1

2

I respectfully acknowledge that I work and live in Utah, which is named for the Ute tribe.

Utah is traditional and ancestral homeland of 8 distinct tribal nations, including the Shoshone, Paiute, Goshute and Ute peoples.

I do my work with passion and with the hope it will benefit and respect this land and the enduring relationship that exists between the indigenous peoples and their traditional homelands.

2

IT'S NOT ABOUT THE FOOD.

- It's not JUST about the food.
- Symbolically, what do the symptoms represent?
- Eating disorders are a window into the struggle of the soul.
- Part of the work in recovery is to uncover the meaning and the purpose behind the symptoms.

3

Foundational Assumptions About Eating Disorders

1. People don't choose eating disorders. Nobody wakes up one day and says "I'd like to have anorexia," or if they do, they're seriously misinformed. Eating disorders are not choices, but serious biologically influenced illnesses.

2. Eating disorders are well-intended. The reason someone develops the disorder and keeps it are very different things. An individual may consciously decide to purge or over-exercise the first time or two they do it, but before long, it becomes a deeply-ingrained subconscious pattern that takes on a life of its own. The development of a full-blown eating disorder seems to be the perfect storm of biological and environmental factors.

3. Eating disorders are complex, multi-faceted illnesses that require intensive treatment. Thankfully, the behaviors seen in these illnesses are learned behaviors, and therefore can be unlearned, but it takes time. Everyone has the capacity for full recovery.

4

Annales Médico-psychologiques, revue psychiatrique
Volume 179, Issue 8, October 2021, Pages 777-781

History of psychiatry

Psilocybin in the treatment of anorexia nervosa: The English transition of a French 1959 case study

La psilocybine dans le traitement de l'anorexie mentale : la traduction en anglais d'une étude de cas française de 1959

Vincent Verroust [a, b, ✉], Rayyan Zafar [c], Meg J. Spriggs [c]

Psilocybin is a psychotropic molecule that is a partial agonist of serotonin 2A receptors and is the main psychoactive compound in hallucinogenic mushrooms. After the observation in 1953 in Mexico of ritual practices involving ingestion of such mushrooms, psilocybin was chemically characterized and synthesized in 1958 thanks to the collaboration between the *Muséum national d'Histoire naturelle* in France and the Sandoz pharmaceutical laboratories in Switzerland. The interest of this substance in psychiatric therapy was then evaluated for the first time at the Sainte-Anne Hospital in Paris, by the team of Professor Jean Delay. Among the patients who received this substance was a 35-year-old woman who was hospitalized for compulsive manifestations emblematic of anorexia nervosa and who experienced an immediate and lasting improvement. The original 1959 article (published in the *Annales de la Société Médico-Psychologique)* gives details of the patient's family background, biography and clinical examination. It then outlines the observations after two injections of psilocybin four days apart, in particular the autobiographical verbal statements that allowed the patient to understand the psychogenesis of her illness. After a long hiatus, psilocybin is once again the subject of medical research, with clinical trials now underway assessing psilocybin in the treatment of anorexia nervosa (NCT04505189; NCT04052568; NCT04661514) and this 1959 case study, is the first known demonstration of the safety and efficacy of psilocybin treatment of anorexia nervosa. This case study thus provides an interesting insight into possible therapeutic mechanisms and is of great interest to the field moving forward.

5

PARTS WORK

Parts work is at the foundation of psychotherapy modalities like Internal Family Systems, Ego State Therapy, Voice Dialogue, Gestalt & Jungian archetype analysis.

Parts work helps us see that our apparently solid self actually consists of a variety of 'parts'. You can think of them as little people inside us. Each has its own perspective, feelings, memories, goals, and motivations.

They can function as a cohesive whole, or sometimes become fragmented or create conflict with each other and with the core Self (the confident, compassionate, whole person at the heart of every individual).

We can restore mental harmony by healing wounded parts & changing the dynamics that create discord among these parts.

6

7

What is Internal Family Systems?

7

INTERNAL FAMILY SYSTEMS (IFS)

IFS is a form of psychotherapy developed by Richard Schwartz in his therapy sessions with individuals with eating disorders.

It acknowledges the innate multiplicity of the mind and starts from the premise that the mind is composed of distinct subpersonalities or "parts“, i.e. self critical voices, pessimism...

→ The IFS model allows space for all parts to be seen, heard, witnessed, and healed despite how polarized/conflicted some may be with others.

8

Five Basic Assumptions of IFS

1. The human mind is subdivided into an unknown number of parts.
2. Each person has a Self, and the Self should be the chief agent in coordinating the inner family.
3. There is no such thing as a “bad part.” Every part has a positive intent for you, no matter how problematic it might be. IFS aims to help parts discover their non-extreme roles.
4. Personal growth & development leads to growth & development of the internal family. Reorganization of the internal system may lead to rapid changes in the roles of parts. Adjustments made to the internal system will result in changes to the external system and vice versa. Therefore, both the internal and external systems need to be adequately assessed (i.e. simultaneously working on inner life, and outer life).
5. You have all the resources you need inside of you. However, you may not always have access to those resources due to a polarization of inner parts. Similar to ‘external’ family issues, the internal family can be locked in combat, using up emotional energy on ‘drama’ that could be used in resolving problems & maintaining balance.

9

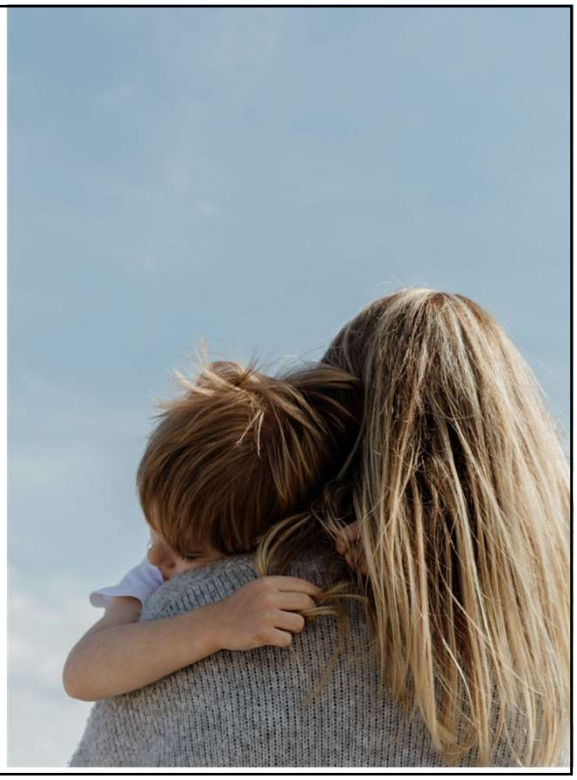
This is fundamentally different from the way we ordinarily relate to our parts.

Usually when we become aware of a part, the first thing we do is evaluate it. Is it good or bad for us?

→ If we decide it is good, we embrace it and give it power. We act from it.

→ If we decide it is bad, we try to suppress it or get rid of it. We tell it to go away.

However, this doesn’t work. You can’t get rid of a part. You can only push it into your unconscious, where it will continue to affect you, but without your awareness.



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In IFS, we do something altogether different & radical.

- We welcome all our parts with curiosity and compassion.
- We seek to understand them and appreciate their efforts to help us– but we don't lose sight of the ways they may be causing us problems.
- We develop a relationship of caring and trust with each part, and then take the steps to release it from its burdens so it can function in a healthy way.

11

In the IFS system, there are two primary types of parts—protectors and exiles.

PROTECTORS
The parts you usually encounter first in exploring yourself. Their job is to handle the world and protect against the pain of the exiles.

EXILES
Young child parts that hold pain from the past, pushed out by protectors.

They're held in a sort of mental prison, but want to be heard, and they want their story told.

For example, Sally has a part that says, "You can't be successful at your ambitious goals. Who do you think you are?" This is hurtful & prevents her from taking action in her life. But when she got to know this part in IFS work, she discovered it was actually afraid she'd be punished if she tried to assert herself—the "protector" was trying to help her avoid pain.

In the above example:

- Sally had a protector that said, "Who do you think you are?" Although this message has prevented Sally from taking action as she'd like, it's trying to keep her safe from the pain of an exile part who felt afraid.
- Exile: It turned out Sally had been punished by the nuns at her strict Catholic school whenever she became too visible, so from then on in her life, she had a terrified exile and a protector who tried to keep Sally invisible.

12

With eating disorders, there can be "extreme polarizations" between parts

- They showed up to keep the system safe and far away from feeling pain
- "What's in the way, is the way" – the obstacle is the path
- Start with the part that is repulsed by the eating disorder
- Be an *harbinger of hope* to the protector parts

13

Parts take on extreme roles because of what has happened to them in the past.

Protectors: `Managers`

Responsible for maintaining a functioning level of consciousness in daily life by warding off any unwanted or counterproductive interactions, emotions, or experiences resulting from external stimuli.

Protectors: `Firefighters`

Serve as a distraction to the mind when exiles break free from suppression. In order to protect the consciousness from feeling the pain of the exiles, firefighters prompt a person to act on impulse and engage in behaviors that are indulgent, addictive, and oftentimes abusive. Firefighters may redirect attention to other areas such as sex, work, food, alcohol, or drugs.

Exiles

Are most often in a state of pain or trauma, which may result from childhood experiences. Managers and firefighters exile these parts and prevent them from reaching the conscious level so that proper functioning and preservation are maintained.

14

The 8 C's of Self

15

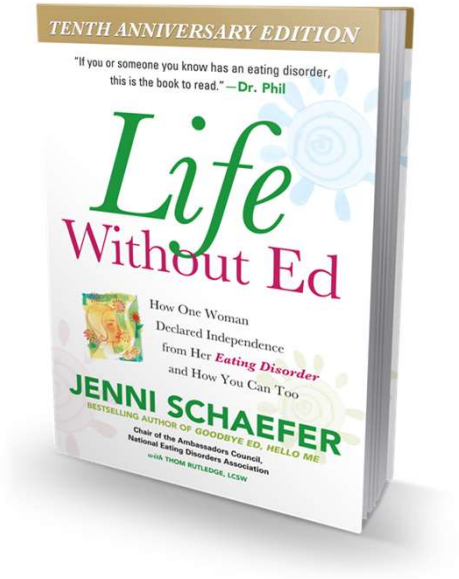
We can't get rid of the part, but we can get rid of the burdens.

An IFS approach takes the stance that there are "no bad parts".

It's about befriending parts and learning to relate to them in a new way.

- Befriending the part ≠ agreeing with it's methods
- Befriending the part ≠ waging a war against it

It's a stance of compassion & understanding.



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Unburdening:

The process of releasing the extreme emotions and/or beliefs that the parts have been carrying.

- ANCESTRAL BURDENS
- SOCIAL CONDITIONING
  - Diet culture
  - Thin beauty ideals
  - Misogyny
- ATTACHMENT WOUNDS

17

"After asking what brought a client to treatment, I ask what their part that wants to restrict/binge says about being here. Recognition of the firefighter's existence, and the invitation for it to speak, is both a profound and a beautiful moment. It is also the first step in befriending that part."

– Mary Kruger, IFS Therapist

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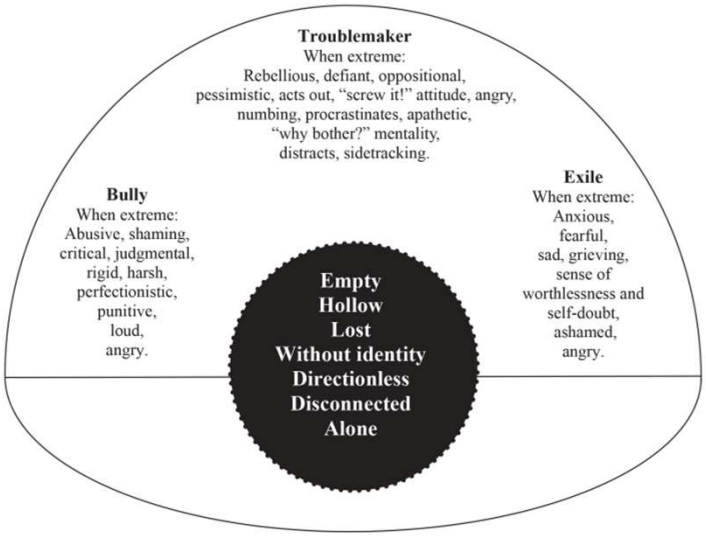
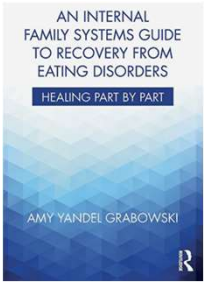
Lack of Self and Parts Out of Balance





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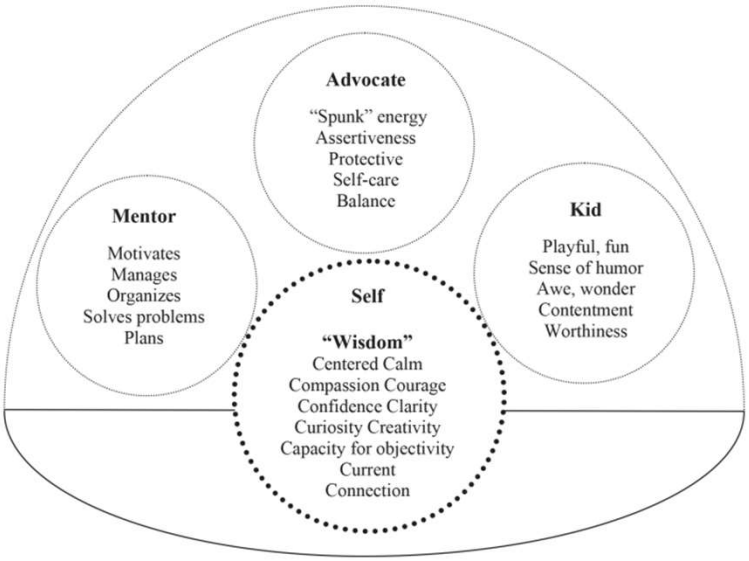
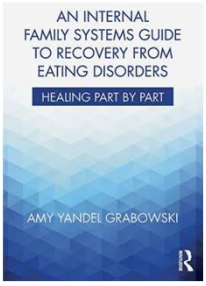
"Self-led" System: Self and Parts in Balance:





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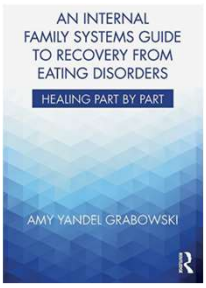
On the continuum of "Parts-led" to "Self-led"



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IFS in Action

22

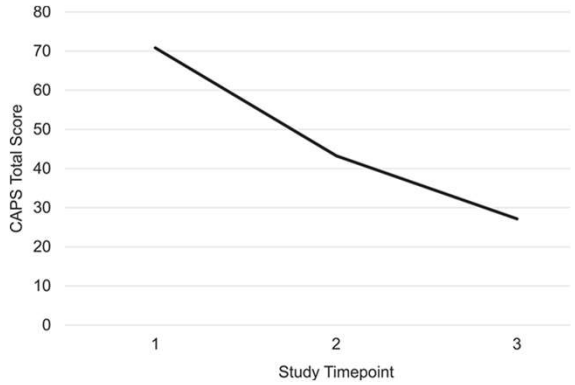
PILOT STUDY

IFS Therapy for Survivors of Multiple Childhood Traumas

17 adults with PTSD & history of multiple childhood traumas participated in a trial of IFS, receiving sixteen 90-min IFS sessions and completing 4 evaluations (pre-, mid-, and post-treatment, and 1-month follow-up).

RESULTS

- Significant decreases in symptoms of PTSD, features of PTSD (e.g.,dissociation, somatization, affect dysregulation, self-perception), as well as depression across the study period.
- Medium effect size observed for self-compassion (d=0.72). Small to large effect sizes observed for indicators of interoceptive awareness (d=0.27–1.21).
- Results provide support for IFS as a promising practice for treating PTSD in adults with a history of childhood trauma.



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Pilot Study: IFS for PTSD and Comorbid Conditions

This pilot study (not yet published) enrolled 13 subjects who were diagnosed with PTSD and completed the 16 sessions of IFS therapy.

RESULTS

- Only one participant still qualified for the diagnosis at the end of the study and at the one-month follow-up.
- That is, 92% of the participants no longer met the PTSD criteria, which translates into a effect size of -4.46.
- In addition, there were significant decreases in depression, affect dysregulation, dissociation, disrupted self-perception, interpersonal relationships, and systems of meaning.

Authors: Hilary Hodgdon, Ph.D., Frank G. Anderson, M.D., Elizabeth Southwell, B.A., Wendy Hrubec, LICSW, Richard Schwartz, Ph.D.

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Ketamine

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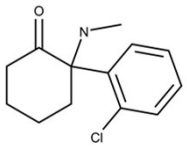

HISTORY OF KETAMINE

1962	Developed by Calvin Stevens at Parke Davis Labs
1965	Professor Edward Domino conducts 1st human studies Calls ketamine a potent psychedelic; coins the term “dissociative anesthetic”
1970	Approved for human use by the US FDA in 1970 for anesthesia Widely used in Vietnam war as a battlefield anesthetic
2000	First controlled study of ketamine for major depressive disorder (MDD)
2019	Spravato (esketamine) nasal spray FDA approved for treatment-resistant depression (TRD)

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USES OF KETAMINE

ON LABEL USES

Anesthesia

OFF-LABEL USES:

Chronic Pain
Major depressive disorder
Suicidality
Post-traumatic stress disorder (PTSD)
Bipolar I and II depressive phases
Obsessive-compulsive disorder (OCD)
Psychological reactions to physical illness
Personality disorders
Substance use disorders
Eating Disorders

27

NMDA RECEPTOR BLOCKADE

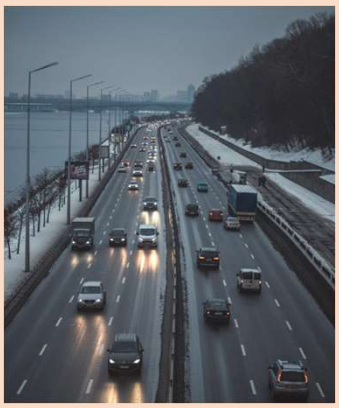
MECHANISM

Blocks NMDA receptors, leading to GABAergic inhibition & a surge of glutamate

▸

EFFECT

Rapid improvements in mood by restoring glutamatergic signaling



ANALOGY

Wakes up dormant neurons like jump starting a car battery; lets them communicate freely

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Ketamine's Uses in Psychiatry

PSYCHEDELIC

Ketamine-Assisted Psychotherapy (KAP)

IM or IV journeys in the ketamine room, with brief therapy before and after, and psychotherapeutic integration sessions in between

PSYCHOLYTIC

Ketamine-Assisted Psychotherapy (KAP)

Lozenges or nasal spray taken before the session to facilitate openness & deeper work, with the therapist present for the entire session.

PSYCHIATRIC

Ketamine or Spravato (esketamine) as a medical intervention.

In office, usually starting at twice a week then decreasing frequency as tolerated. Home maintenance dosing optional (lozenge or nasal spray).

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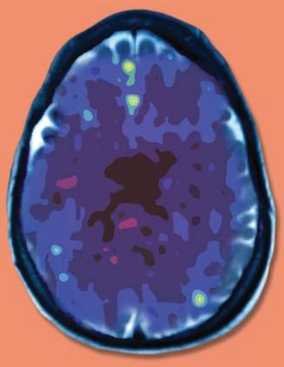
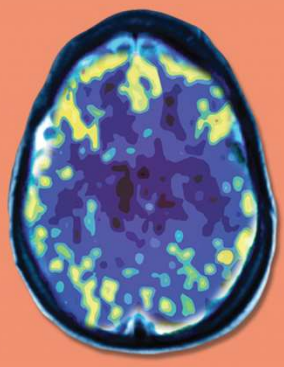
Brain Activity is Reduced During Depression

DEPRESSED



NON-DEPRESSED



A PET scan measures vital functions such as blood flow, oxygen use, and blood sugar (glucose) metabolism

Source: Mark George M.D. Biological Psychiatry Branch
Division of Intramural Research Programs, NIMH 1993

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LATERAL HABENULAR BURST MODE

MECHANISM

Turns off "burst mode" in the lateral habenula (the "anti-reward" center)

▸

EFFECT

A break from stress mode: facilitates emotion processing, reduces avoidance of negative emotions

ANALOGY

Giving a dose of ketamine is like extinguishing the "fire" of stress in the brain

31

BDNF & NEUROPLASTICITY

MECHANISM

Stimulates BDNF, leading to neurogenesis & new connections

▸

EFFECT

Neuron growth & window of opportunity for therapy* AKA neuroplasticity, which strengthens & creates neural connections

ANALOGY

Ketamine is like fertilizer for neurons

*Ideally done during the 24-48 hour window of optimal neuroplasticity after ketamine dosing

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LIMBIC/CORTICAL INTERRUPTION

MECHANISM

Interrupts connection between cortex & limbic system

▶

EFFECT

Time out from ordinary mind (↓ rumination), down regulation of Default Mode Network leading to ↑ cognitive flexibility

ANALOGY

Rebooting your computer

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Ketamine-Assisted Psychotherapy

34

Psychedelics, including ketamine, create brain states that can accelerate therapeutic processes & make eating disorder interventions easier to receive.

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Ketamine-Assisted Psychotherapy (KAP)

In moderate doses, ketamine has psychedelic effects, which can lead to transpersonal experiences, clarity and insight into one's struggles, spiritual experiences, including a sense of meaning and interconnectedness.

KAP is comprised of three parts:

1. PREPARATION: 1-3 sessions
2. DOSING: Intention-setting, then administration, & brief processing after
3. INTEGRATION: 1-3 sessions of psychotherapy 24-48 hrs after

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KAP for Eating Disorders

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KETAMINE FOR EATING DISORDERS

Indication	Study Sample	Treatment Protocol	Results	Citation
Comorbid anorexia and depression	n = 1 Age: 29	9 IV infusions at 0.5mg/kg over 40 min	Partial remission/reduction in depression and suicidality	Dechant et al., 2020
Anorexia (restrictive type & binge/purge type)	n = 15 Avg Age: 33.3	2–15 IV infusions at 20 mg/h for 10 hr + nalmefene	9 responded & had prolonged remission with 2-9 infusions. Response associated with a decrease in compulsion score.	Mills et al., 1998
Bulimia (binge/purge type)	n = 1 Age: 21	18 IV infusions at 0.5 mg/kg over 40 min + therapy	Complete and sustained remission of ED symptoms	Ragnhildstveit et al., 2021
Anorexia & binge/purge ED with TRD	n = 4 Avg Age: 36.8	5–9 IV or IM doses at 0.5 mg/kg titrated to 0.9 mg/kg over 30–90 min	Clinically meaningful changes in depression and modest changes in anxiety & disordered eating.	Schwartz et al., 2021
Comorbid anorexia and depression	n = 1 Age: 29	4 infusions at 0.75 mg/kg titrated to 1.2 mg/kg over 45 min + keto diet	Reduced depression & obsessive/compulsive tendencies after dose 4. Complete and sustained recovery for 6 mo post-treatment	Scolnick et al., 2020
AN-R and EDNOS-BP + comorbid depression; AN-BP; BN-BP	Review	IV and IM ketamine	Results were encouraging & suggest therapeutic value—but are limited to case series & reports on anorexia. Further research is needed.	Ragnhildstveit et al., 2021
Anorexia or bulimia + comorbid depression & anxiety	n = 5 Avg Age: 32.2	4 weekly IM injections in a group-setting	4/5 had significant depression improvements. 2/5 had significant improvements in anxiety.	Robison et al., 2022

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Treatment of compulsive behavior in eating disorders with ketamine

20mg/h of IV ketamine for 10h with 20mg twice daily nalmefene (as opioid antagonist) to treat 15 chronic ED patients, all resistant to several other forms of treatment.

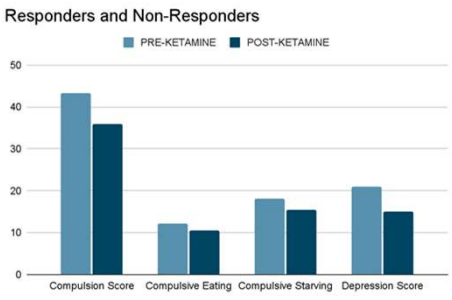
RESULTS:

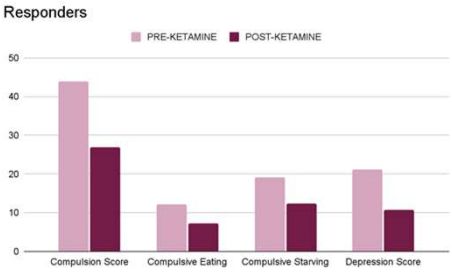
9 (responders) showed prolonged remission when treated with 2-9 infusions at intervals of 5 days to 3 weeks.

→ Clinical response was linked to a significant decrease in Compulsion: Before ketamine: 44.0 +/- 2.5; After ketamine: 27.0 +/- 3.5

6 patients were non-responders

→ No significant response to at least 5 infusions





(Mills et al., 1998)

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Group-Based KAP (G-KAP) for eating disorders

Novel group-based KAP protocol developed and tested out at a residential eating disorder treatment center (Center for Change):

- Groups of 4 adults with weekly group preparation, processing and integration + individual integration sessions
- Collaborative care model with G-KAP integrated with multidisciplinary team (medical, dietary, specialized ED therapy, family therapy...)

STUDY OUTCOMES

- Improvements in depression & anxiety (PHQ-9, GAD-7 scores)
- G-KAP was well-tolerated and safe
- Feasibility of implementing G-KAP for patients in residential treatment
- Reduced cost when using a group-based format
- Paper published in May 2022

(Robison et al., 2022)

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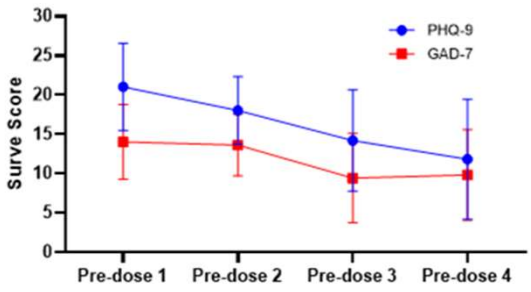
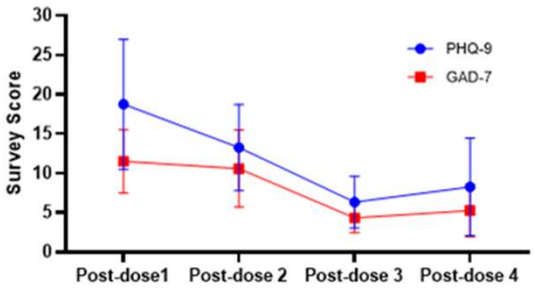
RESULTS: G-KAP for eating disorders

Mean pre-dose survey scores



Mean 4-hour post-dose survey scores



FIGURES: Mean pre-dose and 4-hour post dose PHQ-9 and GAD-7 scores for the 5 participants receiving IM ketamine treatment across the 4-week study period

PHQ-9 = Depression score GAD-7 = Anxiety score

(Robison et al., 2022)

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"Trying ketamine allowed me to see the possibility of a life I could have. While the effects did not last, my very first experience snapped me out of a state of life-long, deep disconnection that I didn't even know I had been experiencing. Suddenly, I was able to live in the world in the way people had always described it. Though I am still trying to figure out how to attain that level of connection after catching a glimpse, that one experience was so essential. I could finally feel hunger and fullness cues. I felt what it's like to live in a body, instead of living a short distance from it. I felt connected to others and genuinely cared about their well-being. I felt human for the first time in a long time."

– G-KAP Participant

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KAP for Anorexia Nervosa
with caregiver support

Therapy sessions focused on developing of self-regulation and emotion-processing skills in order to increase client self-efficacy & confidence in moving through stress/distress.

Emphasis placed on caregiver/family support and involvement.

PROTOCOL

Preparation: 2-3 sessions (caregiver involvement if appropriate)

Ketamine dosing: Intention-setting before & processing after

Caregiver skills development: Emotion coaching sessions provided to caregivers concurrently

Integration: 1-2 sessions (caregiver involvement if appropriate)

(Robison et al., UNPUBLISHED DATA)

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STUDY RESULTS

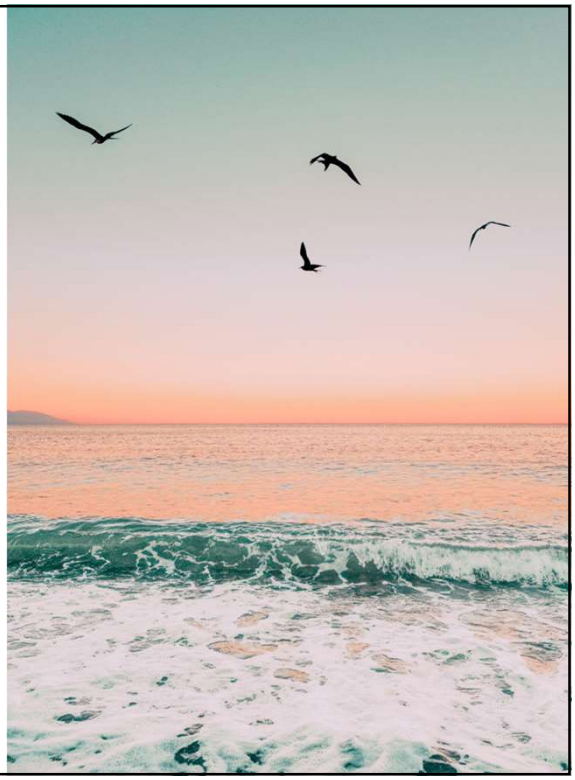
5 patients with moderate-severe anorexia attended 9 total sessions.

Ketamine was delivered IM with dose ranges of 40-100mg.

Caregivers/support persons attended two virtual coaching sessions to learn & practice skills to support the patient at home.

Scale	Avg Score Before	Avg Score After
Depression (PHQ-9)	16	11.8
Anxiety (GAD-7)	14.2	9.2
Eating Disorder (EDE)	4.15	3.3
Embodiment (EES)	68.4	80

(Robison et al., UNPUBLISHED DATA)



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Eating Disorders & Parts Work

45

Rationale for pairing IFS with ketamine

These parts are a natural aspect of our psychological make-up, and as such, awareness of these parts often emerges during psychedelic therapy.

→ Doing Parts Work as preparation gives clients a framework for understanding parts that may emerge in sessions.

→ Seeing the nature of our parts can help us be more compassionate towards aspects of ourselves we have difficulty embracing.

→ Parts work paired with ketamine increases self-awareness, integration, and feeling more complete or whole.

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It is completely okay to examine what "good" things your eating disorder did for you, the things that kept you holding onto it, such as:

- A way to instantly numb out
- A means to separate from reality and escape stress
- A sense of having a magic solution for controlling body size

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Eating disorders are maintained as patients cognitively associate the eating disorder with being able to manage emotions.

Schmidt & Treasure (2006) proposed a model of inter- and intra-personal factors that maintain anorexia:

- Self-starvation communicates suffering on the body, which elicits concern & intervention from others while dulling the body's capacity to experience emotions.
- During early stages, caloric restriction is maintained by the reinforcing effect of relief from overwhelming or intolerable emotional experiences; i.e., starvation is positively reinforced.

Emotional avoidance is achieved by focusing on rigid adherence to calorie/weight/exercise rules.

→ Focusing exclusively on food is associated with a downgrade in emotional salience. Many patients report they feel numb to emotional experience as well physical sensations of exhaustion, hunger, & so on.

→ Powerful pro-eating disorder beliefs are maintained as patients cognitively associate their pathology with controlling emotions that have long felt unmanageable.

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ADDRESSING IDENTITY

A unique challenge in treatment is rooted in difficulty with de-identifying from one's own eating disorder.

Bowlby et al. (2012) studied psychotherapists with histories of eating disorders, investigating their work with eating disorder patients & how they viewed recovery. They conducted interviews with 13 female participants. Six different themes regarding perceptions of recovery emerged, including:

- That recovery involves changing attitudes toward the self
- That recovery requires de-identification with the illness
- That developing a sense of purpose is essential to recovery

Most participants discussed their challenges in fully accepting the notion that their eating disorders were separate from their identities.

They expressed finding security in their eating disorders, fearing the loss of specialness in recovery, & struggling to let go of an important part of their emotional world & self-history by prioritizing recovery.

> "I think giving up the identification with the eating disorder is something people really struggle with. It is giving up the fantasy of special-ness. Who am I if not eating disordered? What makes me special and how do I get attention? It is hard to redefine through other things, less noticeable things."
>
> (Bowlby et al., 2012, p. 7)

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De-identification with the eating disorder, conceptualizing recovery as battling, divorcing from, or killing off "Ed" can be distressing when one has come to weave Ed into the fabric of their self-concept.

IFS takes a different approach: "NO BAD PARTS"

Rather than deidentification with the disorder, the IFS model encourages patients' acceptance of all parts of themselves, no matter how destructive.

> "Perhaps paradoxically, IFS therapists find that the more clients accept those parts, the more they change. In fact, in many cases, it is the lack of acceptance (in the form of striving for change) that becomes their biggest obstacle."

(Schwartz, *"Moving from Acceptance Toward Transformation With Internal Family Systems Therapy"* 2013)

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Going for a New Role

- The goal of a "parts" approach is not to get rid of the eating disorder, rather to set the "part" free from the disordered eating role it took on.
- Eating disorder behaviors are seen and experienced as "parts" that have picked up the role of disordered eating in an attempt to protect and help the system survive.
- Ask the protector parts: "Of all the things you could do, in the system, what would you do instead?"
- From the IFS perspective, recovery is much more than "fixing" the body weight and stopping disordered eating behaviors—it's about regaining Self-leadership in the system.

  → This allows for parts to shift out of roles that are not best for the whole system long-term.

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Accessing the True Self

The goal is to learn ways of accessing Self-Energy, the true essence at the core of each individual.

The Self views eating disorder parts with compassion, openness, and curiosity.

When an ED part builds a connection with Self, the part can let go of some of its intensity and let Self in to help with its fears, concerns, and extreme role.

Acting from a Self-led place allows clients' parts to become less reactive, trust Self more, and stop overpowering the whole system by having the client constantly blended with eating disorder thoughts, urges, and behaviors.

The process of becoming more familiar with what being in Self feels like is an ongoing journey for unburdening the system and becoming more balanced as a complete System.

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Concluding Thoughts

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Integrating ketamine-assisted therapy within conventional treatment models:

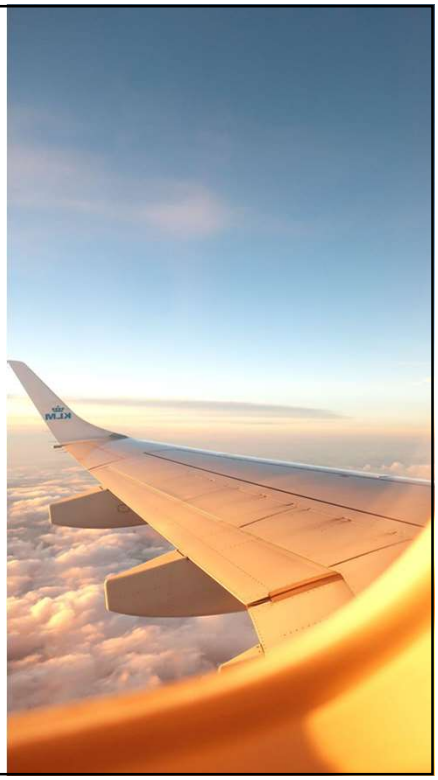
Treatment of ED is unique due to the medical, nutritional & psychological needs of the person.

UNIQUE PREPARATION CONSIDERATIONS:

- Medical & safety screening needs to be ED-informed
- Dietary preparation for certain substances (i.e. fasting before ketamine)

MULTIDISCIPLINARY TREATMENT TEAM

It's important for eating disorder clinicians to be involved in the preparation, integration & safety aspects of treatment.



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The Potential of Ketamine-Assisted Psychotherapy for Eating Disorders

Despite our best efforts, there remains a need for new treatment strategies to help those for who have not successfully responded to conventional treatments

Ketamine therapy & conventential treatment modalities don't need to be mutually exclusive in eating disorder treatment:

→ Consider them adjunctive, to reduce fears related to recovery, increase flexibility & openness so ED-specific interventions are easier to receive

Though ketamine may be generally safe from a medical perspective, careful medical and psychological screening and monitoring is important

In my opinion, it's a worthwhile pursuit:

→ I've witnessed first-hand the powerful healing that can occur for those suffering from mental health issues & for whom other methods have not been effective

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Thank You.

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Appendix

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