In recent years, researchers in the “psychedelic renaissance” have been reinvestigating the therapeutic potential of psychedelic compounds for conditions like post-traumatic stress disorder, clinical anxiety/depression, and addiction. Each of these has treatment-resistant cases, sometimes decades in the making, but studies employing psychedelics to address them are yielding impressive results. Given the evolving legal situation around these substances as well as corporate investment in them, their availability and appeal promise to increase. The question facing Christians is: How do these developments impact the theological significance of psychedelics as a broader phenomenon? This paper argues that since the population standing to benefit from these treatments is likely to include Christians, a thoughtful and rigorous response is necessary. The inquiry proceeds by analyzing some of the pertinent research, showing the insufficiency of previous Christian responses, and considering some hurdles and objections before issuing a call to theologize on this timely and important cultural moment.

I. INTRODUCTION

In what is being called the “psychedelic renaissance” (Sessa, 2017; Pollan, 2018, 21ff.), professionals in medicine and psychology have been reinvestigating the therapeutic and spiritual potential latent in a panoply of psychedelic compounds. While this category has become somewhat elastic, most lists include:

- MDMA (the active ingredient in pure “ecstasy” or “molly”)
- Psilocybin (naturally occurring in “magic” mushrooms)
- LSD
- DMT (smoked in extract or drunk in a leaf brew with harmala-containing plants, as in ayahuasca)
- 5-MeO-DMT (available in psychoactive toad venom as well as some plants)
- Mescaline (present in peyote, San Pedro, and other cacti)
- Salvia divinorum (whose leaves are smoked, brewed in a tea, or chewed)
- Ketamine (a synthetic anesthetic and dissociative hallucinogen)
- Ibogaine (from a handful of plants native to Africa or the Amazon)

Given the striking applications now being researched, some of these substances are on track to be medicalized—that is, made legally available as treatments—and will therefore be more accessible to and used by the public. The challenge of this situation for Christian theologians, ministers, and practitioners is that Christianity currently has limited theological resources for reflecting on the therapeutic potential of these compounds within a broader theological understanding.
The purpose of this article is to begin addressing this shortfall in a call to theologize the psychedelic renaissance in relation to a Christian theological outlook. In so doing, I shall analyze some of the emblematic research, show how it renders previous Christian theological positions on the matter insufficient, and consider some of the barriers as well as objections to the kind of theologizing for which I am calling.

II. SOME PROMISING MEDICAL FINDINGS

Contemporary research on psychedelics is growing, but promising results have already amassed. MDMA, for example, is now in Phase III of the Food and Drug Administration's (FDA's) drug review process for post-traumatic stress disorder (PTSD). This phase involves large sample clinical trials and is the final hurdle to making the drug available. Facilitating the process is the FDA's bestowal of its “breakthrough therapy” designation on the treatment. The purpose of this status is to give promising remedies for serious conditions priority review and therefore a smoother and more expeditious path to medicalization. So armed, officials at the Multidisciplinary Association for Psychedelic Studies (MAPS), the nonprofit organization sponsoring the research, hope for FDA approval by 2023. In the meantime, MDMA in conjunction with MAPS’ therapeutic protocol has provided durable relief in the majority of treatment-resistant PTSD subjects, tracked up to 74 months (Mithoefer et al., 2013). What this means is that in studies conducted with participants whose PTSD had resisted existing pharmacotherapies—Zoloft (sertraline) and Paxil (paroxetine)—a majority (74% in one study) saw “meaningful, sustained reductions” in their condition after undergoing MDMA-assisted psychotherapy (Mithoefer et al., 2013, 33). At the completion of MAPS’ six Phase II trials with 107 treatment-resistant participants, who had suffered an average of 17.8 years, 54.2% no longer met the criteria for PTSD one to two months following treatment (Mithoefer et al., 2019, 2739; Burge, 2017). Interestingly, as a result of MAPS’ commitment to “teaching [sufferers] techniques that can translate from the MDMA state to the regular state, the non-drug state, about working with their emotions, not suppressing their emotions” (Reid, 2019, 43:48ff.), to be used after treatment completion, the number of participants who no longer qualified as having PTSD continued to increase after the two-month mark: At month 12, 68% no longer qualified (Burge, 2017; Reid, 2019, 43:48ff.). MAPS’ first Phase III trial improved upon these results: Two months after treatment, 67% of the 90 participants failed to qualify for the disorder (Mitchell et al., 2021).

Strong early-stage signals of potential efficacy are also emerging in psilocybin research. For example, two recent studies with life-threatening cancer patients saw clinically significant reductions in anxiety and depression immediately following treatment, enduring in the majority of cases for six months or more (Ross et al., 2016, 1175; Griffiths et al., 2016, 1191 and 1195). One of these studies reported a reduction in severity of condition so significant as to merit new categorization. The average Beck Depression Inventory (BDI) for the two groups treated with the compound (one group with a low-dose session and then a high-dose session, another group in the reverse order) was 18.40 and 17.77, respectively, at baseline and 8.00 and 6.17, respectively, at the sixth month following treatment (Griffiths et al., 2016, 1188). This difference amounts to a shift from “moderate depression” to “none to mild depression” (Beck, Steer, and Garbin, 1988, 79–80). A similar result obtained in another study with participants suffering from treatment-resistant major depression: The average BDI in this study was 34.5 at baseline and 19.5 at the sixth-month mark, a transition from “severe” to “moderate” depression (Carhart-Harris et al., 2018, 405). Like MAPS with MDMA for PTSD, Compass Pathways, a for-profit psilocybin initiative, and Usona Institute, a nonprofit medical research organization, have both procured the FDA’s “breakthrough therapy” status for Phase II studies building on the existing work with psilocybin for treatment-resistant depression (Bauer, 2019). If these studies are successful, Phase III inquiries will ensue, precipitating the compound’s availability for treatment.

For a final example, researchers are looking into ibogaine as treatment for opioid use disorder (OUD). Knowledge of the substance, present in iboga and other plants, is still developing and there are potential dangers, but the findings thus far give cause to be optimistic. One study analyzed the results from thirty subjects in terms of opioid detoxification (i.e., the compound’s ability to alleviate opioid withdrawal symptoms in the short-run) and use (i.e., its ability to help sufferers stay off opioids in the long-run). In the study’s results, the impact of ibogaine on opioid withdrawal paralleled...
that of the best existing treatment, methadone, in previous research (Brown and Alper, 2018, 30; Handelsman et al., 1987). However, ibogaine excelled the existing treatments when it came to use. A number of measures factor into making this latter assessment, but two in particular saw striking results. First, on the opioid “Drug Use” measure (the extent to which subjects are using, in this case, opioids at a given juncture in the study), ibogaine outperformed the existing pharmacotherapies in previous studies: Three months following ibogaine treatment, 33% of the subjects reported no opioid use in 30 days, higher than the 18% who had not used opioids in 30 days just four weeks after buprenorphine treatment (Bentzley et al., 2015) and the 26% who had not done so six weeks after methadone treatment (Amato et al., 2013).

Second, on the “Family/Social Status” measure, which concerns difficulties in relationships with those closest to the user, problem severity went from 0.24 ± 0.16 at baseline down to 0.04 ± 0.07 at the 12-month mark. To illustrate the significance of this shift, the highest baseline score, indicating the most severe pretreatment problem, was 0.40 ± 0.08 (for drug use) and the lowest baseline score, indicating the least severe pretreatment problem, was 0.08 ± 0.18 (for alcohol use). So the measure of difficulties in close relationships, which began roughly halfway between these figures and ended up less than the lower one, gravitated from a fairly severe problem to almost no problem at all. To avoid being overly optimistic, it should be noted that long-term abstinence rates for the study were not quite what one might hope (only 23% of those who began the study had not used opioids in the last 30 days at the 12-month mark). Nevertheless, the treatment’s promise lies in the fact that its dosage is only intermittent, unlike that of existing pharmacotherapies. That is, instead of a daily regimen of methadone or buprenorphine, for which, in both cases, the dropout rates are high, ibogaine therapy typically involves one or two treatments (Brown, 2018).

In the words of one study participant, you could safely say that iboga will give an opiate addict several months to a half a year of freedom from cravings and an expanded awareness. This gives the user a period of time in which to get his/her life together and learn to face things straightforwardly, directly, and honestly. Iboga will not do the work for you. However, it will help you do your own work. (Brown and Alper, 2018, 32)

In addition to the results with PTSD, depression, and OUD, psychedelic compounds have shown extraordinary promise in early clinical studies for alcohol use disorder (Sessa et al., 2019; Krebs and Johansen, 2012), tobacco dependence (Johnson, Garcia-Romeu, and Griffiths, 2017), obsessive-compulsive disorder (Moreno et al., 2006), autism (Danforth et al., 2016), and cluster headaches. Because of this promise, a group of private donors have given Johns Hopkins University $17 million to establish its Center for Psychedelic and Consciousness Research (Carey, 2019). Moreover, a panoply of for-profit start-ups have emerged in the last year, preparing to offer psychedelics in one form or another as their legal status evolves. Amongst the major players are ATAI Life Sciences—which also owns part of Compass Pathways in addition to other holdings—MindMed, and Field Trip. All four are publicly traded on Nasdaq (MindMed is also on Canada’s NEO Exchange).

III. THE PROBLEM

The preceding are the medical facts, and they are growing. But medical facts are not the only facts, for, of course, psychedelics also have a peculiar effect on the mind of those who ingest them, what neuroscientist Robin Carhart-Harris calls “shaking the snow globe” (Pollan, 2018, 15 and 384) and what addiction specialist Matthew Johnson calls “a reboot of the system—a biological control-alt-delete” that interrupts our “underlying addiction to a pattern of thinking” (Pollan, 2018, 366 and 384). This is what makes ibogaine and other psychedelics help loosen the grip of substance use disorders. But, as Terence McKenna said, it can also, “throw into doubt everything one assumes about the reality one inhabits” (1991, 67), especially with an improper “set and setting” (i.e., mindset of one taking the drug and physical and social environment in which one takes it). Even the “gentler” (Miller, 2017, 73) MDMA molecule can shepherd emotionally intense experiences (Bouso, 2001, 256) and, with improper set and setting, produce negative outcomes (Jansen, 2001, 91–2). Partly because of this unpredictable character and its sometimes unpredictable aftereffects, psychedelics bear the weight of a tumultuous political history. As Ayalet Waldman summarizes,
It was [Timothy Leary’s] exhortation—“Tune in, turn on, and drop out. Out of high school, junior executive, senior executive. And follow me!”—that caused the parental panic that led to Senate hearings on campus drug use. [...] Whereas the media had once published long interviews with, for example, Cary Grant on the personal insights and increased happiness he experienced as a result of LSD-based therapy, now Life magazine devoted a cover story to “The exploding threat of the mind drug that got out of control.” [...] After hundreds, even thousands of panicked articles and television and radio news stories, the reputation of psychedelics was destroyed. In 1970, Nixon signed the Controlled Substances Act, putting LSD, psilocybin, and other psychedelics on Schedule I, and launched the War on Drugs with a punitive ferocity that has only just recently begun to abate. (2018, 120)

Thus, an important background feature of discussions about psychedelic medicine is the public consciousness of both the real and the imagined dangers of these substances.

A related issue, and, in the context of the present essay, the key one, is that most Christian traditions decry engagement with these compounds. The Roman Catholic catechism, for example, says, “The virtue of temperance disposes us to avoid every kind of excess: the abuse of food, alcohol, tobacco, or medicine” and, a sentence later, “The use of drugs inflicts very grave damage on human health and life. Their use, except on strictly therapeutic grounds, is a grave offense” (USCCB, 1995, §2290–91; emphasis original).

Similarly, the United Methodist Church (UMC) Book of Discipline says,

Since the use of illegal drugs, as well as illegal and problematic use of alcohol, is a major factor in crime, disease, death, and family dysfunction, we support educational programs as well as other prevention strategies encouraging abstinence from illegal drug use [...].

Millions of living human beings are testimony to the beneficial consequences of therapeutic drug use, and millions of others are testimony to the detrimental consequences of drug misuse... We support the strict administration of laws regulating the sale and distribution of alcohol and controlled substances. (2016a, 162)

Then, concerning psychedelics specifically, the UMC’s Book of Resolutions states,

Psychedelics or hallucinogens, which include LSD, psilocybin, mescaline, PCP, and DMT, produce changes in perception and altered states of consciousness. Not only is medical use of psychedelics or hallucinogens limited, if present at all, but the use of these drugs may result in permanent psychiatric problems. (2016b)

I choose these declarations because, although neither is as comprehensive as it could be, they reflect two of the more thorough treatments of drug use by the leadership of a major Christian tradition. In contrast, most Christian confessions that officially address the subject circumscribe their appraisal to drug addiction or, at most, what the Russian Orthodox Church calls “ruinous drug-taking” (ROC, 2000, §XI.3). These more limited discussions dispense entirely with such questions as what counts as a drug and how people should or should not engage with substances both in and outside this category.

It will always be important for church bodies to move prudently and sometimes, ipso facto, slowly in expressing positions on controversial matters of great import. Moreover, it is clear from the above decrees that these churches share a concern for therapeutic medicine that might leave room for psychedelic treatments like those under discussion without changing much in their dictums. And this holds for most other churches as well. My task here is to acknowledge the already evolving legal statuses and uses of these substances and to begin laying the groundwork for robust Christian theologizing of what these developments mean. In particular, I am interested in how Christian practitioners who unexpectedly find themselves utilizing legal psychedelic therapies can or cannot, should or should not, integrate what they feel and learn from “shaking the snow globe” into a life of Christian faith as well as what role priests and pastors have or do not have in this process. I will now flesh out this interest through the example of MDMA.
IV. THE PASTORAL SITUATION

For the purposes of this essay, the decisive point in all this is that much of what the studies in psychedelic medicine are finding is germane to theological reflection. To illustrate, the authors of one MAPS Phase II PTSD study chose to work exclusively with military personnel and first responders because the prevalence of the disorder in these populations, 17.1% and 10–32%, respectively, is much higher than the lifetime occurrence in the general population, 8% (Mithoefer et al., 2018, 486). But even the existing psychotherapies, which are more effective than the existing pharmacotherapies, leave 60%–72% of the veterans who try them still diagnosable with PTSD (Mithoefer et al., 2018, 487). Thus, MAPS’ result in the study, namely that 67% of the participants no longer qualified for the diagnosis at the twelve-month follow-up (Mithoefer et al., 2018, 492), which matches the organization’s aforementioned overall Phase II results of 68% and initial Phase III results of 67%, is quite appealing. If the MAPS clinical trials continue to be as successful as they have been, many more veterans and first responders are going to be engaging MDMA-assisted psychotherapy when it becomes legally available (not to mention those who are already self-medicating [Philipps, 2018, A12]). And some of these patients will be Christians.

The issue is that reduction or removal of PTSD symptoms is not all MDMA offers. In fact, it would appear that it offers this precisely because it offers something much deeper (a relationship I will explore further in the next section). George R. Greer and Requa Tolbert describe MDMA’s impact: “In the right circumstances, MDMA reduces or somehow [sic] eliminates the neurophysiological fear response to a perceived threat to emotional integrity…With this barrier of fear removed, a loving and forgiving awareness seemed to occur quite naturally and spontaneously” (Greer and Tolbert, 1990, 33), resulting in acceptance and even love of self and others (Bravo, 2001, 28; Holland, 2001, 9). Or, as Julie Holland puts it, “MDMA increases the ratio of love to fear” (Holland, 2001, 9).

In connection with this point, it is important to ponder how Christian veterans or first responders might be inclined to integrate such an experience. It would be understandable if they underwent therapy to expunge their PTSD but also came away feeling that they had experienced more deeply than ever the “perfect love that casts out fear” (1 Jn 4:18, NRSV), “the peace of God, which surpasses all understanding” (Phil 4:7),10 the loving your neighbor as yourself lauded by Jesus (Mk 12:31), or the eschatological vision of wolves and lions living and walking with lambs and calves (Is 11:6). The extent to which these biblical allusions offer a meaningful way to think about the experience of MDMA and vice versa is a question that requires the sort of reflection I am inviting. At very least, however, it makes sense to think about what priests or pastors could or should say in response to the newly treated veteran or first responder. Hitherto, these spiritual guides could simply cite exhortations to obey the law in Romans 13 and, if Roman Catholic, the catechism (USCCB, 1995, §2238ff.), since MDMA was outlawed in 1985. But the legal tableau on this front is in flux. Not only MDMA but also psilocybin and other psychedelic compounds11 promise to be licit in as soon as a few years (Illing, 2019) because the science suggests they help people engage their suffering more deeply and productively. Hence, the matter would benefit from a more thoroughgoing and thoughtful Christian response.

Making a related point, though with a different emphasis, June McDaniel notes that “small-scale drug trials of MDMA are being performed in a highly controlled clinical environment without any spiritual or moral interpretative framework to help the subjects understand their experiences” (2017, 721). “Not only do they avoid religious issues in therapy,” she says, “they also consciously avoid any language that might imply that they were ‘leading’ the patients. Thus, the ‘natural healing of the body’ might be discussed during therapy, but issues of transcendent meaning and depth that might be explored in spiritual contexts are ignored” (McDaniel, 2017, 739). Here, McDaniel refers to what MAPS Founder and Executive Director, Rick Doblin identifies as “one key element in our method”: “we believe that we are empowering people to heal themselves.” Thus, patients spend about half the MDMA session reflecting internally while the therapists quietly observe (Reid, 2019, 24:13ff.). The rest of the time, the patient and therapists discuss thoughts and feelings that came up during these internal periods. While the therapists might not entirely “ignore” a religious matter if it came up for the patient, McDaniel is right that they do not initiate this or any other topic and that they “are not trained in religious issues” (2017, 739), at least not as part of MAPS’ protocol.12

For McDaniel, the deficiency in this approach is that a “spiritual or moral interpretative framework” “could help patients integrate and find meaning in the intense, traumatic experiences they
have undergone. Pastoral counselors, psychologists, and religious professionals might find it useful to explore this form of therapy further” (McDaniel, 2017, 721). After all, she says,

People suffering from PTSD and trying to heal from such pain must generally choose distant religious alternatives, such as Central and South American shamanism and various forms of animism, if they wish to incorporate religious ideas in their healing. There is no clear way (at least thus far in the literature) to incorporate religious symbolism from the major world religions into the therapy. (McDaniel, 2017, 739)

Although I agree that making it possible to incorporate religion into therapy is a worthwhile endeavor, it is the converse of this principle that interests me in this paper: My aim is not to determine how “religious symbolism” can “help patients integrate and find meaning in the intense, traumatic experiences they have undergone.” Rather, I seek to lay the groundwork for thinking about how, if at all, what is learned in psychedelic-assisted therapy could be integrated into a Christian faith and practice. Without this, the former project, though worthwhile, would instrumentalize theology in service to therapy. Nevertheless, McDaniel’s work demarcates several results of MDMA-assisted psychotherapy that overlap with Christian desiderata: patience, service, compassion, and existential meaning among them. This demarcation further suggests a need for the robust theologizing I have described.

There are many hurdles to such reflection, but two in particular merit attention as a way to begin the conversation. The first is that undergirding most, if not all, Christian aversion to engagement with psychedelic compounds is an understanding of intoxication that does not apply to them. The second is that, for both good and ill, and with both good and ill exceptions, churches have largely left the question of what counts as “therapeutic” up to the medical profession. The trouble with the latter is that the medical community has been tragically imperfect on this issue and, besides, tends, out of necessity, to favor a curative rather than preventative approach to physical and mental health. I shall take these hurdles in turn before considering some important theological objections to my proposal.

V. THEOLOGIZING INTOXICATION

Christian aversion to drunkenness is ancient, rooted in biblical injunctions: “Do not drink wine to excess or let drunkenness go with you on your way” (Tb 4:15b, NRSV); “it is now the moment for you to wake from sleep…let us live honorably as in the day, not in reveling and drunkenness, not in debauchery and licentiousness, not in quarreling and jealousy” (Rom 13:13); “Do not get drunk with wine, for that is debauchery; but be filled with the Spirit” (Eph 5:18). On the other hand is the biblical witness that the Lord brings forth ‘wine to gladden the human heart’ (Ps 104:15). Similarly, “wine drunk at the proper time and in moderation is rejoicing of heart and gladness of soul. Wine drunk to excess leads to bitterness of spirit, to quarrels and stumbling” (Sir 31:28–9). The message is clear: Drink without drunkenness.

The church fathers conclude similarly. In the Paedagogus, St. Clement of Alexandria says, “Wine makes the man who drinks more mellow toward himself, better disposed toward his servants, and more genial with his friends. But, when he is overcome by wine, then he returns every offense of a drunken neighbor” (1954, 114). Referring to the drink as medicine, Clement lists several of its benefits, including warmth, intestinal relief, and conviviality, but warns of the dangers of drunkenness: irritation and error, indolence and poverty, impropriety and licentiousness, and all manner of physical discomfort. He thus disparages the importation of wines from abroad, implying that such connoisseurship fails to recognize God as the source of all of them: “There exist all these various brands of wine, but for the temperate drinker it is only wine cultivated by the one only God” (Clement, 1954, 120).

For his part, St. Augustine, like many of the church fathers and owing to his episcopal vocation, usually addressed the matter of alcohol in the context of its impact in contemporary pastoral situations. Thus, he denounces the drunken cemetery frolics honoring Christian martyrs (Ep. 22, 1951, 81ff.; see Fox, 2015, 440ff. for context) and disqualifies Donatists as baptizers on account of their frequent drunkenness (Ep. 93, 1951, 101ff.; see Cook, 2006, 57 for context). However, he addresses the subject of intoxication more generally in his dialogue, On the Free Choice of the Will. In the context of
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Book I’s theodicean inquiry about where evil comes from and what counts as evil, Augustine and his interlocutor Evodius (his traveling companion when he wrote the first book of the work) discuss the distinction between evil things and things people use in an evil manner. Augustine queries:

Do you think we should censure silver and gold because of greedy men, food because of gluttons, wine because of drunkards, attractive women because of fornicators and adulterers, and so on? Especially since you recognize that the physician makes good use of fire whereas the poisoner makes evil use of bread! (2010, 28–9)

Then, in Book III’s soliloquy that famously leaves Evodius behind, Augustine repeats the point:

just as I might praise wine as good of its kind while faulting someone who got drunk on it, and yet put the same person whom I faulted and who is still drunk ahead of the wine I praised on which he got drunk, so too material creations are rightly praised at their level, although those who turn away from the perception of truth by using them immoderately are to be faulted. (2010, 84)

At the outset, then, the project of theologizing intoxication anew meets with a trenchant problem: It would appear that the critical stance Christianity has always taken towards intoxicating substances ensues from, and is theologically justified by, its very roots. Indeed, many have argued against intoxication in general precisely on anti-drunkenness grounds. And not without extratextual motivation. Even today, drunkenness has been a central factor in too many untimely deaths and destroyed families to enumerate. The decisiveness of this fact for theologizing intoxication qua intoxication is less obvious than is presupposed in these arguments, however. For the theological context, the problem is this: Given the pervasiveness of alcohol consumption in our society, the appeals, harms, excesses, and moral status of this ancient depressant and how we feel about them condition all conversation on substances that alter the felt-quality of consciousness. Thus, our society’s views about intoxication, based as they are on its views about alcohol intoxication, disadvantage the consideration of responsible psychedelic use right out of the gate.

From the standpoint of physical and psychological health, this is an unfortunate error, for the impact of intoxication relative to the impact of a less extreme state varies with the substance taken. As indicated by St. Clement, moderate consumption of alcohol has a number of benefits, including mood enhancement, stress reduction, increased sociability and social integration, and improved mental health (Peele and Brodsky, 2000; Baum-Baicker, 1985), while heavy and/or binge drinking causes the opposite of almost all these effects as well as a range of other physical, psychological, and social problems (Dasgupta, 2011, 77ff.). So, moderate alcohol consumption is largely salutary; alcohol intoxication is largely unsalutary. With MDMA, conversely, it is the intoxicating doses that have the promising results for PTSD described above, while low doses yield an “antitherapeutic effect”: MAPS’ studies found that low doses “activate people, but they don’t reduce the fear enough so [...] those undergoing treatment] have this little bit of energy from the drug that enables them to access [the trauma], but it still sucks... They still got better to some extent, but the people who had the therapy without any MDMA got even better,” a result that was, itself, well beneath the success of those who received the full, intoxicating dose with their therapy (Reid, 2019, 41:23ff). So, alcohol and MDMA differ when it comes to evaluating intoxication relative to the low-dose state: While alcohol intoxication is less salutary than lose-dose alcohol consumption, MAPS’ work suggests that, therapeutically speaking, low-dose MDMA consumption is less salutary than MDMA intoxication. Similar stories could be told for psilocybin, ibogaine, and other psychedelic compounds. Thus, any rigorous theology of intoxication must avoid inadvertently establishing alcohol intoxication as a model for evaluating intoxication by other substances.

A second problem that arises in theologizing the kind of intoxication under discussion here, i.e. that involved in psychedelic medicine, is the lack of consensus about just what theologically vets a given compound as genuinely medicinal or therapeutic in the first place. As previously noted, the Roman Catholic catechism stipulates that the use of drugs “except on strictly therapeutic grounds, is a grave offense.” The question is: what counts as therapeutic and why, and who decides? The catechism does not elaborate, but, in what is probably the most comprehensive ecclesiastical treatment
of drugs from any Christian tradition, the Pontifical Council for Health Pastoral Care, now called the Pontifical Council for Health Care Workers (PCHCW), attempts to build on the catechetical dictum. The council highlights two important facts in connection with evaluating drugs: First, alcohol shares with certain more stigmatized drugs the potential to destroy the physical and psychological health and relationships of its users. As the PCHCW puts it, “In many societies, wine and alcohol [sic] form part of dining; obviously, since these products are not completely free from dangers, they can become drugs, provoking serious illnesses and very high rates of mortality” (2002, §166). Second, “heroin, for example, is useful and can under the control of a physician alleviate the pains of seriously-ill patients, but in a drug-addicted context, it becomes a destructive substance” (PCHCW, 2002, §158). That diamorphine (or diacetylmorphine; “Heroin” was its original trade name from Bayer and has since stuck informally) can be medicinal is well-documented and evinced by its availability in some medical systems, particularly that of the United Kingdom (Nutt, 2012, 224; Gossop et al., 2005). The upshot of these two facts is that some drugs, such as alcohol, are socially innocuous enough to be part of our daily lives while also harboring the potential to become gravely dangerous while other drugs, such as diamorphine, are rightly assessed as potentially hazardous but remain generally unacknowledged for their therapeutic value. Medicines, including diamorphine, and other psychoactive substances, including alcohol, can, as the PCHCW says, “become drugs” and drugs can become medicines.

Who, though, makes the determination of which category is appropriate in a given case? The PCHCW seems to imply that it is the prescribing doctor, for it is “under the control of a physician” that diamorphine is “useful.” While it is impossible to overstate the importance of medical expertise in this question, here, too, is where the problem of what counts as therapeutic and why becomes most trenchant. The problem has two prongs. The first prong concerns the high price of error potentially made by individual doctors or the field as a whole. The above PCHCW report was published in 2002. Since that time, much has come to light about the role pharmaceutical companies and doctors played in the ongoing OUD epidemic. In particular, we now know that the aggressive and misleading marketing of OxyContin (oxycodone) by Purdue Pharma and the drug’s subsequent overprescription by doctors correlated with increased opioid misuse (nonprescribed use), diversion (nonprescribed user), and addiction (Van Zee, 2009; Makary, Overton, and Wang, 2017). Second, we know that overdose deaths involving opioids have gone up annually since the turn of the century, escalating from 8,048 in 1999 to 47,600 in 2017 (NIDA, 2019). And, finally, we know that a prescription opioid was the first regular opioid for most of those who began their heroin use this century, as high as 75% (Cicero et al., 2014, 823) or 79.5% (Muhuri, Gfroerer, and Davies, 2013), depending on the study, whereas heroin itself was the first regular opioid for over 80% of those who began in the 1960s (Cicero et al., 2014, 823).

Specifying exactly which factors contributed to the opioid epidemic and to which degree is not the point here, nor is it to suggest that we should distrust the medical system in the United States. For one, while it is true that the majority of recent heroin users began with prescription opioids, it is also true that a mere fraction of those who misuse prescription opioids move on to heroin. According to one study, only 3.6% of those who began misusing prescription opioids used heroin within the next five years (Muhuri, Gfroerer, and Davies, 2013). Thus, as one review of the relevant literature puts it, “the available data suggest that nonmedical prescription-opioid use is neither necessary nor sufficient for the initiation of heroin use and that other factors are contributing to the increase in the rate of heroin use and related mortality” (Compton, Jones, and Baldwin, 2016, 158). And this is to say nothing of patients who use opioids as prescribed, a population that, according to a Cochrane review study of long-term opioid pain prescription, suffers addiction at a rate of only 0.27%, where reported (Noble et al., 2010), though another review study placed it at 8%–12% (Vowels et al., 2015). For this reason and others, Carl L. Hart stresses that “co-occurring psychiatric disorders—such as excessive anxiety, depression, and schizophrenia—and socioeconomic factors—such as resource-deprived communities and un- and underemployment—account for a substantial proportion” of addictions (2021, 12). In particular, he says,

It is certainly possible to die from an overdose of an opioid alone, but such overdoses account for a minority of the thousands of opioid-related deaths. Most are caused when people combine an opioid with alcohol, an anticonvulsant, an antihistamine, a benzodiazepine, or another sedative. People are not dying because of opioids; they are dying because of ignorance. (Hart, 2021, 235)
And,

The differential potencies between these opioids has become a major topic of concern because fentanyl is increasingly sold as heroin, mixed with heroin, or pressed into counterfeit opioid pills... This, of course, can be problematic—even fatal—for unsuspecting heroin users who ingest too much of the substance thinking that it is heroin alone. Even so, it is important to remember that the problem isn’t fentanyl per se. The problem is fentanyl-contaminated heroin and fentanyl-tainted counterfeit opioid pills. The problem is ignorance. (Hart, 2021, 67)

And, finally,

the highest drug-related mortality rates in the United States are found in regions, including Appalachia and Oklahoma, with lower rates of university completion and greater economic distress. Attention-grabbing headlines claiming that opioids (or any other drug) are killing people are wrong. Ignorance and poverty are killing people, just as they have for centuries. (Hart, 2021, 79)

In addition, the medical community has responded to the epidemic. In particular, Purdue Pharma has acknowledged the role of its misleading marketing in the crisis and discontinued its promotion of OxyContin (Whalen, 2018) and doctors are writing fewer opioid scripts, down 18% in 2015 from 2010 (Guy et al., 2017). In fact, many have argued that the medical community has over-responded, depriving people of pain relief in cases where the risk of addiction is statistically low. The appraisal of diamorphine’s dangers by D. Bruce Scott, MD, even before the opioid epidemic, is representative of this commentary: “Fear that patients, given these drugs [i.e. opioids] to relieve pain, would become addicted and dependent has meant that vast numbers of those suffering even severe pain are denied adequate analgesia” when “the problem of creating addiction in treating acute pain is so small as to be infinitesimal.” Contrariwise, he says, it is well within our capacity to “derive the maximum benefit [from these compounds] without fear of addiction, if the drugs are used rationally” (Scott, 1988, xii).

However, while multiple factors have contributed to the ongoing opioid epidemic—to degrees that are difficult to specify—and while the medical community has been responsive to the tragedy, it is clear that insurance companies and doctors played a decisive role in the systematic employment of opioids outside of what Scott calls rational use. That is to say, they unwittingly or unwittingly encouraged the kind of use that would now predictably lead to dependency. Thus, in theologizing intoxication, we must regard the medical context as an imperfect criterion on which to deem drug use “medicinal” or “therapeutic,” if those designations are to determine what counts as coherent within a Christian theological outlook rather than “misused.” Otherwise, there is no theological ground on which to critique that context to prevent or evaluate vicissitudes like those of the opioid epidemic. A similar conclusion has been drawn by John-Mark L. Miravalle in relation to the overprescription of antidepressants:

A likely reason for this inability to convey exactly what is wrong with indiscriminately issued antidepressant prescriptions is that modern psychiatry appears to lack a uniform and well-defined anthropology. What is the human person? How is one to care for him? What constitutes human wellness? Without clear answers to these questions, professionals may be deprived of the basis of authentic psychology and morality (both sciences depending on an accurate anthropological model) for forming guidelines for the proper distribution of mood-altering drugs. (2010, 1)

To be clear, the PCHCW does not explicitly specify the medical context as the criterion for deeming drug use medicinal or therapeutic and therefore theologically coherent. However, as previously noted, it states that diamorphine “is useful and can under the control of a physician alleviate the pains of seriously-ill patients, but in a drug-addicted context, it becomes a destructive substance.” Again, it is true that diamorphine is both medically useful and potentially destructive, but the PCHCW’s statement fails to note that the medical and “drug-addicted” contexts are not mutually exclusive and, furthermore, do not exhaust the pertinent categories. A similar declaration comes from evangelical protestant leader John Piper (2014), who discourages the use of cannabis in general but adds, “I doubt
that we should oppose a regulated medical use of marijuana, controlled by appropriate physician oversight and prescriptions.

Pronouncements such as these set up a false dichotomy between drug use “under the control of a physician” on the one hand and, in the case of the PCHCW’s statements, the “drug-addicted context” on the other. The issue is that, on the one hand, the former can become the latter, as the opioid epidemic demonstrated, and that, on the other hand, not all usage and/or substances encourage or even permit addiction outside the medical context. Crucial is the example of psychedelics. According to David Nutt, once chair of the United Kingdom’s Advisory Council on the Misuse of Drugs (ACMD), “if anything [psychedelics, specifically LSD and psilocybin] are anti-addictive, as they cause a sudden tolerance which means that if you immediately take another dose it will probably have very little effect, so there is no incentive to take more” (Nutt, 2012, 254). In addition, as Alan Watts noted, “The standard dosage of each substance maintains its effects for from five to eight hours, and the experience is often so deeply revealing and moving that one hesitates to approach it again until it has been thoroughly ‘digested,’ and this may be a matter of months” (2013, 14).

By relying on an ill-conceived distinction, the type of response given by the PCHCW and Piper misses out on an opportunity to address whether, when, why, and how various instances of drug use—whether involving medical supervision, addiction, both, or neither—could or should (or could or should not) be theologically situated. Instead, it inadvertently leaves the task to lawmakers and physicians who have neither the theological training nor the personal investment for it, as Miravalle illustrates. The desire not to withhold pain alleviation is noble, but what is the theological significance of the experience itself that provides this pain alleviation? And what is the theological significance of an existence in which such experiences are had intentionally and more than once? A rigorous theological response to our era’s tragic medical missteps with opioids and its promising scientific developments in psychedelics would benefit from revisiting the question of what vets and contextualizes the employment of psychotropic substances from a theological point of view.

The second prong of this problem is that leaving the question of what vets the consumption of psychotropic substances entirely to the medical community renders a preventive approach to the problems these compounds address impracticable. In preventive care, the focus is on obviating disorder or disease via regular checkups; social determinants of health like nutrition, lifestyle initiatives, and environmental improvements; as well as other such prophylactic measures (see Blank, 1988, 34ff.; Simon, Soni, and Cawley, 2017, 390 and 396). Curative care, in contrast, seeks to eliminate existing disorder or disease. A robust curative approach has a number of advantages, such as the ability to address issues that only admit of curative treatment (De Sa, 1993) and to provide care for those with insufficient access to the resources or information necessary to pursue prevention. However, a curative approach that is insufficiently preventive also has a number of drawbacks, such as allowing people to develop pathology they could otherwise avoid and imposing a binary “yes, you have it”/“no, you do not” distinction on illnesses (Rose, 2008, 38 and 41ff). Since so many psychological and neurological disorders exist on a spectrum, the latter drawback results in a range of cases that go undiagnosed because they fall closer to the “no” end of the spectrum, despite needing attention (Rose, 2008, 44–5).

The United States currently employs such a predominantly curative approach (Blank, 1988, 34 and 36; Simon, Soni, and Cawley, 2017, 390), though the industry is transitioning. Applied to psychedelic medicine, one effect is that people whose symptoms are not acute or numerous enough to fall on the “yes” side of the spectrum with respect to PTSD or major depression cannot qualify to participate in clinical trials (or, in the future, to receive treatment) with MDMA or psilocybin, respectively. A possible consequence is that some sufferers will have no recourse to the pharmacologically-assisted psychotherapy that might prevent an advanced state of their condition precisely because it is not yet in that state. To take the psilocybin example, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) outlines nine symptoms for diagnosing major depressive disorder (MDD):

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

The presence of at least five of these symptoms, inclusive of either (1) or (2), during the same two-week period, represents a MDD episode, so long as the symptoms “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” and the “episode is not attributable to the physiological effects of a substance or to another medical condition” (APA, 2013, 160–1).

The research on psilocybin and this disorder is still nascent. Only one clinical trial addressing major depression, as opposed to depressive symptoms in terminal cancer patients, preceded the Compass Pathways and Usona Institute studies that received the FDA's breakthrough status, which are still in progress. However, both studies adduced above, that on psilocybin for major depression and that on psilocybin for depressive symptoms in cancer patients, based their findings partially on the reduction in Beck Depression Index (BDI) that accompanied the treatment. Among other symptoms, the BDI assesses the intensity of many that map onto the above MDD criteria (the numbers here are those of the criteria; the wording of the symptoms is that of the BDI): (1) “mood”; (2) “lack of satisfaction”; (3) “loss of appetite” and “weight loss”; (4) “sleep disturbance”; (5) “fatiguability”; (7) “self-dislike,” “self-accusation,” “sense of failure,” “sense of punishment,” and “guilt feelings”; (8) “indecisiveness”; and (9) “suicidal wishes” (Beck, Steer, and Garbin, 1988, 79). In other words, the BDI assesses how a patient stands with regard to almost all of the MDD criteria. Thus, if, as the existing studies suggest, psilocybin-assisted therapy can lower a patient’s BDI, this may amount to the patient no longer qualifying as symptomatic on one or more of the MDD criteria, or even for major depression as a whole. Moreover, and crucially for the present point, if a patient meets some of the criteria but not enough for a MDD diagnosis, psilocybin-assisted psychotherapy could reduce some of the associated symptoms, thereby preventing the onset of pathology. Similarly, the therapy could help those who are unlikely to be diagnosed with major depression or another disorder work through experiences that, because of life circumstances, they share with those who have been diagnosed. A therapeutic approach that is licensed and regulated but does not require a medical diagnosis, like that being implemented subsequent to the passing of Oregon Measure 109, would allow for both, but leaving the question of what vets the consumption of psychotropic substances entirely to the medical community renders this impossible.

Again, there is room for Christian theological reflection alongside the expertise of other professionals, for this is not a matter of irrelevance to Christianity. For example, in a spirit similar to that of Miravalle’s words above, Pope John Paul II (1993) addressed the American Psychiatric Association and World Psychiatric Association, saying, “no adequate assessment of the nature of the human person or the requirements for human fulfillment and psycho-social well-being can be made without respect for man’s spiritual dimension and capacity for self-transcendence.” To the extent that mental disorder is ineluctably spiritual in this way, the question becomes: What would qualify or disqualify psychedelic-assisted psychotherapy as respecting and supporting humanity’s spiritual dimension in Christian terms? And where might or might not there be overlap between, on the one hand, preventing mental disorder and/or working through life circumstances via this treatment and, on the other, the spiritual development and/or pastoral care typical of the Christian life generally? As the debate over the legal status of psychedelic substances develops, these questions at the intersection
of theology and preventive medicine merit nuanced attention. Specifically, they will be decisive for
determining what, if anything outside the medical context, should theologically vet psychedelic-as-
sisted treatments as genuinely therapeutic on the terms of a Christian theology of intoxication that
takes the question seriously.

VI. TWO IMPORTANT OBJECTIONS

Before concluding, it is necessary to address two of the more likely theological criticisms of this pro-
posal. The first concerns the possible perception that the employment of psychedelic compounds,
for any reason, is primarily a hedonistic pursuit and the second stipulates that all psychedelic usage
entails the relinquishment of reason. Inasmuch as these charges stick and inasmuch as hedonism and
the suspension of rational agency are inconsistent with a Christian theological outlook, it would seem
that my call for nuanced theological reflection on the psychedelic renaissance should be rejected out
of hand.

In relation to the first charge, the PCHCW report muses, “Why does one take drugs?...in the use
of any product, there is the curiosity of trying new sensations, of infringing prohibitions, of searching
for immediate pleasure, and attempting to get out of an interior malaise in which one ends up and for
which no solution is in view” (2002, §148). Earlier, it cites Pope John Paul II’s “Homily at the Mass for
Ex-Drug Addicts” in a similar vein: “It is a sad fact, that alongside the absence of intimacy with God,
and without justification, there is a seeking after drugs, beginning a journey of flight in order to forget
oneself, to dazzle oneself, and to escape from oppressive and unbearable situations” (PCHCW, 2002,
§35). Thus, for the wide array of compounds the PCHCW considers—including cannabis; psyche-
delics like MDMA, LSD, and ketamine as well as cocaine, crack, heroin, and amphetamines; and even
glue, solvents, tranquilizers, and sleeping pills (2002, §91–147 and 177)—it bifurcates the motiva-
tion of those taking them into pleasure and escape. While this is not the venue to evaluate the report
at any length, one weakness is that it treats these diverse compounds as if they belonged to a single
category, with largely the same appeal and dangers. With regard to psychedelics in particular, how-
ever, the scientist who first synthesized LSD and discovered its psychotropic effects, Albert Hoffman,
indeed noted that, in his first, accidental encounter with the substance, “a kaleidoscopic flood of fan-
tastic images dazzled me” (Hagenbach and Wertmüller, 2011, 44). Note the similar wording to that of
the PCHCW: “dazzling.” And Ben Sessa, a medical doctor and researcher with both observational
and, as a subject in clinical trials, legal personal experience with LSD, psilocybin, ketamine, DMT,
and MDMA (2017, 20), recapitulates one of the phenomenological categories of the psychedelic
experience originally adduced by Walter N. Pahnke and William A. Richards: “Deeply felt positive
mood: Euphoria, delight, rapture, and sensual love. The psychedelic experience is a Maslowian peak
experience; a life-transforming ultimate soaring through unbridled pastures of joyous ecstasy” (Sessa,
2017, 29; Pahnke and Richards, 1966, 180-81). So, the PCHCW is right to include psychedelics in its
description of drugs as offering “immediate pleasure” and as potentially being pursued on that basis.

In response, it is important to note that the psychedelic experience is not an unqualifiedly positive
one, as the litany of discussions about “bad trips”—or, as the scientific literature calls them, “challeng-
ing experiences” (Carbonaro et al., 2016; Barrett, Johnson, and Griffiths, 2017)—demonstrates. To
the extent that psychedelics are pleasurable, however, the decisive question is whether this is the only
or even primary motivator for their employment and whether they might offer other fruit of value to
a Christian theological outlook. In considering this question, the PCHCW’s comments about the
importance of pleasure within a wider framework are instructive:

Obviously, desires and pleasures fulfil an important function in the internal organization of the indi-
vidual, and they constitute the dynamics upon which human psychology is based. Neglecting or
ignoring them is often dangerous for the equilibrium of a person. An asceticism that would like to
suppress them or a hedonism that tries to exalt them damages the person, whereas establishing a
hierarchy between desires and pleasures is of paramount importance. For this reason, education has
to take the trouble to teach the child how to find satisfaction in the world through his activities and
relationships, and not in a selfish life. In this way, he will above all experience pleasure that will enrich
him, because it will be a fruit of the gift of himself, and not the result of an unbridled subjective
search. Such pleasure is the result of one’s efforts and from the joy of existing in relationship to the reality of the world, with others, and with God. (2002, §175)

So, the PCHCW’s problem with taking the drugs its report considers is that it exalts pleasure and pursues unenriching ones that are out of the context of “relationship to the reality of the world, with others, and with God.”

But Pahnke and Richards list other features of the psychedelic experience that are relevant to Christian thought and practice. One of these is a,

sense of sacredness…Inherent in the nondifferentiated unity of mystical consciousness is a profound sense of holiness and sacredness that is felt to be at a more basic level than any religious or philosophical concepts held by the experiencer. Furthermore, an acute awareness of finitude is reported, as though one had stood before the Infinite in profound humility, overwhelmed [sic] by feelings of awe and reverence. (1966, 180)

Although it is outside the scope of this paper to explore the nature and coherency of mysticism in depth, it is important, briefly, to mention Denys Turner’s highly influential study of medieval mysticism, which argues that what is usually meant by the term “mystical consciousness” is a modern invention (1995, 7). Rather than an obviously universal phenomenon, the idea of mysticism, Turner contends, reflects a modern emphasis on “experientialism” (Turner, 1995, 5) that the so-called medieval Christian “mystics” would not have known or, if they did, would have rejected. If successful, Turner’s account would complicate the notion that the usual understanding of mystical consciousness is even pan-Christian, let alone pan-religious or pan-spiritual. It would then remain to determine just how much any alternative to that understanding shares with the phenomenon Pahnke and Richards have in mind.

This, of course, is another matter to be explored in the theological reflection this essay invites. Fortunately, however, my argument for the necessity of that reflection does not depend on deciding mysticism’s case. Even if Turner is right that what “mysticism” usually denotes is a hopelessly modern phenomenon, too experiential and insufficiently representative of Christian religiosity throughout history, this would not rule out the value of some alternate awareness of time and space, like that inhabited upon ingesting a psychedelic. Moreover, Christianity esteems humility, reverence, and awareness of finitude, which Pahnke and Richards adduce as part of the psychedelic state, and these orientations in a Christian context imply further desiderata such as submission, repentance, and forgiveness. In other words, psychedelics—employed in ways and with ends that the science suggests are salutary—can put those who take them into mindsets that facilitate repentance and other theologically relevant comportments. To the extent that this is part of the aim in a given case, their use would not constitute what the PCHCW calls mere “curiosity of trying new sensations, of infringing prohibitions, of searching for immediate pleasure.”

Similarly relevant is, in Sessa’s recapitulation of Pahnke and Richards’ features of the psychedelic frame of mind, “Positive changes in attitude and/or behavior: An important aspect of the experience. Because although ineffable, transient, and illogical, the psychedelic state can provide real and lasting positive developmental change for an individual” (2017, 30). In fact, it is precisely the desire to explore this possibility that motivates all the studies adduced above and others like them. In the original explication, Pahnke and Richards elaborate on the point:

In one’s relationships with other persons, greater sensitivity, increased tolerance, and more real compassion are reported. Theologically-trained persons frequently feel that they have acquired new and profound insights into the meaning Martin Buber sought to convey in his term “the I-Thou relationship,” finally knowing the meaning of genuinely meeting another person without the subtle masks that separate man from man. (1966, 183)

All of this suggests the space to theologize about a use of psychedelics that is consistent with what the PCHCW calls, “pleasure that will enrich him, because it will be a fruit of the gift of himself, and not the result of an unbridled subjective search,” pleasure that is “the result of one’s efforts and from the
joy of existing in relationship to the reality of the world, with others, and with God.” To be sure, that theologizing may ultimately decide that no such use is possible, but this is not so obvious as to rule out the theologizing in the first place.

More interesting is the second potential charge, namely that the employment of psychedelics entails a suspension of rational agency and is, therefore, inconsistent with Christian spirituality. Before engaging the complexity of this point, it is worth noting that it is by no means a consensus that the psychedelic state is an irrational one. One regular user, for example, described his experience of LSD this way: “It’s a bit like falling in love. You turn your world upside down. Behavior and thought patterns change when you fall in love… it is a bit like that. Except you keep your rationality” (Høifødt, 2018, 33). Another said,

the Psychedelic implants the very breath of primordial awe…I can now understand the psychology of divine inspiration or of magical thinking. When I look at a medieval painting or an alchemical text, it is no longer obscured by its incompatibility with modern thought. Moreover, this understanding does not obviate rationalism; it only broadens the perspective. (Hayes, 2000, 279)

And, in reference to his *iboga* experience, Hamilton Morris said,

I would say that it was the most logical I have ever felt in my entire life. I truly felt that I was seeing myself like an outside observer, without any kind of emotional attachments. And I could understand the way that I had distorted various things, and I could understand frameworks of justifications and delusions in such a way as to understand my own behavior, forgive myself for it, and correct it in the future. And, in the wake of that experience, I did make changes to my life and I do feel better as a result of it. (Rogan, 2021, 2:37:04ff.)

On the other hand, it would be unduly sanguine to infer from these comments that what Carhart-Harris calls “shaking the snow globe” involves no suspension of rationality whatsoever. Alan Watts once described his encounters with LSD thus:

For me, it has been at times an experience in which I was at once completely lost in the corridors of the mind and yet relating that very lostness to the exact order of logic and language, simultaneously very mad and very sane. But beyond these occasional lost and insane episodes, there are the experiences of the world as a system of total harmony and glory. (2013, 116)

Pahnke and Richards report similarly:

one may become thoroughly disoriented and confused, symptoms that may well be labelled psychotic. Generally, one can vacillate almost at will from experiential depths to the clarity of usual, rational consciousness; that is to say, one can “go in” and have an experience and then “come out” and discuss the experience with other people or speak about it into the microphone of a tape-recorder, after which, of course, one can “go in” again. (1966, 188)

What both of these descriptions assert is that while there is a rationality to the psychedelic experience, it is not wholly without its suspension thereof. Insofar as the psychedelic state does involve irrationality, then, a theological response to the present objection is required. A particularly well-articulated version of the charge is available in the PCHCW’s citation of Pope John Paul II’s address to the participants at the Sixth International Conference on Drugs and Alcoholism against Life:

taking drugs… is always illicit, because it involves an unjustified and irrational renunciation of thinking, willing, and acting as free persons… These phenomena—it must be remembered—are not only detrimental to the physical and psychic well-being but frustrate the person precisely in his or her capacity for communion and self-giving [*dono*]. (PCHCW, 2002, §43; JPII, 1991, §4)
The logic behind this assertion is that rationality involves full command of one’s “thinking, willing, and acting.” If, as a result of ingesting a psychotropic compound, we are no longer entirely in control of our reasoning process and judgment, our desires, and our actions, then we cannot realistically hope to determine, value, and do that which leads or pertains to communion and self-giving. Thus, by virtue of temporarily inducing a state with elements like those described by Watts and Pahnke and Richards, psychedelics involve an irrationality that disqualifies their employment as a subject for serious theological discussion.

This objection merits careful and sustained attention in the theological reflection for which I am calling. As a first pass, however, one might question the objection’s premise of rationality as a sine qua non of Christian spirituality—or, more properly, its premise of what Hans Urs von Balthasar calls the “delimited form of ratio in its characteristic closure” (2000, 253) as a sine qua non of Christian spirituality. Balthasar describes a “bad infinity” or “endless busyness,” in which “every true proposition can be further analyzed, divided, related, developed, and reflected from every point of view” (2000, 253 and 251). Yet, as endless and infinite as this multiplication of plausible theories can be, it is merely an “index” of the “true, but never graspable, infinity of God” (Balthasar, 2000, 253). When we realize this, Balthasar says, we cannot help but become dissatisfied with the delimited and cerebral ratio. However, he cautions that we should not consequently run in the other direction to a “vitalism” that affirms [real] “life” over against reason. While it might seem that “life” understood in opposition to rational knowledge of the truth could transcend the finitude of what is seemingly reason’s [over-] analysis, life is not genuinely in opposition to truth and is therefore not up to the task of supplanting or transcending reason (Balthasar, 2000, 253–4). Instead, Balthasar commends a broader understanding of rationality, wherein reason transcends itself and “ever richer life coincides with ever greater truth” (2000, 254).

In accordance with this picture, we might interpret the kind of psychedelic experience (or parts of it) that Watts called “occasional lost and insane episodes” and Pahnke and Richards call, “thoroughly disoriented and confused, symptoms that may well be labelled psychotic” as the absence of Balthasar’s “delimited form of ratio.” If so, one might temporarily set aside this more narrowly defined rationality yet nevertheless count as rational in the more expansive sense by dint of what such suspension of delimited ratio more deeply constitutes. Being “lost,” “confused,” “disorientated,” “psychotic,” or “insane” is not rational unless what is actually happening in such states is an intentional and temporary suspension of the sometimes very rigid control mechanisms that protect us but also potentially occlude the openness to ourselves, others, and God that makes the deepest transformation possible. Inter alia, the above research suggests: (1) that MDMA can help those with PTSD more productively engage their trauma by “increas[ing] the ratio of love to fear”; (2) that psilocybin can result in an anxiety and/or depression reduction still operative six months after the experience; and (3) that, in the words of the above study participant, “iboga will give an opiate addict several months to a half a year of freedom from cravings and an expanded awareness…to get his/her life together and learn to face things straightforwardly, directly, and honestly.” In light of these developments, the temporary and intentional suspension of delimited ratio that is sometimes involved in experiencing the relevant compounds might itself qualify as rational in the more expansive sense. Arguably, reason has here, as Balthasar says, transcended itself.

In line with this perspective, Warren Kinghorn draws upon St. Thomas Aquinas in considering the ways psychiatric medicine does and does not encourage the kind of freedom necessary to live in accordance with “God’s ratio,” that is “God’s ordering of the world” (2018, 267). In the Conference on Drugs and Alcoholism against Life quote above, Pope John Paul II stipulates that the use of drugs constitutes a relinquishment of rationality that blocks “thinking, willing, and acting” and therefore frustrates the “capacity for communion and self-giving.” Balthasar’s analysis undermines the common but limited notion of reason that makes this formula tick, instead offering a broader sense of reason that, precisely in its pursuit of communion and self-giving, could relinquish that common and limited form of rationality. While Kinghorn is not specifically interested in the issue of whether psychiatric medicines relinquish or should relinquish this more limited form of rationality, he is interested in delineating what counts as the willing in the “thinking, willing, and acting” of “God’s ratio.” As Kinghorn says, “true freedom’ is not the capacity for unconstrained, autonomous pursuit of any end
whosoever” but a “freedom enacted by charity, the grace-borne love of God by which human beings are made capable of loving God and all creation in God” (2018, 267). Hence, he tells us,

To act “rationally” for Aquinas is not to exercise intellectual prowess nor to act in accord with human conventions about what is reasonable, but rather to think and to live in harmony with God’s ratio, God’s providential, creative ordering of the world. The rational life is one that is lived in harmony with God and with God’s rule of creation. (Kinghorn, 2018, 269)

It is in the context of encouraging the true freedom involved in this true rationality that Kinghorn discusses improper and proper engagement with psychiatric medications. He enumerates three instances in which psychiatric medicine discourages true freedom: (1) when it inhibits emotional “signposts” that would otherwise tell us to resist the evil in the “sociocultural context to which the emotion is a response” (Kinghorn, 2018, 279); (2) when the diagnosis that calls for the medicine also engenders a pessimism about recovery because its decisiveness and biological nature make the illness seem inevitable and permanent (Kinghorn, 2018, 280–1); and (3) when it implies that its role is to remove unwanted experiences and behaviors that, as “symptoms,” are separate from the self rather than deeply related to the person (Kinghorn, 2018, 282).

Kinghorn also delineates three ways psychiatric medicine can, contrariwise, encourage the kind of agency that leads to Thomas’ summum bonum: (1) when the source of the psychological disorder truly is biological, rendering the medication a much welcome corrective to the “breakdown in the body’s ability to sustain the appropriate operations of sensation, perception, emotion, and practical reason” (2018, 277); (2) when the medication is “alleviating suffering that has become incapacitating” (2018, 278) or what John Hick called “dysteleological” suffering, those afflictions that “crush the character and wrest from it whatever virtues it possessed” (2010, 331); and, controversially but most Thomistically in terms of Kinghorn’s language, (3) when it lowers “barriers to habituation in virtue” (2018, 277). Kinghorn notes that this last possibility for encouraging agency in Aquinas’ sense might seem counterintuitive in light of the latter’s emphasis on the “natural.” Moreover, Kinghorn acknowledges that the above possibilities for discouraging agency give reason for pause. Nevertheless, he contends that if, like the substance use disorder (SUD) drug naltrexone, a particular compound “facilitates the shedding of vice and the acquisition of virtue” (Kinghorn, 2018, 278), it might qualify as encouraging the kind of agency that is consistent with God’s ratio.

Kinghorn’s analysis concerns psychiatric medicine, broadly construed, but his delineation of the ways psychiatric medicine can encourage or discourage true freedom offers a fruitful schema for theologically evaluating psychedelic medicine in particular. Before doing so, however, it is important to note that the encouraging and discouraging ways are interconnected insofar as one and the same diagnosis or prescription can facilitate or hinder human agency in Aquinas’ sense, or do both at once. In fact, each of Kinghorn’s three encouraging ways implies one or more of the discouraging ways, and vice versa. Illustrative of the former implication is a point of Kinghorn’s about the considerable evidence for biological causation in a number of psychiatric conditions, including bipolar I disorder, schizophrenia, melancholic depression, and obsessive-compulsive disorder (2018, 277). In such cases, “medication can be received from a Thomistic perspective as a gift that enables the body to support the proper operation of the practical reason” (Kinghorn, 2018, 277). This signals medication as an effective response to genuine biological causation in psychological disorder (first way of encouraging agency). However, the acceptance of such biological explanations also drives the pessimism about recovery and impersonal focus on symptoms rather than people (second and third ways of discouraging agency). Likewise, psychiatric medicine can encourage agency by alleviating dysteleological suffering (second way), but, sometimes, such alleviation actually discourages agency by eliminating signposts to evils causing the suffering in the first place (first way). And, finally, Kinghorn’s suggestion that psychiatric medicine might help patients shed vice and acquire virtue, as when naltrexone curbs cravings for alcohol or opioids (third way), similarly raises questions about eliminating signposts, as Kinghorn notes. For example, he wonders whether the apparently virtuous behavior that follows [a program of psychiatric medication] is, in practice, the person’s own. If I take naltrexone to curb heavy drinking, am I developing sustained
habits of continence and eventually temperance that will allow me more freedom to pursue what is
good for me? Or, conversely, is the decreased reward for drinking alcohol simply allowing me to pur-
sue addictive pleasure in other ways, or to avoid investigation of the psychological and social context
that reinforced my drinking patterns to begin with? The latter is not virtue, because my abstinence is
not habituated. (Kinghorn, 2018, 279)

And these can be operative at the same time. As Kinghorn puts it,

Life is messy, and in practice [fitting and unfitting responses to a challenging or oppressive context]
will be overlapping and mutually interacting categories: a depressed person might be doing the best
she can to live in an extremely challenging environment, and also bear significant genetic predispo-
sition for depression, live with the discouragement and anguish of chronic suffering, and (like all
humans) turn to ends that are not life-giving. This sort of discernment [outlined by Kinghorn] is
essential for the wise use of psychiatric medication. (2018, 284–5)

In light of the complexity and interconnectedness of the encouraging and discouraging ways, it makes
sense to evaluate medicines holistically, with the expectation that most will not be unambiguous
in encouraging or discouraging agency in Thomas’ sense but can do either or both in varying ways
and degrees, depending on the situation. With this in mind, I will now offer some brief com-
mentary regarding the agency potential of psychedelic medicine, with special emphasis on the three com-
pounds for which I provided data above: MDMA, psilocybin, and ibogaine.

All of the research in psychedelic medicine implicitly or explicitly affirms a biological approach
to the disorder the compound in question promises to treat. For example, in MAPS’ Winter 2016
Bulletin, Amy Emerson et al. tell us that,

Unlike SSRIs, MDMA is a potent releaser of monoamines, and at higher doses evokes sustained glu-
tamate release in the hippocampus. These combined effects may facilitate fear extinction learning,
by triggering neuroplasticity via Brain Derived Neurotrophic Factor (BDNF) expression, and assist
with the recoding of traumatic memories, thus treating the core psychopathology of PTSD. (2016,
26)

The authors are here locating the “psychopathology of PTSD” in the brain regions that MDMA
targets. So thoroughly is this etiology biological that one could be forgiven for suspecting that the
treatment discourages Thomistic agency in just the ways Kinghorn outlines: by prompting pessimism
about recovery and/or treating people as “symptoms.” However, the biological explanation does not
have these impacts in this and other cases of psychedelic medicine. If anything, the field might be
criticized as too optimistic about recovery,22 given the ubiquitous excitement about the results coming
in from various studies. The research investigates the potential for psychedelics to render people free
from PTSD, major depression, addiction, and other disorders. Its biological explanations thus incline
toward the very opposite of fatalistic resignation.

Similarly, far from treating people as symptoms, psychedelic medicine is unambiguously per-
son-centered. In fact, the family physician Erica Zelfand and therapist Timothy Crespi, both MAPS-
trained in MDMA-assisted psychotherapy, describe their work in precisely those terms (2017, 11). As
I previously noted, those undergoing MAPS’ treatment spend about half the MDMA session reflect-
ing internally with the therapists quietly observing and the other half talking to the therapist about
thoughts and feelings that came up during these internal periods. In one such conversation, a US
marine deployed in Iraq speaks of engaging with his trauma from being blown up in the war:

I feel like I should tell y’all something. Really amazing. It’s hard to put it in words. I tried thinking
about that aspect of me that’s just really raging. And also, besides that image I told y’all about of
fighting with him, I have this image of it in a jail cell, like I have that part of me locked up in jail. And
it’s dark but it’s got bright red eyes and…just really evil. And I thought of that and I felt like I put
that person there and I went to it and just opened the door and hugged that person. And then the
eyes just faded away and no longer had kind of an evil look to itself. I visualized both of us just taking
apart the jail cell and just really becoming friends… Part of me realized I was taking that person and keeping him locked up because I was so afraid of him and that by putting him in that cell and keeping him locked up, I was making it worse for him. It really would be more beneficial if we kind of worked together. I thought I was being a peaceful person, but I didn’t realize how much I was punishing that aspect of me. I think maybe in Iraq I saw what it was capable of. And a part of me just feels so bad that I did that to him. I mean, I know it’s me; I just… describe-it-wise… And when I try to think of that really rageful aspect of me, I know it’s there, but I really feel so much more at peace with everything. Even if I try and think about Iraq and everything, I somehow feel really peaceful about the fact that that’s my journey. I know this is part of the drug, but when I try and think, “Am I going to be able to hold onto this understanding, this wisdom, this knowledge I have now?” I feel like it’s so profound that I don’t think I could really forget it. I don’t know why I couldn’t have come up with this on my own, but I’m glad I found it. (Doblin, 2018)

Importantly, the marine’s language—“that aspect of me,” “that part of me,” “I know it’s me,” and so on—and the accompanying self-understanding are features of MAPS’ chosen therapeutic approach, Internal Family Systems (see Schwartz and Sweezy, 2020). While there has been some Christian engagement with this approach (e.g., Cook and Miller, 2018; Riemersma, 2020; Steege, 2010), other forms of therapy more commonly employed in a Christian context would surely frame insights gleaned from a psychedelic-assisted psychotherapy session in different terms. The important point at present is simply that nothing in the marine’s words suggests even a hint of “reduc[ing] a person to symptoms” (Kinghorn, 2018, 283) but, indeed, seems to accord with Kinghorn’s prescription that the “wise use of psychiatric medication” “start with the person” (2018, 282).

So, psychedelic medicine affirms biological explanations for psychiatric disorder in a way that does not prompt pessimism about recovery or reduce people to symptoms. And, of course, the purpose of the emerging treatments is precisely to address human suffering, e.g., in the research explicated here, the suffering involved in PTSD, major depression, and SUD. But, of course, all medicine aims to address human suffering. What matters in terms of Kinghorn’s Thomistic analysis is that it does so without obscuring any signs to evils that may have caused the suffering in the first place. Now, it should already be clear from the marine’s comments above that MDMA-assisted psychotherapy aims to reveal rather than conceal such signals. After all, his treatment facilitated the realization that “I was taking that person and keeping him locked up because I was so afraid of him and that by putting him in that cell and keeping him locked up, I was making it worse for him.” This is not an approach to medicine that palliates suffering by numbing it and therefore obscuring its cause.

But MDMA is not alone in this regard. In one of the studies on psilocybin-assisted psychotherapy for anxiety associated with a cancer diagnosis, post-treatment commentary from patients exhibits increased ability to engage with the causes of suffering in their lives, be it the “evils,” to use Kinghorn’s locution, of others or their own sins. One participant, for example, reported that the psilocybin experience “made me more aware that: I cannot just live for material stuff and success” (Belser et al., 2017, 375). Another, who “struggled with emotional/compulsive eating following her cancer diagnosis,” reported “gaining confidence to commit to dietary goals and a YMCA membership, losing 30 pounds as a result, an outcome she attributed directly to her psilocybin session” (Belser et al., 2017, 375). A third discussed the experience of forgiveness common to many of the participants: “I felt like I let go of a lot of anger and resentment towards my parents. I mean, I thought I had already done that, but I really hadn’t, and I kind of saw them more as, like, these flawed human beings who did the best they could” (Belser et al., 2017, 364). Examples like these begin to show the force of my earlier suggestion that psychedelics can facilitate such states as submission, repentance, and forgiveness, even though the language employed in them lacks theological rigor and specificity. My primary reason in raising the examples, however, is that they demonstrate psychedelic medicine’s sensitivity to the importance of addressing underlying causes of psychological disorder rather than curtailing Thomistic agency by using medication as a quick but shallow fix.

Indeed, all but one participant in the study expressed a desire to repeat the psilocybin experience after sufficient time to integrate the session just completed, and the outlier’s reasoning is instructive with regard to the concern for addressing underlying causes. This participant—the youngest, at 21
years of age—said that psilocybin is very different from “party drugs” because of how much “psychological work” is involved. He compared the experience to “studying” and “going to school”: “You have a lot of things to learn from it, but how much fun is learning, you know? It is not that fun, especially when you have to face some hard things” (Belser et al., 2017, 377). The nursing researcher Caroline Dorsen makes the point in relation to psychedelic medicine generally:

In my study, plant medicine facilitators conceptualized plant medicine use as almost the polar opposite of drug use, even though there is some overlap of substances ingested. Facilitators described the purpose of drug use as “checking out” or having fun to “numb the pain” of life and its small and large traumas. In contrast, plant medicine use is all about facing life’s difficulties in a safe and supportive environment. (Harrison, 2019)

It should be noted that Dorsen’s study itself points out that many participants were not so confident about such distinctions between “drug use” and “plant medicine use” (Dorsen, Palamar, and Shedlin, 2019, 71). Moreover, it is not clear to what extent the opinions about “drug use” held by those queried, or about “party drugs” held by the participant in the psilocybin study, are grounded in a rigorous understanding of the benefits and dangers of the relevant compounds. Nevertheless, this research lends further credibility to the notion that psychedelic medicine is not an approach that “numbs the pain” or obscures the causes of suffering that would otherwise manifest.

This recalls, for a final note, Kinghorn’s Thomistically-inspired concern that, when psychiatric medicine “facilitates the shedding of vice and the acquisition of virtue,” as in some of the above instances with MDMA and psilocybin, “the apparently virtuous behavior that follows is, in practice, the person’s own.” In the case of psychedelic medicine, we are not dealing with substances that, perhaps like the naltrexone example Kinghorn raises, allow “me to pursue addictive pleasure in other ways, or to avoid investigation of the psychological and social context that reinforced my drinking patterns to begin with” but rather moves in precisely the opposite spirit. The instances above involve “hard” “psychological work” examining oneself and one’s relationships with others. It is for this reason that, as I previously noted, MAPS’ Rick Doblin says, “we believe that we are empowering people to heal themselves” and “[we are] teaching [sufferers] techniques that can translate from the MDMA state to the regular state, the non-drug state, about working with their emotions, not suppressing their emotions.” If anything, the former assertion is so agent-affirmative as to strike some theologians as Pelagian: People do not heal themselves; God alone heals. In any case, there is no indication here that MDMA or psilocybin is doing the work for patients or that the virtue acquired in the process is not their own. In a similar key are the aforementioned remarks by the ibogaine study participant:

you could safely say that iboga will give an opiate addict several months to a half a year of freedom from cravings and an expanded awareness. This gives the user a period of time in which to get his/her life together and learn to face things straightforwardly, directly, and honestly. Iboga will not do the work for you. However, it will help you do your own work. (Brown and Alper, 2018, 32)

Unlike most pharmacotherapies, psychedelic medicine does not require a daily, or even regular, regimen of medication. MAPS’ MDMA-assisted psychotherapy prescribes up to three doses (Burge, 2020) and most of the studies with psilocybin employ one or two (Ross et al., 2016; Carhart-Harris, et al. 2018). Similarly, the ibogaine work cited in this paper involved a single session with a “test” dose (to determine the severity of dependence), a “flood” dose, and a possible “booster” dose, all within hours of each other (Brown and Alper, 2018, 26). And, although evidence suggests that further ibogaine treatment may facilitate long-term abstinence (Schenberg et al., 2014, 998), as previously noted, ibogaine therapy typically involves one or two treatments (Brown, 2018). Nor does the medication in any of these treatments make the person a different person. Instead, these treatments work by challenging entrenched patterns that underlie patient behavior and experience, so as to help them acquire new wisdom.

The upshot of these arguments is that the two objections I have here considered—i.e. that psychedelic usage, and thus psychedelic medicine, is primarily hedonistic and entails the relinquishment
of reason—are misguided and therefore insufficient as a basis for ruling out the kind of inquiry this essay invites. Psychedelic compounds do not reliably deliver the hedonic desideratum and on many of the occasions where they do, this is not the primary motivation for taking them. Then, while the psychedelic experience does involve a kind of irrationality, it is more accurately conceived of as the kind that is in opposition to the idol that Balthasar calls the “delimited form of ratio in its characteristic closure.” In contrast, psychedelic medicine arguably coheres with and often supports the true rationality that Balthasar says transcends itself and that Kinghorn calls “God’s ratio.” For one, its biological explanations for psychological disorder do not engender pessimism about recovery or reduce persons to “symptoms,” thereby robbing them of the agency inherent to proper rationality and personhood. Second, its intervention with respect to suffering does not jettison freedom by distracting patients from signs to the suffering’s causes, nor do the substances step in and cultivate virtue for them, similarly revoking their agency.

VII. CONCLUSION

In this article, I have adumbrated a small sampling of the medical and psychological research being conducted with psychedelics. Studies like these begin continually and are getting considerable attention in the popular press. If the results of the ongoing work align with what a growing number of studies have already shown, some psychedelic compounds will soon become legal through one avenue or another, and the FDA has, in some cases, facilitated this process via its “breakthrough” designation. Doctors, scientists, policy makers, and government officials are already beginning to change their perspective on these substances. The question I have posed here is: What should Christian theologians say? The usual appeals to the illegality of psychedelics or to the authority of doctors will no longer do, as the law and expert opinion are currently in flux, and, in any case, neither have always proffered the best solution, as I have tried to demonstrate in at least the case of the latter. I have also delineated a cluster of reasons it is challenging to re-theologize the intoxication that even responsible psychedelic use entails as well as responded to what I take to be some of the stronger objections likely to emerge from a rigorous theological point of view. The point in all this is not to commend psychedelics to Christian theologians and practitioners or anyone else but to galvanize discussion about their theological significance and the appropriate Christian response to their renaissance in science, medicine, public policy, and culture.

In delineating the above features of the psychedelic experience and noting its implications for theology, Pahnke and Richards say, “there is an increasing need for contemporary theologians to include mystical consciousness in their rational reflections” (1966, 196). That was 1966. Work in the general direction they name here has indeed emerged since then, but, today, a more specific need is on the horizon. The revival of psychedelic research brings promising solutions to some of our most intractable medical problems. The task at present is therefore to conceptualize just how Christianity should evaluate psychedelics anew, in light of these developments. Hopefully, the theological will to meet this more specific version of Pahnke and Richards’ call emerges to accompany the evolution of thinking in the broader culture. If for no other reason, the theological community should be motivated by the fact that commentators with neither the training nor the interest in Christian theologizing will be only too happy to fill the silence about the spiritual significance of these compounds in the absence of thoughtful, constructive theology. But there is also further cause. Even if one ultimately decides that an intentional, even legally medical employment of psychedelics is incompatible with Christianity, the research suggests their use promotes some of its values: a productive approach to human suffering and the cultivation of joy, love, awe, and perhaps even worship. At very least, this merits a thoughtful theological response to the religious and spiritual questions the psychedelic renaissance poses.

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NOTES

1 This list reflects the more inclusive approach of those such as Rick Doblin (Pollan, 2018, 37) and Ben Sesma (2017, 34f.). Others are more restrictive, limiting the category to what are sometimes called the “classical psychedelics”: psilocybin, LSD, DMT, and mescaline. See, for example, Nutt (2012, 247).

2 See http://maps.org/research/mdma/ for the most current assessment.

3 The protocol involves three therapeutic sessions with MDMA, each prefaced by three preparatory sessions without it (Reid, 2019, 43-48ff.).

4 To understand MDMA's role in the therapy, contrast this 54.2% with the 22.6% success rate of those in the control group, who underwent MAPS's therapeutic protocol without MDMA (Mithoefer et al., 2019, 2739). However, as MAPS Founder and Executive Director Rick Doblin, and others have noted, the fact that the psychotherapeutic approach itself is at least temporarily curing nearly a quarter of chronic sufferers who have failed to respond to existing pharmacotherapies is already remarkable and, as he says, “demonstrates that we’re trying our best with the therapy” (Reid, 2019, 43-48ff.).

5 Again, it is noteworthy that 32% of the placebo-plus-therapy control group no longer qualified for the disorder at this point (Mitchell et al., 2021), demonstrating that MAPS’s therapeutic protocol, even without the drug, is a promising treatment, even if less so than the full MDMA-assisted psychotherapy.

6 See Table 2 in Brown and Alper (2018, 28).

7 This talk also serves as an accessible summary of the relevant data and issues.

8 At present, only observational studies have been completed for this disorder (e.g., Sewell, Halpern, and Pope, Jr., 2006 and Schindler et al., 2005), but several clinical trials are in progress.

9 The phrase “set and setting” was first used in print by Timothy Leary (for one such use, see Leary and Alpert, 1992, 11), though Pollan (2018, 151 and 190) notes that the concepts described by the phrase and their importance were first articulated by Humphrey Osmond and Abram Hoffer in the 1950s.

10 Foundational researchers of the relationship between psychedelics and religious experience, Walter N. Pahnke and William A. Richards explicitly cited this verse in describing the “deeply-felt positive mood” characteristic of the psychedelic experience. See Pahnke and Richards (1966, 180).

11 In addition to the medicalization being pursued through the FDA for MDMA and psilocybin, the illegality of psychedelics is, in other ways, loosening across the board. Oregonians, for example, recently passed legislation that would render psilocybin legal in the context of a licensed therapeutic, though not strictly “medical,” model (see https://healingadvocacyfund.org for details). Moreover, various cities—including Denver; Ann Arbor and Detroit; Washington, D.C.; Seattle and Portland Townsend; and several municipalities in both California (Oakland, Santa Cruz, and Arcata) and Massachusetts (Somerville, Cambridge, Northampton, and Easthampton)—have decriminalized, deprioritized, or reduced penalties in relation to psilocybin and/or other psychedelic plants and fungi, sometimes as part of a broader drug policy agenda. Neither medicalization nor full legalization, the measures in these cities involve steps such as reclassifying cases related to certain psychedelic substances or to all drugs as noncriminal or as lesser offenses, diverting funds away from investigating or prosecuting them, and eschewing or lessening the severe sanctions that would otherwise result from them. On the state level, Oregon has decriminalized all drugs, New Jersey has reduced penalties for the possession of psilocybin, New Mexico has allowed the cultivation (though not “manufacturing,” which includes “preparation” and “packaging”) of psilocybin-containing mushrooms since 2005 (Madrid and Bigelow, 2005), and Texas and Utah have passed bills calling for a workgroup to study the therapeutic use of several psychedelics. Moreover, psychedelic reform bills of various kinds are active in Georgia (Hitchens et al., 2022), Hawaii (Chang et al., 2022), Iowa (Shpley, 2022a, 2021b), Kansas (Coleman, 2022), Maryland (Carter, 2022; Moon and Cardin, 2022), Massachusetts (Miranda et al., 2021), Michigan (Irwin and Hollier, 2021), Missouri (Davis, 2022), New York (Meeks, 2021; Rivera, 2021; Rosenthal, 2021), Oklahoma (Pae et al., 2022 Phillips and Rosecrants, 2022), Rhode Island (Potter et al., 2022), Vermont (Cina et al., 2021), and Virginia (Adams, 2022, Hashmi, 2022) and bills proposing to allocate funds to study the matter have been introduced in Florida (Book, 2022, Greico, 2022) and Pennsylvania (Brown and Alper, 2022). Moreover, the FDA has also approved s-ketamine (aka esketamine), which is, along with r-ketamine (aka arketamine), one of two mirror image molecules that make up ketamine, in nasal spray form for treatment-resistant depression (Walsh, 2019). See https://psychedelicalpha.com/data/psychedelic-laws for the most current information on the continually evolving legal situation.

12 One only member of the co-therapist team utilized in MAPS’s protocol must be licensed (https://mapspublicbenefit.com/training/program-application-requirements/) and MAPS does accept applications to their therapy training from religious professionals.

13 For just a few examples, see the reference to “oceanic drunkenness” in PCHCW (2002, $165) as well as the same equation of alcohol and cannabis in evangelical protestant leader Piper (2014).

14 For discussion of both studies and others on this question, see Compton, Jones, and Baldwin (2016, 154–63).

15 The authors note that, despite this decrease, the prescription rate remained three times higher in 2015 than in 1999.

16 For a recent example, see Blank (1998, 121ff).

17 This trial resulted in a number of papers, including Carhart-Harris et al. (2018) and Roseman, Nutt, and Carhart-Harris (2018).

18 See https://healingadvocacyfund.org for details. Section 8, point (4) of the measure states, “the [Oregon Health Authority] may not require a client to be diagnosed with or have any particular medical condition as a condition to being provided psilocybin services” (http://oregonvotes.org/irr/2020/034text.pdf).

19 For a recent example, see Blank (1998, 121ff).

20 The word in the original languages of the two speakers would not, of course, have been identical to “dazzling,” since John Paul II’s “Homily” was in Italian, Hoffman’s account was in German, and “dazzling” is Norse. The comparison is interesting, however, from a semantic, if not an etymological, point of view.

21 For a few academic discussions, see Richards (2016, 104f); Cortright (1997, 198ff); Goldsmith (2011, 194–206); and Grof (2001, 308-19). More formally, a dense trove of “trip reports,” some in all their nightmarish particularities, is available at: http://erowid.org/.

22 Andrew Well tells the story of a reporter from The New York Times, who asked him about his views on drugs. He recommended she read his book on the subject, The Natural Mind, and, after doing so, she called him to say she found it curious and dated, the “product of another time.” When he asked what she meant, she replied, “Well, it is so optimistic.” (Grob, Huxley, and McKenna, 1998, 32).

23 Interestingly, early research suggests that psychedelic medicine might, however, impact personality. For example, two studies (MacLean, Johnson, and Grifllths, 2011 and Roseman et al., 2018) found a statistically significant increase in openness to experience, a domain of the NEO Personality Inventory (NEO-PI-R), following a high-dose (30 and 25 mg, respectively) psilocybin-assisted psychotherapy session and peruring for months (16 and 3, respectively). Results pertaining to an increase in openness to experience similarly exist for LSD (Lebdev et al., 2016) and Roseman et al’s psilocybin study also found an increase in extraversion and decrease in neuroticism. Finally, MDMA-assisted psychotherapy researchers found that, at the 12-month follow-up to their
protocol, participants showed a reduction in neuroticism and increases in agreeableness, openness to experience, and extroversion, prompting the conclusion that, "the effect of MDMA-assisted psychotherapy extends beyond effects on specific PTSD symptomatology, and fundamentally alters personality structure" (Mithoefer et al., 2018, 494). There are two caveats to such superlative pronouncements, however. First, the MDMA researchers note that "although many personality theorists would argue that personality traits are relatively stable constructs throughout much of adulthood and are not subject to change, certain personality features are associated with traumatic experience" (Mithoefer et al., 2018, 494). The implication here is that a possible reason the NEO-PI-R scores in this study changed rather than conforming to the usual trait stability over time is that the participants’ trauma had brought about a personality change that the MDMA-assisted psychotherapy simply reversed. Second, some personality psychologists have argued that the NEO-PI-R has ill-conceived foundations or is otherwise intractably suspect (see Block, 1995 and, blisteringly, Paul, 2004, 186ff.). A more constructive proposal offers that NEO-PI-R traits are merely one layer of personality, alongside a second layer comprising goals and values and a third layer comprising identity in the form of a "self-defining life story" (McAdams and Walden, 2010, 53-4). Either way, the significance of these two caveats is that any suggestion of a psychedelic-assisted psychotherapy that "fundamentally alters personality structure" must demonstrate that the treatment is not merely reversing trauma-instilled traits and that it changes the fundamental structure of personality elements not captured by the NEO-PI-R.

24 With regard to the former, many excellent inquires exist on the failure of the US federal government’s “War on Drugs” to meet even its own stated aims, much less those that might be desired from an advanced and humane society. For just a tiny sampling, see Nutt (2012, 264–91); Hars (2015); J. P. Gray (2001); and M. Gray (2000).

25 For a few of the more influential studies, see Turner (1995); McIntosh (1998); and Bernard McGinn’s Presence of God series.

REFERENCES


