

# THE PSYCHOLOGY OF PLANTS

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AN ETHNOGRAPHY OF PATIENT-PROVIER RELATIONSHIPS  
AT THE TAKIWASI CENTER FOR REHABILITATION

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## Introduction

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Nora: How is your relationship with Jorge [the patient's psychologist] different than your relationship with your psychologist at the rehabilitation center in Barcelona?

Iago: It is similar but deeper... In Barcelona, they are more outside. Here...they are taking plants with you, vomiting with you in the maloka with you. These things open you up to say, "Jorge, I have this problem." There have been moments when he put down limits that he had to, saying, "You can't do this, you can't leave, you can't talk to anyone." It hurts you then, right? Annoys you. But you accept it because it is part of the responsibility, the protection. At the end there is... a lot of gratitude.

In September of 1992, four Peruvian health professionals and a French doctor established a drug addiction rehabilitation center in Tarapoto, Peru. They intended, by founding the center, to investigate the systematic use of Amazonian "shamanistic knowledge" in the treatment of drug addiction (Mabit, 2005). Today, the Takiwasi Center for Drug Addiction Rehabilitation continues to use medicinal plants of traditional Amazonian medicine in conjunction with Western psychology in the treatment of patients from around the globe. For almost fifteen years, the Takiwasi center has sought, and continues to seek, "an efficient, low cost and culturally adapted alternative therapy" (Giove, 2002).

I had the unique opportunity to spend two months as a research intern with the Takiwasi Center in the summer of 2006. The internship was established on the premise that I would complete an ethnographic research project during my stay. At Takiwasi, some of the plants that they administer to treat drug addiction are consciousness-altering. Both patients and providers participate in the ritual ingestion of these plants. I was interested in how the communal, ritual ingestion of these plants affected the patient-provider relationship.<sup>2</sup>

After analyzing my data and reflecting on my experience, I would posit that the ritual ingestion of plants at Takiwasi, when coupled with the rest of their treatment program, affects patient provider

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<sup>1</sup> A small circular building on Takiwasi property.

<sup>2</sup> When I first arrived, I was interested in how the paramount importance of spiritual development for both patients and psychologists affected the relationship between these two parties. When I came back to Hampshire, I realized that my original question assumed that patients and psychologists at Takiwasi experienced spiritual development. My would-be thesis question therefore assumed too much. Luckily, in trying to get my interviewees to talk about their spiritual development, I had steered most of the conversations toward the inclusion of traditional medicine in the treatment. I had asked patients and psychologists how their engagement with the traditional medicine, or "taking plants" as they put it, affected the healing process.

relationships in two main ways. First, the plants engender the patient's trust toward his psychologist and in his treatment. Second, they facilitate a deeper level of disclosure from patient to provider. The relationship between patient and provider is the crux of the psychotherapeutic encounter. The inclusion of plants in Takiwasi's treatment paradigm offers a distinct advantage to the Center's ability to effectively treat drug addiction.

Most literature dealing with the therapeutic value of consciousness-altering substances is dedicated to hallucinogens, but the Takiwasi clinic does not associate the plants that they use with the term "hallucinogen." Hallucinogens, by definition, are "illusions without object." The clinic's founder, Jacques Mabit (1988) argues that the images stimulated by the use of ayahuasca in a therapeutic context are not without object. He argues that the visions reference an object, whether it be psychological, extra-personal or otherwise. This distinguishes them, according to Mabit, from hallucinations. Mabit uses the term "entheogens" to refer to the plants used at Takiwasi. Entheogens are vision-producing plants that have generally social and religious significance (Grob, 1999). The literature addressing the therapeutic potential of entheogens, is scarce, however, and most of it concerned with the Santo Daime Church in Brazil (Riba and Barbanci, 2005; Barbosa, 2005). I have found nothing, in fact, that specifically addresses the role of psychedelics in the patient-provider relationship.

This study builds on the existing literature in the therapeutic use of hallucinogens, and that concerning the therapeutic potential of entheogens where it exists. Most of the research reported here is primary, however. I have drawn together ethnographic data to show specifically how the use of entheogens in drug addiction therapy influences therapist and patient understandings of their relationship.

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There are things about the center that will make you suspicious. It was started by a French doctor, it is funded in large part by non-addicts who come to the center in order to take the plants themselves, some of its patients are European, and, as I have mentioned, they use a consciousness-

altering plants to treat drug addiction. I do not intend to deny your criticisms—they were once my own. Through my ethnographic data, however, I hope to erode your doubt. I argue that the enhancements offered to the patient-psychologist relationship by the inclusion of traditional medicine in Takiwasi's treatment paradigm are so immense that they deserve our attention, genuine curiosity and, at least temporary, suspension of skepticism.

In this paper, I also engage a critical discussion of the politics and economics of the Takiwasi Center. I describe the history, economic structure, employee hierarchy and treatment modality of the clinic. I examine some of the keywords upon which the paper rests, including “spiritual,” and “traditional,” looking at how patients and psychologists must conceptualize and/ or capitalize on these terms.

A discussion of these issues, important as it is, is best placed after a thorough discussion of the ethnographic data itself. With this system of organization, the focus of the paper will be where it belongs: on the conversations and people who gave it form.

### **The Takiwasi Center**

The Center's property is well manicured. On my second day there, the head gardener, José, was kind enough to give me a walking tour of it. As he explained it, the property emerged as one giant garden. It is surrounded on two sides by drooping vines and palm leaves, and behind those, neighbors. A river marks the border of the West property line and Prolongación road marks the East.

The stated objective of the Takiwasi Center is “to revalue the human and natural resources of traditional medicines and to create a true (*verdadera*) therapeutic alternative to drug addiction.” Takiwasi is not aligned with any political party and no patient is refused treatment on account of his political affiliations. The center seeks a treatment that is non-confessional, in terms of religious orientation, and non-coercive” (Giove, 2002). It is run by a small, committed staff of cooks, janitors, gardeners, medical personnel, traditional healers and psychologists.

### Employee Structure

Mabit is the principle director of the center and a Peruvian psychologist named Jaime Torres is the administrative director. Rosa Giove, a Peruvian doctor and a *curendera*, runs workshops with the patients and also leads ayahuasca sessions. While I was there, the rest of the therapeutic team comprised one other curendero (in addition to Giove and Mabit), five psychologists, one physical education instructor, one nurse, and one curendero in-training. The five psychologists held five different nationalities: the only woman was French, and the remaining four men were Mexican, Chilean, Brazilian and Peruvian. The physical education instructor, the nurse the curendero and the curendero-in-training were all Peruvian. I have chosen to examine only the relationship between patients and psychologists.<sup>3</sup>

### The Patients

The Takiwasi Center attracts patients from a variety of nationalities socioeconomic backgrounds. Mabit puts it this way (2002):

Here, the local alcoholic peasant meets the European college student dependent on pot, the urban bourgeois who functions on cocaine, the dealer addicted to a cocaine-based paste, or the delinquent pathological liar who smokes crack.

Generally, patients come from a French-speaking European country, Spain or Peru. According to the most recent ethnographic census of the center, which was completed in 2000 (Giove), two-thirds of the patients consume mainly a highly addictive and debilitating cocaine-based paste. 80% consume alcohol alone or in addition to other drugs. More than half of the patients (53.5%) have already tried treatment by the time they arrive at Takiwasi, one-third of which have tried psychiatric services.

The patient perspectives I report in this ethnography are drawn from interviews with only three male patients. I was offered access to the patients only after I had completed all of my interviews with

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<sup>3</sup> I will not explore relationships between patients and the curenderos, the nurse or the physical education instructor. The last two were excluded from analysis for a lack of time and space. Curenderos were excluded from analysis because, as one of them put it: "The relationship between the patients and I as a curendero, and their relationship with a psychologist are different relationships. A psychologist has a type of work, a way of thinking, right? A curendero has another type of thinking, you know?... The curendero has the capacity to lower or save this person... It is not like that with the psychologists. Psychologists have problems with the patients. But the curenderos are different." As this curendero explained it, the relationship of curendero to patient has different goals and characteristics than the relationships formed between psychologists and patients.

the therapeutic team and then, only through the mediation of the therapeutic team. Two psychologists selected three of the most mentally stable patients for me to interview. They were all European. All had completed at least five months of treatment. One participant came from a high socio-economic background. The socioeconomic backgrounds of the other two patients were not explicit, but were implicitly European middle class.

The patient understandings that I report here are of course constrained by the limitations I faced in participant selection. I regret that my paper lacks the perspectives of any newly entered patients, Peruvian patients, or patients from a less-privileged socioeconomic background. By my understanding, the selection of the patients by the therapeutic team did not represent an attempt promote a particular set of patient perspectives. The selection of the patients was based on their ability to speak Spanish (the newer European patients sometimes could not), their availability,<sup>4</sup> and, as previously described, their emotional stability. In the year before my arrival, three patients had left the center prematurely with three separate female visitors. My presence as a young female offered a potential detriment, therefore, to successful treatment. The limitations I faced are worth noting, but do not significantly compromise my data.

#### Treatment at Takiwasi

The basic infrastructure by which Takiwasi realizes this goal can be divided into three parts: psychotherapy, ergotherapy and traditional medicine or “the plants.” The psychotherapy of Takiwasi is ostensibly the psychotherapy of any drug rehabilitation center. Patients meet with their psychologist once per week and also attend group therapy and meditation sessions one to two times per week.

The ergotherapy can best be understood as the “social reintegration therapy” of any other drug

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4 The patients at Takiwasi are occupied with some activity for almost every hour of the day. These activities include, but are not limited to the practice of artisan, landscaping and carpentry skills, workshops in mask making, authentic movement, rockclimbing, yoga and karate, psychological appointments, group talking-therapy, purges, body work, ayahuasca sessions, diets, outings, meals and sleep. It was planned, for example, that I would interview a newly arrived patient from France, but the openings in his schedule and mine ultimately did not overlap.

rehabilitation center. In ergotherapy, the patients cook, clean, landscape, work carpentry, and generally develop their ability to exist in a real-world working environment. Each morning from 8:30am to 1:00pm is spent in ergotherapy.

The third element of the Takiwasi treatment modality is not found at a typical addiction rehabilitation center. The plants structure and inform the treatment. Mabit (2002) writes:

All the Amazonian healers or shamans explain that psychoactive plants are not only a mixture of chemical substances but are living entities with a "spirit" which can help and cure if they are respected but kill if they are abused.

Takiwasi uses three types of plants in its treatment: purging plants, plants of the diet and ayahuasca. The plants structure the treatment.

The treatment program from a typical Takiwasi patient begins once he demonstrates his motivation to be cured in several getting-to-know you appointments. Once this is accomplished, moves to Takiwasi. He spends the first 10-15 days in relative isolation taking plants that make him vomit.

For the next two months, the patient engages in ergotherapy, psychotherapy and weekly purges. This stage is understood as the "physical rehabilitation stage." At two months, the patient begins his mental/ spiritual rehabilitation stage. It is at this point that he takes his first ayahuasca. A great deal of literature addresses the ayahuasca plant (for a complete review, please see Metzner (1999)), but suffice it to say here that the ayahuasca vine is a one of the most revered plants of traditional Amazonian medicine. When mixed with another plant called *chacrana*, the ayahuasca vine has the ability to produce in its users visions similar to those produced by peyote. During his first ayahuasca session, the patients, his fellow patients, and a part of the therapeutic team are guided through the experience by two curenderos.

After his first ayahuasca session, the patient immediately embarks on his first diet. The diet is an eight day, solitary stay in a jungle lean-to. Each day, the patient is visited by a curendero who gives him a plant mixture that is understood to promote a specific type of spiritual and/ or emotional growth, and physical cleansing. Two to three times during the diet, the patient is also visited by a psychologist.

Each ingestion of psychoactive plants, from the ayahuasca sessions to an eight day stay in the jungle, is governed by strict guidelines concerning sexual activity, diet, interpersonal contact and daily activities. Any ingestion of plants is also facilitated by a therapist or *curendero*, and carried out within, according to Mabit “a precise and rigorous symbolic frame.” For a further discussion of the importance of a ritual context in the ingestion of plants, please see Mabit (2002).

The patient continues to take ayahuasca on a weekly basis for the rest of his treatment, which could last anywhere from four to ten months. During this time he will also complete three to five more diets, depending on the length of his stay at the Center. During the last three months of his treatment, he will continue his spiritual and emotional rehabilitation, but will also increase the intensity of his social reintegration, often working in the outside community. While I was there, one patient in his last month was teaching music lessons to mentally disabled children in Tarapoto as part of his social reintegration phase.

More than fifty other plants in addition to ayahuasca are used in Takiwasi as parts of the diets, purges, baths and general health maintenance. For more information about the specifics of each part of the therapy, please see Mabit M (1998).

### **Guiding Philosophy: What is the Role of *Las Plantas* in treatment?**

Michel Mabit, the acting “Director of Communications” in 1999, writes:

By modifying his state of consciousness with drugs, the drug addict looks for a meaning in his life and often for an unconscious access to “God” ... The majority of today's drugs are made with plants (wine, alcohol, heroin, cocaine, marijuana) which are considered as “sacred” in many cultures and for that reason are taken ritually... The aim of Takiwasi is to help the patient to get over his addiction teaching him that he can modify his state of consciousness without damaging himself and gain a more spiritual outlook on his life, giving him strength and faith. He will experience and understand this vision of life himself from inside during the Ayahuasca sessions and the diet.

The point of treatment is to find something “*más allá*” [literally more over there] that will help the patient overcome addiction. By finding something greater than themselves, the patients are able to fill the great hole left behind when the drug is taken from their lives.

Although all of the psychologists talked about it, this philosophy was best articulated by Eloise, a female psychologist from France. She said, “The drug—cocaine, alcohol, pills—is filling the huge hole in them left by their parents or whatever life thing. It is a false spirituality. Ok. The spiritual development fills the hole. It is something that is greater than the human being. That gives him an inspiration. Something greater than your daily life.”

The Center operates from a Catholic faith; many members of the therapeutic team are Catholic, it has a small chapel on the property, and Catholic iconography dot its walls and landscape of the Center. The Center’s religious disposition likely influenced the faith of many of the patients. Jaime explained the Catholic tilt of the Center in terms of a Peruvian cultural preference, however, and positioned it as one in many possible manifestations of a spiritual practice.

Eloise, Jorge and Jaime also pointed out that the patients spiritual formation did not have to conform to any previously established structure of spirituality. Eloise states, “It does not always have to do with religion... In the diet, for example, the person is totally overcome by nature. They find something greater. Could be a human being that has dedicated their life to something important. Mandela etc.”

Jorge is a Chilean Buddhist. He told me, “The spirituality can take almost whatever form—it doesn’t really matter—what is important is that the development imbues the patient with a sense of responsibility for his actions, a code of ethics that is clear and has clear consequences for his spirit.”

For Jorge, Adán and Joaquin, the imperative to the inclusion of plants in the treatment was the way that they helped the patient to develop a spiritual path. The importance of developing a spiritual path was to not only “fill the hole,” but also to develop an inner code of ethics.

Joaquin described the same concept in terms of an “internal padre.” The internal padre slowly replaces outside authorities in helping the patient to regulate his actions. The development of an internal padre can be understood as the development an internal code of ethics. This code of ethics is learned through taking plants, and engaging with the treatment in general. According to Joaquin, the

development of an internal padre, or, in the words of Adán, understanding that which “injures the spirit,” is what facilitates a successful treatment.

In my interviews with patients, the development of an internal padre, or an internal code of ethics did not arise explicitly. For the most part, patients understood the plants to aid in their search for something greater than the drug. I asked Iago how his spiritual life had changed over the course of his treatment.

“It has changed a lot,” he answered. “By mostly the plants and the diets... I think that a person with an addictive personality, if you don’t have a spiritual life, you are not going to leave the drug... Because the spiritual part is what tops, puts a top on the great hole that is left behind. Because when you leave the drug, there is a very large hole and you have to top it with something. “Me... I tried to top it with a lot of things: with women, with sports, and no no no it didn’t work. And so, with the spirituality, it is like greater than all of this...”

When I gave a talk about this paper to a group of my fellow students at Mt. Holyoke College, one bright young woman raised her hand after I finished. She asked me how I would respond to the criticism that Takiwasi patients are trading a reliance on one drug for a reliance on ayahuasca. One is led to wonder if the Takiwasi treatment facilitates a continued reliance on substance to imbue one’s life with meaning, to find something “greater.” Her question is a good one, and best answered by Iago.

“... In my way, I pray every day. And always I ask to God that I stay present to everything. My heart and my mind is present to everything... Because it is what saves me, right?”

“And why is this presence in every moment going to save you?” I asked.

“Because, it is the...” Iago searches for the words. “It is the force that I have found...” He jumps back in time to the period right after his second diet. “I was not in the diet anymore and I was forgetting to pray [*pedir a Dios*], I was forgetting my thoughts, my books of spirituality, of everything, of my world of spirituality, you know? And quickly returned all of my thoughts of the drug and the wanting to do drugs, they all came back to me. And then I realized that I can’t forget it. Not even for one day.”

Iago answers the criticism illuminated by the Mt. Holyoke student. He shows that the diet, the plants, gave him the initial window into his spirituality. In this way, they were directly responsible for topping the “hole” that he felt in himself when he ended his drug use. But the plants themselves were not enough. In Iago’s experience, they had to be supplemented by a spiritual practice, one that would remind him, in Iago’s case, to stay present.<sup>5</sup>

### **The Plants and the Relationship**

I have already described how patients and providers understand the inclusion of the plants in their treatment. Here, I ask: How do they understand the role of the plants in their relationships with each other?

#### **The Relationship**

As I saw it, the role of the psychologist at Takiwasi is broken down into two categories: process and change. First, the psychologist helps the patient to process his emotions and experiences. The emotions and experiences generated by the plants, and also those generated from the patients’ daily lives and personal histories, are processed in therapy.

Then, in the second facet of his or her role, the psychologist helps the patient implement the revelations afforded to him by taking plants and/ or the therapeutic process into his daily life.<sup>6</sup> All of the psychologists emphasized the importance of the implementation process. When I asked him why the therapy sessions were important to the treatment, a Brazilian psychologist named Fernando answered:

I have found that ... you make the most of [the visions] if you have the post ayahuasca interview or session. You really can understand it and make it profound, deepen the experience of what you had and integrate it in your life,

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5 Due to limitations of time and space I did not include two important points about the role of the plants in the Takiwasi treatment. First, the plants are one element in an integrated treatment. Over and over again, the importance of the dynamic relationship between plants, ergotherapy and psychotherapy was emphasized. Second, the plants were understood to perform more functions in the treatment of the patients than to simply show them something that could fill the hole, or govern the spirit. In addition to facilitating this process, the plants were understood by patients and psychologists to: convince them of the severity of their drug problem, illuminate its emotional roots, clean the body energetically, clarify the patient’s sense of worth, and reconnect the patients with their bodies.

6 Because Fabienne, Jaime and Jose Miguel have more experience, they also help to interpret the ayahuasca visions and phenomena of the diet. In “post-ayahuasca sessions” Jacques helps to interpret the rest.

really. Because a lot of times, with a lot of patients, they have had many many sessions, but at the end they have not resolved the problems that they were shown in the session with other human beings, no? ... The psychology is where you work the vision into the relationships with other human beings. in the encounter of vision and feelings.

Joaquin echoed Fernando's sentiments, adding that ergotherapy was an important stage upon which the patients were encouraged to change their behavior. In ergotherapy, the psychologists were able to see if the patients were actually applying the revelations to their daily lives, with their companeros.

The patients had little reprieve from the watchful eyes of their psychologists. Almost all of the psychologists felt like they "lived" at the clinic. It was true that they arrived at Takiwasi at 8:30am 6 days a week. They had an hour off for lunch, and usually stayed at the clinic until 6 or 7 (except on Saturdays, when the Takiwasi staff finishes work at 1pm). One psychologist returned for the night shift each day of the week, which lasted until 10pm, and weekends were covered on a rotating shift. Eloise states, "Here we are with them day and night. We work the reality with them." A patient's progress is demonstrated to his psychologist, not just in a once weekly interview, but on a continual, day to day basis.

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Another important concept of the patient-psychologist relationship at Takiwasi was "limits." This word came up over and over again in my interviews. The way that "limits" was used by Takiwasi patients and providers might best be translated as boundaries in American psychological parlance. It had to do with setting clear boundaries between psychologist and patient in order to affect a treatment that was human but professional. Eloise, when I asked her what her advice to a new psychologist would be, said, "[The patients] are in treatment—they are not here to make friends. You have to put distance, limits but with caring."

Fernando, too, emphasized the importance of maintaining the dynamic tension between distance and care. He reported that his best relationship with a patient was with a patient who forced him to practice this tension. The patient had endured a sexually and emotionally abusive childhood. He refused to follow rules and, at times, acted abusively to other patients. Fernando discussed how, with this

patient, he had to struggle to “maintain a relationship with someone who is so aggressive, but knowing that, in his way, he is asking for a lot of care.” The relationship, he said, was teaching him to put down limits “with care.”

The concept of limits also relates to the role of the psychologist as the impler of change. Often, the changes that have to be made in a patient’s life have to do with setting limits for himself. Joaquin told me, “The drug addict patient generally has not been able to set limits for himself or to go through any pain... Applying the knowledge that he learned in the sessions can be a very difficult practice in limits. If a mom is sending you chocolates and in the session you realize that you can’t accept presents from your mom anymore, the psychologists are going to help the patient apply those rules.” Joaquin pointed out that over time, the patient’s dependency on the psychologist to set the limits lessons. The patient learns to set them himself. Joaquin described this process as another part of the development of the “internal padre.” The idea here was that a father sets limits for his child.

When I interviewed him, Iago had been at the clinic for nine months. He seemed to have developed an acceptance of the limits as a worthwhile part of his treatment. He told me, “We have to respect right. Sometimes there is a joke that comes out or whatever, but always we have to respect. They put limits on us, and we put them on ourselves.”

“If it were a real friendship here, the psychologist could not really say the limits, right?” I asked.

“Of course, of course. For this...It’s that there is a friendship, but there is a respect for the limits. There is not a necessity to say it all the time. It just happens.”

In a separate interview, Iago’s psychologist, Jorge, affirmed Iago’s ability to respect the limits. He said that Iago’s respect for the limits was the deciding factor in making their relationship one of his best. He says of the relationship, “I acted only as a psychologist and the patient understood his role as patient. There were jokes sometimes when things were funny, but the relationship was, for the major part, professional. It took maturity on the part of the patient for this to occur.”

Limits ensure that the relationship between patient and psychologist will remain primarily

therapeutic. Epstein and colleagues (1992) remind us that, while exploitation can arise in any relationship, the psychotherapy setting provides an especially conducive forum for it to occur. Therapists have been known to exploit their patients for money, sex, companionship, and personal ambition (Epstein et al., 1992). At Takiwasi, the psychologists were fierce in their implementation of limits. They understood their uncompromising commitment to limits as an integral part of the patient's therapeutic process.

The plants affected the relationship between patients and providers in innumerable ways. I was able to tease out two of them for this paper. The plants first facilitated an increased level of disclosure, or sharing between patients and psychologists. Second, they facilitated greater trust in the patients toward their treatment.

#### The Pedestal Breaks and People Start Talking

Iago: ...Here in Takiwasi each psychologist has his good and bad things like everybody.

Nora: Again, it seems like it... the psychologists can't pretend that they have it all together.

Iago: Of course, they say the same thing.

One of the most striking elements of the Takiwasi Center was the absence of a strong hierarchy between psychologist and patient. Instead of being viewed as an ultimate authority, the psychologist was seen by his or her patients as a flawed, but earnest, human. Rather than leading to anarchy, however, the absence of the "omnipotent" psychologist, facilitated the patients' increased willingness to share themselves and their issues.

My first clue that the hierarchy between patient and psychologist was weak came one morning in the garden. As a garden helper, I was part of the crew of patients, psychologists, and hired help who were clearing out the underbrush of the Takiwasi property. The sight of the psychologists working side by side with the patients struck my interest. In my field notes, I noted the lack of even an implicit hierarchy, where the psychologists would have been working harder than the patients to "set an example." All parties were working, but the only one who seemed to be assuming the role of a leader was the head gardener, José.

My suspicions of a broken hierarchy were confirmed after attending the goodbye party of a Mexican psychologist named Adán. After two years at Takiwasi, Adán was leaving to study in France. When the time came to make “toasts” (without alcohol), I expected everyone to shower Adán with compliments and well wishes. Instead, all who spoke of him offered their memories of his process at the Center, of his ups and downs, his contributions to the clinic as well as the difficulties that he experienced there. That is not to say that Frederick, one of Adán’s patients, was not moved to tears when he spoke to Adán of his gratitude. He was. Nevertheless, I was astounded at how honest the toasts were, how no one made any attempt to hide the fact that Adán, too, had come through a long process to arrive where he stood that day.

I have already mentioned deeper disclosure as the consequence of a broken hierarchy, and I will explore this concept further in the next section. The question remains, however, of how this hierarchy is eroded in the first place. In one sense, it is simply due to the psychology practiced at Takiwasi. The psychologists work in the garden with the patients—they speak honestly about their own limitations and those of the therapeutic team. The form of practice demonstrated here, however, is the secondary culprit in pedestal demolition. First and foremost, the plants are responsible. I will demonstrate with an anecdote that a fellow intern told me about the first time she took ayahuasca at Takiwasi.

She took her seat next to a polite, young American man who was studying rainforest ecology. Before the session began, she and the young biologist introduced themselves to each other and exchanged the common pleasantries—where are you from, how many times have you taken the plant, what is your name, etc. Then they quietly focused their attention inward until the session began. About 45 minutes after ingesting the brew, the young man began to vomit incessantly. My friend listened as the contents of his vomit turned from food to phlegm to bile to nothing but sound. He uncontrollably made loud retching noises, and invariably said something like, “Whew, huh, mmm,” during the few minutes of reprieve between lurching episodes.

My friend listened to all of this from the position that she held the *entire* night, which was sitting

with her head hung between her knees, shuttering against her will, and swallowing over and over again the taste that she later described to me as “a rodent that crawled into my mouth and died.”

I offer this anecdote to illustrate how quickly social graces and first impressions fade while under the influence of ayahuasca. The young American’s experience is a testament to the loss of control that one experiences after ingesting the plant. The plant strips its ingester to his bare human bones, exposing them for the other members of the session to see.<sup>7</sup>

In this way, the plants erode the pedestal of the psychologist for the patients. Eloise said, “It is impossible to be in a relationship without taking plants... When they take together they are put on the same level. We don’t have the same role. *But...* We vomit together, we pass through difficult moments together. And so in some moments we are just equal human beings. You see?”

I did see. I answered, “Yes, and more specifically, there is no façade of a psychologist who is good and a patient who is bad?”

“No, no no. Because with ayahuasca—“ she made a pfft sound with her lips and shot her hand through the air in a straight line.

Fernando also noted how taking plants with the patients had affected his relationships with them. He says, “I think that [taking plants] with them give us a sense of community and of communion. In the same moment, all of people of the group, apart from their hierarchy, of their function in the society, pass through the same process of introspection together... And so, it is the sense OK we are together in this life, each person confronting his problems.”

Both Jorge and Joaquin noted how the fall of the facade did not lead to a lack of respect. Fernando echoed this observation when I asked him if the sessions with plants had compromised the patients’ respect for him. “My experience until now is that no. I thought this also... The sense is rather that I am a human being also and that I have my... until the moment they have respected me a lot, no?”

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<sup>7</sup> This is not to say that sessions are meant to be collaborative and communal. To the contrary, participants are instructed to refrain from making noise where possible, and to never touch or interact with another participant during the session.

Instead, Joaquin claimed that the process ended up engendering respect in the patients for their psychologists. The patients were led to see that the psychologists were neither naive nerds from the university who know nothing about real life, nor were they morally superior “experts.”

In my interviews with patients, it became clear that the ayahuasca sessions with their psychologists indeed engendered a respect in patients for the psychologists. As predicted by José Miguel, this respect was based in a shared humanness rather than a compulsory respect for a moral superior. It led the patients to more readily share information with them. Jeremy, a 21 year old patient from France, said that taking plants with his psychologists made him “come to know the human behind [the psychologist],” and then reported matter-of-factly that it was easier for him to talk with a human than it was to talk with an expert.

For Iago, the plants led him to share more deeply with his psychologist for two reasons. Like Jeremy, taking plants with his psychologist showed him the “human behind the psychologist.” I asked him how his relationship with Jorge was different than his relationship with his psychologists in Spain.

“It is similar, but deeper,” he answered. “Here, the great difference is that they are present. They are there taking plants with you, vomiting in the maloka with you, these things open you up to say, ‘Jorge, I have this problem.’ ... It is difficult to get very deep in Barcelona, but here, in taking the plants, you have to deepen yourself... Because I have to talk about this deep, deep things and so... there is a link with Jorge.”

Iago explained here the second way that the plants facilitate a higher level of disclosure. Patients not only have a greater sense of the humanness of their providers, they are also bombarded with intimate psychological material from their sessions. Iago demonstrates how, because the plants show you your deepest, darkest layers, you have access to them—you can then share them with a psychologist who has deep, dark layers too.

### Trust

The plants helped the patients to better trust in their treatment in two ways. First, the patients

trusted in the ayahuasca plant to guide the actions of their providers.<sup>8</sup> Second, the plants helped the patients to trust in their treatment or their psychologists by sometimes providing an alternative perspective to resistance.

When I asked him why it was important for the therapeutic team to take plants, Iago told me that the plant works a lot with [psychologists] on how to interact with the patients. He said that for Jorge, the sessions are about his girlfriend and his personal life, but also largely about how the psychologists interact with, in Iago's words, "us."

In answer to the same question, Frederick responded frankly, "It is important for the psychologists to take plants because the psychologists get information about how to carry out the treatment." All of the psychologists, with the exception of Jorge, told me that the Center had tried to employ psychologists who refused to take plants. "I remember one psychologist who after 2 years still never took Ywar panga," Jaime remembered.

"Ayahuasca?" I asked.

"Two times, no more. He was afraid. The patients understood that and said 'why should we believe him?' 'Why should we listen to him?'"

The unspoken question here is 'why should we trust him?' The patients understand the plants to provide trustworthy information to the psychologists. Without the advice of the plants, the treatment practices are regulated only by the subjective reasoning of the psychologist himself. This, according to Frederick and Iago, was not enough.

In my interviews with psychologists, I consistently asked them to recount sessions in which they had received information about their practice as a psychologist. The vivid stories poured into the reels of my audio tapes. Here, I recount only one of the most compelling.

Eloise learned one the guiding philosophies for her practice during an ayahuasca session. "The ayahuasca showed me that I had the eye of an eagle... In the vision came out the eye of the eagle, and—

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<sup>8</sup> The providers, too, relied on the plants to guide their therapeutic method.

“Eloise makes gestures to show that one beam (of light?) came from her heart and one from her “eagle” eye— “and where they met was a crystal. [The eye of the eagle] is very strong and can see everything. But also can be very harsh: ‘I see this and that of you...’ For this, it should be balanced by the heart. But the heart alone it is too much caring and all that—the two together can make a powerful balance.”

The patients know that their psychologists are constantly receiving messages like this during the ayahuasca session. In accordance with the understandings of Takiwasi’s traditional medicine, the patients understand these bits of advice to come from the ayahuasca plant herself.<sup>9</sup> Of course, most academics and mental health professionals would take for granted that the visionary effects of ayahuasca are the results of modified brain chemistry. Either interpretation allows for the fact that one’s perspective is dramatically expanded by the ingestion of the drug. Regardless of how they arrive into the conscious realm, the visions of the psychologist assure the patient that his treatment is just.

The visions of the patients themselves can also lead them to trust in their treatment. In the following example, Iago’s ayahuasca experience led him to end his resistance to his ergotherapy treatment. Interestingly, his opposition was perhaps justified. In the session, however, he reached a sense of empathy for his psychologist that contextualized his sense of injustice, and thus disarmed his anger.

At the time of my research, Adán had been the director of the ergotherapy program for almost two years. This meant that he led the patients in working, taking directions, and relating to other people. Fernando, too, worked in this branch of the treatment. He had been “apprenticing” with Adán for the last six months. In my interviews with them, both Adán and Fernando discussed the difficulty of their roles. They had to decide right and wrong constantly and quickly, to determine these poles with a group of people whose most infamous and generalized talent was manipulation.

In our interview, Iago described a period of time in which he felt upset with Adán’s harsh

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<sup>9</sup> As I mentioned earlier, the plant is understood to be a spirit. When one takes the plant, one opens the energetic body to the ayahuasca spirit.

discipline during ergo therapy.

“...And with Adán, I would get upset for the way that he was treating my companeros. For example Simon. Always getting the isolation room. And I told him that ‘Adán, this is not better. He is always in isolation but he doesn’t understand it...’” Iago explains that Adán yelled back at him that he should not involve himself in things that didn’t concern him. “It was one of the only arguments I ever had [with a member of the therapeutic team]...”

At my prompting, Iago then told me about how an ayahuasca session had brought about the end of this conflict with Adán.

“And so with Adán, I didn’t really accept the punishments that he was giving to the other patients [*mis companeros*]. Never did he punish me, but what I realized is that the role of Adán is very difficult—the most difficult of all the psychologists. To always have to define right and wrong—hard! And the ayahuasca put me in the role of Adán, no?”

“Really?” I said. “Amazing.”

“Hmm.” He answered and paused. “During a session. Like I was... Like I was Adán. I felt like I was Adán.” Iago’s voice was low and secretive. He went on to explain in rapid Spanish how he subsequently talked to Adán and I told him that he was not going to criticize his disciplinary method anymore.

I asked him how it felt to be in the role of Adán.

“It went over bad. It did. I didn’t like to feel this, no?” He hung his head and shook it for a moment, exhaling loudly. “I didn’t like to feel the rejection of the people that you punished. At times there would be people who insulted him, someone who said to him, ‘He’s an exploiter, he is a-’ This is bad treatment, it is. And I felt it, when they insult you feel bad, right?”

Iago went on to describe how the session was one of his best, and that it spoke to a larger theme in his life. He concluded, “With this session, the ayahuasca told me that I need to put myself in the roles of others, empathize.”

Although I won't go into detail, Adán's stern discipline as head ergotherapist was a theme that arose again in my interviews with Adán and Fernando. Fernando talked about how he had brought to Adán's attention the overly severe discipline that Adán was enacting. This, Fernando told me, was a good example of how the therapeutic team members relied on each other to help monitor the therapeutic practice of each individual. In his interview, Adán explained how a session of ayahuasca had made him realize that his method of discipline was too harsh. In conjunction with the feedback that he was receiving from the therapeutic team, Adán was driven to adjust his disciplinary action as head ergotherapist.

During my interviews, the conversation often returned to the topic of trust. The plants seemed to diminish the patients' doubt in their treatment by imbuing them with the sense that a "moral superior" guided the providers of Takiwasi. Even if the patients didn't agree with the treatment, the plants allowed them to understand how difficult the task of their psychologist was. This empathy reduced the frustration and anger of having to follow directions with which they didn't agree. It's an empathy that can only be brought about by the most visceral means of communication.

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I have now offered a glimpse of what is fascinating about Takiwasi. I have discussed how the plants enhance the patient-psychologist relationship and how they bring about the spiritual development of people who had previously made a religion out of substance abuse. Next, I investigate what is problematic about the Center.

### **The Problems**

I will first describe how my personal involvement with the clinic led me to feel hesitant about discussing its "problems." Then I will depict the financial structure of the clinic, and I will address the questions that arise whenever Global North- Global South collaboration takes place, especially one that relies on notions of "traditional."

### A Speech and the Internet: How I arrived at Takiwasi

I first heard about Takiwasi in the spring of 2005. A professor of mine had recommended to our class that we attend the keynote address of the 2005 convention for the Society for the Anthropology of Consciousness. I arrived at the talk to find Dr. Jacques Mabit discussing the guiding philosophy of his alternative drug treatment center in Peru. My friend and I were intrigued by this French doctor. He drew a picture of the left-brain on the board and told us it was the realm of Western science. Then he drew a huge balloon coming out of the side of it and called it the right-brain—he said it was the side that Western science did not deal in. He argued that the one of the main reasons that drug addicts take drugs is their sensing something legitimate about the right brain, but having no way to access it. I took a brochure home with me and tucked it into the folder I keep called “Sometime.”

A year later I was sending my resume in broken Spanish to the Center, exchanging emails, and finally booking a flight to Peru. Mabit accepted my application on the following conditions:

- I had to pay \$200 per month to the clinic as a research fee. This fee did not include room and board, but did include the costs of “*auto-experimentacion*”<sup>10</sup>.
- I was to complete a research project of my own design and carry it out during my internship there
- I was to avoid contact with the patients outside of formal interviews.
- I would work in the garden and the laboratory in addition to doing my ethnographic research.

I arrived at the Takiwasi Center on May 20, 2006.

### Engaging with the Medicine: Ethnographic Implications

Across the hall from the director’s office, and kitty corner to the secretary’s large office, is the office of Dr. Jacques Mabit. In the area of the office that looks out onto the Takiwasi property are three comfortable leather chairs and a small coffee table. In one corner is a bookshelf filled with binders and books, as well as a few pictures of Jacques and his son when the boy was about eight. His desk fills the other end of the room. It is stacked with papers, binders and books. A computer peeks out from behind

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<sup>10</sup> These funds will be discussed further in the *Costs and Funding* section.

the towers.

On the first day of my arrival I sat in this office, awaiting an interview with Jacques. Jacques entered and bowed a hello.

“Sabes espanol?” he smiled.

In halting Spanish, I made it through an explanation of my research topic (patient-provider relationships). He then asked me if there was anything that I needed to work out. By this time, he had switched to English for me. I was taken aback by the fact that our interview had anything to do with me—I stammered, rummaged around in my psyche for any unresolved issues and came up almost empty handed. He gently offered, “Your relationship with your parents...” He looked up at me sideways.

Oh. Yes. How could I forget that in fact I was at his clinic in large part because my father had died the October before. Without his death I would have still been in the United States, going to school in Massachusetts. Strangely, I didn’t tell him that I was sad about my father’s death, or that I was grieving it. I told him, the truth, which was that my father had died and I didn’t know whether to just decide to let it go (as if that were possible) or if I should try to pull the grief from my past, get it up from it’s compartmental location in my mind...

He sighed. He said to me gently but frankly, “Hopefully the plants will teach you that there is no deciding to go back to it or forward to it, there is only dealing with what comes up in this moment.”

With the help of Adán, a psychologist from Mexico, Mabit then arranged for me to move out of the hostel I was staying in. I would move into Takiwasi’s “annex house.”<sup>11</sup> He then got up to leave the office. As he was opening the door he said, “Are you going to take plants?” I was immediately terrified and intrigued. We stammered around dates and I agreed to take them Monday, then Thursday, then Monday finally and then okay, yes, Monday will be fine. That was two days away.

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<sup>11</sup> The annex house is owned by Takiwasi and rented for \$70 a month to psychologists and visitors.

### Ethical Roadblocks in Ethnography

From an ethnographic perspective, taking plants had its advantages and disadvantages. In terms of advantages, taking plants allowed me to establish a deeper empathy for my participants. Renato Rosaldo (1999) discusses how shared experience can deepen an ethnographer's understanding of his participants in his ethnography of the Ilongot grieving practice of head hunting. The Ilongot engage in the unpalatable practice of hunting human heads as part of their cultural response to death. The practice is not limited to hunting the heads of those responsible for the death of a community member. Ilongot tribe members might head hunt a person who is unrelated to the death. Before the death of his wife, Rosaldo could not comprehend this practice. But after his wife died suddenly during one of their field work expeditions, Rosaldo (1999) explains how he developed a visceral understanding of how head hunting among the Ilongot could be therapeutic to them. In a similar way, my engagement with the traditional medicine allowed me to empathize with experiences that I would have otherwise dismissed. I listened earnestly when the participants spoke of ideas that conflicted with my rationalist understanding of reality. I had no reason to mark their experiences as pathological or imagined, because I did not mark my own that way.

In terms of disadvantages, taking plants made this paper much more difficult to write. The Takiwasi center helped me a lot. I am very grateful to the people there. I therefore hesitated to hold up their practices to the mis-matched, rationalist scrutiny of academia. At times, the Takiwasi Center seems to crumble under a conventional anthropological analysis, one that looks critically at notions of traditional and modern, one that looks critically at the intersection between North and South, one that looks critically at a French doctor who is now a traditional healer of the ancestral medicine of Peru.

I also questioned my right to analyze the participants of my study and the political, economic, and social structures in which they exist. The knowledge that my informants know much more about the Takiwasi Center than I can ever hope to garner from my thirteen interviews with them paralyzed me. I

still question my right to offer my perspective when my knowledge of the Center is so incomplete.

But, had I listened to them, these sentiments would have done more harm than protection. Barbara Myerhoff (1978) discusses the phenomenon of “ethnographer’s guilt.” She describes the tendency of the ethnographer to protect one’s participants from analysis, especially when one’s participants have proved themselves deserving of the utmost respect and admiration. Myerhoff (1978) reminds us that exalting participants as heroes instead of presenting them as flawed and brave humans, would strip them of their true accomplishments. In conjunction with post-modernist ethnography wherein one’s limitations are unapologetically exposed (Richardson, 1998), Myerhoff’s advocacy for a whole-truth account can be viewed as the only way in which to give the participants of an ethnographic study the utmost respect and admiration that they deserve. Myerhoff swayed me to include, and do my best to position, the clinic’s economic structure and political position. Its inclusion is important to a viable argument for the importance of a center like Takiwasi.

In order to dismantle the veneer of objectivity vested to any socially scientific paper, I have written this paper in the first person and included my own experience where I saw fit. I hope that the inclusion of my voice and my experiences will disrupt the myth of ethnographic authority. Lauren Richardson (1994), in her summary of the postmodernist position, reminds us that while the ethnographer’s voice may seem authoritative, that privilege is afforded to her by the silence of her participants. Any of the participants that I interviewed might offer a different account of this story, as might any other ethnographer.<sup>12</sup> As a positioned subject, I operate from a particular basis of social, historical, and personal knowledge.<sup>13</sup>

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<sup>12</sup> The story might have been especially different if it had been collected by a native Spanish speaker, which I am not. When I arrived at the clinic, I could understand about 70% of what was said to me, and I could express about 50% of my thoughts. At times, I was literally unable to understand what the other person was saying. By the last two weeks of my stay, however, I was able to converse naturally with my interviewees.

<sup>13</sup> This is not to say that my partial interpretation of events renders the knowledge I present here untrue. A postmodern position challenges the notion that any knowledge could be true in an objective sense. To the contrary, it asks us to view all knowledge as it is distorted by positioned interpretation. Foulcault (1972) reminds us that from that vantage point, we gain a new appreciation of admittedly “positioned knowledge” as knowledge nonetheless. As Richardson (1994) puts it, “A postmodernist position does allow us to know something without claiming to know everything.”

Behar (1994), Emerson, Fretz and Shaw (1995), Rosaldo (1999) and Joraloman (1990) argue that the inclusion of the ethnographer in the ethnography exposes the ethnographer as just another human telling another story rather than an omnipotent social scientist telling the truth. I hope this tact is successful, as I have employed it here.

#### The Notion of Traditional: How a French Doctor Became a Peruvian Healer

As the founder, President and binding glue of the Takiwasi Center, Jacques is constantly bombarded by patients, papers, meetings, emails, therapists, visitors, researchers and event invitations. In the two months that I interned with the clinic, I was in the office three times: once the day I arrived, once for a twenty minute appointment with him, and once the day I was leaving. I never interviewed him, although I asked endlessly and he tried hard to meet my request. The man is busy.

I can only, therefore, surmise from my observations of him what a typical day at the clinic for Jacques Mabit includes. It could include a meeting with the therapeutic team, a consultation with a patient who is considering leaving or who is having an especially difficult time, an interview or meeting with a researcher or work-study visitor, and, twice per week, an ayahuasca ritual with the visitors and/or the patients.

But how did Dr. Mabit, a French naturopath, come to be a traditional healer of Amazonian medicine?

Jacques Mabit first came to Peru in the 1980s with the program Doctors Without Borders.<sup>14</sup> He was intrigued by the fact that the midwives and “traditional” healers of the area that he was working in were consistently able to predict the impending maladies of the patients they referred to him and so he began to conduct ethnographic research on the traditional “*curenderos*”<sup>15</sup> of the area.

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14 Doctors Without Borders is an international humanitarian organization that delivers medical aid to people affected by armed conflict, epidemics, natural or man-made disasters, or exclusion from health care across the globe ([www.doctorswithoutborders.org](http://www.doctorswithoutborders.org)).

15 The term *curendero* refers to any type of traditional healer. In this context, it refers to a specialist of medicinal plants and especially of ayahuasca. A common translation in English would be “shaman,” but this word is inappropriate. *Shaman* in the emic terms of the medicine practiced at Takiwasi referred to a person who used their supernatural powers to both cure and harm or curse.

During the next six years, Mabit and José Campos, a young Peruvian descendent of an Andean family of *curenderos*, traveled together through the Upper-Huallaga river valley. They met more than 70 *curenderos*. These “*maestros*”<sup>16</sup> told them that the only way to understand their work was through ingesting the plants themselves. Mabit and Campos began to take the medicinal plants under the auspices of the *maestros* that they encountered. They observed the use of ayahuasca by the “*ayahuasqueros*” in the treatment and cure of various physical and psychological illnesses. It was in this process, Mabit reports, that he began to make a distinction between the pursuit of “altered states of consciousness” through the use of psychoactive substances and the recreational use of drugs (Mabit, M., 1996).

Following “an indication received in the course of personal investigation-analysis, guided by the master *curenderos* and by the ingestion of sacred (master) plants,” Doctor Mabit founded the Non Governmental Organization Takiwasi in September of 1992. Shortly after, he founded the Center of Rehabilitation of Drug Addicts and Investigation of Traditional Medicine. The Center began accepting patients in August of that year.

Keywords: “Traditional”

Mabit’s story throws into question the notion of “traditional.” Is Mabit a traditional healer? Langford (1999) points out that the word “traditional” references a category invented as a counterpoint to modernity. The fact that “traditional” practices only take on that definition in relationship to modern ones, makes the term “laden with Eurocentric cargo,” as Barnes (2005) puts it.

Barnes (2005) also makes the important point that “traditional” may mean different things to participants engaged in the same traditional practice. The traditional medicine at Takiwasi, for example, is defined by a type of local knowledge that is particular to Tarapoto, Peru. Further, each *curendero* has his or her own micro-culture and location from in which they learned to define the “traditional

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16 “Maestro” or Master is a title of respect used to address elderly *curanderos*.

medicine” that each practices. The term tradition, then, is neither static nor monolithic, but exists in fluid relationship with the people, places and histories that surround it (Barnes, 2005)<sup>17</sup>.

There is no rubric of “traditional Amazonian medicine” against which I can apply his practices. There is no widely recognized certificate of legitimacy or diploma that I can reference and that the reader will recognize<sup>18</sup>. Looking at the etymology of traditional, however, we can begin to question Langford’s (1999) assertion that all “traditional practice” is only traditional in relationship to an opposing modern practice. Tradition came to English from the Latin word tradere – to hand over or deliver (Williams, 1976), the idea being that certain practices are handed down over the generations. Traditional practice is a practice that was learned from the preceding generations. The basic structure of the medicine used at Takiwasi is dynamic and changing, but is not mistaken in its claim to the term “traditional.” It draws its authenticity from the fact that it was passed on to the curenderos of Takiwasi by other “maestro” curenderos. Their pictures line the wall outside of Mabit’s office.

Mabit’s French nationality could lead to skepticism about his authenticity as a practitioner of Amazonian medicine. But Mabit explains his role rather simply; speaking to BBC Radio 4’s Crossing Continents he said, “The idea was the result of my experience as a medical doctor, when I saw how limited traditional treatments were...I met spiritual healers - Shamans - and realized they had resources unknown in the West.” Mabit found a way to practice medicine that was unavailable to him in the Global North, but that was more effective than the medicine that he was able to practice there.

The question then becomes, how is the word “traditional” being used? What purpose does it serve? First, it is used as the clearest way to denote a type of medicine that, while dynamic, has been passed down over generations. Their second use of the word is more controversial. Langford (1999)

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17 Barnes also discusses the function of traditional as “good” medicine and biomedicine as the dark side of healing. Should I review it here?

18 The Takiwasi Center did, however, instigate a program to get traditional healers certified by a board of curenderos. They created this program in order to distinguish the false curenderos that Dobkin de Rios (1994) references from the ones who are recognized by maestro curenderos as authentic.

argues that the term “traditional” is invoked, as it has been at Takiwasi, in order to give the practice an air of legitimacy and to capitalize on people’s disillusionment with modern biomedicine and their curiosity towards alternative medicines.

Costs and Funding: Traditions of the South Meet the Resources of the North

Takiwasi is registered with the Ministry of the Presidency of Peru as Non-Profit, Non Governmental Organization. Takiwasi currently runs on US\$ 100,000 per year with salaries ranging from 250 to 1,000 dollars per month for the therapeutic team.<sup>19</sup> The estimated actual cost of each patient's treatment is US\$ 800 per month, although the suggested price is \$500 per month. The price is adapted to the economic means of the patients and their families. According to Mabit, patients without economic resources are never refused. The center has a maximum capacity of 15 or 20 patients at one time.

The Takiwasi project was initiated 1990 with the financial support of the French Government. The support was accessed through a subsidiary of the French Ministry of Foreign Affairs called “The General Delegation For the Fight against Drugs and Drug Addiction” and also through the French Technical Cooperation. By 1996, these two arms of the French government had provided US\$ 320,000 to the clinic. From 1993-1995 an organization called The European Community donated a total of US\$ 340,000 to the project. Volunteers who are financed by international humanitarian organizations also serve to support the clinic’s operation. The Takiwasi “Director of Communications,” for example, was financed by the United Nations Volunteer Program from 1995 to 1997.

Private donations also play a part in the operation of the clinic. The Association of Support for Takiwasi was created in France in 1993 and is responsible for most of the recruitment of funds for the clinic. Within the three years following its establishment, the Association generated US\$ 10,000.<sup>20</sup>

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<sup>19</sup> According to Mabit (1996), the sum required to cover the running costs would be US\$ 150,000 to provide treatment (with all the related costs), appropriate salaries and training for the team. In order to realize improved and effective investigation and information, Mabit suggests that an additional US\$ 100,000 per year.

<sup>20</sup> Current information on this figure is unfortunately unavailable.

Of the above mentioned donations, US\$ 200,000 were used to buy the land and install all the infrastructure of the center (buildings, materials, vehicles). The rest was used for the running costs of the center (salaries, food, and maintenance).

Since 1997, however, the center has not received any funding from the French government or humanitarian NGOs (website). They continue to take private donations. But, according to the website and Giove (2002) the clinic is now almost entirely self-sufficient. At no more than \$500 per month, the patient contribution does not do much to cover operational costs. Instead, the clinic relies on the sale of medicinal products<sup>21</sup> and provision of services for visitors, who are usually non-Peruvian.

The services for non-Peruvian visitors include short-term research opportunities and what the center terms “Personal Evolution Seminars.” Visiting researchers are asked to pay an internship fee of \$200 per month, and they are asked to work. I paid the fee and worked in the garden and in the laboratory where the plant products are made.

The seminars are advertised as “a unique experience that delves into the sources of ancestral knowledge of the healers in the Amazonian forests of Peru... The therapies in Takiwasi are based on plant ingestion, ritual sessions, sacred plants that liberate emotional knots. They offer a renewal of vital forces and a wakening of spiritual forces. The initiation to traditional medicine leads to ‘perceiving’ the order of things, the veil of dreams, and the hidden sense of our deep nature—it leads to opening up to our ‘inner guide’” (www.takiwasi.com, 2006). The “advertisement” capitalizes on the idea that one can find real spiritual growth by engaging with the lost medicine of the “natives.” They invoke an awkward, New Age rhetoric in order to draw participants. An investigation into the legitimacy of this practice is worthwhile.

Dobkin de Rios (1994) defines “drug tourism” as the travel of citizens of industrialized countries to developing world countries in search of substances that, while banned in most Western nations, are

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21 For more information about the medicinal products created by Takiwasi and sold throughout Peru, please visit their website, [www.takiwasi.com](http://www.takiwasi.com).

considered to be sacred plants in local traditions. She criticizes the drug dilettantes and exploitative tourists that engage in “ayahuasca retreats” and brings to light the important and real phenomenon of untrained “traditional healers” who prey on gullible tourists: “...There are Mestizo men who become instant traditional healers or ayahuasqueros without undergoing any apprenticeship period, without having any teachers, and without control in order to draw in their wealthy Western customers” (1994). Reports like those of Dobkin de Rios (1994) expose the exploitation and injury that can occur within the context of psychedelic drug use. Metzner (1999) points out that ayahuasca tourism can be exploitative to either the tourist or to the healer. He also posits that, when done ethically, it can be a sustainable vehicle for the traffic of resources from the Northern Hemisphere to the Southern one. According to my research and personal experience, this is the case at the Takiwasi Center. The Takiwasi clinic commodifies the traditional medicine that they practice, but the commodification of medicine should not surprise us. Like any social service, medicine has a price. The commodification of traditional medicine only becomes unethical when providers or patients misrepresent themselves or exploit the other party. Because Takiwasi engages in neither of these practices, its commodification of the medicine does not undermine its legitimacy.

The clinic also capitalizes on Mabit’s connection to the global North. Against the negative reputation of “drug tourism” as it is described by Dobkin de Rios (1994), the ‘westernness’ of Takiwasi gives it credibility. They capitalize on that credibility. Both the center and the Western visitors (researchers and seminar participants) are enmeshed in a system where people who can demonstrate their connection to Western ontology/ classical education/ a rationalist intellect will be given more credibility and trust than those who are not. The Takiwasi Center was given privilege and access to the funds of the North by virtue of its connection to this Western ontology.

This is problematic not because Takiwasi capitalized on this opportunity. It is disturbing because if we imagine for a moment that all the founders of the Takiwasi Center had been Peruvian, and if had they begun with the same passion and brilliance with which Mabit and his co-founders began, their

center would have never gotten off of the ground. It would have lacked a critical connection to the global North. That *is* unfair. But it is useless to locate that injustice over the center.

Metzner (1999) and Winkelman (2005) argues that drug tourism can be framed as a renewal of interest in the West for a spiritual relationship with the natural world, rather than Northerners' hedonistic exploitation of the medicine of the Southern Hemisphere.

Winkelman (2005) investigated the question posed by Metzner—this notion that “drug tourists” might better be characterized as people pursuing spiritual and therapeutic opportunities. Winkelman interviewed participants of an ayahuasca retreat in Amazonia about their motivations for participation. In his analysis, he acknowledges that the problems illuminated by Dobkin de Rios may be true in some cases, but he questions whether her analysis is a fair characterization of all “drug tourism” experiences. He writes that, while some ayahuasca retreats are fraught with exploitation, the one he studied was not. The participants were earnestly seeking a type of visceral, multi-level therapy that has been criminalized in the United States.

Winkelman (2005) and Metzner (1999) demonstrate that while drug tourism can be exploitative and dangerous, it is not always so.

Mabit (2002) writes:

To the contrary of what certain theorists say, the exploration of the interior universe by these methods does not require that either the therapist or the subject belong to the native culture of these practices. Rather, these practices give access to personal intra-psychical symbols which remain coherent to the subject and which touch depths that could be called transcultural by virtue of reaching universal psychological complexes (love, hate, rejection, abandon, fear, peace, etc.).

## **Conclusion**

The plants utilized at Takiwasi serve as therapists themselves, working with both the patient and the providers to affect better relationships and psychological healing. I have shown only a tiny window into the ways in which the patient-psychologist relationship is enhanced by the inclusion of these plants. Similarly, I have offered only a glimpse into how the plants enhance the treatment outcomes of the patients. Nevertheless, this research offers insight into the therapeutic potential of entheogens and

shows how they could be incorporated into a viable psychological treatment paradigm. I hope it will inspire more research addressing this important issue.

## **Appendix A: My research Methods**

### Part I: Data Collection

In my research, I use of ethnographic data collected during a two-month internship at the Takiwasi Center. I relied on two ethnographic methods:

- semi-structured interviews
- ethnographic observation

These two methods were best suited to the nature of my research. Semi-structured interviews allowed me to address my research question, but also made space for unpredictable insights of my interviewees to arise. In my interviews, I initially asked questions that were as open-ended as possible. Toward the end, I asked my theory-driven questions. These questions were more explicit in their assumptions and sought to elicit information from my interviewees about the themes I already expected to address in my paper. Copies of the patient and team-member interview guides are included in Part II and III of Appendix A.

My ability to collect ethnographic data was limited because, as one forthright psychologist pointed out, patient and team member relationships are confidential. Nevertheless, I was invited to observe certain rituals and one work party in which patients and psychologists interacted. For the most part, however, my data is drawn from interviews.

In addition to utilizing my ethnographic data, I also draw from literature in ethnomedicine, critical studies of psychology and ethnography, the anthropology of tourism, and the anthropology of non-governmental organizations.

## Part II: The Interview Guide for Psychologists

- Para definir el término “desarrollo espiritual”:
    - ¿Puede UD pensar en un paciente lo que considera haber desarrollado espiritualmente? ¿Qué fueron los cambios específicos que lo pasaron a este paciente?
    - ¿MÁS GENERAL? ¿Qué significa por un paciente “desarrollar espiritualmente”? ¿Qué es incluido en este proceso?
  - ¿Puede contarme, por favor, sobre una relación que se destaca en su memoria como una relación muy buena y saludable entre UD y un paciente? Uno que le hizo sonreír.
    - ¿Puede UD decirme algunas características esenciales y decisivas de lo que considera UD una relación saludable y buena entre paciente y psicólogo?
  - ¿En su experiencia en Takiwasi, que han sido las barreras más grandes y fuertes en la formación de relaciones buenas con sus pacientes?
    - ejemplos
    - resolver
  - ¿Si trata de recordar UD, ha cambiado su método de psicología sobre el tiempo que ha estado en Takiwasi?
    - especialmente, la manera en que le pone en contacto con los pacientes
    - ejemplos para aclarar el cambio
    - porque...
  - ¿Cuáles son los aspectos únicos sobre las relaciones entre pacientes y el equipo que no pueden pasar a un centro de rehabilitación más alopático?
- ¿Es su trabajo a Takiwasi su primer trabajo como un psicólogo?
- ¿Cómo son las otras relaciones distintas?
  - ¿Has preguntado a la planta alguna vez acerca de su trabajo a Takiwasi?
    - ejemplos específicos
  - Una fantasma: hay un nuevo centro de rehabilitación ...
  - ¿Qué es la utilidad de las entrevistas con el psicólogo después una sesión de ayahuasca, una purga o una dieta? ¿Por qué debe ser los dos?
  - ¿Porque tomar plantas?

### Motivado por los Teorías

- ¿Puede UD recordar una sesión con una planta (not just ayahuasca like I said before) que fomentó un click para un paciente?
  - ejemplo
- ¿Cómo afectan las sesiones de ayahuasca el sentido de confianza entre pacientes y UD?
  - Ejemplos...
- ¿Confrontación?
- ¿Como le ha ayudado a UD su trabajo a Takiwasi definir su vida espiritual? ¿Cómo defines su vida espiritual a Takiwasi? Para UD, ¿Qué es incluido en la idea de desarrollo espiritual a-en Takiwasi?
- ¿Que es la parte más difícil en sus relaciones con los pacientes (en su trabajo en Takiwasi)? -  
¿Qué es la parte más gratificante?

### Part III: The Interview Guide for Patients

- Antes de Takiwasi, ¿ha tenido otras experiencias con un centro de tratamiento?
- ¿Cómo son las relaciones que tuvo UD allí distintas que las relaciones que tiene UD en Takiwasi?
- Ejemplos, por favor
  - ¿Puede contarme, por favor, de una relación con un encargado que fue muy buena?
- ¿Qué, en su opinión, es el índole de una relación sana y buena entre paciente y encargado?
- ¿Cuándo tiene UD problemas con un encargado de Takiwasi, que es el fondo del conflicto generalmente?
- ¿Puede contarme un ejemplo específico?
- ¿En su experiencia en Takiwasi, qué ha sido el bloque más grande a la facilitación de buenas relaciones entre pacientes y encargados?
- ¿Cómo resuelven Uds. este bloque?
  - ¿Ha su vida interna o espiritual cambio en su tiempo a Takiwasi?
- ¿como?
  - ¿Qué es la cosa la que es más difícil estar un paciente a Takiwasi?
  - ¿Es importante que toma plantas para curarse?
- ¿porque?
- ejemplos
- ¿importante generalmente?
  - ¿Todo el equipo toma plantas también?
- ¿Es importante que ellos toman plantas también? (THEORY DRIVEN)
  - ¿Que dijera UD a un nuevo centro de rehabilitación si este centro le preguntara a UD por consejos sobre como se puede tener buenas relaciones entre encargados y pacientes?
  
- ¿Qué fueron sus impresiones primeras sobre las relaciones entre pacientes y encargados cuando llegó?
- ¿Como fueron sus relaciones al principio?
- ¿Como han sus relaciones cambiado sobre tiempo?
- Ejemplos

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