



Developing Ethical Guidelines in Psychedelic Psychotherapy

SHANNON CARLIN, M.A., AMFT, MAPS PBC DIRECTOR AND HEAD OF TRAINING AND SUPERVISION

SARAH SCHELD, M.A., MAPS PBC TRAINING AND SUPERVISION ASSOCIATE

The content of this article may be triggering to those who have been impacted by trauma or ethical violations of a sexual nature.

“Ethics is reverence for life rooted in right relationship with another.”

— Kylea Taylor, M.S., LMFT, *The Ethics of Caring*

Ethics: Nonmaleficence

A CODE OF ETHICS FUNCTIONS to define and articulate the moral standards of a group, such as a profession or workplace. Ethical codes in healthcare prioritize a commitment to the dignity of patients and clients (Center for the Study of Ethics in the Professions, 2020). One of the earliest known codes of ethics, written as early as the third century, is the Hippocratic Oath, a set of ethical standards for physicians (Hippocrates, 1923):

Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free.

Many of the early ethical codes, in both Western and Eastern culture, were based on a religious sense of morality. Hippocrates, for example, began the Oath with a declaration to Apollo and the Greek gods and goddesses of medicine. Modern codes are more pragmatic, focusing on practices that have been shown to demonstrate efficacy (Wear et al., 1993). Still, early precepts, such as the Hippocratic Oath, have been fundamental in the evolution of medical ethics.

To this day, a primary tenet of healthcare ethics is *nonmaleficence*. In the 2006 book *Ethics in Health Administration*, Eileen E. Morrison offers this definition of nonmaleficence: “to use the most appropriate treatment for the condition and have provided that treatment with the least amount of pain and suffering possible” (p. 46). Morrison explains that efforts to alleviate suffering in the long term almost always introduce some amount of suffering in the short term. The responsibility of health care providers is to make ethical decisions regarding the potential risks and benefits of treatment procedures, and to provide participants with information and options whenever possible so that they too can make informed choices about their care.

Therapeutic Relationship, Transference, and Countertransference

Attending to the commitment of nonmaleficence in psychotherapy requires therapists to develop relationships with participants that are appropriate and likely to cause the least amount of suffering. The relationship between a participant and their therapist is called the therapeutic relationship; it is an important component of therapy and requires careful attention from therapists. Many psychotherapies emphasize a relational component of therapy: ideally participants can explore various ways of relating, express themselves authentically, establish a deeper sense of safety, and practice healthy boundaries. Through the process of therapy, participants internalize experiences of safety, expression, and boundaries, and apply these experiences in situations and relationships throughout their lives.

One of the ways this relational repatterning happens is through a process called *transference*, in which the participant's feelings about a past situation or person in their life are redirected, or *transferred*, onto the therapist. Sigmund Freud first described transference in 1895, since which the field has created various interpretations and applications of the concept.

Through the process of transference, the participant may, at times, perceive the therapist as a representation of an attachment figure or other symbolic person from the participant's life. In this process of redirection, the participant may explore or test the relationship with the therapist. For example, a participant who had experienced sexual abuse may explore trust and safety with her therapist. This can look countless ways; for example, the participant might explore trust by deciding how close to sit to the therapist in the therapy room, asking if the therapist would hold her hand, or asking if the therapist is attracted to her. Therapists are trained to respond to transference in ways that are likely to support the participant's therapeutic process and unlikely to cause undue harm. In responding to transference, the therapist takes great care to maintain the safety and integrity of the therapeutic container.

The therapist is also responsible for managing their own feelings, including feelings towards the participant, referred to as *countertransference*, while upholding professional boundaries in service to the participant's safety and dignity. By attending to transference and countertransference appropriately, the therapist supports an ethical therapeutic relationship and nonmaleficence.

Speaking to the healing power of therapeutic relationships built on trust, Courtney Hutchinson and Sara Bressi (2018) write, "First and foremost, trauma survivors have experienced ruptures in trust—trust in the safety of the world, in the goodness of others, in their own inherent value. Too often, these ruptures are then tragically repeated and reproduced in relationships with important others, clinicians, and institutions." An ethical practice promotes an environment of safety, support, and trust, where participants can heal from life experiences that were not safe, supportive, or worthy of trust.

Considerations for Psychedelic Psychotherapy

Although psychedelic substances have been used therapeutically for centuries, and the practice of psychedelic-assisted psychotherapy is several decades old, the modality is only now slowly gaining acceptance in standard clinical practice. Clinical trials and regulatory approval of psychedelic medicines are creating legal avenues for psychedelic psychotherapy.

While psychedelic psychotherapy incorporates standard psychotherapeutic principles, aspects of the modality require unique clinical skills and competencies. First of all, psychedelic psychotherapy involves the combination of psychotherapy and a psychedelic substance, requiring collaborative delivery of medical and mental health care. Medical professionals working in the field of psychedelic psychotherapy need

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to be aware of the therapeutic process and approach. Mental health professionals working with psychedelics need to be able to recognize potential medical issues, monitor vital signs, and know when to call for medical attention.

Unlike the typical format of weekly one-hour (or 50-minute) sessions, psychedelic sessions are much longer; for example, MAPS' MDMA-assisted psychotherapy sessions are eight hours long, designed to match the duration of drug effect and the intention to support deep process. Additionally, many psychedelic psychotherapies adopt a co-therapy model: two practitioners working together with each participant, again designed to support the depth of work.

In addition to these logistical differences, psychedelic substances can evoke direct experiences of insight, aspects of self, traumatic memories, somatic sensations, and spirituality. MAPS' approach to MDMA-assisted psychotherapy aims to provide an environment of safety and support for individuals to engage with their own *inner healing intelligence*, a person's innate wisdom and ability to move toward wholeness and authenticity. Practitioners support participants in arriving at their own insights and finding trust in the wisdom of their own body and mind to heal. Psychedelic therapists help participants navigate the psychedelic experience and work with non-ordinary states as a resource in the therapeutic journey.

Psychedelic states present the possibility for greater openness and empathy, which are viewed as assets in therapeutic work lending to authenticity, transparency, self-acceptance, perspective, and connection. It's important to understand, however, that with greater openness and empathy, a person in a psychedelic state may also be highly suggestible, especially prone to the suggestion or influence of others. This introduces an even greater need for client-centered approaches, therapeutic skill in navigating transference and countertransference, and professional boundaries in psychedelic therapy. Psychedelic psychotherapy heightens the importance of trust, trustworthiness, and safety.

The process of therapeutic relationship and the dynamics of trust place a significant amount of power and responsibility in the hands of the practitioner. Many psychotherapeutic ethical codes speak to the need for practitioners to be aware of the power differential in therapeutic relationships and to use their role power consciously and ethically. Cedar Barstow, author of *Right Use of Power* (2008) and a reviewer of the MAPS Code of Ethics, writes, "not only do we all have the capacity to misuse power, but we are all subject to the addictive trance of elevated power that reduces our empathy and inhibitions and pulls us toward prioritizing our own needs and interests because our

higher role or rank allows us to." Psychedelic therapies may also shift the power dynamics between participants and therapists toward greater balance and reciprocity. The therapeutic approach of MDMA-assisted psychotherapy is described as "inner directed," meaning the participant's inner healing force guides the therapeutic process. Instead of directing or interpreting unconscious material, the practitioner respects the participant as the authority of their consciousness and healing, and offers guidance only to support the participant in moving through their process. "Placing clinicians as alternatively facilitators and 'empathic witnesses' disrupts inherent power dynamics in the therapeutic alliance" (Hutchinson & Bressi, 2018, p. 427).

Developing a MAPS Code of Ethics for Psychedelic Psychotherapy

Given that psychedelic substances induce non-ordinary states of consciousness, extra care and attention must be given to support these states and use them skillfully as a therapeutic tool. With these unique aspects in mind, specific training and guidance is needed to support the ethical practice of psychedelic psychotherapy. The groundwork for ethical codes in non-ordinary states has been laid out through the efforts of groups such as the Council on Spiritual Practices, who developed their first version of a "Code of Ethics for Spiritual Guides" in 1996. Learning from the work of others, the MDMA Therapy Training Program sought to develop a Code of Ethics for its practitioners.

In early 2018, the MDMA Therapy Training Program began developing a Code of Ethics, aiming to define the ethical guidelines and agreements of practitioners working on MAPS protocols. Drafting the Code of Ethics took a full year of research, reflection, and review. The Code was edited by the authors of this article: Shannon Carlin, M.A., AMFT, MAPS Public Benefit Corporation (MAPS PBC) Director & Head of Training and Supervision, and Sarah Scheld, M.A., MAPS PBC Training and Supervision Associate. More than a dozen reviewers and contributors from the fields of psychology, psychedelics, medicine, and ethics contributed their experience and perspective, including: Cedar Barstow, MEd, CHT, Marca Cassity, BSN, LMFT, Karen M. Cooper, M.A., R.N., Leia Friedman, M.S., Shai Lavie, MFT, Ismail Lourido Ali, J.D., Annie Mithoefer, BSN, Michael Mithoefer, M.D., Angella Okawa, LMFT, Marcela Ot'olora G., LPC, Bruce Poulter, R.N., Dominic A. Sisti, Ph.D., Kylea Taylor, M.S., LMFT, Verena Wieloch, LPCA, LCAS, and several others who generously provided feedback and wisdom.

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One reviewer, Kylea Taylor, authored the book *The Ethics of Caring*, which describes a method she calls InnerEthics, a practice that supports clinicians in navigating ethical issues and reflecting on their own therapeutic work with expanded states of consciousness. Taylor writes:

The deeper a client moves into a state of consciousness which has an inner or transpersonal focus, the greater the need for a professional's adherence to the ordinary ethical issues and the greater the need for professional self-reflection, supervision, and an ethic of care.

The MAPS Psychedelic Psychotherapy Code of Ethics was published in April 2019, appearing in the Spring edition of the *MAPS Bulletin*. The updated and re-named MAPS Code of Ethics for Psychedelic Psychotherapy has twelve sections:

1. Safety
2. Confidentiality and Privacy
3. Transparency
4. Therapeutic Alliance and Trust
5. Use of Touch
6. Sexual Boundaries
7. Diversity
8. Special Considerations for Non-Ordinary States of Consciousness
9. Finances
10. Competence
11. Relationship to Colleagues and the Profession
12. Relationship to Self

The remainder of this article will focus specifically on the ethical guidelines for sexual boundaries. The reason for this focus, knowing that every section of the code has deep and meaningful history and context worthy of discussion, and that sections are interdependent and inform one another, is to highlight an area that continues to present ethical challenges and social taboos across the disciplines of healthcare and many professions. Additionally, though the Code has undergone minor edits since its original publication, the guideline around sexual intimacy with former clients has specifically undergone significant modification, which is described and explained below.

Practicing integrity in therapeutic relationships requires confronting past experiences and beliefs about love, attachment, and relationship—those of the therapist, client, and society.

Love in Therapy

Psychotherapy is an intimate process, clients risk sharing their fears and grief and practicing trust and connection. Judith A. Schaeffer describes that, in therapy, clients risk being loved and expressing love, which both provide direct experiences counter to the thought that one is unlovable or incapable of loving. The loving attention of a therapist can support a participant's experience of safe and healthy love. Too often experiences of love are entangled in relationships of abuse and neglect. Therapists must work proactively to ensure that their relationships with clients do not repeat familiar patterns of abuse and neglect. Practicing integrity in therapeutic relationships requires confronting past experiences and beliefs about love, attachment, and relationship—those of the therapist, client, and society.

Judith A. Schaeffer (2019) writes:

[T]ransference love arises when clients perceive their therapist as someone from their past and thus transfers love related to an unresolved affiliate conflict from the past to the present. Countertransference love arises when a therapist does this. It also arises simply when a therapist receives a client's transferred feelings, thoughts, and sensations.

Fortunately, what usually comes alive in therapy is non-erotic transferred love. However, that form of love may evolve into other forms: the erotic, the eroticized, and the perverse. And these forms can be initiated by either client or therapist. Similarly, they can be received and responded to by either client or therapist.

Many people carry shame, trauma, and repressed feelings about sexuality. MDMA can be used as a therapeutic tool to support the healing of sexual trauma. MDMA's subjective effects include feelings of openness, empathy, connection to others, and heightened sensuality, which can aid in revisiting traumas with a new/renewed sense of resource and safety.

Psychedelic states may also intensify sexual feelings felt by the participant towards the therapist and sexual feelings felt by the therapist towards the participant, requiring a greater level of therapist self awareness and regulation as well as meaningful training and supervision in how to work with sexual feelings in psychotherapy. Kylea Taylor reflects that psychedelic sessions can open up powerful emotions not only for participants, but also for practitioners, who should not underestimate the unconscious fears and longings that can be catalyzed when holding space for others in expanded states of consciousness.

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Professional Sexual Boundaries

Ethical codes within the field of mental health consistently prohibit sexual relations between professionals and clients who are currently in treatment. However, professional organizations have varying views on when, if ever, it might be considered acceptable for a therapist to engage sexually with *former* clients. For example, the American Psychological Association and the California Association of Marriage and Family Therapists both state that therapy providers must not engage in sexual intimacies with former clients for at least two years after termination of therapy (CAMFT Code of Ethics, 2020; Ethical Principles of Psychologists and Code of Conduct, 2017). The American Psychiatric Association simply states, "sexual activity with a current or former patient is unethical" (The Principles of Medical Ethics, 2013). The CAMFT Ethics Committee recently made substantive revisions to their Code of Ethics, including requirements for therapists to assess certain factors prior to engaging in a sexual relationship with a former client to avoid potential harm or exploitation (Griffin, 2020).

When MAPS began drafting the Code of Ethics, we were faced with this same question: when, if ever, is it ethical for an MDMA-assisted psychotherapy provider to engage sexually with a former participant? As the organization set out to formalize its standards for the clinical practice of MDMA-assisted psychotherapy, we were faced with widely divergent examples in the field of psychotherapy. When we looked into the rationale behind the two year post-termination period, we found that some organizations further clarified the rule by adding that, in addition to the two year period, the practitioner must also demonstrate that the relationship does not involve any exploitation, making this an "almost never rule" (Sturm, 1998). The American Psychological Association additionally claims that permanently prohibiting sexual involve-

ment may compromise the client’s autonomy in choosing their personal relationships (Behnke, 2004). Yet some would argue to support a permanent ban on sexual involvement with clients, claiming that because of the power imbalance, the client may not be in a position to clearly evaluate the risks of becoming intimately involved with their practitioner (Sturm, 1998).

After much consideration and consultation, the MDMA Therapy Training Program determined that practitioners working in the MAPS modality should *never* engage sexually with clients or former clients, at any point during or following treatment.

The vulnerability required to do healing work deserves tremendous respect and should be held with care always. MAPS sought an ethical standard that would do justice to the trust and vulnerability that participants share with their therapists.

The MAPS Code of Ethics for Psychedelic Psychotherapy states that therapy providers “do not engage in sexual intercourse, sexual contact, or sexual intimacy with a participant, former participant, their spouse or partner, or their immediate family member, at any point during treatment or following termination.” Therapy providers who are found to violate this Code face the consequence of losing their MAPS certification to practice MDMA-assisted psychotherapy.

Addressing Sexual Ethics Violations

In the MAPS protocols, sexual engagement between providers and participants is never ethical and it is strictly prohibited. It is the therapist’s responsibility to uphold professional boundaries.

However, shortly after MAPS commenced initial research on the Code of Ethics, in April 2018, the organization learned of a serious ethical violation that had taken place between a MAPS therapist and a study participant. In 2015, a therapist working on a Phase 2 trial of MDMA-assisted psychotherapy for PTSD entered into an inappropriate relationship with a participant, which became sexual. In research settings, participants report grievances to the Institutional Review Board (IRB), the independent ethics committee designated to protect the rights of research participants; however, the scope of the IRB is limited in its ability to address grievances beyond the active phase of clinical trials. The participant in this situation filed a grievance with the IRB, but since the study was complete and the investigators were no longer working on research protocols, there was little action the IRB could take in response to the grievance. The participant then reported the grievance to MAPS. At the time the organization didn’t have a formal process for handling grievances directly; clinical trial Sponsors refer to the IRB which has structures and procedures to handle grievances. However, the lack of meaningful support and responsive action motivated MAPS to respond to the grievance and provide resources for the participant to access care while

addressing the ethical violation. For more information, please see MAPS’ Public Announcement of Ethical Violation by Former MAPS-Sponsored Investigators (2019). This ethical breach highlighted the crucial need to bring honest attention to the real potential for such violations, and to create structures to prevent and address ethical transgressions.

Clear grievance procedures are needed for participants in psychedelic psychotherapy. MAPS is aware that there are gaps for participant protection in psychedelic research and clinical settings. While ethical review in research settings is handled by IRBs, the ethical oversight of clinical practice beyond research is typically handled by professional associations and licensing boards. As the modality of psychedelic psychotherapy enters into standard clinical practice, new guidelines, associations, and perhaps new credentialing boards will be needed to protect consumer and provider liability.

In light of this, MAPS has been developing procedures for addressing grievances, which has included hiring an Ethics and Compliance Officer, establishing pathways for receiving grievances, and policies for appropriate review and response to grievances. Community members in the psychedelic field are currently working to establish professional associations focused on psychedelic therapies. The establishment of standing ethics boards specializing in psychedelic psychotherapy could go further to provide meaningful resources to clients who have been harmed by ethical violations—resources such as funds and appropriate referrals for reparative psychotherapy, referrals to peer support groups, education and support to family members and others who may be impacted, not to mention resources for providers in the wake of grievances filed against them, to encourage and support authentic self-reflection and responsibility.

The MDMA Therapy Training Program is committed to ethical practice. The Code of Ethics is now a foundation for our training curriculum. All therapy providers and study staff members working on MAPS protocols are oriented to the Code and sign their agreement to uphold its tenets. Structures to enforce the Code and support participants, such as a Participant Bill of Rights, are in development. The Code of Ethics will remain a living document to grow and adapt with the ongoing integration of feedback and evolution of needs over time.

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Supporting Providers in their Ethical Commitments

Participant safety is the first priority in the field of healthcare. In service to participant safety, it is essential for practitioners to understand the legal and ethical parameters of therapeutic work. Clinical training programs relay the rules against sexual involvement with clients, and impress a strong warning never to have sex with a client, yet a significant number of care professionals still cross that line. This is a violation of trust in a profession that requires so much trust from patients and clients.

Data from a national pool of mental health professionals shows that the incidence of sexual contact between clients and practitioners in the United States ranges between 7–12% (Alpert & Steinberg, 2017). Given that these cases are self-reported, it's likely that the prevalence may even be higher.

Kenneth S. Pope and colleagues conducted extensive research in the 1980s exploring the topic of sexual attraction to clients. In Pope's survey of over 500 therapists, 87% reported having been sexually attracted to a client, and although only a minority acted on their feelings, many felt guilty, anxious, or confused about their attraction. About 50% of psychotherapists claimed they did not receive any guidance or training concerning sexual attraction to clients, and only 9% reported that they had received adequate training or supervision on the matter (Pope et al., 2006).

Pope highlights the need for training programs to acknowledge and examine the phenomenon of sexual attraction to clients and to provide clinicians with tools to recognize and work with this form of countertransference. Clinical training programs should support trainees in acquiring the knowledge and skills necessary to recognize and respond appropriately to sexual attraction, both attraction expressed by the client as well as attraction felt by the therapist. Competence in working with erotic transference supports clinicians in their ability to uphold professional boundaries, and further, in the ability to actually use erotic transference as a therapeutic tool.

Sexual attraction is a common human experience, especially in intimate settings. Psychotherapists don't tell clients to simply stop feeling a feeling and to be sure not to act on it,

instead, they help clients explore feelings and develop tools to work with them so they can know themselves better and make conscious decisions. Therapists are provided basic instruction in how to respond to a client's expression of attraction to the therapist, but they are provided very little, if any, guidance to work with their own attraction to a client. The clinical field must break the taboo and do for therapists what therapists aim to do for clients, provide safe and open spaces to develop tools and work with feelings, including sexual feelings, and especially sexual feelings in the therapeutic environment.

In addition to focused efforts to create procedures and resources to support *clients* who have been harmed by ethical violations, clinical programs should also put resources towards preventing ethical infringements through meaningful training, supervision, and ongoing support for clinicians. When asked how to address sexual ethics violations in psychotherapy, many leaders in the field respond that the focus must be on a preventative approach, working with providers to foster open dialogue and authentic support in the times it is most needed.

Ongoing supervision, peer consultation, and support groups can be non-judgmental spaces for providers to talk about the most challenging aspects of their work, which is so important for the ongoing safety, integrity, quality, and sustainability of their practice and their own well-being. As with many health care professions, isolation and burnout are common for psychotherapists.

While ongoing supervision and resources for self and community care are essential throughout a practitioner's career, practitioners must also take responsibility for their own projections, countertransference, and personal needs in relation to participants, engaging in ongoing self reflection, and receiving and integrating feedback from supervisors and peers.

Thankfully, more and more people are addressing issues of sexual abuse and gender-related discrimination in psychedelic spaces. By promoting safe spaces to gather feedback, listening to the stories of survivors, and openly discussing the ethical challenges facing providers, we create healing environments worthy of trust.



SHANNON CARLIN, M.A., AMFT, is the Director and Head of Training and Supervision at MAPS Public Benefit Corporation (MAPS PBC). As the Director of Training and Supervision, Shannon oversees the development and implementation of the programs that provide training and supervision to prepare mental health and medical professionals to deliver MDMA-assisted psychotherapy in approved clinical settings. Shannon started working with MAPS in 2011 before joining MAPS PBC in 2016. In her dedication to supporting people through growth and healing, Shannon has served as a co-therapist on MAPS-sponsored Phase 2 trials researching MDMA-assisted psychotherapy for anxiety associated with life-threatening illness and MDMA-assisted psychotherapy for severe PTSD. Shannon's direct clinical work continues to inform the development and implementation of the training programs she oversees. Shannon received her master's degree in Integral Counseling Psychology from the California Institute of Integral Studies (CIIS) and a bachelor's degree in Cultural Anthropology from the University of California, Santa Cruz.

SARAH SCHELD, M.A., is Training and Supervision Associate at MAPS Public Benefit Corporation (MAPS PBC). In her role with the MDMA Therapy Training Program, Sarah supports supervision and training for MDMA-assisted psychotherapy providers, and program and curriculum development. She received her M.A. from the California Institute of Integral Studies' East-West Psychology program, focusing on psychedelic and Gnostic studies. Sarah has trained extensively in somatic experiential psychotherapies such as Hakomi and Somatic Experiencing, and spoken publicly on somatic and trauma-informed approaches to psychedelic psychotherapy. In addition to her dedication to therapeutic trauma work, Sarah enjoys engaging in trauma healing through art and storytelling; with a professional background in production design and filmmaking, her writing and film work explore the archetype of rape and sexual violence. She is passionate about the role of trauma awareness and the skillful use of psychedelic medicines in individual and collective healing. She lives in Occidental, California.

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