inSocialWork Podcast Series
University of Buffalo School of Social Work

Episode: A Conversation About the Place of Spirituality in Social Work

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Prof. Peter Sobota [00:00:12] Pools of sorrow. Waves of joy are drifting through my open mind. Possessing and caressing me I know you expected me to go the easy route in reference. Lucy in the sky with diamonds. But I thought John Lennon's Across the Universe captured a charm from the UB school of social work. Welcome to In Social Work. Hi everybody. It's good, as always to have you on introspection, powerful insights, shifts and perspective and emotional release. Start after goals of many therapeutic interventions. The conversation around the use of psychedelic assisted psychotherapy has moved us into a much needed debate amongst social workers, mental health professionals, researchers and users of psychedelics. The debate can be fact and evidence driven, and sometimes steeped in unsupported skepticism and a value laden perspective, with an added dose of myth and misinformation. On today's show, we'll speak with a social worker who's an educator, trainer and practitioner of psychedelic assisted psychotherapy. Brooke Scott will introduce us to the core ideas and evidence associated with psychedelic assisted therapy or communities. This start will address the concerns the social media with training therapists and preparing social workers who, by the way, happen to be the largest providers of mental health services in the United States to provide in their educational curriculums. No doubt there is plenty of room for additional and longer term research and evidence, but brochure workers would be wise to be open minded about the potential benefits of Pat for mental health conditions. Let's be fair, bright treatments for depressive disorders, post-traumatic stress disorder and substance abuse do not exactly have ideal outcome. Brooke Scott, MSW, is the program manager at the Columbia School of Social Work Psychedelic Therapy Training program and an adjunct lecturer there. She is also a practicing therapist at Goldman Psychology in New York City, where she offers group and individual ketamine assisted psychotherapy. Brooke Scott. Hi, and welcome to Social Work.

Brooke Stott [00:02:35] Hey. Thank you so much for having me.

Prof. Peter Sobota [00:02:37] Oh, no. No, thank you for for agreeing to talk with us. And before we get going, I know you're based in, Manhattan. And I have a question for you. After a terrific start, what the heck is going on with the Yankees?

Brooke Stott [00:02:54] I wish I could answer that question. I wish I had the slightest clue. I honestly don't follow baseball and couldn't answer for you.

Prof. Peter Sobota [00:03:03] Okay. All right. I guess that's fair. And at this point, I wish I didn't care because things the wheels have come off, so I don't I don't know what's going on. So again, thanks for joining us. And for taking the time and before we dive into our, topic for, for today. I always start the podcast. Especially when we have social workers on and ask them if they would be willing to kind of briefly. Actually, if you could tell us how you first found yourself, you know, being interested in the field of social work and then how you

got, interested in, you know, psychedelic assisted therapies. So would you be willing to give us a, kind of a brief journey through that? Yeah, probably much longer story, but, yeah.

Brooke Stott [00:03:56] If I can get the highlights. All right. Great. Yeah. So, you know, with social work, I think I originally it was probably around 2008 the first time at that at that point in my life I was in like substance use recovery. And I was considering, you know, is substance use counseling something I would want to do full time? And so I, I started going through the process of applying to a social work program, where I was and, you know, relatedly, you know, I think I was treating a lot of, of, like, toxic shame and, and gender dysphoria and things with, with substances during, you know, my undergrad time and early adulthood and, you know, my GPA wasn't, wasn't very good. And my undergrad, and so I kind of had some reservations, and I actually ended up backing out of that around 2007, 2008. Went kind of to California, had had some adventures and did all that. And then, you know, again in like 2014, I, I was starting to access gender affirming care and, you know, seeing a therapist who was a social worker, and she had made some recommendations about it. And so, again, I kind of started looking at programs and going to info sessions, and I backed away once more. And then finally and, maybe 2017, I decided to take like a non matriculated master's level social work class just to prove that I could do the work and and get my GPA up. And that went really well. And then I applied to a program, at Salem State in Massachusetts. Indeed, there at the time they had a Saturday MSW program. So I was kind of working in the field and, going through the MSW program. So that was kind of how I got into social work. You know, the psychedelic piece. I was probably 17 when I started, you know, engaging with psychedelics and in different ways. And I think, you know, a lot of my earlier use would fall under the umbrella of recreational. But I don't love using that term because I think, you know, oftentimes the intention might might be recreational with it. But yeah, you know, the experience that's, that's produced by it, isn't necessarily recreational. And kind of what I mean by that is like, you're going to be confronted with things that they need to be confronted with about their life, about who they are, about how they're living in, you know, the environment might not always be conducive to to processing that in a therapeutic way. But nonetheless, people have transformative experiences and, and they grow in those settings. And so, you know, a lot of my, my earlier use looks like that. And then a little over ten years ago, I spent six months in Peru, working at an ayahuasca retreat center, kind of co facilitating with, you know, there would be people, ayahuasca, who would lead the ceremonies. But often there's language barriers and there's other things. And so it'd be a matter of people who are having a hard time during ceremonies of, you know, sitting with them, kind of coaching them, helping them get to the bathroom and just kind of coordinating things with guests in between in between the ceremonies in, you know, I would say over the last now, almost 25 years, psychedelics have been really, really central to my own growth and development in my story of who I am. And I didn't anticipate, you know, until a few years ago that it would be able to come full circle and that the world.

Prof. Peter Sobota [00:07:33] Would catch up with you. Right? Right. Yeah.

Brooke Stott [00:07:36] And so, fortunately, you know, a few years ago, I went through, CIA, California Institute of Integral Studies, psychedelic assisted therapy, certificate program. And I've since done, done quite a few other trainings, in the area and, you know, came into an opportunity to be in this field full time. You know, both with my work at Columbia and, and as a practitioner myself.

Prof. Peter Sobota [00:08:01] Yeah. Well, thank you so, so thank you so much. I, you know, asking this question was one of my better ideas. I mean, these people tell some really amazing stories. And, apparently you and social work were not going to be denied. That was obviously one way or the other.

Brooke Stott [00:08:20] Was it?

Prof. Peter Sobota [00:08:21] It was going to happen. Yeah. And you know, I was listening to and you know, I, I, I've been an academic for over 20 years now. So I used to be on an admissions committee and I would read applications and and I'm not just complimenting you because you're our guest today, but I have to say, and I'll probably get in trouble for this, but I have to admit that many social workers have interesting stories. And also, our nontraditional students are frequently some of, like, the most interesting students. We we have not that we don't have terrific students in their mid to early 20s, but, there is something to be said. And I can say this as an older person and there's something to be said for being alive for a little longer sometimes. Yeah, definitely. Yeah. So thank you. I really do appreciate that. And the other comment I wanted to make was, I think, you know, we'll talk about this. I'm sure, I'd be willing to bet, but we're, you know, people have there's a morality involved with drug use of any kind, unfortunately. Still, but I think a lot of people forget that we as a species have been, I think, seeking to alter our consciousness, probably for as long as we've been walking around. So these are these are not, you know, easy or even new ideas. And I think we've we've complicated them with misinformation and, judgment. Anyway, that's enough, all right. I got to stop, as you know. Yeah. This is part of my interests. I, I'm looking forward to talking with you. So let's lay out maybe the playing field for folks maybe, like me, who really don't know a ton about, psychedelic assisted treatment. I'm going to start calling it Pat because I'm never going to get that out on a regular basis. But if we could start with some definitions. So here's a very simple one. What is it? What is psychedelic assisted treatment or what would that even be? What you call it?

Brooke Stott [00:10:38] Psychedelic assisted therapy.

Prof. Peter Sobota [00:10:40] Therapy.

Brooke Stott [00:10:40] Oh. For this. Yeah. For this specific model and. Okay. Yeah. To kind of define that, I mean, to the point you were just making, right. Like, you know, mind altering and psychoactive compounds and plants have been have been used by humans for thousands and thousands of years and there’s archeological evidence about that. You know, there are indigenous traditions that that have kept that alive over, you know, over the centuries and still to this day. And, you know, when when I'm talking about psychedelic, I will add, you know, some people keep a really specific definition about, compounds that are specifically working, like on the serotonin system, and they consider true psychedelics to be things like psilocybin, which is the psychoactive ingredient in, mushrooms or LSD and DMT. I'm using a wider definition, which is really about like the experience, a visionary type experience or an expanded state that's produced by a substance, and that would include ketamine and MDMA in that. So I'm using that broader term when I talk about psychedelics today. Okay. And so, you know, as mentioned, there are a number of different models for psychedelic healing that exist and that have existed. And I think, you know, there are different, different models that are appropriate for different people. And I think all of these models can coexist, and they all have value, and they have different clientele that they're going to support. And so, you know, there are there are therapeutic models that just have kind of like a guide. There are safe, self-guided,

processes with this. There are, you know, both indigenous and more like neo shamanic type ceremonial uses compounds. But when we talk about psychedelic assisted therapy, you know, there's a wide array of protocols that are out there, but there's kind of a universal formula that they will follow. And so that's including, you know, assessment and evaluation first, just to determine the safety and how appropriate it is. And intervention and preparatory sessions that are really, really spent, you know, kind of shaping the container and in getting the person prepared to fully have a safe experience and to really be able to be, to let go and be vulnerable and to do the work that they need to do. And then you have your experimental sessions, which is, you know, where the whatever compound you're working with, that's where the dosing will happen. And then separate from that, you also have integration sessions, and that's where you're kind of working together to put the pieces together and actually do something with what has happened in the experiential sessions. And so you kind of have those four building blocks and in they go in some version of that order, and it could be any number of each of those sessions. What I would say really sets, you know, what really sets psychedelic assisted therapy apart from the other models. And and this isn't a value statement. This isn't to say it's superior in any way to the other models, but what I think sets it apart is, is an emphasis on what happens in those prep sessions, in those integration sessions. It's not to say that other models don't have some version of Prep in in some version of integration, but I think what's really specific with psychedelic assisted therapy is, is the therapy is, is that this is happening in the context of a greater therapeutic process. And it's not necessarily just about the psychedelic experience in, in, you know, then you're kind of having to put the pieces together in a way that you can make sense.

Prof. Peter Sobota [00:14:09] Is it accurate to say that it's not a standalone? Intervention.

Brooke Stott [00:14:17] Well, you know, it's again, it's like there's it goes in so many directions because some of the top psilocybin clinical trials that are happening right now that are in the beginning of phase three or so clinical trials are like, you know, these are for major depressive disorder and treatment resistant depression. And these models, it's just one psilocybin session. And there's maybe 1 or 2 prep in 1 or 2 integration after it. That's it. And that's the whole intervention. And you know, there are people who are, spokes kind of like faces for this or for people who have had successful work with this, who just had these sessions in don't go on to do other therapies after or other things. But I think for a lot of people, you know, they're in therapy before, some are in a are still in getting some supportive therapy during and most people, for different reasons, will still get some type of therapeutic support after but the, the, the the severity and the frequency that they experience, symptoms like the prevalence of their symptoms, are going to be greatly, greatly reduced. And hopefully, you know, they're not incapacitated by them anymore.

Prof. Peter Sobota [00:15:29] Yeah. Okay. Thanks. So I you know, some of what you said I want to come back to if that's okay, but not right this moment because I, you know, you know, we we had a framework. But of course, I'm thinking while you're, while you're chatting, but I was interested in what you said about what was unique here was I am not sure I'm going to get the words right, but is it the the preparatory sessions? And what was the other word that you used?

Brooke Stott [00:15:59] The integration.

Prof. Peter Sobota [00:16:00] Session. Integrate. Oh, the integration was afterward. That wasn't. Yeah. Okay. Can you just give us a sense of what thematically goes on in preparatory sessions?

Brooke Stott [00:16:11] Yeah. So I think, you know, when we're talking about prep sessions, it's a lot of so it's like an orientation to the space. So like okay, that's happening and it's an orientation to the process in the protocol. It's like, you know, what is the compound that we're using? What are the possible side effects? One of the possible benefits, it's really like extensive not just informed consent but understood consent to what's happening. You know, there's used to therapeutic touch in psychedelic assisted therapy. So, like, this is. Yeah, to really go in deep with that and to, to fully get consent and to talk about like, maybe a hand on the shoulder is okay specifically if I for it. But I don't want anything else. Or maybe there's somebody who does want, you know, something that might be a little bit more involved. And also, what are the therapies boundaries around therapeutic touch.

Prof. Peter Sobota [00:17:00] Maybe down here.

Brooke Stott [00:17:01] And on somebody's shoulder?

Prof. Peter Sobota [00:17:03] Yeah.

Brooke Stott [00:17:04] Yeah. It's also an opportunity to explore both the therapists and the client's social identities, you know, their social interactions and really seeing, like, how are my identities that I bring into this space going to impact you and going to impact our work together? You know, whether we're talking about differences of race or gender identity or sexual orientation or culture or religion, any of these pieces, if you think about how highly sensitive somebody is when they go into these expanded states, should there be, let's say, some kind of like blind spot that I have and I commit some microaggression in that space that totally derails the person's experience. There needs to be a platform set for us to be able to talk about that in a, in an open and healthy way. So yeah, what you can see here, just to sum up with this is like you're you're building this, you're kind of building this container, you're setting this thing up so that the person feels safe to go into a vulnerable space and can actually concentrate on the work that they're trying to do in the experience experiential session and not be focused on a sense of needing, you know, to be safe.

Prof. Peter Sobota [00:18:09] Yeah, exactly. And you know what? It it's, you know, we're talking about this in the context and and almost you didn't say this, but you kind of bridged it. There's a certain building in of safety. And, you know, you could you could talk about this in the context of a, you know, trauma informed care or even, you know, human rights perspective brought to the, to the interaction. But as you were talking about it in this specific context, I have to tell you that my immediate reaction was, we should be doing this all the time. No matter no matter what kind of model we're using. But, you know, it's it all sounded. Very much in line with what the evidence says about the container of of therapeutic relationship. Right. It's unique. So yeah, thanks for that. So all right, so, let's let me just stir the pot a little bit here kind of early. I don't know if this is really stirring the pot, but, I think when you bring up drugs and not drugs, but especially psychoactive drugs or, psychedelic drugs, you know, anybody who is looking for a way to discredit it or to be skeptical is, of course, going to get a little nervous. And they're going to say, well, what's the evidence? You know, like they're going to play the evidence card. And and I think that's legitimate on some levels. So I, I'd like to lay it out on all legitimate. How's that. What is is you know, as far as you know, in your experience, what is the state of the evidence base for these kinds of treatments? I mean, I know that's a monster question. So, you know, we narrow it down as much as you would like.

Brooke Stott [00:20:04] Sure. I mean, it is a big question, and it's it's a really important question. And it's an important question right now because those who are following what's going on with the MDMA clinical trial process and FDA review, especially to the advisory panel that that that happened, recently, there's a lot of question about not just like, what is the reset start show, but like what is like the actual quality of that research and does it still work? So I will say so like currently there's there's got to be well over 100 clinical trials going on for pairings of different psychedelic compounds with different diagnostic presentations. So there's a lot happening in the space. I think if you really wanted to see like what's the most notable, you know, in the past, I don't know, seven years or so, or maybe five years now. More than that. Yeah. Let's say 7 or 8 years. There's been five instances where the FDA has granted, a psychedelic assisted therapy model with the breakthrough therapy designation, which is just saying that the phase two results were so promising is considered a breakthrough therapy. And it kind of eases the phase three process a little bit. But so, you know, the examples of this are MDMA for the for the treatment of PTSD. And that was by, you know, Mount which is now Lycos. And that's the one that we're going to hear about in another. So what the initial decision is, also psilocybin for treatment resistant depression has gotten that designation. Psilocybin for major depressive disorder, in LSD like compound for generalized anxiety disorder. That just happened, earlier this year. And also, another version of psilocybin for major depressive disorder happened earlier this year. And so in terms of, you know, the evidence to support it, you know, a lot of the findings are very promising. I think that the flip side where people have concerns is really around are the people who are providing these therapies, are willing to engage in these clinical trials, like, can you account for levels of bias, like, are these people who are going to be largely pro psychedelic in certain ways, and are there ways that that can influence results? You know, there's a lot of questions, I think, around those pieces in it. They're valid questions to consider. I think a lot of people know that, like, yes, this works, but what does this look like to roll out as something that is like nationally available to people? Because that's a whole different landscape than a very controlled clinical trial?

Prof. Peter Sobota [00:22:37] Yeah. Although some of the points you were making about, you know, people who might self-select into this and how that might skew the data. I mean, isn't it fair to say that people who would seek treatment for psycho pharmacological interventions, that's a, you know, a competing variable right there. Or if people go to, for example, narrative therapy or analytical psychology, as, as an approach to therapy. So, let's be fair.

Brooke Stott [00:23:07] Yeah. Nuts.

Prof. Peter Sobota [00:23:08] And and let's be reasonable and not look for ways, I think, only to, to discover the other thing that I was thinking about while you were talking. And this was early on, but I didn't want to interrupt you. Is that in terms of the different, all the different kind of trials that are going on, what also might be. Confusing is, I would imagine there there's research conducted in like academic settings and then there are there's academic, not academic, there's treatment, conducted or research conducted in clinical populations. And then there's like the VA, which is like its own world sometimes, and I'm not sure they're all doing the same thing. Would that be fair?

Brooke Stott [00:23:57] Well, I mean, ultimately I think I think you're right. One point actually, I'm just going to circle back to something real quick. I thought you were saying about, you know, being fair with things. I will say that I think that, like, not all but the

majority of criticisms against psychedelic assisted therapy are by no means specific to psychedelic assisted therapy.

Prof. Peter Sobota [00:24:17] Yeah.

Brooke Stott [00:24:17] And these issues in plenty of other places. Because this is such a contentious topic, it's like it's it's just really in the spotlight with them. But to go back to your question there, it depends what we're talking about. Because to your point, like let's say like in an academic setting. So like Johns Hopkins does loads and loads of research with them and they have a pretty specific protocol that they tend to follow. That protocol is not the same as the clinical trial for psilocybin for major depressive disorder, for example. It's a they have. So they it follows that formula that I mentioned earlier of you know like assessment preparation experimental and integration. Some version of that formula. But it's not exactly the same. Now when we talk about something that is getting approved for clinical trials. So let's say like the, the the maps and like us MDMA assisted therapy. That's a very specific protocol. And that's a protocol that has about I mean 40 plus hours of therapy is is involved in it. So it's very intensive. The thought, I mean, or what has been proposed, we don't know, is that like that protocol is approved along with MDMA. And so then the FDA sets the Rems, they're setting specifications on the protocol. Now the question is also then it's one thing to do the on label prescribe version of that protocol. But then can people take it and then do an off label to which, you know, it won't get insurance coverage in it? You know, you may not have the same protections, right. But there's going to be, I think, variations in what it looks like when it when it rolls out.

Prof. Peter Sobota [00:25:51] Again, much like many of the other things that we do.

Brooke Stott [00:25:55] Absolutely, absolutely.

Prof. Peter Sobota [00:25:58] You know, my biases come if you are ready. Okay. I really got to behave. So if we can. And feel free to beg off on this if you don't want to do this. But I again, I mentioned this earlier that you actually are a provider for ketamine assisted psychotherapy. And, if I could ask you, we've been talking broadly, if you're willing and if not, well, you know, we can move on. But in terms of your practice, I'm curious what kinds of applications, if you can even talk about it this way, or users of this model or even the kinds of issues do you find yourself helping your clients with? Yeah. To, you know.

Brooke Stott [00:26:44] Yeah, yeah, I know that's a good question. I'm happy to speak on it, you know.

Prof. Peter Sobota [00:26:47] Great. Okay.

Brooke Stott [00:26:48] Working. So there's, you know, working with ketamine. Also, again, it's a little bit different because we're we're already we're working with it in an off label manner. And there is no set protocol of I mean certainly there are best practices for sure, but there is no like this is the ketamine assisted psychotherapy protocol to follow. Which means also like ketamine is used for really wide range of diagnostic presentations. Also, notably ketamine works on the glutamate system, not the serotonin nervous system.

Prof. Peter Sobota [00:27:17] I was going to ask you about that. That's how it's different, right? Yeah, yeah.

Brooke Stott [00:27:20] And so the benefit of that is people who are on like SSRI scenarios and other types of antidepressant medications do not need to get off of those in order to do work with ketamine, like you would, would say MDMA and potentially psilocybin.

Prof. Peter Sobota [00:27:34] I recall tell me if I've got this right. I actually recall reading and they might have it even for prep of talking with you. Do some providers or organizations, which require people to stay on an SSRI if they're going to participate in ketamine treatment?

Brooke Stott [00:27:52] Well, not necessarily that I think most therapists, you're you're not totally wrong on that. I think most therapists don't necessarily encourage people like, you need to get off your medications. I think some people make that decision just to see if it's if it's an option. But what is true, it depends on, you know, it's this isn't across the board, but for a lot of insurance providers to cover Esketamine nasal spray, which is not ketamine assisted psychotherapy, it's a purely pharmacological model of using ketamine, where it's just a nasal spray. There's not necessarily any therapy that goes with it in order for that to be covered. And this is something that's on label, FDA approved in order for that to be covered, it's treatment resistant depression. And oftentimes you need to have been on an antidepressant med that has failed and now be on a second antidepressant medication in combination. I think it's a minimum of six months that you have to have tried something else, in in for you to get that as ketamine covered by your insurance, in a lot of cases.

Prof. Peter Sobota [00:28:55] Is s ketamine is it's provato.

Brooke Stott [00:28:58] Yes, exactly. Yeah. Okay.

Prof. Peter Sobota [00:29:00] Those are the same things. Okay.

Brooke Stott [00:29:01] Yes. All right.

Prof. Peter Sobota [00:29:03] You know what? I. Unless I missed this, I asked you to talk about what you do.

Brooke Stott [00:29:09] More specifically, I think we got a little.

Prof. Peter Sobota [00:29:11] No, I think it was me, but, yeah, I'd. I'd like to bring it back because I wasn't sure if you were going to be willing to do it.

Brooke Stott [00:29:16] Yeah, yeah, yeah. So the reason that I, that I started going down that road is just to say that there's a really wide spectrum of presentations, whether it's for PTSD and trauma, anxiety disorders, adjustment disorder, any kind of depressive disorders. I mean, there's such a wide array of presentations for which, ketamine assisted psychotherapy can be an option. And so, you know, in my individual work and I'll talk a little bit about both, but in my individual work, I use what's, what's maybe more of what's called like a psychoanalytic model.

Prof. Peter Sobota [00:29:50] Psycho lytic. Yeah.

Brooke Stott [00:29:52] And so in a psycho lytic model, I'm doing it with clients who are already ongoing therapy clients of mine. And we use ketamine, really as like an accelerant to the ongoing psychotherapy process. And so, I mean, people can still have big

experiences and larger dosing. But essentially what happens is, you know, we'll do our preparation for it will look usually like a three hour session. And so in that three hour session, say the first half hour is like a check in and and kind of getting ready. And then they'll have generally it's usually around 60 to maybe up to 80 minutes where they're, you know, they're taking, ketamine tablets. And they are kind of laying there listening to a curated playlist and have, you know, an eye mask on in our really internal in their experience. And after that period, we then have another, usually again 60 or 80 minutes, depending where we essentially have. I mean, yes, it's kind of integration. Yes. It's kind of like part of our, our ongoing. Review process. And it's really in that window that I find, I mean, yeah, there's pharmacological benefits to the ketamine and yes, like people get sometimes insights or profound, you know, visionary experiences in the medicine. But, to me there's a window directly following it where people are just really, open the rigidity, softness they have access to, to thoughts and emotions and, and all of these things that they may be struggle to access normally. And so I find that window of time, right after to be, you know, just it's just wide open. It usually is like a really fluid. I mean, it's just as a therapist, it's just very it's very enjoyable to do therapy in that hour.

Prof. Peter Sobota [00:31:33] Yeah. But but it sounds like you're describing a multi hour experience here.

Brooke Stott [00:31:39] Yeah. Those the experience sessions are three hours long. And so those are longer sessions. And again then you kind of we will have sessions in between that are just regular sessions. And another piece I want to bring into this is, is I also work as a study therapist and co-investigator, with, with research collective that's called flourish. And we we're kind of a team of trans and gender expansive researchers and mental health workers who are doing work with psychedelic assisted therapies within trans and gender expansive communities. And, we've done a couple ketamine group series, and we're actually in the middle of of one currently. And these are, group dosing sessions. So so we had six people in our first group. We had eight people in the group right now. And so, you know, we're doing kind of like group preparation. All these sessions are together as a group. There is group dosing sessions that are then followed by group therapy immediately after with sessions in between. The first time it was like we were doing modules around like understanding parts, the inner critic responses to shame, toxic shame, and how to kind of recalibrate to kind of guide that. In the current group, we're using these these sessions in between, and we're bringing in components of CPT like cognitive processing therapy, looking at, you know, kind of this concept of cognitive fusion. And how identified am I with, you know, these narratives that I had formed in, you know, response to trauma or chronic invalidation or, you know, all of these pieces? And so what I will say about the group work that's really amazing is when you're talking about people who have been chronically invalidated, who have toxic shame, who spend a lot of time inside themselves, when they have this experience with a group of peers and they hear, they're heard, they're seen, and people share the same experience with them, and they get their stories and they're validated and things. There's like a whole other level of, of, of medicine and healing that's happening that is just purely community based and is really just on top of the typical therapeutic stuff that's that's going on.

Prof. Peter Sobota [00:33:53] Yeah. Interesting. I know what you and I spoke about this very briefly when I was trying to talk you into this. Yeah. And and I remember you took you reference the group and I went, whoa. If you remember, I said, I can't do the podcast now. I got way too many friends. Yeah. So I stopped talking. But I'm going to talk now if you'll let me, the group that you were just, describing. How many clients.

Brooke Stott [00:34:20] The group that's going on right now has eight participants.

Prof. Peter Sobota [00:34:23] Wow. And how many? How many folks per say are you leading the group?

Brooke Stott [00:34:28] It's it's myself and two others.

Prof. Peter Sobota [00:34:30] Two? That was. I was going to ask two other people. Yeah. You know, I, I, I was a practitioner before I had my current gig, and I loved doing group therapy. I worked in a substance abuse clinic, and we, especially as people got further along, it was it was mind blowing. But it was hard work. There's just a lot going on. You you have to be used to thinking on your feet, and I it just sounds a little intimidating to me to have people who are, you know, taking, a drug that might even enhance the power and the vulnerability of that setting when it's working really well. And my dad, I'm not trying to discounted in any way, but it sounds like that's what you're saying, and it's manageable.

Brooke Stott [00:35:21] It's it is manageable. And to your point, it is it can be intense. You know, it's like people people really can have strong, strong experiences. And some people can ride those out. And and it's good for them. And some people can be a little bit destabilized by it. You know, I find, you know, a lot of times with groups and I don't know, it's the same thing when I was doing like the ayahuasca retreats, like, I don't know if people are in tune with, like, this is the first. This is the beginning. This is the middle, and I know it's ending, but there tends to be an arc, almost like there's a just a treatment arc, even with like ongoing longer term trauma therapy or something like that. So for sure, I have always found like the beginning of groups or the beginning of retreats or things like that, it's like people are really trying to figure out, like, do they trust people? Do they feel safe? What's going on? What is this?

Prof. Peter Sobota [00:36:11] The stages of group forming and knowing that, yeah, this.

Brooke Stott [00:36:14] Is in the beginning of that can be really intense to try to to try to hold for sure.

Prof. Peter Sobota [00:36:20] Oh, really? That's the tricky part.

Brooke Stott [00:36:22] Yeah yeah yeah, yeah. Trickiest part I mean, I will say like with, with the previous on Group series, we did, you know, there hit a point with it too though, where it became really fluid and it, it really started to almost become easy, especially the integration sessions, because everybody feels safe with each other. And now everybody's talking and sharing and it's just like it organically, you know, brings itself to where it needs to go, and you're not trying to necessarily form it and push it along like you need to in the beginning. Yeah.

Prof. Peter Sobota [00:36:55] Interesting. Wonderful. Well, actually, you know, I was going to ask you about to walk us through the process, but I think you just kind of did that in a way. So, I mean, does that.

Brooke Stott [00:37:08] Yeah, I would, I would say that's the you know, generally the deal is, is again, we do we do the preparation for things. We have experiential sessions. I like working in a model because, you know, ketamine is shorter acting and then the than the substances that are currently in in clinical trials where you have time to, to to do actual sessions following, you know, they're they're coming down from the experience. And then

after that you make sure that you have time just for integration before they're doing any more experiential sessions.

Prof. Peter Sobota [00:37:38] Yeah. I'm gonna I'm in a parking lot. This, short show, I think. I think I'm in. Well, I'm not the only person. This conversation. But what, you know, while you were talking, I'm thinking about multi hours of into with an individual. How long are the group sessions?

Brooke Stott [00:37:58] The group sessions are also three hours.

Prof. Peter Sobota [00:38:01] Okay. So there's that long. So this is I mean maybe one of the advantages and maybe even challenges of this approach is that it's relatively time intensive given the other models that are available. Let's just contrast it with that. And then there's the other issue of of maybe not all of this is reimbursable. Right. And and this sounds to me like in some ways it would be fair to raise some questions about equity and justice for other populations, but I wish I would have thought of that before and built in time for that. But that would be something I know. That's something that I want to learn more about. Yeah. And. Yeah. All right. So I just want to acknowledge that that's going ahead. Yeah.

Brooke Stott [00:38:54] I will just add to that, I mean, which, you know, is just complicating it. You know, ketamine is fairly short acting, but when we're talking about MDMA and psilocybin, those are 6 to 8 hour sessions. And so those are twice as long or more. And and in some cases with MDMA, like people were staying overnight on site after their experiential sessions. And so what I will what I will quickly say is, is like, yes, it's very time intensive, and there's high costs associated with it. And also keeping in mind. Right, like, like we were saying before, like there are a lot of mental health treatments that are expensive, that are covered by insurance when it's their effectiveness is proven. And, you know, in the long run, it costs less than. There are few, publications about this, but really do. A cost effective comparison of MDMA is the therapy versus what it generally costs to treat somebody with severe PTSD per year?

Prof. Peter Sobota [00:39:50] Absolutely. Yeah, absolutely. Okay. Thanks. So I don't know if this is a fair question. I'm sure you're going to tell me, if there even if there's a way to answer it. Is there a way to talk about how your clients typically describe their experience? Is that even something that is noticeable? I don't know. Yeah.

Brooke Stott [00:40:16] I yeah, I can, I can say some things and I think it's for people who have not had the experiences, like they would probably draw conclusions that that may or may not be accurate. I think it's, there's you can say things about the experience which, which I will in a moment here. And I think the challenge is like there's components of the experience that are truly ineffable. And no matter how much you try to describe them or simulate them or, you know, look at art or music that that's based in them. Capture it until you do it.

Prof. Peter Sobota [00:40:49] Agreed.

Brooke Stott [00:40:51] Yeah. And so like what I will say at least like, you know, let's say with ketamine and again like dosage, it makes a big piece of this, a light dose of ketamine, a very light dose may feel like having like a drink or two or something like a glass of wine, you know, a heavier but still light dose may feel like, like a sedative and relaxing in these other pieces when you start to get up into higher dosages or you change the route of

administration to something that's like an IAM or an IV or something like that. It gets extremely psychedelic, gets very psychedelic and very, you know, it is an anesthetic. Dissociative by nature. Ketamine is in. So, it's like with a with a decent dose of it, there is a dissociation from your environment and from your, from your body, and, and, and a lot of people describe it. They have experiences either that they're like out in deep space or the deep underwater, or sometimes that they're in a void. Sometimes people have like waking dream visionary, you know, experiences. I think people do have just like, colors and shapes and things that come in. Some people experience, you know, really intense reliving of moments from the past. There's a lot of different pieces. But I also feel people report a lot of like, again, kind of like, I mean, some people do experience fear and terror, so I don't want to say. Yeah.

Prof. Peter Sobota [00:42:19] No, no. Exactly.

Brooke Stott [00:42:20] Yeah, yeah. But there are people who really say, like, this is the first time I've been able to, like, relax. Or when they come back into their body, it's like they're coming back into their body in a more embodied way than they have for a long time. You know, a lot of, again, like softening of rigidity, deeper thinking, more emotional sensitivity. And those effects will stay with people oftentimes even in the days that follow the experience. Yeah.

Prof. Peter Sobota [00:42:47] Oh, thanks. Yeah. Thanks for even taking that one on. I know I didn't want to get you talking about other people's experience, but yeah, I'm sure I'm sure you talk about it. Are there any myths that are really prevalent about this treatment that you would like to debunk right now?

Brooke Stott [00:43:06] Yeah. I mean I'm sure there's a lot of but

Prof. Peter Sobota [00:43:11] Oh.

Brooke Stott [00:43:12] I think what I think let's.

Prof. Peter Sobota [00:43:13] Do the greatest hits.

Brooke Stott [00:43:15] Okay. I think like some of the things that are going to come to mind for me are going. A sound a little bit like they're there in the antithesis. But really, my point is just to kind of maybe counteract some of the media hype that that's that's since died down a bit, but is still somewhat, which is the idea that like, psychedelics are a panacea or, you know, like there aren't these major risks with them or all these pieces. And like the reality is with these is like there are medical complications that can happen, especially with like cardiac issues or, you know, hypertension, high blood pressure. It is true that for certain people and there's a lot more research that needs to be done on this. But but anecdotally, there's the potential for trigger triggering like manic episodes or psychosis and things like that. There's also the question about like, you know, abuse of power in, in homes that can come from, from a therapist who's, who's acting in an unethical way. So there's those risk. But I will see, like, I think one of the biggest risks that often does go unmentioned is especially if you're working within a specific protocol, but even just generally speaking, is like, you can really I mean, yeah, sometimes people can be retraumatized or like they've built up these walls of protection to, to allow them to function in the world despite their, their trauma and despite how it impacts them. And they've kind of had this, whatever it is that that protects them from it. And oftentimes in a psychedelic experience, you're going to completely dismantle that wall and you can't just

put it back together again. You can't just build it right back up. And so the challenge is, is, you know, people are walking around after these experience oftentimes like highly, highly sensitive, you know, on unable to fully process the experience. And so they never comes into question again, especially if somebody is in a fixed protocol and they're not seeing you for ongoing therapy. Right. How are you putting the pieces back together and making sure, like that person's going to be safe?

Prof. Peter Sobota [00:45:12] Yeah. And again, that's also true for many of the other things we do.

Brooke Stott [00:45:17] Under ADR is yeah, same thing with eMDR with people.

Prof. Peter Sobota [00:45:23] But I also think and and these are legitimate risks. I'm not I'm not arguing with you at all. But it also sounds, like what you addressed earlier. Were you that preparation and integration for a phase are, you know, they're kind of baked in to the model. So yes, of course, as with many things, bad things and unexpected things can happen, you know, the bad trip, if you will. But it sounds like there are overt attempts to assess for the possibility and to, to mitigate that along the way. So you kind of touched on this a little bit, but are there any other like risks that you would like to speak to that are, you know, fair? You mentioned a couple so that, that.

Brooke Stott [00:46:14] I have, but I it's those are like those are the biggest risks to me that that come to mind are those that I just mentioned. I'm sure that I'm sure if I really sat and thought about it, there are others. But I think, again, this this piece about people not having the support that they need outside of sessions or after sessions, to me is arguably the biggest risk because the other things in in the assessment and evaluation that happens and also in the prep sessions, there's a lot of filtration that's built into those to try and prevent medical issues or psychiatric issues. But but this other piece. You know, it's a little bit harder to predict.

Prof. Peter Sobota [00:46:53] So I think people are going to ask. You know, like, what does this cost? Yeah. You know, what are the fees involved? And you mentioned that insurance doesn't always cover this. And, you know, that's a spectrum of different, substances that we were talking about. I mean, can you speak to that or is that too all over the place to, to really talk about it in any kind of fair way?

Brooke Stott [00:47:21] Yeah. No, I mean, I can touch on it a little bit, I think. I mean, I think one of the challenge, a few challenges with this because this comes up at any time. Right. And I might be speaking to if I'm giving a guest lecture or giving a talk about this to especially social work classes like of course, and health equity are a big topic. There's a there's a few challenges with this. One is that other than ketamine, these are all in the clinical trial process and the whole. And the reason why this taking this clinical trial route is important is because with enough evidence, these things can and are likely to be covered by insurance, including, you know, Medicaid and Medicare. There just needs to be enough evidence to support that. And that's what we're in the process of building. You know, again, if you looked at, for example, somebody who's going to go through like a substance use, like detox rehab program and then IOP program, I mean, the cost of that is included or higher than the cost of these.

Prof. Peter Sobota [00:48:17] Absolutely. Yeah.

Brooke Stott [00:48:18] So so there's those pieces of it, I think, you know, with the ketamine piece again, it's like as ketamine does privado that's, that is covered by insurance and that's FDA approved. But that's not ketamine. This is psychotherapy. There are people who are working to get racemic ketamine, approved for mental health treatment. So racemic ketamine just being not as ketamine, it's talking about which kind of way the molecule faces and and okay. But yeah. But with that is, is is is trying to get racemic ketamine to be, to be approved, FDA approved for mental health treatment so that it can be, covered by insurance is now what I will say is currently there are ways of making it more affordable. And it depends like how many hoops you want to go through. But for example, like, you know, we I've, I've worked with a private, private practice prescriber here in the state of New York. This, practice really well. And so they actually they can't take insurance for the prescription itself, but ketamine is very inexpensive. But they can they can take and do take insurance for that assessment, which if paid out of pocket is, say, $250. Three.

Prof. Peter Sobota [00:49:31] Gotcha. Okay.

Brooke Stott [00:49:32] All right. So like the prescriber can choose to take insurance for that. Similarly, you know, oftentimes and I've done my myself, especially when I was seeing some people with this in, in Massachusetts before I came to New York. But, you know, as a therapist, if you we don't bill of course, therapy sessions by intervention. And so if I'm billing a 60 or in some cases, a two hour minute therapy session, I mean, I'm just billing that as insurance and maybe there's still an hour after that that has to be paid out of pocket. I will say, like there are things like there's like ketamine access fund and there are some other programs that are set up, to, to raise funds for people who otherwise wouldn't have access to this interesting, something new that you're starting to see. Well, they're not new, but that's coming about is like, there's like in the which is, kind of like a, it's, you know, a company with sign up essentially to offer this as a benefit to their employee. And so but it is it's like an employer paid version of, of something where it's a benefit that certain cap providers and eventually I think the goal of psychedelic assisted therapies, providers, other psychedelics take this in fee as payment and that's provided by employers as a benefit. And so there's some of those things happening. But those are like the like I'm trying to work an angle. Think what we really need is, is full coverage.

Prof. Peter Sobota [00:50:56] Yeah. Well I'm laughing because I'm thinking about a point in time where it was a big deal for acupuncture to be covered by health insurance, right? Like, oh my god. Oh yeah. So yeah. Well, all right, so we're maybe we're on our way. So. All right, one last. You know, I want to save time because I want to talk about social work specifically and specifically social work education, because this is really interesting. But here pretty quickly if you can. Yeah. If, if a client is interested in accessing this kind of care and therapy. Yeah. Where do they go? Because I'm thinking, you know, if it was me. Yeah. I mean I work at a university, so I yeah, I've got access to people. I could talk to people and they'd probably set me on my way. But not everybody has that option. So where would clients who are interested in accessing this kind? Take care. Do you have any recommendations about that?

Brooke Stott [00:51:59] Yeah. I mean, honestly, at this point there are filters like if you go on Psychology Today, ketamine assisted psychotherapy is one of the filters that you can select. And in there find a therapist. If you use other platforms like Manhattan, alternative is a is a big one, especially for people, Bipoc, LGBTQ, plus community sex workers tend to use that platform for therapists. They also have a filter for for therapists who offer.

Prof. Peter Sobota [00:52:22] Ketamine.

Brooke Stott [00:52:23] Therapy. And if you went on to Google and I feel like you could be almost anywhere at this point and you googled like ketamine therapy near me, you're you're almost for sure going to come back with. It's become.

Prof. Peter Sobota [00:52:35] Ongoing. I'm going down the rabbit hole here. Yeah. Any suggestions on how to find? People who are good at this quality of care. Yeah. Or how do you assess that? Maybe that's the better question. How would a maybe this is too much for now, but how would a potential client assess for the quality of care?

Brooke Stott [00:52:57] My my my quick and easy answer to that is that it's it's to me therapy's about compatibility, right. Like it's not about like, good therapies, bad therapies. As much as like who's the right therapist for somebody. And so in times where I've tried to find a therapist for friends in their area, who does this work is like, I'm kind of looking for certain things that feel compatible about their presentation, about how they do things. And so that might be, for instance, for people I'm looking for, it might be around like, are they like, you know, a sex positive? Are they are they queer affirming and they trans affirming? Are they, you know, those pieces of it? I think some of the other things you want to take into consideration is like, are they offering you prep and integration sessions, or are they telling you just to come in and take it and then go home and, you know, figure it all out on your own?

Prof. Peter Sobota [00:53:46] Oh, geez. Okay. All right. So all right. Well thank you everyone. Yeah. This is this is I could go on and on. So, okay, let let's let's pivot to social work. And, you know, we have a lot of practitioners who listen to this show as well as as academics. So how do social workers who want to provide this kind of therapy, how do they get trained and or certified? Yeah. To be able to provide this.

Brooke Stott [00:54:21] Yeah, yeah, it's a good question. And I think I can speak to it here. So right now there is no you can get a certificate stating that you have done certain amount of training, but there is no like certification that says, I can do this or I can't do this, nor is there a specific license for that. That very well can change, but currently that's the case. You know, there are some instances, for example, where people actually are just working at a certain therapy practice and are getting on the job training. People who work with there's a company, if you're somebody who's practice, there's journey clinical and they're they just do the prescribing. You pay a membership to them, you refer your client to them, they do the psychiatric and medical assessment, they write the prescription, and then you do the therapy for people who work. They work with Journey Clinical. They include trainings as part access to ketamine training as part of their their package. Similarly, you know, if we're talking about postgraduate training, which is probably what most of your listeners would be thinking about, there's there's at this point, there's quite a few, Fluance is one based here in New York. I think that they have a lot of excellent trainings and they're very like practical and hands on. And you can focus on ketamine, psilocybin, MDMA integration, I mean, all kinds of things. Other good ones are like Beckley Academy has the California Institute of Integral Studies, Naropa University has a program. You, Cal Berkeley has a post postgrad program. So in terms of post-grad, you know, there's all of those options. I'll, maybe I'll, I'll speak quickly to like, the work that, that we're doing at Columbia and what it looks like on this. Yeah. Yeah. So so we will be launching in two months, our first cohort and this is equivalent to the other big training programs that people are taking. Students are taking, in their final year, MSW students, this is their specialized year. You take two courses in the spring and two courses in the fall specific to

psychedelic assisted therapy. So total of four courses, and our practicum is is doing work with ketamine different ketamine clinics. And so.

Prof. Peter Sobota [00:56:34] So like their field placement if you will. Gotcha. Oh wow.

Brooke Stott [00:56:38] Yeah. And so the number of classroom hours learning is equivalent with these these year long or most of them are nine, 910 months. But same number of classroom hours, except no other ones are offering like practicum placement where you're getting 600 hours of of on the job training, hands on training. And so. Are again. We've been doing other work. We did a learning series, Foundations in Psychedelic Assisted Therapy for Social Workers that's available for free online. But our main project, is, you know, we're launching this, this program, this full comprehensive program. Part of what we're doing also is sharing for free with any university or college, our School of Social Work or nursing, for that matter, or whoever who is interested in offering this. We are sharing all of our curriculum, our syllabi, our assignments, our readings. Everything is available for free to anybody who's interested. And so we have a number of universities that we've been working with. I mean, we did we've taken about 30, 30, faculty from six top schools of social work and nursing and brought them through the a seven day, you know, maps, MDMA assisted psychotherapy in a retreat center upstate and then out at you Sona Institute in Madison, Wisconsin. We did like a four day intensive training with them. So our goal is, you know, there are schools now that are starting to launch at least electives in this topic. And so yeah.

Prof. Peter Sobota [00:58:05] That's a way to sneak them in.

Brooke Stott [00:58:07] Right? Exactly, exactly, exactly. And so our hope is to start making this available in, in actual curriculums for social work. And again also nursing. You know, and you mentioned in that like what are, you know, like why social workers even and why, you know, why are social workers good for doing this, this kind of work?

Prof. Peter Sobota [00:58:29] Yeah. I was going to invite you to just hop on your soapbox here and, you know, of all people, you know, you know what the pushback is sometimes, right? So I think you know, why, of all people should social why are they well suited to this? I mean, I know how I would answer that, but I want you to to. Yeah. Take a job with that if you would I yeah.

Brooke Stott [00:58:52] I mean, I'm interested in your response as well. You know, I think that that there's a handful of points that, that I really defer back to in the first of which is like just the prevalence of social workers. And, you know, there's, publication on mental health workforce from the essay that talks about the prevalence of different, you know, different disciplines within the mental health, workforce and social workers are by far, by far the most prevalent in the workforce. And they're also set by 2030. They go through like percentages that they're predicted to increase. Social workers are predicted to, increase by 114%. You know, going down from there, I mean, psychologist is only predicted for 13% increase, and psychiatrist is actually predicted for a 20% decrease. And there's a fraction of those, professions available as it is, a lot of psychedelic assisted therapy work prior to recent years is fully in the form of psych psychiatry and, to a lesser extent, some psychology. Another big thing is the cost to provide services, the cost of a social workers time to provide these services, compared to a psychiatrist and often a psychologist, is notably lower. So from an access place prevalence in cost. And then the other piece is one, as social workers like our social work values really center, you know, health equity and disparities. You know, anti anti-racism pro sex positive, all of these different things and

meeting those values brought into this space is there you go it. And then the last piece I want to mention is we just see increased diversity of marginalized voices among providers in social work when we compared to, say, psychiatry. And so it's hard for people from marginalized communities to trust new types of health care and to try to trust health care in general. And so if you can see your identity represented in the people who are providing the services, you're going to be a lot more apt to to trust that and to go for it. And so I think those are some of the big reasons that that social workers feel.

Prof. Peter Sobota [01:01:03] Yeah. What you know. Well. You did it a lot better. And you also stole all my thunder. So that's. That was really. That was really, wonderful. I also think it's where we're located, you know, we we, you know, social work is, you know, our claim to fame is this micro mess of macro focus of, of a perspective and intervention. So we're accessible to people in different locations and, you know, damn it, we we used to be the kind of the social change people, right? We we we we acknowledge the environment. And a changing environment requires changing approaches and, and open mindedness and actually not so much open mindedness and radical this, but aligning ourselves with the newest evidence that we have about what helps people. So, we're right. Well, we're we're we're out of time. We're not running out of time at the time. But thank you so much. I just wanted to make sure I, you know, I, I feel like I rushed you through a couple of pieces there, and I apologize for that, but, is there anything I want to give you? The last word. Is there anything that you would like to say to kind of wrap this up or something that I didn't ask you about, that you make sure you want people to hear.

Brooke Stott [01:02:25] If if there's anything. And again, it's like we're trying to talk about a lot in an hour. So yes, on on not having to rush through peace. You know, you, you kind of towards the end briefly mentioned like a piece around push back. And I think the one thing I want to say, like what I find when I'm talking to, whether it's social workers or otherwise, oftentimes it's people who are not in the psychedelic assisted therapy field. And questions come up around, you know, indigenous practices and appropriation and reciprocity. Questions come up around lack of diversity among, you know, research participants and researchers. Questions come up about access and health equity. And I think a lot of people kind of have this idea that those those issues aren't being talked about in the psychedelic assisted therapy world, and that everybody's just kind of pushing ahead. And I it's not to say that any of those things are near where they need to be, but what I do think it's important to name is like there's a huge amount of people in and organizations who are extremely like talented, intelligent people who are really pouring their entire career into these issues, into addressing these issues. And again, like, we all have to be considering these things and doing work to move the needle on them, but just just for people to know, I think we're on the outside that like, these issues aren't unacknowledged. They're not where they need to be. But there are some people who are really, really doing amazing work with it. And it's a shame for for their work to go unheard and unnoticed.

Prof. Peter Sobota [01:03:56] Perfect. I think we should have. Leave it right there. Brooke, stop. We can't thank you enough for, taking the time and and, you know, getting us really to think I think that is not only educating us, but getting us to think in a broader way. Thanks again.

Brooke Stott [01:04:13] Yeah, gladly. Thank you.

Prof. Peter Sobota [01:04:17] Thanks again to Brooke Scott for joining us. The open minded crew at In Social Work is our tech and web guru, Steve Sherman. Our graduate

production assistant, Ryan Troth. Say hi Ryan. Hello. And I'm Peter Swoboda. Thanks again for joining us. We'll see you next time, everybody.