history of personal use of psychedelics by professionals. We then report on the results of a survey that was sent to all 145 therapists associated with Usona Institute's Phase II clinical trial of psilocybin for major depressive disorder. Thirty-two of these individuals (22% response rate) participated in the survey.

Results: We found that experiential learning is common in psychotherapy but not in psychiatry, meaning psychedelic therapy straddles two different traditions. In our survey, the majority of psychedelic therapists identified as white, female, and having doctoral degrees. Most of the sample had personal experience with at least one serotonergic psychedelic (28/32; 88%), with psilocybin being most common (26/32; 81%; median number of uses = 2–10; median last use 6–12 months before survey). Participants had myriad intentions for using psychedelics (e.g., personal development, spiritual growth, fun, curiosity). All respondents endorsed favorable views regarding the efficacy of psilocybin therapy.

Conclusion: Personal experience with psychedelics was notably common in this sample of psychedelic therapists, but the study was limited by a low response rate and a lack of diversity among participants. Future research is needed to address these limitations as well as to identify whether personal experience with psychedelics contributes to therapists' competency or introduces bias to the field. Nonetheless, these findings are the first to delineate the personal use of psychedelics among professionals and can inform a pressing debate for the field.

Keywords: psychedelic therapists, personal experience, psychedelics, psychedelic-assisted psychotherapy, experiential learning, facilitators

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Introduction

Learning through personal experience and reflection (i.e., experiential learning or “learning by doing”) is common to many professional disciplines. It is thought to impart knowledge that may be difficult to attain through traditional pedagogical means (lectures, reading, etc.), and facilitates understanding of processes and mechanisms, rather than outcomes.¹ One area where the importance of experiential learning is particularly engrained and valued is psychotherapy. Many psychotherapy programs require trainees to engage in psychotherapy themselves to foster empathy and better understand the therapeutic process.²

Psychedelic therapy is a paradigm that uses classic psychedelics (e.g., psilocybin, lysergic acid diethylamide [LSD], mescaline, ayahuasca/n,n-dimethyltryptamine), as an adjunct to psychotherapy, and many proponents of this approach argue that personal experience with psychedelics is integral to understanding the effects of these substances and being an effective psychedelic therapist.^{3,4} However, controversy has emerged given that the psychedelic therapy model includes taking illicit and stigmatized substances that carry some risks (see: Schlag et al⁵).

In this article, we review the literature on experiential learning in psychotherapy and psychiatry as well as the history of personal use of psychedelics by clinicians and researchers. We then present findings on characteristics of a sample of psychedelic therapists, including their experience with psychedelic substances.

Experiential learning in psychotherapy and psychiatry
Historically, models for professional development in standard (i.e., nonpsychedelic) psychotherapy and psychiatry have observed a provider’s education and clinical training as primary contributors to competency.^{6,7} This approach often highlights the importance of supervised training when delivering appropriate clinical care.^{8,9} The level of education of providers, their personal lived experiences, and belief in the specific psychotherapeutic approaches they are employing are also relevant variables to patient outcomes.

Most pertinently, practitioners’ engagement in their own therapy has been promoted as an important experiential learning experience, specifically as a way to enhance distress tolerance, awareness of personal impact, empathy for clients, personal mindfulness skills, emotional intelligence, self-regulation, and a sense of mastery in the therapeutic process.^{10,11} Experiential training can nurture tacit knowledge embodied in practice and intuition that is otherwise difficult to articulate or conceptualize theoretically.¹² Incorporation of personal therapy for experiential learning has been documented across psychoanalysis/psychodynamic, cognitive-behavioral, humanistic/experiential, and systemic/family therapies, but not all training programs require personal therapy.¹³

Unlike psychotherapy training, physician training, including training of psychiatrists, has almost never included a pharmacological experiential component (i.e., personally trying medications that the physician will later prescribe). Anesthesiologists are not encouraged to try anesthetics, oncologists are not encouraged to try chemotherapy agents, and psychiatrists are not encouraged to try psychotropics. There are likely many reasons for this. First, taking a drug almost always confers greater health risks than undergoing psychotherapy, including addiction and other adverse effects.¹⁴

Indeed, famous cases exist where physicians have developed problems from using drugs they advocated as treatments; Sigmund Freud using cocaine and John Lilly using ketamine are often taught in medical training as cautionary tales.¹⁵ Relatedly, the greater regulatory oversight and liability concerns related to pharmacological interventions likely make these kinds of trainings impractical. There have been times and places where psychiatry residents have been offered to try psychotropics, such as mellaril, to gain experiential knowledge of what their patients experience (Victor Reus, personal communication), but the lack of any published description of this practice suggests that it is vanishingly rare.

In fact, for at least the past 60 years, requiring or even encouraging psychiatric trainees to try psychotropics they were prescribing has been considered outlandish (Reese Jones, pers. comm.). Thus, psychedelic therapy, which includes psychotherapy and administration of a psychoactive substance, straddles two different traditions when it comes to the appropriateness or necessity of experiential learning in training practitioners.

Psychedelic therapy

[Personal psychedelic use may] provide the doctors with direct insight, based on first-hand experience into the strange world of LSD inebriation, and make it possible for them to truly understand these phenomena in their patients, to interpret them properly, and to take full advantage of them.—Albert Hofmann, discoverer of LSD³

There is a long history of researchers and clinicians who work with psychedelics valuing personal experience with the substances for their professional development, including Hofmann’s self-experiments with LSD, and dating even further back with other hallucinogens such as mescaline.^{16,17} Moreover, in some indigenous cultures, it is not uncommon for the facilitator or one providing support to take the substances with—or even instead of—the patient or one seeking care.^{18,19}

From 1969 through 1976, 203 mental health professionals at Spring Grove Hospital in Baltimore, Maryland, were administered 1–3 doses of LSD for the purposes of understanding: (1) the unconscious, (2) the problems of

youth involved in drug abuse, (3) how more informed studies with psychedelic drugs might be designed, and (4) how to improve therapeutic skills including empathy and personal insight.²⁰ Follow-up reports indicated that participants valued the experience and derived personal benefits that were confirmed by family members and professional colleagues. More recently, the Multidisciplinary Association for Psychedelic Studies (MAPS) received permission to administer 3,4-methylenedioxymethamphetamine (MDMA) to 20 of its study therapists for professional development purposes as a part of a clinical trial (NCT01404754). In Canada, 16 health care professionals were granted permission to take psilocybin themselves for personal training in 2020.⁵

Several psychedelic therapist training programs also incorporate the use of ketamine as an experiential learning component, given that the drug can be legally prescribed off-label by medical professionals in the United States and approximates some of the phenomenology of classic psychedelic experiences.²¹ However, MDMA and ketamine are generally considered pharmacologically distinct from the classic psychedelics, and there are currently few avenues available for mental health professionals to legally obtain experiences with classic psychedelics in most countries.

There are a number of potential advantages to psychedelic therapists having personal experience with the substances they work with—although most have yet to be empirically studied. One prevalent hypothesis is that firsthand experience with psychedelics can help therapists better empathize with the highly emotional and, at times, ontologically shocking nature of psychedelic experiences. Psychedelic experiences are often claimed to be ineffable (i.e., difficult to describe with language). Thus, personal use may enable understanding of the treatment's phenomenology that is otherwise unattainable.

This understanding may be relevant for therapists given that aspects of the subjective experience (mystical states, insight, awe, etc.) have been linked to a variety of positive mental health outcomes with psychedelics.^{22–25} However, some argue the subjective experience may not be necessary for the drugs' therapeutic effects (see: Olson²⁶), and no research efforts to date have investigated whether personal psychedelic experience actually enhances competency for psychedelic therapists. A final potential benefit of personal use by mental health professionals is that patients tend to prefer psychedelic therapists who have used psychedelics themselves. Earleywine et al²⁷ surveyed depressed patients online ($N=803$), and found that personal psychedelic experience among therapists was rated on average as at least “somewhat important,” and notably, personal experience was particularly valued among people of color. Similarly, in a thematic analysis of online psychedelic forums, Engel et al²⁸ found that psychedelic users pre-

ferred guides with their own past use. The heightened state of comfort engendered by an experienced guide may be relevant to treatment outcomes given that one's mood and comfort with the setting strongly influence the valence of the acute drug experience.^{29,30}

There are also several ways in which personal use by therapists may be detrimental. Previous experience with psychedelics may introduce a form of self-selection that leads to a positive bias, given the highly meaningful and transcendent states they can induce in users.³¹ Furthermore, psychedelic use has been linked to directionally specific changes in thinking styles, personality, and beliefs.^{32–35} Therefore, personal use among psychedelic professionals may directionally influence these characteristics, leading to a phenotypically homogeneous group. This may come at a cost as diverse opinions and perspectives facilitate deeper reflection, critical thinking, and decision making across a wide variety of human social groups.^{36–39}

Another drawback to personal use among professionals is that data suggest that nonusers of psychedelics can have a diminished opinion of a researcher's work if they disclose their own experience with psychedelics. Specifically, Forstmann and Sagioglou⁴⁰ surveyed a sample of U.S. adults ($N=952$) and found that fictitious researchers with self-admitted psychedelic use were rated as being more biased, less professional, and less honest. However, it did not influence assessment of the quality of the research, or how much value and significance they ascribed to the findings.

Finally, many individuals are discouraged from using psychedelics because of contraindicated medical conditions (e.g., hypertension, schizophrenia), contraindicated medications (e.g., lithium), their religious affiliation, and/or racially based discrimination,^{41,42} meaning they cannot engage in experiential learning with psychedelics without taking on considerable medical, social, or legal risk.^{43,44} Thus, requiring or expecting personal experiences with these substances as a prerequisite for becoming a psychedelic therapist demands consideration about people living with certain health conditions, religious backgrounds, and personal choice—raising accessibility and equity concerns.

The current study

Experiential learning is an important training component for many professional disciplines, and seems to be particularly relevant in the case of psychedelic therapy based on anecdotal reports. However, there has been little study of psychedelic therapists' personal experience with psychedelic substances, motives, or other training experiences. To address this gap, we created a self-report questionnaire and it was administered to a sample of psychedelic therapists.

Materials and Methods

Participants

Participants in our study were facilitators in Usona Institute's Phase II trial (i.e., "PSIL201"; NCT03866174) of a single dose of psilocybin for major depressive disorder (MDD). Usona Institute and its staff had no role in survey design or data analysis. Every facilitator at every PSIL201 trial site was e-mailed on June 3, 2021, April 27, 2022, and May 20, 2022, to be included in the study. Sites surveyed include University of California, San Francisco (UCSF); New York University (NYU); Yale University; Johns Hopkins University; Segal Trials; Great Lakes Clinical Trials; Emory; Cedar Clinical Research; Hassman Research Institute; Pacific Neuroscience Institute, and University of Wisconsin, Madison.

For the PSIL201 study, facilitator qualifications were specified as follows: Lead facilitators at all study sites were doctoral-level psychotherapists or physicians with experience in the psychological treatment of MDD. Specifically, the lead facilitators were clinical and counseling psychologists (PhD/PsyD) or psychiatrists and appropriately trained/experienced physicians (MD or DO). Cofacilitators at all study sites held a minimum of a bachelor's degree in a mental health field. Preference was given to those with experience working in the mental health field and/or prior experience working in clinical research trials, especially with psilocybin.

A total of 145 facilitators were asked to participate in the survey study, and 32 participants completed the survey (response rate of 22%). All participants were over 18 years of age and the study was approved by the institutional review board at UCSF.

Materials and procedure

The survey took ~15–20 minutes to complete, and included questions about demographics, previous training experiences, personal psychedelic experiences, and belief in efficacy of psilocybin compared with placebo in Usona's Phase II trial. The survey assessed age, racial/ethnic identity, and gender identity. Participants were asked about their education, clinical degrees, and licensure. We inquired about prior psychedelic training, including with MAPS and the California Institute of Integral Studies (CIIS) as well as shammanic or "other" training, and how many years of experience they had providing non-psychedelic pharmacotherapy, and individual, couples/family, or group psychotherapies.

Participants indicated whether they had personally provided treatment with a range of psychoactive substances. As a subset of their previous treatment experiences, participants answered whether they provided psychedelic harm reduction/risk reduction in a festival, community, or social setting as well how important they believed this role was in preparation for facilitation. Participants were also asked whether they had personally

used the same substances. Participants documented lifetime use, time since most recent use, intentions for use, and the degree to which they ever had a transformative experience with the substance (0 = not at all transformative, 1 = "slightly transformative," 2 = "moderately transformative," 3 = "quite transformative," 4 = "absolutely transformative").

The intentions for use options included community bonding, cognitive enhancement, curiosity, escapism, fun, interpersonal bonding, mental health treatment, personal development, spiritual growth, improved physical health, and other.

Finally, participants were asked to share how effective they believed psilocybin therapy to be in treating MDD. This was rated on a 4-point Likert scale (0 = "no more effective than placebo," 1 = "slightly more effective than placebo," 2 = "moderately more effective than placebo," 3 = "substantially more effective than placebo"; full survey can be found in Supplementary Data).

Results

Demographics

The sample initially consisted of $N=38$ participants who began the survey; however, 6 of these individuals did not fully complete the survey and were removed from all analyses. Notably, all six of these participants stopped the survey when prompted to answer questions regarding their personal substance use. The median age range of the remaining sample ($N=32$) was 35–44 years old. Full demographic details related to age, gender, and race/ethnicity are given in Table 1.

Education and general clinical experience

The highest levels of education reported by participants were doctoral (e.g., MD/PhD/PsyD; 18/32; 56%),

Table 1. Demographics

	<i>Count (%)</i>
Age (years)	
18–34	13 (41)
35–44	8 (25)
45–54	3 (9)
55–64	1 (3)
65+	7 (22)
Gender	
Female	19 (59)
Male	12 (38)
Nonbinary	1 (3)
Race/ethnicity	
White	28 (88)
Latin American	1 (3)
South Asian	1 (3)
Hispanic	1 (3)
Arab/black/white	1 (3)

masters (10/32; 31%), and bachelors (4/32; 13%) degrees. Of the 18 doctoral-level therapists, 15 (83%) reported being licensed, and 9 of the 10 masters-level therapists reported being licensed (90%). Participants had a range of clinical experiences providing non-psychedelic pharmacotherapy and psychotherapy. Of the 32 participants, 9 (28%) indicated having experience providing nonpsychedelic pharmacological treatment; 6 of these 9 individuals reported practicing pharmacological therapy for less than 5 years and the remaining 3 participants practiced for 5–15 years.

In terms of providing nonpsychedelic psychotherapy, 25 of 32 (78%) reported having experience providing individual psychotherapy, 15 of 32 (47%) group therapy, and 10 of 32 (31%) couples/family therapy. Of the 32 participants, 6 (19%) participants reported having no prior psychotherapy experience of any kind.

Psychedelic therapy training and experience

Approximately half of the sample (17/32; 53%), including 3 of 4 participants with a bachelor's degree as their highest formal education, endorsed having some kind of psychedelic training experience before joining Usona. Of the 17 participants with previous psychedelic therapy training, 6 (35%) attended MAPS therapy training program, 5 (29%) the CIIS Certificate in Psychedelic-Assisted Therapies and Research, and 1 (6%) indicated unspecified underground/shamanic training.

The most common training experience endorsed was "Other" (11/17; 65%), which included training with university teams (e.g., Johns Hopkins University, Yale University; 2/17; 12%), holotropic breathwork training (1/17; 6%), Integrative Psychiatry Institute (IPI) Ketamine Medical Provider Online Training (1/17; 6%), and Salt City Psychedelic Therapy and Research (SCPTR) Psychedelic Therapy Training Program (1/17; 6%).

In addition to psychedelic training, 19 of 32 (59%) participants also indicated personally providing treatment with psychedelics and related substances outside of the

Usona trial. The most common substance incorporated into treatment was psilocybin (16/19; 84%); participants also worked with ketamine (10/19; 53%), ayahuasca (2/19; 11%), LSD (2/19; 11%), cannabis (2/19; 11%), and MDMA (1/19; 6%). Despite most of the sample having outside experience providing psychedelic therapy, the number of patients treated by each participant tended to be low, with 10 of 19 (53%) participants indicating treating 1–10 patients, 5 of 19 (26%) treating 11–50 patients, 1 of 19 (5%) treating 51–70 patients, and 2 of 19 (11%) treating 100+ patients (median and mode: 1–10 patients).

Lastly, 14/32 (44%) participants reported experience providing psychedelic harm reduction/risk reduction in a festival, community, or other social settings. Most rated these experiences as important or extremely important in preparing them for the role of psychedelic therapist (0–3 scale; $M=2.43$, $SD=0.85$).

Personal history of using psychedelic substances

Table 2 includes participants' personal history of substance use with psychedelics and related substances, their number of lifetime uses and most recent use, if they had consciousness-altering effects, and the degree to which they perceived they had a transformative experience. Table 3 outlines the distributions of previous uses and most recent use. Participants were also asked to choose among a number of possible intentions for each substance used (Table 4). The total number of distinct surveyed substances used by each participant is plotted in Figure 1.

We calculated the number of different substances used as a function of highest level of education (bachelor's $M=3.75$, $SD=1.89$; master's $M=5.90$, $SD=2.60$; doctoral $M=6.78$, $SD=3.08$); although statistical tests were not performed given the small sample size in some subgroups (e.g., bachelor's $n=4$). When excluding cannabis from the analysis, the trend remained similar (bachelor's $M=2.75$, $SD=1.89$; master's $M=4.90$, $SD=2.60$; doctoral $M=5.72$, $SD=3.10$). Lastly, given that individuals

Table 2. Personal Use of Psychoactive Substances

	<i>Previous experience</i>	<i>Consciousness altering experience</i>	<i>M transformative experience (SD)</i>	<i>Median last use</i>	<i>Median no. of uses</i>
Psilocybin	26/32 (81%)	26/26 (100%)	3 (1.05)	6–12 months	2–10
LSD	26/32 (81%)	26/26 (100%)	2.85 (1.16)	3.5–7.5 years ^a	2–10
Mescaline	13/32 (41%)	10/13 (77%)	2.64 (1.36)	3.5–7.5 years	2–10
Ayahuasca	10/32 (31%)	10/10 (100%)	3 (1.05)	1–5 years	6.5–18 ^b
DMT	11/32 (34%)	10/11 (91%)	3 (1.18)	1–5 years	2–10
MDMA	28/32 (88%)	25/28 (89%)	2.8 (1.26)	1–5 years	2–10
Ketamine	16/32 (50%)	16/16 (100%)	2 (1.37)	6–12 months	2–10

^aThe median number of LSD and mescaline last use fell directly between the 1–5 and 6–10 year ranges. Thus, 3.5–7.5 was calculated as the median of this range.

^bThe median number of ayahuasca uses fell directly between the 2–10 and 11–25 uses. Thus, 6.5–18 was calculated as the median of this range. DMT, n,n-dimethyltryptamine; LSD, lysergic acid diethylamide; MDMA, 3,4-methylenedioxymethamphetamine.

Table 3. Characteristics of Psychoactive Substance Use

<i>Substance</i>	<i>No. of uses</i>	<i>Count (%)</i>	<i>Most recent use</i>	<i>Count (%)</i>
Psilocybin	0	6 (19)	N/A	6 (19)
	Once	3 (9)	Within the last month	4 (13)
	2–10	13 (41)	Within the last 1–6 months	6 (19)
	11–25	4 (13)	Within the last 6–12 months	6 (19)
	26–50	3 (9)	Within the last 1–5 years	4 (13)
	More than 50 times	3 (9)	Within the last 6–10 years	2 (6)
LSD	0	6 (19)	N/A	6 (19)
	Once	4 (13)	Within the last month	2 (6)
	2–10	13 (41)	Within the last 1–6 months	2 (6)
	11–25	6 (19)	Within the last 6–12 months	3 (9)
	26–50	3 (9)	Within the last 1–5 years	6 (19)
	More than 50 times	0 (0)	Within the last 6–10 years	5 (16)
Mescaline	0	20 (63)	N/A	20 (63)
	Once	3 (9)	Within the last month	1 (3)
	2–10	7 (22)	Within the last 1–6 months	2 (6)
	11–25	2 (6)	Within the last 6–12 months	0 (0)
	26–50	1 (3)	Within the last 1–5 years	3 (9)
	More than 50 times	0 (0)	Within the last 6–10 years	1 (3)
Ayahuasca	0	22 (69)	N/A	22 (69)
	Once	3 (9)	Within the last month	2 (6)
	2–10	2 (6)	Within the last 1–6 months	1 (3)
	11–25	2 (6)	Within the last 6–12 months	1 (3)
	26–50	1 (3)	Within the last 1–5 years	5 (16)
	More than 50 times	2 (6)	Within the last 6–10 years	0 (0)
DMT	0	20 (63)	N/A	20 (63)
	Once	4 (13)	Within the last month	0 (0)
	2–10	8 (25)	Within the last 1–6 months	2 (6)
	11–25	0 (0)	Within the last 6–12 months	0 (0)
	26–50	0 (0)	Within the last 1–5 years	7 (22)
	More than 50 times	0 (0)	Within the last 6–10 years	2 (6)
MDMA	0	4 (13)	N/A	4 (13)
	Once	5 (16)	Within the last month	6 (19)
	2–10	15 (47)	Within the last 1–6 months	4 (13)
	11–25	4 (13)	Within the last 6–12 months	3 (9)
	26–50	1 (3)	Within the last 1–5 years	6 (19)
	More than 50 times	3 (9)	Within the last 6–10 years	3 (9)
Ketamine	0	16 (50)	N/A	16 (50)
	Once	1 (3)	Within the last month	1 (3)
	2–10	12 (38)	Within the last 1–6 months	6 (19)
	11–25	0 (0)	Within the last 6–12 months	5 (16)
	26–50	0 (0)	Within the last 1–5 years	4 (13)
	More than 50 times	3 (9)	Within the last 6–10 years	0 (0)
			More than 10 years ago	0 (0)

N/A, not any.

have greater cumulative opportunities for substance use as they age, we calculated the number of substances used as a function of age group but did not find a clear relationship (18–34: $M=5.77$, $SD=3.49$; 35–44: $M=6.88$, $SD=3.14$; 45–54: $M=5.00$, $SD=2.65$; 55–64: $M=5.00$, $SD=0$; 65+: $M=5.43$, $SD=1.72$).

Belief in psilocybin therapy efficacy

When asked “compared to placebo, how effective do you believe psilocybin therapy will be for treating major depressive disorder in PSIL201?” one participant in our sample did not respond to the question ($N=31$). The remaining participants held highly favorable views

Table 4. Intentions for Psychoactive Substance Use

	<i>Psilocybin</i> , n=26, %	<i>LSD</i> , n=26, %	<i>Mescaline</i> , n=13, %	<i>Ayahuasca</i> , n=10, %	<i>DMT</i> , n=11, %	<i>MDMA</i> , n=8, %	<i>Ketamine</i> , n=6, %
Community bonding	50	58	46	50	9	61	19
Cognitive enhancement	42	27	15	0	0	4	0
Curiosity	58	69	46	40	82	39	50
Escapism	8	4	0	0	0	7	13
Fun	50	54	15	0	0	50	19
Interpersonal bonding	54	50	8	0	0	64	6
Mental health treatment	39	19	8	10	0	32	25
Personal development	92	66	69	90	46	54	63
Spiritual growth	85	58	62	80	73	21	50
Improve physical health	19	4	0	30	0	7	13
Other	8	4	0	10	0	4	19

regarding the efficacy of psilocybin therapy (0–3 scale; $M=2.61$, $SD=0.62$), with no participant selecting “0” and all but two participants selecting that it was “moderately” or “substantially” more effective than placebo (Fig. 2).

An independent samples t -test indicated no differences in belief in efficacy among males ($M=2.58$, $SD=0.79$) and females ($M=2.67$, $SD=0.49$), $p=0.72$, two-tailed. We also tested whether there were age-related differences in belief in efficacy by dividing the sample between those 44 or younger and 45 or older (see: Barnett et al⁴⁵). An independent samples t -test indicated no differences in belief in efficacy between those 44 or younger ($M=2.65$, $SD=0.59$) and those 45 or older ($M=2.55$, $SD=0.69$), $p=0.14$, two-tailed.

Lastly, a comparison between those with ($M=2.33$, $SD=0.71$) and without ($M=2.73$, $SD=0.55$) previous experience providing pharmacotherapy did not reveal differences in belief in efficacy, $p=0.11$, two-tailed. Of the 26 participants with psilocybin use, 23 (89%) indicated having a “moderately” to “extremely” transformative experience with the substance, but the degree of

transformative experience was not significantly correlated with beliefs about therapeutic efficacy ($\rho=0.28$, $p=0.17$, two-tailed).

Discussion

There are three main findings from this survey study of psychedelic therapists working on a Phase II clinical trial of psilocybin therapy for MDD. First, respondents were overwhelmingly white identified, predominantly women, and most had a doctoral degree as well as some prior didactic or experiential training in psychedelic therapy. Second, the vast majority reported personal experience using psychedelic compounds, with psilocybin being the most commonly used. Third, respondents were highly optimistic about the efficacy of psilocybin therapy for treating MDD.

In terms of demographics, the sample was generally consistent with the characteristics of nonpsychedelic psychotherapists in the United States, who tend to also be disproportionately women (63%), white (83.7%), and middle aged ($M=43.7$ years).⁴⁶ Facilitators of color may

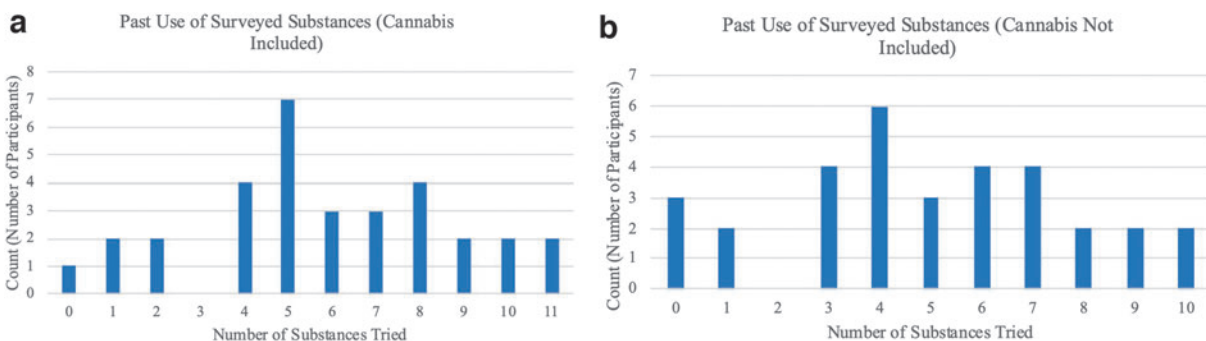
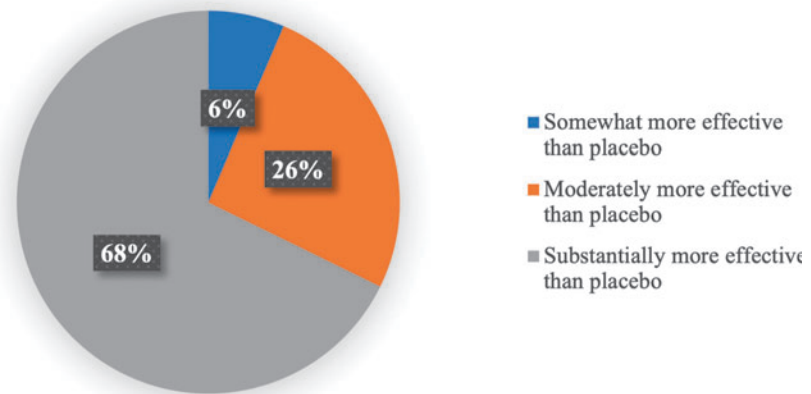


Fig. 1. The total number of surveyed substances used by each participant is plotted with (a) and without (b) cannabis included.

"Compared to placebo, how effective do you believe psilocybin therapy will be for treating major depressive disorder in PSIL201?"

Fig. 2. Participants' belief in psilocybin therapy efficacy compared with placebo.



be particularly under-represented in our sample given that people of color have been disproportionately targeted by law enforcement for substance use in the United States;⁴⁷ that is, nonwhite facilitators may have been less comfortable taking the survey and disclosing their use. The lack of diversity among trained facilitators represents a systemic issue for the field of psychedelic therapy, and likely contributes to the racial homogeneity of study participants typically found in psychedelic clinical trials.^{48,49}

The proportion of therapists with a doctoral degree tended to be higher than that typically found in non-psychedelic psychotherapy; however, this likely reflects rules of the sponsor for the study (i.e., there must be a licensed PhD/PsyD or MD in each therapy pair). It is important to note that four participants did not have formal psychotherapy graduate training but had pursued other relevant training experiences. This is an important issue for the scalability of psychedelic therapy, as a looming bottleneck for the field is the limited number of therapists available who are trained to provide the treatment.⁵⁰ Bachelor's-level clinicians, or those with relevant community-based training experiences, may be a means for expanding access to these treatments and increasing diversity of psychedelic therapists.^{51,52} Finally, participants who provided harm-reduction services at a festival, community, or other social setting found the experience to be important for preparing to be a psychedelic therapist, suggesting this may have potential to be a useful training experience for trainees looking to enter the field.

This sample of psychedelic therapists had considerable experience using classic psychedelic drugs and related hallucinogens themselves, with 28 of 32 (88%) endorsing use of a classic psychedelic and all but 1 participant try-

ing at least one hallucinogen-related substance. This figure differs from the general population lifetime rate of psychedelic use, which tends to be around 10–15%;⁵³ although several recent studies have indicated that usage seems to be increasing.^{54–56} Only one of four individuals without previous classic psychedelic experience had previous psychedelic training, making these individuals unique and relatively psychedelic-naïve candidates to provide the treatment. Given their paucity of experience in the field, these individuals may represent interesting case studies in understanding the role of experiential learning with psychedelics.

In terms of intentions, personal development and spiritual growth were the most common reasons reported for substance use, particularly with the classic psychedelics. However, most participants also reported intentions related to having fun and curiosity—in line with the findings of Roberts et al.⁵⁷ and Dollar⁵⁸ on the general population of psychedelic users. Although the role of intentions has often been noted as being critical to the acute experience and subsequent outcomes among psychedelic users,^{29,59} there has been limited research prospectively testing the relationship between intentions and drug effects.⁶⁰ Nonetheless, our results add to a growing body of literature suggesting a distinct set of intentions among psychedelic users.

Overall, participants were highly optimistic about the efficacy of psilocybin therapy for MDD, with all but two participants believing that it was “moderately” or “substantially” more effective than placebo. A high degree of belief in efficacy among this sample was anticipated given that participants self-selected to work on a psychedelic trial and to fill out a survey about their own psychedelic use. Participants' views regarding efficacy contrast starkly with those held by nonpsychedelic

mental health professionals. For instance, Davis et al⁶¹ found that only 22.2% of clinical psychologists said that they were open or favorably disposed toward psychedelic therapy.

A study of American psychiatrists revealed that 42.5% moderately or strongly agreed that psychedelics show promise in treating psychiatric disorders.⁴⁵ The discrepancy in belief in efficacy between clinical psychologists and psychiatrists is consistent with other research indicating that psychiatrists report the highest familiarity and willingness to incorporate psychedelics into therapeutic practice among mental health professionals,⁶² and intuitively unsurprising given that psychedelic therapy is a drug-based intervention. A comparison between those with and without previous experience providing pharmacotherapy in our data set did not support this hypothesis; although the limited number of individuals with pharmacotherapy experience ($n=9$) limits interpretability.

There are a number of limitations and lines of future research that are important to consider with this study. First, the response rate among the contacted Usona facilitators was low, leaving a small sample size and potentially unrepresentative group. This prompts consideration about the continued negative connotation surrounding exploration of nonordinary states of consciousness carried in professional and academic environments. The “War on Drugs” created a culture of labeling psychedelic substances as stigmatized drugs and propagated systemic negative stereotypes related to any activities that involved the use of psychedelics for recreational, religious, or therapeutic purposes.

One interpretation of the low response rate is that only a small proportion of the practitioners working as psychedelic facilitators felt comfortable answering questions—anononymously and confidentially—about their personal experiences with psychedelic substances, but other explanations such as the lack of compensation for participating in the study may also be relevant. In any case, it is challenging to understand the potential contribution that personal use may have on developing competency for psychedelic facilitators if professionals do not feel safe discussing how their lived experiences may inform their work.

Another limitation is that this study only examined psychedelic therapists associated with Usona’s Phase II clinical trial, and the findings may not generalize to all psychedelic therapists, particularly those solely working in the unregulated underground market. In addition, although we did not find a statistically significant relationship among transformative experiences with psilocybin and belief in efficacy, the small sample size and ceiling effects related to both measures may have contributed to the null relationship found here.

Another general consideration is that given that all six participants who did not complete the survey stopped

when prompted to answer questions regarding their personal use, an intuitive hypothesis is that they did so to avoid possible legal repercussions related to sharing this information. If so, this suggests that perhaps other therapists did not even start the survey because of this concern and that our results could have underestimated the prevalence of psychedelic use among our population of interest.

Lastly, it is worth noting that researchers and clinicians must keep a vigilant eye on the past to inform the future—Timothy Leary’s personal use and exuberance led some to doubt his scientific rigor and infamously contributed to his dismissal at Harvard University in the 1960s. Today, personal use among professionals continues to affect the public’s perception of one’s work,⁴⁰ and will be an area that must be carefully navigated as the field increasingly enters the public eye. Given the high stakes and hope being invested into the field, it is a duty for professionals to maintain a high level of clinical equipoise and allow no exceptions to standards for research or clinical care.^{59,63}

Although experiential learning is valued across many professional disciplines, including psychotherapy, it is not in physician training and there are distinct concerns that must be taken into consideration in the context of psychedelic therapy. Personal experience with psychedelics may help professionals empathize and better understand the nature—and possibly mechanisms—of psychedelic treatment. In contrast, normalizing, expecting, or requiring personal use among practitioners may also introduce bias into the field and limit who can be in the conversation due to issues related to contraindications and subsequent accessibility.

Additional research is needed to examine the role of personal experience in therapist competency and address issues related to generalizability. Nonetheless, the findings presented here are the first to empirically delineate characteristics of psychedelic therapists, and establish fertile groundwork for future study.

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Authors’ Contributions

J.S.A. contributed to formal analysis, project administration, supervision, visualization writing—original draft, and writing—review and editing; Z.S. was involved in project administration, supervision, and writing—original draft; N.E. carried out data curation, formal analysis, visualization, and writing—original draft; L.F. contributed to data curation, formal analysis, and writing—original draft; M.P. carried out conceptualization, data curation, methodology, and supervision; J.M. took charge

of data curation, methodology, and supervision; E.R.B. contributed to conceptualization and writing—review and editing; G.F.-O. was involved in conceptualization and writing—review and editing; J.D.W. was in charge of conceptualization, supervision, writing—original draft, writing—review and editing.

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Supplementary Material

Supplementary Data

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