PSYCHEDELIC THERAPY RESEARCH WALL CHART — INTEGRATIVE DOMAIN GRAPH

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Legend: RCT=randomized controlled trial; EBM=evidence-based medicine; PAT=psychedelic-assisted therapy;
KAP=ketamine-assisted psychotherapy; SAP=special access / compassionate pathways; AE=adverse event;
SAE=serious adverse event; 5-HT2A=serotonin 2A receptor; SUD=substance use disorder; ReSPCT=reporting of setting guidelines

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MASTER ROOT
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START
|
+-- D0: WHAT KIND OF RESEARCH QUESTION?
|   |
|   +-- efficacy / effectiveness ------------------------------------> A: TRIALS + EBM
|   +-- safety / tolerability ---------------------------------------> B: RISK + AE
|   +-- mechanism ---------------------------------------------------> C: PHARMACOLOGY + NEUROSCIENCE
|   +-- psychotherapy process ---------------------------------------> D: THERAPEUTIC MODEL
|   +-- mindset / setting / context ---------------------------------> E: EXTRA-PHARMACOLOGY
|   +-- lived experience / meaning ----------------------------------> F: PHENOMENOLOGY + QUALITATIVE
|   +-- ethnography / anthropology / ritual -------------------------> G: ETHNOGRAPHY + INDIGENOUS KNOWLEDGE
|   +-- implementation / training / delivery ------------------------> H: CLINICAL TRANSLATION
|   +-- ethics / law / policy / access ------------------------------> I: GOVERNANCE + JUSTICE
|   +-- economics / industry / institutions -------------------------> J: POLITICAL ECONOMY
|
+-- D1: WHAT UNIT OF ANALYSIS?
|   |
|   +-- molecule ----------------------------------------------------> receptor / pharmacology / kinetics
|   +-- session -----------------------------------------------------> acute experience / process
|   +-- therapy arc -------------------------------------------------> prep + dosing + integration
|   +-- patient / participant ---------------------------------------> outcomes / safety / meaning
|   +-- dyad / group ------------------------------------------------> therapeutic relationship / social process
|   +-- clinic / trial ----------------------------------------------> protocol / staffing / setting
|   +-- community / tradition ---------------------------------------> ritual / lineage / authority
|   +-- health system / market / law --------------------------------> access / regulation / incentives
|
+-- D2: MAIN FAILURE TO AVOID?
    |
    +-- reducing everything to molecule alone -----------------------> misses context/process
    +-- romanticizing context while ignoring safety -----------------> misses risk
    +-- overgeneralizing small promising trials ---------------------> EBM failure
    +-- appropriating Indigenous traditions as "input data" ---------> ethical failure
    +-- collapsing all substances into one category -----------------> pharmacological and cultural error
    +-- confusing hype, policy, and evidence ------------------------> translational failure

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A. TRIALS + EVIDENCE-BASED MEDICINE
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A0: CLINICAL QUESTION
|
+-- depression / TRD / mood spectrum -----------------------------> common modern trial lane
+-- PTSD / trauma ------------------------------------------------> major lane
+-- anxiety / existential distress -------------------------------> important lane
+-- SUD / alcohol / tobacco / opioids / other --------------------> growing lane
+-- OCD / eating disorders / pain / headache / palliative ---------> specialty lanes
+-- wellness / enhancement / non-clinical outcomes ---------------> different evidentiary standard
|
+-- D: clinical disorder or broad suffering/well-being target?
    +-- clinical disorder -> stronger trial standard
    +-- broad suffering -> outcome framing more complex

A1: STUDY DESIGN
|
+-- case report / case series ------------------------------------> signal generation
+-- observational / naturalistic ---------------------------------> ecological validity / confounding
+-- open-label ---------------------------------------------------> early clinical signal / expectancy risk
+-- randomized controlled trial ----------------------------------> strongest causal design if well executed
+-- active placebo / active comparator ---------------------------> stronger control for expectancy
+-- pragmatic trial ----------------------------------------------> real-world translation
+-- systematic review / meta-analysis ----------------------------> synthesis, not magic
|
+-- D: is the strongest design feasible and ethical?
    +-- Y -> pursue
    +-- N -> interpret limitations explicitly

A2: INTERNAL VALIDITY
|
+-- randomization adequate? --------------------------------------> confounding reduction
+-- allocation concealed? ----------------------------------------> selection bias reduction
+-- blinding plausible? ------------------------------------------> expectancy/detection bias reduction
+-- dropout balanced / explained? --------------------------------> attrition bias handling
+-- protocol preregistered? --------------------------------------> selective reporting check
|
+-- D: outcome subjective and expectancy-sensitive?
    +-- Y -> blinding / comparator design especially important
    +-- N -> still important but less dominant

A3: EXTERNAL VALIDITY
|
+-- population representative? -----------------------------------> generalizability
+-- psychiatric comorbidity excluded heavily? --------------------> narrower applicability
+-- medical complexity excluded? --------------------------------> narrower applicability
+-- therapist expertise unrealistic? ----------------------------> implementation issue
+-- setting highly curated? --------------------------------------> translation issue
|
+-- D: trial participants unlike real clinical population?
    +-- Y -> caution in extrapolation
    +-- N -> stronger applicability

A4: OUTCOMES
|
+-- symptom scores -----------------------------------------------> conventional psychiatric metric
+-- remission / response -----------------------------------------> clinically legible
+-- functioning / quality of life --------------------------------> important patient-centered outcomes
+-- durability ---------------------------------------------------> essential in PAT claims
+-- adverse events / difficult experiences ----------------------> safety
+-- mechanism mediators ------------------------------------------> hypothesis support, not endpoint substitute
|
+-- D: only surrogate / short-term endpoint reported?
    +-- Y -> weaker clinical meaning
    +-- N -> stronger relevance

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B. SAFETY, RISK, AND HARM
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B0: RISK TYPES
|
+-- acute physiological ------------------------------------------> BP/HR, nausea, dissociation, ataxia etc.
+-- acute psychological ------------------------------------------> anxiety, panic, paranoia, disorganization
+-- post-acute destabilization -----------------------------------> mood instability, insomnia, confusion
+-- persistent adverse change ------------------------------------> rare but important category
+-- interaction risk ---------------------------------------------> meds, comorbidity, environment
+-- legal / social / cultural harm -------------------------------> stigma, coercion, criminalization, exploitation
|
+-- D: safety framed narrowly as "no major medical event"?
    +-- Y -> incomplete
    +-- N -> broader safety model

B1: WHO IS AT RISK?
|
+-- bipolar-spectrum vulnerability -------------------------------> mania / destabilization concern
+-- psychosis-spectrum vulnerability -----------------------------> exacerbation concern
+-- cardiac / neurological / seizure risk ------------------------> substance-dependent concern
+-- polypharmacy -------------------------------------------------> interaction risk
+-- trauma history / dissociation --------------------------------> process sensitivity
+-- social precarity ---------------------------------------------> integration/support risk
|
+-- D: exclusion criteria protecting science or merely sanitizing population?
    +-- protecting science -> maybe justified
    +-- oversanitizing -> translational blind spot

B2: SESSION-SPECIFIC RISK
|
+-- preparation inadequate ---------------------------------------> destabilization / non-consent-like dynamics
+-- dosing environment unsafe ------------------------------------> acute harm risk
+-- therapist boundary problems ---------------------------------> serious ethical risk
+-- poor crisis response ----------------------------------------> avoidable escalation
+-- no integration ----------------------------------------------> meaning fallout / instability
|
+-- D: risk management protocol explicit?
    +-- Y -> stronger safety frame
    +-- N -> unacceptable in clinical setting

B3: COMPARATIVE SAFETY LOGIC
|
+-- classic psychedelics -----------------------------------------> acute intense altered state, usually shorter-to-medium duration
+-- ketamine / esketamine ----------------------------------------> dissociation, shorter duration, clinical familiarity
+-- MDMA ---------------------------------------------------------> autonomic + empathogenic profile, trauma-focused interest
+-- ibogaine -----------------------------------------------------> substantial cardiac/medical caution
+-- 5-MeO-DMT ----------------------------------------------------> intense rapid-onset/brief but powerful experiences
|
+-- D: "psychedelics" treated as one safety bucket?
    +-- Y -> serious category error
    +-- N -> substance-specific evaluation better

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C. PHARMACOLOGY, MECHANISM, AND NEUROSCIENCE
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C0: SUBSTANCE FAMILIES
|
+-- classic serotonergic psychedelics ----------------------------> psilocybin/psilocin, LSD, mescaline lineages, DMT lineages
+-- entactogens --------------------------------------------------> MDMA-like
+-- dissociatives ------------------------------------------------> ketamine/esketamine and adjacent dissociatives
+-- atypical/non-classical lines ---------------------------------> ibogaine/noribogaine, 5-MeO-DMT, salvinorin A, others
+-- adjacent/contested inclusion ----------------------------------> muscimol/Amanita, deliriants, PCP-like compounds, etc.
|
+-- D: same receptor story for all?
    +-- Y -> wrong
    +-- N -> substance family distinction preserved

C1: MECHANISTIC LEVELS
|
+-- receptor pharmacology ----------------------------------------> e.g. 5-HT2A emphasis for classic psychedelics
+-- network dynamics / connectivity ------------------------------> systems-level changes
+-- plasticity / learning hypotheses -----------------------------> attractive but often oversold
+-- memory reconsolidation / fear extinction models --------------> trauma/addiction relevance
+-- social-affective openness / salience shift -------------------> therapeutic hypotheses
+-- mystical / self-transcendent / insight pathways --------------> experiential mediators
|
+-- D: mechanism claim directly proven or inferential?
    +-- proven narrowly -> state carefully
    +-- inferential -> avoid overclaiming

C2: DOSE AND TIME
|
+-- microdose ----------------------------------------------------> sub-hallucinogenic/superceptual claim space
+-- low/moderate dose --------------------------------------------> milder alteration
+-- high dose ----------------------------------------------------> stronger acute state / stronger risk + meaning
|
+-- D: duration manageable in ordinary clinic?
    +-- Y -> easier implementation
    +-- N -> staffing/setting burden rises

C3: MECHANISM-TO-THERAPY GAP
|
+-- receptor effect known? ---------------------------------------> not same as therapeutic mechanism known
+-- network change observed? -------------------------------------> not same as clinical mediation proved
+-- biomarker shift found? ---------------------------------------> not same as patient benefit established
|
+-- D: neuroscience being used as marketing halo?
    +-- Y -> caution
    +-- N -> integrate modestly

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D. THERAPEUTIC MODEL AND CLINICAL PROCESS
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D0: WHAT IS THE TREATMENT?
|
+-- drug alone ---------------------------------------------------> pharmacotherapy frame
+-- drug + structured psychotherapy ------------------------------> classic PAT frame
+-- drug + supportive monitoring ---------------------------------> lighter-touch frame
+-- repeated ketamine-style protocol -----------------------------> somewhat different model
+-- ceremonial / communal + therapeutic meaning ------------------> non-clinic frame
|
+-- D: intervention not clearly specified?
    +-- Y -> hard to interpret
    +-- N -> better

D1: COMMON PROCESS PHASES
|
+-- screening ----------------------------------------------------> risk / fit / diagnosis / consent
+-- preparation --------------------------------------------------> alliance, expectations, orientation
+-- dosing session -----------------------------------------------> acute support / observation
+-- integration --------------------------------------------------> meaning-making, behavioral incorporation
+-- follow-up ----------------------------------------------------> durability / safety / relapse monitoring
|
+-- D: one phase missing or weak?
    +-- Y -> treatment model incomplete
    +-- N -> more coherent pathway

D2: THERAPIST VARIABLES
|
+-- training model -----------------------------------------------> unclear field-wide standardization problem
+-- experience / lineage -----------------------------------------> affects process
+-- style: nondirective vs directive -----------------------------> meaningful variation
+-- cultural humility / power awareness --------------------------> critical
|
+-- D: therapist variable treated as noise rather than intervention component?
    +-- Y -> under-theorized
    +-- N -> stronger process science

D3: PROCESS OUTCOMES
|
+-- mystical-type experience -------------------------------------> one prominent mediator hypothesis
+-- emotional breakthrough ---------------------------------------> another mediator line
+-- therapeutic alliance -----------------------------------------> likely important
+-- self-compassion / acceptance / flexibility -------------------> common candidate mediators
+-- narrative revision / autobiographical meaning ----------------> qualitative importance
|
+-- D: process measures absent?
    +-- Y -> mechanism impoverished
    +-- N -> richer model

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E. MINDSET, ENVIRONMENT / CONTEXT / SETTING, AND EXTRA-PHARMACOLOGICAL VARIABLES
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E0: PATIENT MINDSET
|
+-- expectations -------------------------------------------------> powerful expectancy effects
+-- mood / readiness ---------------------------------------------> sessions trajectory
+-- prior trauma / attachment / spirituality ---------------------> process shaping
+-- hopes / fears / cultural scripts -----------------------------> meaning-making
|
+-- D: mindset variables measured?
    +-- Y -> stronger process science
    +-- N -> missing major determinant

E1: ENVIRONMENT / CONTEXT / SETTING
|
+-- physical room ------------------------------------------------> aesthetics, privacy, safety
+-- music / silence / sensory modulation -------------------------> strong influence
+-- therapist presence / number ----------------------------------> interactional setting
+-- institutional container --------------------------------------> clinic vs retreat vs lab vs community
+-- cultural safety ----------------------------------------------> not optional
|
+-- D: setting reported systematically?
    +-- Y -> stronger reproducibility
    +-- N -> hidden intervention component

E2: ReSPCT-TYPE REPORTING LOGIC
|
+-- physical environment -----------------------------------------> document
+-- dosing procedures --------------------------------------------> document
+-- therapeutic framework ---------------------------------------> document
+-- subjective / contextual variables ----------------------------> document
|
+-- D: trial claims causal clarity while underreporting setting?
    +-- Y -> methodological weakness
    +-- N -> stronger reporting

E3: CONTEXTUAL PLURALISM
|
+-- clinic model -------------------------------------------------> biomedical legitimacy
+-- retreat/ceremonial model -------------------------------------> communal/ritual context
+-- hybrid model -------------------------------------------------> translation attempt
|
+-- D: one context treated as universally normatively superior?
    +-- Y -> simplistic
    +-- N -> better comparative inquiry

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F. PHENOMENOLOGY, QUALITATIVE RESEARCH, AND SUBJECTIVE PROCESS
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F0: WHY QUALITATIVE METHODS MATTER
|
+-- meaning is central -------------------------------------------> subjective content not noise
+-- adverse experiences need nuanced description ------------------> yes
+-- healing may unfold narratively/socially ----------------------> yes
|
+-- D: outcomes reduced to symptom scale only?
    +-- Y -> partial picture
    +-- N -> richer understanding

F1: COMMON QUALITATIVE DOMAINS
|
+-- selfhood / identity change -----------------------------------> common
+-- trauma narrative revision ------------------------------------> common
+-- embodiment / somatic process ---------------------------------> common
+-- spirituality / sacredness / cosmology ------------------------> common
+-- relationship / attachment shifts ----------------------------> common
+-- difficult/challenging experience integration -----------------> crucial
|
+-- D: trial has no language for participants' lived meaning?
    +-- Y -> interpretive blind spot
    +-- N -> stronger depth

F2: METHODS
|
+-- interviews ---------------------------------------------------> depth
+-- thematic analysis --------------------------------------------> common
+-- IPA / phenomenology ------------------------------------------> depth of subjectivity
+-- mixed methods ------------------------------------------------> bridge qual and quant
|
+-- D: qualitative component tokenistic?
    +-- Y -> weak integration
    +-- N -> meaningful complement

F3: HARD QUESTION
|
+-- are experiences merely epiphenomenal? ------------------------> one view
+-- are experiences part of the mechanism? -----------------------> another view
|
+-- D: field prematurely choosing one answer?
    +-- Y -> theoretical narrowing
    +-- N -> keep open plural inquiry

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G. ETHNOGRAPHY, ANTHROPOLOGY, RITUAL, AND INDIGENOUS KNOWLEDGES
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G0: ETHNOGRAPHIC RESEARCH TARGETS
|
+-- ayahuasca churches / retreats / healing centers --------------> major literature
+-- peyote / mescaline ceremonial contexts -----------------------> major Indigenous and legal context
+-- iboga / Bwiti contexts ---------------------------------------> major lineage context
+-- mushroom / psilocybin traditions ----------------------------> diverse historical and contemporary contexts
+-- neo-shamanic / globalized retreat cultures ------------------> tourism/commodification context
|
+-- D: ethnography treated as colorful preface to biomedical research?
    +-- Y -> extractive stance
    +-- N -> more reciprocal scholarship

G1: WHAT ETHNOGRAPHY CONTRIBUTES
|
+-- thick description of practice --------------------------------> cannot get from RCT alone
+-- authority and lineage ---------------------------------------> who is trusted and why
+-- ritual structure ---------------------------------------------> therapeutic container
+-- power/safety dynamics ---------------------------------------> crucial
+-- globalization / tourism / commodification -------------------> essential
+-- ecological and land relations --------------------------------> often central
|
+-- D: are local worlds flattened into mindset and "setting" only?
    +-- Y -> reductionismx
    +-- N -> stronger anthropological respect

G2: INDIGENOUS AND DECOLONIAL QUESTIONS
|
+-- sovereignty --------------------------------------------------> central
+-- reciprocity --------------------------------------------------> central
+-- intellectual/cultural property ------------------------------> central
+-- benefit sharing / Nagoya-like concerns ----------------------> relevant
+-- extraction without return -----------------------------------> ethical failure
|
+-- D: "translation to medicine" erasing source communities?
    +-- Y -> decolonial critique warranted
    +-- N -> better reciprocity possible

G3: RITUAL VS THERAPY
|
+-- ritual not equal therapy -------------------------------------> but may be therapeutic
+-- therapy not equal ritual -------------------------------------> but may borrow ritual forms
+-- hybridization common ----------------------------------------> analytically important
|
+-- D: category boundaries examined or assumed?
    +-- examined -> stronger scholarship
    +-- assumed -> conceptual confusion likely

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H. IMPLEMENTATION, TRAINING, AND CLINICAL TRANSLATION
================================================================================================================

H0: IF EVIDENCE IMPROVES, THEN WHAT?
|
+-- who prescribes / screens? ------------------------------------> psychiatrists, physicians, others depending system
+-- who conducts sessions? --------------------------------------> therapists / guides / teams
+-- what setting? -----------------------------------------------> hospital, clinic, outpient, retreat-like adaptation
+-- how many staff-hours? ---------------------------------------> huge implementation question
|
+-- D: delivery model economically and logistically plausible?
    +-- Y -> translational promise
    +-- N -> evidence may not scale

H1: TRAINING
|
+-- uniform training standard ------------------------------------> unrealistic and counterproductive
+-- competencies include:
|   +-- crisis management
|   +-- trauma-informed practice
|   +-- boundaries / ethics
|   +-- cultural humility
|   +-- medical screening knowledge
|   +-- integration work
|
+-- D: training model transparent and evaluated?
    +-- Y -> stronger profession-building
    +-- N -> risk

H2: PATIENT PATHWAY
|
+-- referral / triage --------------------------------------------> entry
+-- screening ---------------------------------------------------> inclusion/exclusion
+-- prep --------------------------------------------------------> alliance
+-- dosing ------------------------------------------------------> acute care
|
+-- integration -------------------------------------------------> change consolidation
+-- monitoring --------------------------------------------------> follow-up
|
+-- D: system built only around dosing day?
    +-- Y -> unsafe/incomplete
    +-- N -> more whole-care model

H3: ACCESS
|
+-- private cash-pay clinics ------------------------------------> inequity risk
+-- research-only access ----------------------------------------> scarcity
+-- special access pathways -------------------------------------> uneven access
+-- public system integration -----------------------------------> hard but equitable aspiration
|
+-- D: access stratified by wealth / geography / race / status?
    +-- Y -> justice problem
    +-- N -> stronger public health orientation

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I. ETHICS, LAW, POLICY, AND JUSTICE
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I0: ETHICAL DOMAINS
|
+-- informed consent --------------------------------------------> difficult under hype/expectancy
+-- therapist boundary safety -----------------------------------> essential
+-- vulnerable populations --------------------------------------> careful inclusion/exclusion
+-- expectancy / suggestibility ---------------------------------> unusual relevance
+-- spiritual coercion / worldview imposition -------------------> real concern
+-- commercialization vs care -----------------------------------> tension
|
+-- D: ethics framed only as IRB compliance?
    +-- Y -> too narrow
    +-- N -> better

I1: LEGAL / REGULATORY LANDSCAPE
|
+-- clinical trials ---------------------------------------------> core pathway
+-- special access / compassionate pathways ---------------------> patchwork
+-- decriminalization / legal access shifts ---------------------> rapidly changing, not same as medical approval
+-- ceremonial exemptions / Indigenous protections --------------> distinct logic
|
+-- D: legal availability confused with evidence-based indication?
    +-- Y -> major public confusion
    +-- N -> cleaner discourse

I2: PUBLIC HEALTH QUESTIONS
|
+-- diversion / misuse ------------------------------------------> concern
+-- retreat/underground harm ------------------------------------> concern
+-- workforce credentialing -------------------------------------> concern
+-- adverse event reporting outside trials ----------------------> concern
|
+-- D: policy focused only on therapeutic promise?
    +-- Y -> lopsided
    +-- N -> stronger balance

I3: JUSTICE LENS
|
+-- who was criminalized historically? --------------------------> central justice question
+-- who profits now? --------------------------------------------> central
+-- whose knowledge is cited vs compensated? --------------------> central
+-- whose risks are externalized? -------------------------------> central
|
+-- D: renaissance narrative ignoring historical violence?
    +-- Y -> ethical shallowness
    +-- N -> stronger historical realism

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J. POLITICAL ECONOMY, COMMERCIALIZATION, AND INSTITUTIONS
================================================================================================================

J0: RESEARCH FUNDING SHAPES KNOWLEDGE
|
+-- academic grants ---------------------------------------------> slower, more independent
+-- philanthropy ------------------------------------------------> catalytic, agenda-shaping
+-- venture-backed commercialization ----------------------------> speed + pressure + IP logic
+-- nonprofit/community research --------------------------------> different priorities
|
+-- D: commercial pathway shaping endpoint and delivery model?
    +-- Y -> interrogate incentives
    +-- N -> still examine institutional bias

J1: WHAT GETS STUDIED?
|
+-- patentable formulations / protocols -------------------------> likely favored
+-- scalable clinic-compatible substances -----------------------> likely favored
+-- slower/ritual/community models ------------------------------> often less funded
+-- naturalistic/ethnographic realities -------------------------> often secondary
|
+-- D: research agenda broader than investable product thesis?
    +-- Y -> healthier field
    +-- N -> commercialization bias visible

J2: THERAPY AS LABOR
|
+-- high therapist time -----------------------------------------> costly
+-- extensive prep/integration ----------------------------------> costly but possibly necessary
+-- short-session compounds or lighter-touch models -------------> economically attractive
|
+-- D: treatment model economically incompatible with broad access?
    +-- Y -> major translation problem
    +-- N -> more scalable

J3: HYPE CYCLE
|
+-- renaissance narrative ---------------------------------------> funding/public attention
+-- inflated expectation ----------------------------------------> trial/clinic pressure
+-- disappointment / backlash risk ------------------------------> real
|
+-- D: communication calibrated?
    +-- Y -> healthier field development
    +-- N -> boom-bust dynamics likely

================================================================================================================
K. SUBSTANCE LANDSCAPE
================================================================================================================

K0: CLASSIC SEROTONERGIC PSYCHEDELICS
|
+-- psilocybin / psilocin ---------------------------------------> major clinical research lane
+-- LSD ---------------------------------------------------------> historically central, modern revival
+-- mescaline lineages ------------------------------------------> peyote, San Pedro, other cactus traditions
+-- DMT lineages ------------------------------------------------> ayahuasca, pharmahuasca, inhaled/injected contexts
|
+-- D: same route, duration, setting, cultural meaning?
    +-- Y -> false
    +-- N -> preserve distinctions

K1: EMPATHOGEN / ENTACTOGEN LINE
|
+-- MDMA ---------------------------------------------------------> trauma/PTSD interest, distinct pharmacology and phenomenology
|
+-- D: grouped under "psychedelic" for convenience only?
    +-- Y -> category simplification
    +-- N -> still distinct line

K2: DISSOCIATIVE LINE
|
+-- ketamine ----------------------------------------------------> already medically established in other contexts, PAT/KAP overlap
+-- esketamine --------------------------------------------------> regulated medical lane distinct from broader PAT discourse
+-- other dissociatives -----------------------------------------> more peripheral / different risk profile
|
+-- D: dissociation treated as same experiential/clinical logic as classics?
    +-- Y -> oversimplification
    +-- N -> better

K3: IBOGA / IBOGAINE LINE
|
+-- iboga / ibogaine / noribogaine -------------------------------> major addiction / detox interest, major safety complexity
|
+-- D: cardiac and medical caution foregrounded?
    +-- Y -> necessary
    +-- N -> unsafe discourse

K4: OTHER / EMERGING / CONTESTED LINES
|
+-- 5-MeO-DMT ---------------------------------------------------> intense emerging interest
+-- salvinorin A / Salvia divinorum ------------------------------> distinct pharmacology and phenomenology
+-- muscimol / Amanita muscaria ---------------------------------> adjacent/contested in "psychedelic" discourse
+-- microdosing across substances -------------------------------> distinct evidence questions
|
+-- D: adjacent compounds collapsed into one movement narrative?
    +-- Y -> conceptual blur
    +-- N -> better taxonomy

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L. METHODS PLURALISM AND EPISTEMOLOGY
================================================================================================================

L0: WHAT COUNTS AS EVIDENCE?
|
+-- RCT ---------------------------------------------------------> causal efficacy estimate
+-- observational / registry ------------------------------------> real-world signal
+-- qualitative interviews --------------------------------------> lived process
+-- ethnography -------------------------------------------------> social world and ritual reality
+-- historical archive ------------------------------------------> forgotten clinical and cultural lineages
+-- philosophy / ethics -----------------------------------------> conceptual clarity
+-- neuroscience ------------------------------------------------> mechanism hints
|
+-- D: one method granted total authority?
    +-- Y -> epistemic narrowing
    +-- N -> pluralism

L1: TRIANGULATION
|
+-- efficacy + safety + mechanism + meaning + implementation ------> stronger field
+-- efficacy alone ----------------------------------------------> incomplete
+-- ethnography alone -------------------------------------------> incomplete for clinical adoption
|
+-- D: are methods speaking to each other?
    +-- Y -> cumulative science
    +-- N -> fragmented field

L2: ONTOLOGICAL MODESTY
|
+-- biological account ------------------------------------------> partial
+-- psychological account ---------------------------------------> partial
+-- social/cultural account -------------------------------------> partial
+-- spiritual/religious account ---------------------------------> meaningful for many participants
|
+-- D: one account asserted to exhaust the phenomenon?
    +-- Y -> reductionism
    +-- N -> more adequate plural view

================================================================================================================
M. DECISION SPINES
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M0: IF YOU ARE READING A NEW CLINICAL STUDY
|
+-- substance and dose clearly specified? -----------------------N--> weak
|
+-- prep / dosing / integration described? ----------------------N--> weak
|
+-- setting/context reported? -----------------------------------N--> major limitation
|
+-- comparator/blinding adequate? -------------------------------N--> bias concern
|
+-- outcomes clinically meaningful and durable? -----------------N--> caution
|
+-- population applicable? --------------------------------------N--> limited generalization
|
+-- conclusion proportionate? -----------------------------------Y--> stronger paper
                                                                  N--> hype alert

M1: IF YOU ARE COMPARING SUBSTANCES
|
+-- same pharmacology? ------------------------------------------N--> do not lump
|
+-- same duration / route / acute burden? -----------------------N--> do not lump
|
+-- same therapeutic model? -------------------------------------N--> do not lump
|
+-- same cultural lineage / legal context? ----------------------N--> do not lump
                                                                  Y--> comparison more meaningful

M2: IF YOU ARE DESIGNING RESEARCH
|
+-- molecule-only question? -------------------------------------> include mechanism but not only mechanism
+-- therapy-process question? -----------------------------------> measure alliance, expectations, integration, phenomenology
+-- cultural/ethical question? ----------------------------------> include anthropology/community voices
+-- implementation question? ------------------------------------> include staffing/access/economics
+-- justice question? -------------------------------------------> include history, reciprocity, policy, who benefits

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N. FINAL COMPRESSIONS
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N0: FIVE FIELD-LEVEL QUESTIONS
|
+-- what exactly is the intervention: molecule, session, therapy, ritual, or system?
+-- for whom, under what conditions, and with what exclusions?
+-- what outcomes matter: symptoms, function, meaning, durability, safety, justice?
+-- what methods are needed to answer this question adequately?
+-- who is centered, cited, protected, paid, and benefited?

N1: DESIGN INVARIANTS
|
+-- never reduce psychedelic therapy research to pharmacology alone
+-- never reduce it to narrative/ritual alone when clinical claims are being made
+-- distinguish substances, settings, lineages, and therapeutic models
+-- treat mindset/setting as intervention components, not decorative extras
+-- preserve methodological pluralism: trials, qualitative work, ethnography, history, ethics, implementation
+-- make justice, reciprocity, and power visible, not peripheral
+-- separate evidence, hype, legality, and commercialization analytically

N2: FINAL WALL-CHART COMPRESSION
|
+-- PSYCHEDELIC THERAPY RESEARCH IS:
|       a plural field spanning molecules, minds, relationships, rituals, institutions, and markets
|       studied through trials, observation, phenomenology, ethnography, neuroscience, ethics, and policy
|       under conditions of unusual hype, unusual expectancy, and unusually consequential context effects
|
+-- PRACTICAL RULE:
        do not ask only: "does this substance work?";
        ask instead: "what exactly is being done, by whom, with what preparation and setting,
        for which population, by what evidence, at what risk, within what history, and for whose benefit?"
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