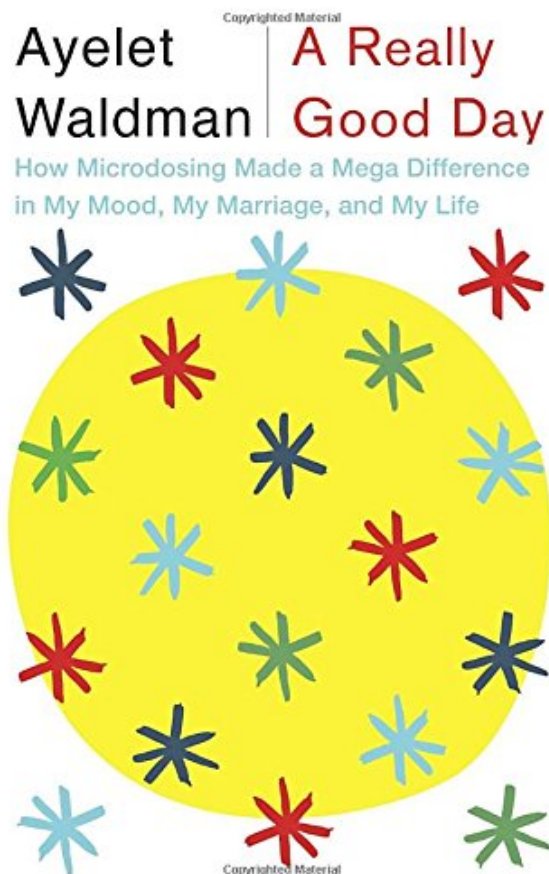


**A REALLY GOOD DAY: HOW
MICRODOSING MADE A MEGA
DIFFERENCE IN MY MOOD, MY
MARRIAGE, AND MY LIFE BY AYELET
WALDMAN**



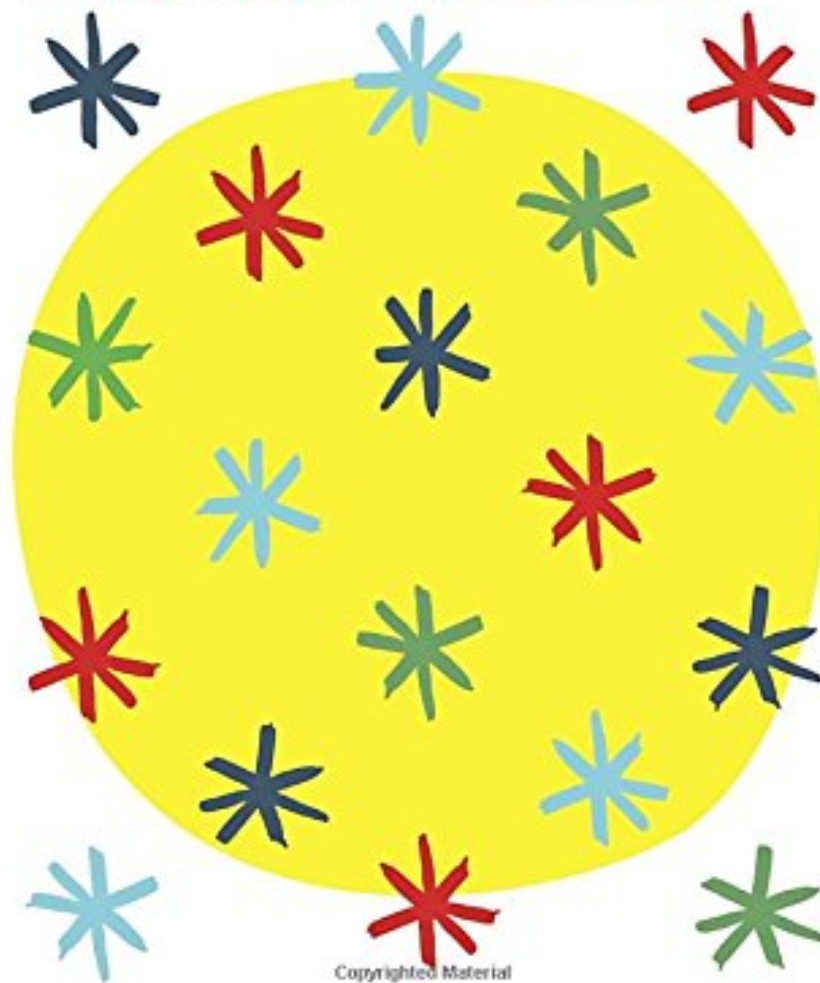
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Review

"Genuinely brave and human... In normalizing the conversation about LSD, she may one day help others feel normal." —Jennifer Senior, *The New York Times*

"A wildly brilliant, radically candid, and rigorous daybook of [Waldman's] life-changing, last-resort journey." —Lisa Shea, *Elle*

"Relentlessly honest and surprisingly funny." —Sharon Peters, *USA Today*

"An intriguing and thorough look at the therapeutic possibilities of an illegal drug... Engaging and deeply researched." —Nora Krug, *The Washington Post*

"Smart, outspoken, provoking, and funny... Poignant, sometimes hilarious... Waldman calls for renewed research and drug-law reform in this informative, candid, altogether irresistible quest." —Donna Seaman, *Booklist*

"Honest and intelligent... A humane, well-reasoned, and absolutely necessary argument for a major overhaul of America's drug policy. The book triumphantly coheres in a lucid manifesto of how and why the racist, immoral undertaking called the War on Drugs has failed... Passionate, persuasive." —Claire Vaye Watkins, *The New Republic*

About the Author

AYELET WALDMAN is the author of the novels *Love and Treasure*, *Red Hook Road*, *Love and Other*

Impossible Pursuits, and Daughter's Keeper, as well as of the essay collection *Bad Mother: A Chronicle of Maternal Crimes, Minor Calamities, and Occasional Moments of Grace*, and the Mommy-Track Mystery series. She was a federal public defender and taught a course on the legal implications of the War on Drugs at the UC Berkeley law school. She lives in Berkeley, California, with her husband, Michael Chabon, and their four children.

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This morning I took LSD.

The table I'm sitting at right now is not breathing. My keyboard is not exploding in psychedelic fireworks, lightning bolts shooting from the letters "R" and "P." I am not giddy and frantic, or zoned out with bliss. I feel no transcendent sense of oneness with the universe or with the divine. On the contrary. I feel normal.

Well, except for one thing: I'm content and relaxed. I'm busy, but not stressed. That might be normal for some people, but it isn't for me.

I did not drop a tab of acid. What I took is known as a "microdose," a subtherapeutic dose of a drug administered at a quantity low enough to elicit no adverse side effects yet high enough for a measurable cellular response. A microdose of a psychedelic drug is approximately one-tenth of a typical dose. A recreational user of LSD looking for a trip complete with visual hallucinations might ingest between one hundred and one hundred and fifty micrograms of the drug. I took ten micrograms.

Microdosing of psychedelics, so new and renegade a concept that I had to teach it to my computer's spellcheck, was popularized by a psychologist and former psychedelic researcher named James Fadiman in a series of lectures and podcast interviews and in a book published in 2011 called *The Psychedelic Explorer's Guide: Safe, Therapeutic, and Sacred Journeys*. Since 2010, Dr. Fadiman has been collecting reports from individuals who experimented with regular microdosing of LSD and psilocybin, a naturally occurring chemical found in a variety of different species of mushroom. Soon after his book's publication, in a lecture at a conference on the potential therapeutic value of psychedelic drugs, Fadiman presented what he had learned from reading the dozens of reports mailed and e-mailed to him, some though by no means all of them anonymously. He said about microdosing, "What many people are reporting is, at the end of the day, they say, 'That was a really good day.'

A really good day. Predictably, regularly, unexceptionally. That is all I have ever wanted.

For as long as I can remember, I have been held hostage by the vagaries of mood. When my mood is good, I am cheerful, productive, and affectionate. I sparkle at parties, I write decent sentences, I have what the kids call swag. When my mood swings, however, I am beset by self-loathing and knotted with guilt and shame. I am overtaken by a pervasive sense of hopelessness, a grim pessimism about even the possibility of happiness. My symptoms have never been serious enough to require hospitalization, nor have they ever prevented me from functioning either personally or professionally, but they have made my life and the lives of the people whom I love much more difficult.

I have sought many treatments for these moods and miseries. Though I managed to be one of the only neurotic Jewish children growing up in the seventies and eighties in the New York area to stay out of a shrink's office, I did eventually dip my toe. Or, to be more accurate, I waded into therapy with the eagerness of a dehydrated camel sloshing into an oasis mud puddle. I wallowed in therapy of all kinds.

My first therapist was a psychiatric resident assigned to me by University Health Services when I was a

third-year law student. I was looking for help dealing with a breakup that at the time felt tragic but that now seems like that moment when you look up from your phone just in time to avoid being plowed down by a city bus. I sat in my therapist's office and sobbed. Once I stopped crying (two or three sessions in), we talked about my boyfriend and my ambivalence about the breakup. We talked about the guy (and the other guys, and the one or two girls) I cheated on him with. We talked about my mother's anger and my father's emotional reserve, and about how hard it was to grow up in a home where two people spent so much time fighting.

Since that first series of appointments, I have spent hundreds of hours in the offices of psychiatrists and psychologists, social workers and licensed family therapists, wearing my unique assprint into so many leather couches. I've nattered on to Freudians and diligently filled out the workbooks assigned by cognitive behavioral therapists. I enjoy these sessions; I'm analytical and an extrovert, so I enjoy picking apart my life and my feelings, especially with people I'm paying for the privilege. I was a good student in elementary school, and I find workbooks soothing.

Even though I am a cynic about all things countercultural (nothing makes me roll my eyes faster than a yogini pressing her lily-white palms together in a Namaste), I have on occasion even abandoned mainstream therapy for the decidedly alternative. In my eighth month of pregnancy with my second child, desperate to avoid another Caesarean section, I engaged in a series of sessions of hypnotherapy, during which I "rebirthed" my oldest child. This would, the hypnotist promised, guarantee a vaginal birth this time. I lay on her couch, my knees bent up around my ears, as she guided me in excruciating detail through the vaginal birth I did not have. Together we imagined every twisting contraction, the burn of crowning, the exertion of pushing. I panted, I moaned, I gritted my teeth and bore down. It turns out that the only thing one is guaranteed to produce by such efforts is a massive and propulsive fart.

One month, two doulas, a midwife, and forty-four hours of nonimaginary contractions later, my son was delivered by an obstetrician who waited with surprising patience for me to finish futilely visualizing my cervix opening before he performed the second of what went on to be four C-sections.

I've done mindfulness-based therapy, which required me to spend torturous minutes meditating, and many more torturous hours discussing with my therapist why I hate meditating so much. I responded to a crisis in a friend's marriage by forcing my long-suffering husband into an infuriating kind of couples therapy that involved repeating back each other's words, theoretically in a tone not dripping with passive-aggressive fury. ("I hear that it upsets you when I criticize how you load the dishwasher, but I feel sad when you insist on putting the glasses on the bottom rack, and I feel rage because, despite your vaunted intelligence, you can't seem to learn that that's how they get broken." Oops.) We might still be frantically using "I" language with one another had my husband not pointed out that it was the therapy that was the most serious threat to our marriage. "I" had to agree.*

Despite all of these hundreds of hours of talk therapy, I can't say that I have ever experienced much in the way of a change of either outlook or behavior.

And then, one day, on my way home from giving a depressingly poorly attended reading in bucolic and beautiful Marin County,† I found myself considering the possibility of steering my wheel hard to the right and hurtling off the Richmond Bridge. The thought was more than idle, less than concrete, and though I managed to make it across safely, I was so shaken by the experience that I called a psychiatrist.

That psychiatrist diagnosed me with bipolar II disorder, a less serious variant of bipolar I, which was once known as manic depression. Though this diagnosis was a shock, it wasn't a surprise. Bipolar disorder runs in

families, and my father and other members of my family have it. I suppose in the back of my mind I always feared that my shifting moods might be an expression of the disease.

Bipolar disorder is characterized by changes in mood, energy, and activity levels. Most people experience these different emotional states, but in bipolar people they are intense, sometimes drastic and disturbing. Like “Maybe I’ll spontaneously drive my car off this bridge!” disturbing. They can have a profound impact on daily functioning and relationships. Up to one in five people with bipolar disorder will commit suicide, and rates may even, paradoxically, be higher for those suffering from bipolar II. Psychiatrists posit that individuals with bipolar I, though their suffering is more intense, are less able either to formulate a desire to commit suicide, or to carry it out. People with bipolar II possess the competence necessary to end their suffering.

Though these statistics scared me, having a diagnosis was also in many ways a profound relief. It explained so much! Like my tendency to overshare at dinner parties and on the Internet. Or the day I stood, trembling with rage, as the dry cleaner shrugged his shoulders at the ruin he’d made of my expensive new shirt. The purchase itself was made in a period of overspending typical of bipolar disorder, and my reaction to the dry cleaner’s perfunctory apology was a symptom of what’s known as “irritability.” Irritability, or “irritable mood,” is a clinical term, a piece of jargon, defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders as “a mood state in which apparently minimal stimulus or irritant produces excessive reaction, usually characterized by anger, aggressiveness or belligerence.” It seems kind of an anodyne way to describe shrieking at one’s local dry cleaner.

My diagnosis gave me the language to understand the more positive aspects of what was happening to me as well. It shed light on experiences like the time I wrote three novels in six months, with a clarity of focus and attention to detail that I had never before experienced. This type of sublime creative energy is characteristic of the elevated and productive mood state known as hypomania. So exhilarating and fruitful were these periods that I sometimes thought they were sufficient compensation for the other, dark side of the disease.

After my diagnosis, I embarked on seven years of psychotropic medications, suspended only for a brief period in the early stages of one of my pregnancies. The list of meds I’ve tried and rejected is so long that my friends use me as a kind of walking Physicians’ Desk Reference, able to recite symptoms and side effects for anything their shrink might prescribe, like the soothing voice-over at the end of a drug commercial: “Abilify is not for everyone. Call your doctor if you have high fever, stiff muscles, or confusion.” Off the top of my head, I have over the long course of this journey in mental illness and mood alteration been prescribed the following medications: selective serotonin reuptake inhibitors (SSRIs) including: citalopram (Celexa), its nongeneric and thus more costly fraternal twin sister escitalopram (Lexapro), fluoxetine (Prozac), and sertraline (Zoloft); the serotonin-norepinephrine reuptake inhibitors duloxetine (Cymbalta), venlafaxine (Effexor), and venlafaxine XR (Effexor XR); the atypical antidepressant bupropion (Wellbutrin); the mood stabilizers lamotrigine (Lamictal) and topiramate (Topamax); amphetamine (Adderall, Adderall XR), methylphenidate (Ritalin and Concerta), and atomoxetine (Strattera); the benzodiazepines alprazolam (Xanax), diazepam (Valium), and lorazepam (Ativan); the atypical antipsychotic quetiapine (Seroquel) (a particularly bizarre prescription since I have never been remotely psychotic); the sleep aids zolpidem (Ambien) and eszopiclone (Lunesta). I’m sure I’m forgetting some. That can happen when you take a shit-ton of drugs.

Some of these medications worked for a little while— sometimes a few days, sometimes a few months. But with every new pill there were new side effects. Since SSRIs made me gain weight and deadened my libido, standard practice dictated that we add new meds to combat the weight gain and to pump up my sex drive. Those drugs made me irritable, so the doctor prescribed something else to calm me down; round and round

in a seemingly futile cycle.

Unfortunately, this kind of trial-and-error experience is quite prevalent in mental health treatment. These drugs act on people in different and unexpected ways, and it is often difficult to concoct the precise cocktail to address an individual's array of issues. Furthermore, practitioners, even the best ones, still lack a complete understanding of the complexity and nuance both of the many psychological and mood disorders and of the many pharmaceuticals available to treat them. Were mental health research more adequately funded, perhaps there might be more clarity. Certainly, misdiagnosis might be less common.

Years after my initial diagnosis, while tumbling down an Internet rabbit hole the genesis of which I can't remember, I stumbled across an abstract of a clinical study on PMS that made me question whether my diagnosis of bipolar disorder was correct. My bipolar disorder did not comply with the requirements written in the DSM-5. My hypomania rarely lasted the requisite four days, and never toppled into mania, and, though I regularly fell into black moods, I had never had a major depressive episode. My moods were not as extreme as my father's, nor had I ever suffered any real professional or personal damage as a result of them.* Was I really bipolar?

When I got out the mood charts I'd been keeping since my diagnosis and compared them to my menstrual cycle, it became strikingly clear. My mood, my sleep patterns, my energy levels, all fluctuated in direct correspondence with my menstrual cycle. During the week before my period, my mood dropped. I became depressed, more prone to anger; my sleep was out of whack. I also noticed another dip in mood in the middle of my cycle, this one lasting only for a day or so. This dip happened immediately before ovulation, and was characterized not so much by depression as by fury. It was during these pre-period periods that I traumatized that poor dry cleaner and picked fights with my stoical husband over issues of global importance like the proper loading of the dishwasher.

I consulted a psychiatrist recommended by the Women's Mood and Hormone Clinic at the medical center of the University of California, San Francisco, a psychiatric clinic that treats women with mood disorders that can be attributed, in part, to hormonal influences on the brain. My new doctor immediately evaluated me for PMS.

PMS—defined as mood fluctuations and physical symptoms in the days preceding menstruation—is experienced in some form by as many as 80 percent of all ovulating women. Nineteen percent suffer symptoms serious enough to interfere with work, school, or relationships, and between 3 and 8 percent suffer from PMDD, or premenstrual dysphoric disorder, symptoms so severe that those who suffer from them can be, at times, effectively disabled.

Although it's long been known that 67 percent of women's admissions to psychiatric facilities occur during the week immediately prior to menstruation, only recently have researchers begun to consider the effect of PMS on women with mood disorders. Premenstrual exacerbation, or PME, is when an underlying condition is worsened during a phase of a woman's menstrual cycle. However, because I only ever experienced mood swings during two periods in my luteal phase (the days before ovulation and the week leading up to menstruation), my new psychiatrist concluded that I did not suffer from bipolar disorder at all, even bipolar disorder complicated by PME, but, rather, from mild PMDD, not so serious as to be disabling, but troubling nonetheless. Especially to my dry cleaner.

This change in diagnosis immediately felt right to me. Though there'd been comfort in having the bipolar diagnosis to explain my shifting moods, the fact that I never experienced serious mania or profound depression had always given me pause. Many a morning I would feel fine and stable, stare at the handful of

pills in the palm of my hand, and wonder whether it really made sense to swallow something that I knew would soon make me irritable and/or sap my sex drive. And yet I also knew what happened to people with bipolar disorder who said, “I feel fine!” and stopped taking their meds, so I was a good soldier and took whatever my psychopharmacologist prescribed. Now, finally, I was on the right track.

Mood stabilizers don't work on PMDD. Instead, low doses of hormones, including birth-control pills, are often prescribed, as are SSRIs, the latter given only in the week or ten days preceding menstruation. Research has also shown a positive effect from calcium supplements, light therapy, and cognitive therapy.

Because evidence of the link between hormone replacement therapy and breast cancer made me skittish, I initially opted for the monthly short course of SSRIs. Though antidepressants normally take four to six weeks to become effective, in premenstrual women, as soon as SSRIs are absorbed, they inhibit the enzyme 3-β-HSD from metabolizing progesterone. Because the drop in progesterone is the culprit in premenstrual blues, the change is immediate and profound. In my case, within twenty minutes of taking a pill, my mood lifted.†

Unfortunately, SSRIs don't have the same magical effect prior to ovulation, when a woman's hormones shift rapidly, estrogen levels peaking and LH (luteinizing hormone produced by the pituitary gland) surging. As Dr. Louann Brizendine, the founder of the UCSF Women's Mood and Hormone Clinic, told me, “Abrupt changes in hormones are like the rug being pulled out from under the brain.” Because SSRIs don't work during this period, I relied on techniques learned in cognitive behavioral therapy and, when I found myself flinging my children's toys across the room or starting a social-media flame war, the occasional anti-anxiety pill. A chill pill, if you will.

Once I understood the cyclical nature of my sleeplessness, I could wean myself off sleeping pills, and throw away most of my pharmacopeia. For a while, I was far better able to control my moods. I still cycled, but because I could anticipate my rages and my periods of sadness, I was able to plan for them and deal with them. I monitored my calendar the way a pilot monitors her cockpit controls, not only to determine when to start taking my medication, but also so that I could schedule important meetings and events to coincide with less volatile days of the month. Dr. Brizendine requires her patients' partners to take the initiative during the premenstrual period, urging them to stop all arguments, jot down the subject on a piece of paper, and reintroduce it later in the month, when it can be dismissed without rancor. My husband kept track of my cycle and developed a bland and pleasant tone in which to ask the question “Do you think you might need an SSRI today?” I did my part by neither defenestrating nor decapitating him, but instead taking my pill.

For five years, things were predictable and peaceful. Then the inevitable happened. I entered perimenopause, and my period became irregular. Some cycles lasted thirty days, others twenty. Sometimes I'd skip a period or two altogether. With my period behaving like an ambivalent Victorian suitor who drops his visiting card rarely and on no discernible schedule, I could not time my SSRIs. My doctor convinced me to overcome my trepidation and try a low-dose estradiol patch to combat my shifting moods. The patch, however, did not provide the instant and profound relief I was used to. More troublingly, the use of unopposed estrogen—estrogen taken alone—is associated with an increased risk of endometrial and uterine cancer. This risk can be eliminated by adding progestin, but that's been associated with an increased risk of breast cancer. Furthermore, progestin has a marked negative effect on mood, especially in women with PMS or PMDD. Since the only reason I was wearing the patch was to ameliorate my low moods, I was not about to add a medication that would make me depressed and possibly give me cancer.

And then things took a turn for the worse. I found myself in a state of seemingly perpetual irritability. I seethed, I turned that fury on the people around me, and then I collapsed in shame at my outbursts. These

alternating states of anger and despair came far more frequently than before, and made me feel hopeless. I couldn't seem to find pleasure in my life, or even contentment. I saw the world through a sad and dingy scrim. I knew there was light and love on the other side, but I couldn't manage to lift the grimy curtain of my unhappiness.

My husband, who had been dealing with my vicissitudes of mood for years, seemed finally to be exhausted by them. We fought, and we seemed to take far longer to recover from our altercations. Or perhaps that's more of my despondency talking. Perhaps he was no less patient than before, but my depression made me newly terrified that he would once and for all pack his bags and leave me alone with my ugly self.

It was in this state of mind that I stumbled across James Fadiman's book.

Before becoming a writer, I was a federal public defender and law professor with a particular interest in criminal justice reform. For many years, I taught a seminar called *The Legal and Social Implications of the War on Drugs* at the UC Berkeley

School of Law, and was a consultant to the Drug Policy Alliance, an organization dedicated to the reform of U.S. drug laws. However, though I have experience and expertise with drug-policy reform issues, I knew very little about psychedelic drugs. I had never taken LSD, and my experience with other hallucinogens began and ended in my freshman year of college, with a pleasurable but somewhat disconcerting few hours spent languidly spinning on a tire swing after consuming a very small quantity of psilocybin in the form of "magic mushrooms."* I have always been too afraid of enduring a terrifying bad trip or suffering lasting psychiatric harm to experiment further. But microdosing seemed different, less frightening. The doses Fadiman discussed were sub-perceptual, so small that there was no possibility of any kind of hallucination, positive or negative. Not so much going on an acid trip as going on an acid errand.

The individuals whose reports Fadiman presented in his book experienced "joy and gratitude," increased focus, better mood. I wanted that. They reported rarely losing their tempers, becoming more fun to be with. I really wanted that. They experienced that most seductive and elusive thing: a really good day. I needed that! None reported any negative experiences, but, then, the book was hardly a thorough research study. It provided, however, a glimmer of hope. With reservations, of course.

There has never been an officially sanctioned study of microdosing. The closest thing to research is Fadiman's anecdotal data collection, assembling reports from individuals who reach out to him. There is, however, a tremendous amount of data on LSD. Before the drug was criminalized, it was thoroughly studied. Thousands of doses were administered in therapeutic and research settings, with very few negative effects. LSD has a very low toxicity level and a large safety range.* This means that even massive doses are not physically dangerous. Microdoses have no discernible biological effects at all.

I contacted James Fadiman and received a memo entitled "To a Potential Self-Study Psychedelic Researcher." The document makes clear that it is not meant as an encouragement to engage in illegal activity but is, rather, a set of cautions and procedures designed to minimize harm, should you engage in illegal activity without the encouragement of James Fadiman.

The protocol is simple. To participate in the international selfstudy group on the effects of sub-perceptual doses of LSD on normal daily functioning, a "self-study psychedelic researcher" is to take microdoses of LSD on repeating three-day cycles. The suggested dose is ten micrograms, one-tenth or less of what a person would have to take in order to experience an altered state of consciousness. The idea is to take a dose so small that you don't actually feel anything unusual. Or at least nothing immediately tangible. On Day 1 of

every cycle, participants are to take ten micrograms of LSD. They are to keep to their normal schedules of work, leisure, meals, coffee, naps, exercise, and social life. They are instructed to monitor mood, physical strength, symptoms, productivity, and the ease with which they do their work, and to “write a few notes about how [the] day went.” On Days 2 and 3, participants are to take no LSD, but merely to continue monitoring and noting.

I read Fadiman’s memo, I reread his book, I researched, and I considered. The idea of becoming a “self-study psychedelic researcher” felt ridiculous. I am the mother of four children. I am, to use my children’s gibe, “totally basic.” I wear yoga pants all day, I post photos of particularly indulgent desserts on Instagram. I am the mom surreptitiously checking her phone at Back to School Night, the woman standing behind you in Starbucks ordering the skinny vanilla latte, the one getting a mammogram in the room next to yours, the one digging through her too-full purse looking for her keys while you wait impatiently for her parking spot. I am a former attorney and law professor, a lawabiding citizen. A nerd. If a cashier hands me incorrect change, I return the excess. I don’t cheat on my taxes, don’t jump the turnstile in the subway, don’t park in handicapped spots. I write and lecture on the criminal justice system; I don’t regularly commit crimes.

But I was suffering. Worse, I was making the people around me suffer. I was in pain, and I was desperate, and it suddenly seemed like I had nothing to lose. I decided to try a one-month experiment. I would follow James Fadiman’s protocol, taking a microdose of LSD every three days. I would carefully track the results, keeping notes of the effects. Because I am a writer, I would write these notes up in a form that might be useful not just to myself or to Fadiman, but to others curious about the potential therapeutic uses of microdosing. I would also use this month to learn more about psychedelic drugs and to think deeply about what brought me to try something so unusual, so desperate. A single month out of fifty years. What harm—or what help—could there be in that?

*Lately, we’ve started going to a more traditional kind of couples therapy, in which we each try to recruit the therapist to take our side against the other. She’s annoyingly neutral—Switzerland in sensible shoes.

†The single audience member, a malodorous gentleman slumped in a rear seat, woke up halfway through the reading, gazed at me with pity, and trundled his shopping cart heaped with beer bottles out the door.

*Other than the time I was fired for cursing out a sexist boss. But I’d waited until my last week of work before taking on the guy. He was such a complete and utter shitheel that I consider that experience an example of forbearance rather than (or perhaps in addition to) loss of control.

† Incidentally, alcohol seems to act on the same receptors, so a glass of wine can have the same effect. As appealing as was the idea of spending a week of every month in a mild state of inebriation, I opted for the pills.

*Or maybe the mushrooms weren’t magic at all. I didn’t hallucinate, and who wouldn’t become dizzy spinning on a tire swing? It’s possible that all I ate was a handful of dried shiitakes dipped in cow manure.

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A REALLY GOOD DAY: HOW MICRODOSING MADE A MEGA DIFFERENCE IN MY MOOD, MY MARRIAGE, AND MY LIFE BY AYELET WALDMAN PDF

The true story of how a renowned writer's struggle with mood storms led her to try a remedy as drastic as it is forbidden: microdoses of LSD. Her revealing, fascinating journey provides a window into one family and the complex world of a once-infamous drug seen through new eyes.

When a small vial arrives in her mailbox from "Lewis Carroll," Ayelet Waldman is at a low point. Her moods have become intolerably severe; she has tried nearly every medication possible; her husband and children are suffering with her. So she opens the vial, places two drops on her tongue, and joins the ranks of an underground but increasingly vocal group of scientists and civilians successfully using therapeutic microdoses of LSD. As Waldman charts her experience over the course of a month--bursts of productivity, sleepless nights, a newfound sense of equanimity--she also explores the history and mythology of LSD, the cutting-edge research into the drug, and the byzantine policies that control it. Drawing on her experience as a federal public defender, and as the mother of teenagers, and her research into the therapeutic value of psychedelics, Waldman has produced a book that is eye-opening, often hilarious, and utterly enthralling.

- Sales Rank: #6830 in Books
- Published on: 2017-01-10
- Released on: 2017-01-10
- Format: Deckle Edge
- Original language: English
- Dimensions: 8.60" h x 1.00" w x 6.00" l, 1.25 pounds
- Binding: Hardcover
- 256 pages

Review

"Genuinely brave and human... In normalizing the conversation about LSD, she may one day help others feel normal." —Jennifer Senior, *The New York Times*

"A wildly brilliant, radically candid, and rigorous daybook of [Waldman's] life-changing, last-resort journey." —Lisa Shea, *Elle*

"Relentlessly honest and surprisingly funny." —Sharon Peters, *USA Today*

"An intriguing and thorough look at the therapeutic possibilities of an illegal drug... Engaging and deeply researched." —Nora Krug, *The Washington Post*

"Smart, outspoken, provoking, and funny... Poignant, sometimes hilarious... Waldman calls for renewed research and drug-law reform in this informative, candid, altogether irresistible quest." —Donna Seaman, *Booklist*

"Honest and intelligent... A humane, well-reasoned, and absolutely necessary argument for a major overhaul of America's drug policy. The book triumphantly coheres in a lucid manifesto of how and why the racist, immoral undertaking called the War on Drugs has failed... Passionate, persuasive." —Claire Vaye Watkins, *The New Republic*

About the Author

AYELET WALDMAN is the author of the novels *Love and Treasure*, *Red Hook Road*, *Love and Other Impossible Pursuits*, and *Daughter's Keeper*, as well as of the essay collection *Bad Mother: A Chronicle of Maternal Crimes, Minor Calamities, and Occasional Moments of Grace*, and the *Mommy-Track Mystery* series. She was a federal public defender and taught a course on the legal implications of the War on Drugs at the UC Berkeley law school. She lives in Berkeley, California, with her husband, Michael Chabon, and their four children.

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This morning I took LSD.

The table I'm sitting at right now is not breathing. My keyboard is not exploding in psychedelic fireworks, lightning bolts shooting from the letters "R" and "P." I am not giddy and frantic, or zoned out with bliss. I feel no transcendent sense of oneness with the universe or with the divine. On the contrary. I feel normal.

Well, except for one thing: I'm content and relaxed. I'm busy, but not stressed. That might be normal for some people, but it isn't for me.

I did not drop a tab of acid. What I took is known as a "microdose," a subtherapeutic dose of a drug administered at a quantity low enough to elicit no adverse side effects yet high enough for a measurable cellular response. A microdose of a psychedelic drug is approximately one-tenth of a typical dose. A recreational user of LSD looking for a trip complete with visual hallucinations might ingest between one hundred and one hundred and fifty micrograms of the drug. I took ten micrograms.

Microdosing of psychedelics, so new and renegade a concept that I had to teach it to my computer's spellcheck, was popularized by a psychologist and former psychedelic researcher named James Fadiman in a series of lectures and podcast interviews and in a book published in 2011 called *The Psychedelic Explorer's Guide: Safe, Therapeutic, and Sacred Journeys*. Since 2010, Dr. Fadiman has been collecting reports from individuals who experimented with regular microdosing of LSD and psilocybin, a naturally occurring chemical found in a variety of different species of mushroom. Soon after his book's publication, in a lecture at a conference on the potential therapeutic value of psychedelic drugs, Fadiman presented what he had learned from reading the dozens of reports mailed and e-mailed to him, some though by no means all of them anonymously. He said about microdosing, "What many people are reporting is, at the end of the day, they say, 'That was a really good day.'

A really good day. Predictably, regularly, unexceptionally. That is all I have ever wanted.

For as long as I can remember, I have been held hostage by the vagaries of mood. When my mood is good, I am cheerful, productive, and affectionate. I sparkle at parties, I write decent sentences, I have what the kids call swag. When my mood swings, however, I am beset by self-loathing and knotted with guilt and shame. I am overtaken by a pervasive sense of hopelessness, a grim pessimism about even the possibility of happiness. My symptoms have never been serious enough to require hospitalization, nor have they ever prevented me from functioning either personally or professionally, but they have made my life and the lives of the people whom I love much more difficult.

I have sought many treatments for these moods and miseries. Though I managed to be one of the only neurotic Jewish children growing up in the seventies and eighties in the New York area to stay out of a shrink's office, I did eventually dip my toe. Or, to be more accurate, I waded into therapy with the eagerness of a dehydrated camel sloshing into an oasis mud puddle. I wallowed in therapy of all kinds.

My first therapist was a psychiatric resident assigned to me by University Health Services when I was a third-year law student. I was looking for help dealing with a breakup that at the time felt tragic but that now seems like that moment when you look up from your phone just in time to avoid being plowed down by a city bus. I sat in my therapist's office and sobbed. Once I stopped crying (two or three sessions in), we talked about my boyfriend and my ambivalence about the breakup. We talked about the guy (and the other guys, and the one or two girls) I cheated on him with. We talked about my mother's anger and my father's emotional reserve, and about how hard it was to grow up in a home where two people spent so much time fighting.

Since that first series of appointments, I have spent hundreds of hours in the offices of psychiatrists and psychologists, social workers and licensed family therapists, wearing my unique assprint into so many leather couches. I've nattered on to Freudians and diligently filled out the workbooks assigned by cognitive behavioral therapists. I enjoy these sessions; I'm analytical and an extrovert, so I enjoy picking apart my life and my feelings, especially with people I'm paying for the privilege. I was a good student in elementary school, and I find workbooks soothing.

Even though I am a cynic about all things countercultural (nothing makes me roll my eyes faster than a yogini pressing her lily-white palms together in a Namaste), I have on occasion even abandoned mainstream therapy for the decidedly alternative. In my eighth month of pregnancy with my second child, desperate to avoid another Caesarean section, I engaged in a series of sessions of hypnotherapy, during which I "rebirthed" my oldest child. This would, the hypnotist promised, guarantee a vaginal birth this time. I lay on her couch, my knees bent up around my ears, as she guided me in excruciating detail through the vaginal birth I did not have. Together we imagined every twisting contraction, the burn of crowning, the exertion of pushing. I panted, I moaned, I gritted my teeth and bore down. It turns out that the only thing one is guaranteed to produce by such efforts is a massive and propulsive fart.

One month, two doulas, a midwife, and forty-four hours of nonimaginary contractions later, my son was delivered by an obstetrician who waited with surprising patience for me to finish futilely visualizing my cervix opening before he performed the second of what went on to be four C-sections.

I've done mindfulness-based therapy, which required me to spend torturous minutes meditating, and many more torturous hours discussing with my therapist why I hate meditating so much. I responded to a crisis in a friend's marriage by forcing my long-suffering husband into an infuriating kind of couples therapy that involved repeating back each other's words, theoretically in a tone not dripping with passive-aggressive fury. ("I hear that it upsets you when I criticize how you load the dishwasher, but I feel sad when you insist on putting the glasses on the bottom rack, and I feel rage because, despite your vaunted intelligence, you can't seem to learn that that's how they get broken." Oops.) We might still be frantically using "I" language with one another had my husband not pointed out that it was the therapy that was the most serious threat to our marriage. "I" had to agree.*

Despite all of these hundreds of hours of talk therapy, I can't say that I have ever experienced much in the way of a change of either outlook or behavior.

And then, one day, on my way home from giving a depressingly poorly attended reading in bucolic and

beautiful Marin County,† I found myself considering the possibility of steering my wheel hard to the right and hurtling off the Richmond Bridge. The thought was more than idle, less than concrete, and though I managed to make it across safely, I was so shaken by the experience that I called a psychiatrist.

That psychiatrist diagnosed me with bipolar II disorder, a less serious variant of bipolar I, which was once known as manic depression. Though this diagnosis was a shock, it wasn't a surprise. Bipolar disorder runs in families, and my father and other members of my family have it. I suppose in the back of my mind I always feared that my shifting moods might be an expression of the disease.

Bipolar disorder is characterized by changes in mood, energy, and activity levels. Most people experience these different emotional states, but in bipolar people they are intense, sometimes drastic and disturbing. Like "Maybe I'll spontaneously drive my car off this bridge!" disturbing. They can have a profound impact on daily functioning and relationships. Up to one in five people with bipolar disorder will commit suicide, and rates may even, paradoxically, be higher for those suffering from bipolar II. Psychiatrists posit that individuals with bipolar I, though their suffering is more intense, are less able either to formulate a desire to commit suicide, or to carry it out. People with bipolar II possess the competence necessary to end their suffering.

Though these statistics scared me, having a diagnosis was also in many ways a profound relief. It explained so much! Like my tendency to overshare at dinner parties and on the Internet. Or the day I stood, trembling with rage, as the dry cleaner shrugged his shoulders at the ruin he'd made of my expensive new shirt. The purchase itself was made in a period of overspending typical of bipolar disorder, and my reaction to the dry cleaner's perfunctory apology was a symptom of what's known as "irritability." Irritability, or "irritable mood," is a clinical term, a piece of jargon, defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders as "a mood state in which apparently minimal stimulus or irritant produces excessive reaction, usually characterized by anger, aggressiveness or belligerence." It seems kind of an anodyne way to describe shrieking at one's local dry cleaner.

My diagnosis gave me the language to understand the more positive aspects of what was happening to me as well. It shed light on experiences like the time I wrote three novels in six months, with a clarity of focus and attention to detail that I had never before experienced. This type of sublime creative energy is characteristic of the elevated and productive mood state known as hypomania. So exhilarating and fruitful were these periods that I sometimes thought they were sufficient compensation for the other, dark side of the disease.

After my diagnosis, I embarked on seven years of psychotropic medications, suspended only for a brief period in the early stages of one of my pregnancies. The list of meds I've tried and rejected is so long that my friends use me as a kind of walking Physicians' Desk Reference, able to recite symptoms and side effects for anything their shrink might prescribe, like the soothing voice-over at the end of a drug commercial: "Abilify is not for everyone. Call your doctor if you have high fever, stiff muscles, or confusion." Off the top of my head, I have over the long course of this journey in mental illness and mood alteration been prescribed the following medications: selective serotonin reuptake inhibitors (SSRIs) including: citalopram (Celexa), its nongeneric and thus more costly fraternal twin sister escitalopram (Lexapro), fluoxetine (Prozac), and sertraline (Zoloft); the serotonin-norepinephrine reuptake inhibitors duloxetine (Cymbalta), venlafaxine (Effexor), and venlafaxine XR (Effexor XR); the atypical antidepressant bupropion (Wellbutrin); the mood stabilizers lamotrigine (Lamictal) and topiramate (Topamax); amphetamine (Adderall, Adderall XR), methylphenidate (Ritalin and Concerta), and atomoxetine (Strattera); the benzodiazepines alprazolam (Xanax), diazepam (Valium), and lorazepam (Ativan); the atypical antipsychotic quetiapine (Seroquel) (a particularly bizarre prescription since I have never been remotely psychotic); the sleep aids zolpidem (Ambien) and eszopiclone (Lunesta). I'm sure I'm forgetting some. That can happen when you take a shit-

ton of drugs.

Some of these medications worked for a little while— sometimes a few days, sometimes a few months. But with every new pill there were new side effects. Since SSRIs made me gain weight and deadened my libido, standard practice dictated that we add new meds to combat the weight gain and to pump up my sex drive. Those drugs made me irritable, so the doctor prescribed something else to calm me down; round and round in a seemingly futile cycle.

Unfortunately, this kind of trial-and-error experience is quite prevalent in mental health treatment. These drugs act on people in different and unexpected ways, and it is often difficult to concoct the precise cocktail to address an individual's array of issues. Furthermore, practitioners, even the best ones, still lack a complete understanding of the complexity and nuance both of the many psychological and mood disorders and of the many pharmaceuticals available to treat them. Were mental health research more adequately funded, perhaps there might be more clarity. Certainly, misdiagnosis might be less common.

Years after my initial diagnosis, while tumbling down an Internet rabbit hole the genesis of which I can't remember, I stumbled across an abstract of a clinical study on PMS that made me question whether my diagnosis of bipolar disorder was correct. My bipolar disorder did not comply with the requirements written in the DSM-5. My hypomania rarely lasted the requisite four days, and never toppled into mania, and, though I regularly fell into black moods, I had never had a major depressive episode. My moods were not as extreme as my father's, nor had I ever suffered any real professional or personal damage as a result of them.* Was I really bipolar?

When I got out the mood charts I'd been keeping since my diagnosis and compared them to my menstrual cycle, it became strikingly clear. My mood, my sleep patterns, my energy levels, all fluctuated in direct correspondence with my menstrual cycle. During the week before my period, my mood dropped. I became depressed, more prone to anger; my sleep was out of whack. I also noticed another dip in mood in the middle of my cycle, this one lasting only for a day or so. This dip happened immediately before ovulation, and was characterized not so much by depression as by fury. It was during these pre-period periods that I traumatized that poor dry cleaner and picked fights with my stoical husband over issues of global importance like the proper loading of the dishwasher.

I consulted a psychiatrist recommended by the Women's Mood and Hormone Clinic at the medical center of the University of California, San Francisco, a psychiatric clinic that treats women with mood disorders that can be attributed, in part, to hormonal influences on the brain. My new doctor immediately evaluated me for PMS.

PMS—defined as mood fluctuations and physical symptoms in the days preceding menstruation—is experienced in some form by as many as 80 percent of all ovulating women. Nineteen percent suffer symptoms serious enough to interfere with work, school, or relationships, and between 3 and 8 percent suffer from PMDD, or premenstrual dysphoric disorder, symptoms so severe that those who suffer from them can be, at times, effectively disabled.

Although it's long been known that 67 percent of women's admissions to psychiatric facilities occur during the week immediately prior to menstruation, only recently have researchers begun to consider the effect of PMS on women with mood disorders. Premenstrual exacerbation, or PME, is when an underlying condition is worsened during a phase of a woman's menstrual cycle. However, because I only ever experienced mood swings during two periods in my luteal phase (the days before ovulation and the week leading up to menstruation), my new psychiatrist concluded that I did not suffer from bipolar disorder at all, even bipolar

disorder complicated by PME, but, rather, from mild PMDD, not so serious as to be disabling, but troubling nonetheless. Especially to my dry cleaner.

This change in diagnosis immediately felt right to me. Though there'd been comfort in having the bipolar diagnosis to explain my shifting moods, the fact that I never experienced serious mania or profound depression had always given me pause. Many a morning I would feel fine and stable, stare at the handful of pills in the palm of my hand, and wonder whether it really made sense to swallow something that I knew would soon make me irritable and/or sap my sex drive. And yet I also knew what happened to people with bipolar disorder who said, "I feel fine!" and stopped taking their meds, so I was a good soldier and took whatever my psychopharmacologist prescribed. Now, finally, I was on the right track.

Mood stabilizers don't work on PMDD. Instead, low doses of hormones, including birth-control pills, are often prescribed, as are SSRIs, the latter given only in the week or ten days preceding menstruation. Research has also shown a positive effect from calcium supplements, light therapy, and cognitive therapy.

Because evidence of the link between hormone replacement therapy and breast cancer made me skittish, I initially opted for the monthly short course of SSRIs. Though antidepressants normally take four to six weeks to become effective, in premenstrual women, as soon as SSRIs are absorbed, they inhibit the enzyme 3- β -HSD from metabolizing progesterone. Because the drop in progesterone is the culprit in premenstrual blues, the change is immediate and profound. In my case, within twenty minutes of taking a pill, my mood lifted.†

Unfortunately, SSRIs don't have the same magical effect prior to ovulation, when a woman's hormones shift rapidly, estrogen levels peaking and LH (luteinizing hormone produced by the pituitary gland) surging. As Dr. Louann Brizendine, the founder of the UCSF Women's Mood and Hormone Clinic, told me, "Abrupt changes in hormones are like the rug being pulled out from under the brain." Because SSRIs don't work during this period, I relied on techniques learned in cognitive behavioral therapy and, when I found myself flinging my children's toys across the room or starting a social-media flame war, the occasional anti-anxiety pill. A chill pill, if you will.

Once I understood the cyclical nature of my sleeplessness, I could wean myself off sleeping pills, and throw away most of my pharmacopeia. For a while, I was far better able to control my moods. I still cycled, but because I could anticipate my rages and my periods of sadness, I was able to plan for them and deal with them. I monitored my calendar the way a pilot monitors her cockpit controls, not only to determine when to start taking my medication, but also so that I could schedule important meetings and events to coincide with less volatile days of the month. Dr. Brizendine requires her patients' partners to take the initiative during the premenstrual period, urging them to stop all arguments, jot down the subject on a piece of paper, and reintroduce it later in the month, when it can be dismissed without rancor. My husband kept track of my cycle and developed a bland and pleasant tone in which to ask the question "Do you think you might need an SSRI today?" I did my part by neither defenestrating nor decapitating him, but instead taking my pill.

For five years, things were predictable and peaceful. Then the inevitable happened. I entered perimenopause, and my period became irregular. Some cycles lasted thirty days, others twenty. Sometimes I'd skip a period or two altogether. With my period behaving like an ambivalent Victorian suitor who drops his visiting card rarely and on no discernible schedule, I could not time my SSRIs. My doctor convinced me to overcome my trepidation and try a low-dose estradiol patch to combat my shifting moods. The patch, however, did not provide the instant and profound relief I was used to. More troublingly, the use of unopposed estrogen—estrogen taken alone—is associated with an increased risk of endometrial and uterine cancer. This risk can be eliminated by adding progestin, but that's been associated with an increased risk of breast cancer.

Furthermore, progestin has a marked negative effect on mood, especially in women with PMS or PMDD. Since the only reason I was wearing the patch was to ameliorate my low moods, I was not about to add a medication that would make me depressed and possibly give me cancer.

And then things took a turn for the worse. I found myself in a state of seemingly perpetual irritability. I seethed, I turned that fury on the people around me, and then I collapsed in shame at my outbursts. These alternating states of anger and despair came far more frequently than before, and made me feel hopeless. I couldn't seem to find pleasure in my life, or even contentment. I saw the world through a sad and dingy scrim. I knew there was light and love on the other side, but I couldn't manage to lift the grimy curtain of my unhappiness.

My husband, who had been dealing with my vicissitudes of mood for years, seemed finally to be exhausted by them. We fought, and we seemed to take far longer to recover from our altercations. Or perhaps that's more of my despondency talking. Perhaps he was no less patient than before, but my depression made me newly terrified that he would once and for all pack his bags and leave me alone with my ugly self.

It was in this state of mind that I stumbled across James Fadiman's book.

Before becoming a writer, I was a federal public defender and law professor with a particular interest in criminal justice reform. For many years, I taught a seminar called The Legal and Social Implications of the War on Drugs at the UC Berkeley

School of Law, and was a consultant to the Drug Policy Alliance, an organization dedicated to the reform of U.S. drug laws. However, though I have experience and expertise with drug-policy reform issues, I knew very little about psychedelic drugs. I had never taken LSD, and my experience with other hallucinogens began and ended in my freshman year of college, with a pleasurable but somewhat disconcerting few hours spent languidly spinning on a tire swing after consuming a very small quantity of psilocybin in the form of "magic mushrooms."* I have always been too afraid of enduring a terrifying bad trip or suffering lasting psychiatric harm to experiment further. But microdosing seemed different, less frightening. The doses Fadiman discussed were sub-perceptual, so small that there was no possibility of any kind of hallucination, positive or negative. Not so much going on an acid trip as going on an acid errand.

The individuals whose reports Fadiman presented in his book experienced "joy and gratitude," increased focus, better mood. I wanted that. They reported rarely losing their tempers, becoming more fun to be with. I really wanted that. They experienced that most seductive and elusive thing: a really good day. I needed that! None reported any negative experiences, but, then, the book was hardly a thorough research study. It provided, however, a glimmer of hope. With reservations, of course.

There has never been an officially sanctioned study of microdosing. The closest thing to research is Fadiman's anecdotal data collection, assembling reports from individuals who reach out to him. There is, however, a tremendous amount of data on LSD. Before the drug was criminalized, it was thoroughly studied. Thousands of doses were administered in therapeutic and research settings, with very few negative effects. LSD has a very low toxicity level and a large safety range.* This means that even massive doses are not physically dangerous. Microdoses have no discernible biological effects at all.

I contacted James Fadiman and received a memo entitled "To a Potential Self-Study Psychedelic Researcher." The document makes clear that it is not meant as an encouragement to engage in illegal activity but is, rather, a set of cautions and procedures designed to minimize harm, should you engage in illegal activity without the encouragement of James Fadiman.

The protocol is simple. To participate in the international selfstudy group on the effects of sub-perceptual doses of LSD on normal daily functioning, a “self-study psychedelic researcher” is to take microdoses of LSD on repeating three-day cycles. The suggested dose is ten micrograms, one-tenth or less of what a person would have to take in order to experience an altered state of consciousness. The idea is to take a dose so small that you don’t actually feel anything unusual. Or at least nothing immediately tangible. On Day 1 of every cycle, participants are to take ten micrograms of LSD. They are to keep to their normal schedules of work, leisure, meals, coffee, naps, exercise, and social life. They are instructed to monitor mood, physical strength, symptoms, productivity, and the ease with which they do their work, and to “write a few notes about how [the] day went.” On Days 2 and 3, participants are to take no LSD, but merely to continue monitoring and noting.

I read Fadiman’s memo, I reread his book, I researched, and I considered. The idea of becoming a “self-study psychedelic researcher” felt ridiculous. I am the mother of four children. I am, to use my children’s gibe, “totally basic.” I wear yoga pants all day, I post photos of particularly indulgent desserts on Instagram. I am the mom surreptitiously checking her phone at Back to School Night, the woman standing behind you in Starbucks ordering the skinny vanilla latte, the one getting a mammogram in the room next to yours, the one digging through her too-full purse looking for her keys while you wait impatiently for her parking spot. I am a former attorney and law professor, a lawabiding citizen. A nerd. If a cashier hands me incorrect change, I return the excess. I don’t cheat on my taxes, don’t jump the turnstile in the subway, don’t park in handicapped spots. I write and lecture on the criminal justice system; I don’t regularly commit crimes.

But I was suffering. Worse, I was making the people around me suffer. I was in pain, and I was desperate, and it suddenly seemed like I had nothing to lose. I decided to try a one-month experiment. I would follow James Fadiman’s protocol, taking a microdose of LSD every three days. I would carefully track the results, keeping notes of the effects. Because I am a writer, I would write these notes up in a form that might be useful not just to myself or to Fadiman, but to others curious about the potential therapeutic uses of microdosing. I would also use this month to learn more about psychedelic drugs and to think deeply about what brought me to try something so unusual, so desperate. A single month out of fifty years. What harm—or what help—could there be in that?

*Lately, we’ve started going to a more traditional kind of couples therapy, in which we each try to recruit the therapist to take our side against the other. She’s annoyingly neutral—Switzerland in sensible shoes.

†The single audience member, a malodorous gentleman slumped in a rear seat, woke up halfway through the reading, gazed at me with pity, and trundled his shopping cart heaped with beer bottles out the door.

*Other than the time I was fired for cursing out a sexist boss. But I’d waited until my last week of work before taking on the guy. He was such a complete and utter shiteel that I consider that experience an example of forbearance rather than (or perhaps in addition to) loss of control.

† Incidentally, alcohol seems to act on the same receptors, so a glass of wine can have the same effect. As appealing as was the idea of spending a week of every month in a mild state of inebriation, I opted for the pills.

*Or maybe the mushrooms weren't magic at all. I didn't hallucinate, and who wouldn't become dizzy spinning on a tire swing? It's possible that all I ate was a handful of dried shiitakes dipped in cow manure.

Most helpful customer reviews

37 of 38 people found the following review helpful.

A Personal Journey Through Drugs and Drug Policy

By Andrew Starks

I was curious about microdosing and had no prior exposure to Ayelet Waldman, except for an interview on Fresh Air. I was pleasantly surprised.

This book touched me on a few levels. First, the account of her internal struggles, especially the self-loathing dialog that racetracks through her mind, were spot on. Her descriptions were aching, funny, and rang with truth.

I did not expect this book to include a narrative on drug policy. I appreciated the material and it was well done. I've read other books on the topic, including *The New Jim Crow* and *Chasing the Scream* and on this topic, those books are more complete, but not as entertaining.

At bottom, this is a Really Good Book about our failed drug policies. It uses the author's intensely personal account of mental illness and her desperate attempts to get a handle on them as a compelling vehicle to tell that story. If you want a more academic account, the above books (also compelling, given their tone) will be your speed. Nobody will be standing before congress, holding this book out as a drug policy guide.

But I loved the book. It moved me. It spoke about pain that I understood in a way that gave me hope. It also opened my eyes a little wider to the misguided tragedy that is our insane drug policy.

4 of 5 people found the following review helpful.

A Courageously Honest and Moving Book

By Stephen Billias

Ayelet Waldman has written a brutally honest and revealing book about her experiences taking micro-doses of LSD as a treatment for depression. The book is much more about her struggles with mood swings, anxiety and insecurity than it is about drug-taking. She is extremely forthright about her relationships with her husband, children, parents, and friends. It takes a special kind of bravery to write such a self-examining book. I admire her greatly for it. The micro-dosing seems to have induced a healing that has lasted beyond the month-long protocol she followed. This book continues the work she undertook as a lawyer, fighting for people who were unfairly charged and prosecuted for drug crimes. She has been an advocate for decriminalization of drugs for many years. She draws on that experience as well as considerable and well-documented research into the subject of the effects of drugs on the psyche, both positive and negative, and has written a book that should have considerable influence in the field. Ms. Waldman is a pioneer, blazing a path for others to follow! I highly recommend this book to anyone who is interested in exploring themselves, whether through drugs, therapy, meditation, or other means.

1 of 1 people found the following review helpful.

Inspiring

By Mike B

Very well written. For various reasons, I have recently become interested in, shall we say, "alternative" therapies ... Ayayasca, psilocybin, lsd, etc. Thanks to the author for sharing her experiences with microdosing and her history with "the war on drugs". Insightful and inspiring.

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Review

"Genuinely brave and human... In normalizing the conversation about LSD, she may one day help others feel normal." —Jennifer Senior, *The New York Times*

"A wildly brilliant, radically candid, and rigorous daybook of [Waldman's] life-changing, last-resort journey." —Lisa Shea, *Elle*

"Relentlessly honest and surprisingly funny." —Sharon Peters, *USA Today*

"An intriguing and thorough look at the therapeutic possibilities of an illegal drug... Engaging and deeply researched." —Nora Krug, *The Washington Post*

"Smart, outspoken, provoking, and funny... Poignant, sometimes hilarious... Waldman calls for renewed research and drug-law reform in this informative, candid, altogether irresistible quest." —Donna Seaman, *Booklist*

"Honest and intelligent... A humane, well-reasoned, and absolutely necessary argument for a major overhaul of America's drug policy. The book triumphantly coheres in a lucid manifesto of how and why the racist, immoral undertaking called the War on Drugs has failed... Passionate, persuasive." —Claire Vaye Watkins, *The New Republic*

About the Author

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This morning I took LSD.

The table I'm sitting at right now is not breathing. My keyboard is not exploding in psychedelic fireworks, lightning bolts shooting from the letters "R" and "P." I am not giddy and frantic, or zoned out with bliss. I feel no transcendent sense of oneness with the universe or with the divine. On the contrary. I feel normal.

Well, except for one thing: I'm content and relaxed. I'm busy, but not stressed. That might be normal for some people, but it isn't for me.

I did not drop a tab of acid. What I took is known as a "microdose," a subtherapeutic dose of a drug administered at a quantity low enough to elicit no adverse side effects yet high enough for a measurable cellular response. A microdose of a psychedelic drug is approximately one-tenth of a typical dose. A recreational user of LSD looking for a trip complete with visual hallucinations might ingest between one hundred and one hundred and fifty micrograms of the drug. I took ten micrograms.

Microdosing of psychedelics, so new and renegade a concept that I had to teach it to my computer's spellcheck, was popularized by a psychologist and former psychedelic researcher named James Fadiman in a series of lectures and podcast interviews and in a book published in 2011 called *The Psychedelic Explorer's Guide: Safe, Therapeutic, and Sacred Journeys*. Since 2010, Dr. Fadiman has been collecting reports from individuals who experimented with regular microdosing of LSD and psilocybin, a naturally occurring chemical found in a variety of different species of mushroom. Soon after his book's publication, in a lecture at a conference on the potential therapeutic value of psychedelic drugs, Fadiman presented what he had learned from reading the dozens of reports mailed and e-mailed to him, some though by no means all of them anonymously. He said about microdosing, "What many people are reporting is, at the end of the day, they say, 'That was a really good day.'

A really good day. Predictably, regularly, unexceptionally. That is all I have ever wanted.

For as long as I can remember, I have been held hostage by the vagaries of mood. When my mood is good, I am cheerful, productive, and affectionate. I sparkle at parties, I write decent sentences, I have what the kids call swag. When my mood swings, however, I am beset by self-loathing and knotted with guilt and shame. I am overtaken by a pervasive sense of hopelessness, a grim pessimism about even the possibility of happiness. My symptoms have never been serious enough to require hospitalization, nor have they ever prevented me from functioning either personally or professionally, but they have made my life and the lives of the people whom I love much more difficult.

I have sought many treatments for these moods and miseries. Though I managed to be one of the only neurotic Jewish children growing up in the seventies and eighties in the New York area to stay out of a shrink's office, I did eventually dip my toe. Or, to be more accurate, I waded into therapy with the eagerness of a dehydrated camel sloshing into an oasis mud puddle. I wallowed in therapy of all kinds.

My first therapist was a psychiatric resident assigned to me by University Health Services when I was a third-year law student. I was looking for help dealing with a breakup that at the time felt tragic but that now seems like that moment when you look up from your phone just in time to avoid being plowed down by a city bus. I sat in my therapist's office and sobbed. Once I stopped crying (two or three sessions in), we talked about my boyfriend and my ambivalence about the breakup. We talked about the guy (and the other guys, and the one or two girls) I cheated on him with. We talked about my mother's anger and my father's emotional reserve, and about how hard it was to grow up in a home where two people spent so much time fighting.

Since that first series of appointments, I have spent hundreds of hours in the offices of psychiatrists and

psychologists, social workers and licensed family therapists, wearing my unique assprint into so many leather couches. I've nattered on to Freudians and diligently filled out the workbooks assigned by cognitive behavioral therapists. I enjoy these sessions; I'm analytical and an extrovert, so I enjoy picking apart my life and my feelings, especially with people I'm paying for the privilege. I was a good student in elementary school, and I find workbooks soothing.

Even though I am a cynic about all things countercultural (nothing makes me roll my eyes faster than a yogini pressing her lily-white palms together in a Namaste), I have on occasion even abandoned mainstream therapy for the decidedly alternative. In my eighth month of pregnancy with my second child, desperate to avoid another Caesarean section, I engaged in a series of sessions of hypnotherapy, during which I "rebirthed" my oldest child. This would, the hypnotist promised, guarantee a vaginal birth this time. I lay on her couch, my knees bent up around my ears, as she guided me in excruciating detail through the vaginal birth I did not have. Together we imagined every twisting contraction, the burn of crowning, the exertion of pushing. I panted, I moaned, I gritted my teeth and bore down. It turns out that the only thing one is guaranteed to produce by such efforts is a massive and propulsive fart.

One month, two doulas, a midwife, and forty-four hours of nonimaginary contractions later, my son was delivered by an obstetrician who waited with surprising patience for me to finish futilely visualizing my cervix opening before he performed the second of what went on to be four C-sections.

I've done mindfulness-based therapy, which required me to spend torturous minutes meditating, and many more torturous hours discussing with my therapist why I hate meditating so much. I responded to a crisis in a friend's marriage by forcing my long-suffering husband into an infuriating kind of couples therapy that involved repeating back each other's words, theoretically in a tone not dripping with passive-aggressive fury. ("I hear that it upsets you when I criticize how you load the dishwasher, but I feel sad when you insist on putting the glasses on the bottom rack, and I feel rage because, despite your vaunted intelligence, you can't seem to learn that that's how they get broken." Oops.) We might still be frantically using "I" language with one another had my husband not pointed out that it was the therapy that was the most serious threat to our marriage. "I" had to agree.*

Despite all of these hundreds of hours of talk therapy, I can't say that I have ever experienced much in the way of a change of either outlook or behavior.

And then, one day, on my way home from giving a depressingly poorly attended reading in bucolic and beautiful Marin County,† I found myself considering the possibility of steering my wheel hard to the right and hurtling off the Richmond Bridge. The thought was more than idle, less than concrete, and though I managed to make it across safely, I was so shaken by the experience that I called a psychiatrist.

That psychiatrist diagnosed me with bipolar II disorder, a less serious variant of bipolar I, which was once known as manic depression. Though this diagnosis was a shock, it wasn't a surprise. Bipolar disorder runs in families, and my father and other members of my family have it. I suppose in the back of my mind I always feared that my shifting moods might be an expression of the disease.

Bipolar disorder is characterized by changes in mood, energy, and activity levels. Most people experience these different emotional states, but in bipolar people they are intense, sometimes drastic and disturbing. Like "Maybe I'll spontaneously drive my car off this bridge!" disturbing. They can have a profound impact on daily functioning and relationships. Up to one in five people with bipolar disorder will commit suicide, and rates may even, paradoxically, be higher for those suffering from bipolar II. Psychiatrists posit that individuals with bipolar I, though their suffering is more intense, are less able either to formulate a desire to

commit suicide, or to carry it out. People with bipolar II possess the competence necessary to end their suffering.

Though these statistics scared me, having a diagnosis was also in many ways a profound relief. It explained so much! Like my tendency to overshare at dinner parties and on the Internet. Or the day I stood, trembling with rage, as the dry cleaner shrugged his shoulders at the ruin he'd made of my expensive new shirt. The purchase itself was made in a period of overspending typical of bipolar disorder, and my reaction to the dry cleaner's perfunctory apology was a symptom of what's known as "irritability." Irritability, or "irritable mood," is a clinical term, a piece of jargon, defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders as "a mood state in which apparently minimal stimulus or irritant produces excessive reaction, usually characterized by anger, aggressiveness or belligerence." It seems kind of an anodyne way to describe shrieking at one's local dry cleaner.

My diagnosis gave me the language to understand the more positive aspects of what was happening to me as well. It shed light on experiences like the time I wrote three novels in six months, with a clarity of focus and attention to detail that I had never before experienced. This type of sublime creative energy is characteristic of the elevated and productive mood state known as hypomania. So exhilarating and fruitful were these periods that I sometimes thought they were sufficient compensation for the other, dark side of the disease.

After my diagnosis, I embarked on seven years of psychotropic medications, suspended only for a brief period in the early stages of one of my pregnancies. The list of meds I've tried and rejected is so long that my friends use me as a kind of walking Physicians' Desk Reference, able to recite symptoms and side effects for anything their shrink might prescribe, like the soothing voice-over at the end of a drug commercial: "Abilify is not for everyone. Call your doctor if you have high fever, stiff muscles, or confusion." Off the top of my head, I have over the long course of this journey in mental illness and mood alteration been prescribed the following medications: selective serotonin reuptake inhibitors (SSRIs) including: citalopram (Celexa), its nongeneric and thus more costly fraternal twin sister escitalopram (Lexapro), fluoxetine (Prozac), and sertraline (Zoloft); the serotonin-norepinephrine reuptake inhibitors duloxetine (Cymbalta), venlafaxine (Effexor), and venlafaxine XR (Effexor XR); the atypical antidepressant bupropion (Wellbutrin); the mood stabilizers lamotrigine (Lamictal) and topiramate (Topamax); amphetamine (Adderall, Adderall XR), methylphenidate (Ritalin and Concerta), and atomoxetine (Strattera); the benzodiazepines alprazolam (Xanax), diazepam (Valium), and lorazepam (Ativan); the atypical antipsychotic quetiapine (Seroquel) (a particularly bizarre prescription since I have never been remotely psychotic); the sleep aids zolpidem (Ambien) and eszopiclone (Lunesta). I'm sure I'm forgetting some. That can happen when you take a shit-ton of drugs.

Some of these medications worked for a little while— sometimes a few days, sometimes a few months. But with every new pill there were new side effects. Since SSRIs made me gain weight and deadened my libido, standard practice dictated that we add new meds to combat the weight gain and to pump up my sex drive. Those drugs made me irritable, so the doctor prescribed something else to calm me down; round and round in a seemingly futile cycle.

Unfortunately, this kind of trial-and-error experience is quite prevalent in mental health treatment. These drugs act on people in different and unexpected ways, and it is often difficult to concoct the precise cocktail to address an individual's array of issues. Furthermore, practitioners, even the best ones, still lack a complete understanding of the complexity and nuance both of the many psychological and mood disorders and of the many pharmaceuticals available to treat them. Were mental health research more adequately funded, perhaps there might be more clarity. Certainly, misdiagnosis might be less common.

Years after my initial diagnosis, while tumbling down an Internet rabbit hole the genesis of which I can't remember, I stumbled across an abstract of a clinical study on PMS that made me question whether my diagnosis of bipolar disorder was correct. My bipolar disorder did not comply with the requirements written in the DSM-5. My hypomania rarely lasted the requisite four days, and never toppled into mania, and, though I regularly fell into black moods, I had never had a major depressive episode. My moods were not as extreme as my father's, nor had I ever suffered any real professional or personal damage as a result of them.* Was I really bipolar?

When I got out the mood charts I'd been keeping since my diagnosis and compared them to my menstrual cycle, it became strikingly clear. My mood, my sleep patterns, my energy levels, all fluctuated in direct correspondence with my menstrual cycle. During the week before my period, my mood dropped. I became depressed, more prone to anger; my sleep was out of whack. I also noticed another dip in mood in the middle of my cycle, this one lasting only for a day or so. This dip happened immediately before ovulation, and was characterized not so much by depression as by fury. It was during these pre-period periods that I traumatized that poor dry cleaner and picked fights with my stoical husband over issues of global importance like the proper loading of the dishwasher.

I consulted a psychiatrist recommended by the Women's Mood and Hormone Clinic at the medical center of the University of California, San Francisco, a psychiatric clinic that treats women with mood disorders that can be attributed, in part, to hormonal influences on the brain. My new doctor immediately evaluated me for PMS.

PMS—defined as mood fluctuations and physical symptoms in the days preceding menstruation—is experienced in some form by as many as 80 percent of all ovulating women. Nineteen percent suffer symptoms serious enough to interfere with work, school, or relationships, and between 3 and 8 percent suffer from PMDD, or premenstrual dysphoric disorder, symptoms so severe that those who suffer from them can be, at times, effectively disabled.

Although it's long been known that 67 percent of women's admissions to psychiatric facilities occur during the week immediately prior to menstruation, only recently have researchers begun to consider the effect of PMS on women with mood disorders. Premenstrual exacerbation, or PME, is when an underlying condition is worsened during a phase of a woman's menstrual cycle. However, because I only ever experienced mood swings during two periods in my luteal phase (the days before ovulation and the week leading up to menstruation), my new psychiatrist concluded that I did not suffer from bipolar disorder at all, even bipolar disorder complicated by PME, but, rather, from mild PMDD, not so serious as to be disabling, but troubling nonetheless. Especially to my dry cleaner.

This change in diagnosis immediately felt right to me. Though there'd been comfort in having the bipolar diagnosis to explain my shifting moods, the fact that I never experienced serious mania or profound depression had always given me pause. Many a morning I would feel fine and stable, stare at the handful of pills in the palm of my hand, and wonder whether it really made sense to swallow something that I knew would soon make me irritable and/or sap my sex drive. And yet I also knew what happened to people with bipolar disorder who said, "I feel fine!" and stopped taking their meds, so I was a good soldier and took whatever my psychopharmacologist prescribed. Now, finally, I was on the right track.

Mood stabilizers don't work on PMDD. Instead, low doses of hormones, including birth-control pills, are often prescribed, as are SSRIs, the latter given only in the week or ten days preceding menstruation. Research has also shown a positive effect from calcium supplements, light therapy, and cognitive therapy.

Because evidence of the link between hormone replacement therapy and breast cancer made me skittish, I initially opted for the monthly short course of SSRIs. Though antidepressants normally take four to six weeks to become effective, in premenstrual women, as soon as SSRIs are absorbed, they inhibit the enzyme 3- β -HSD from metabolizing progesterone. Because the drop in progesterone is the culprit in premenstrual blues, the change is immediate and profound. In my case, within twenty minutes of taking a pill, my mood lifted.†

Unfortunately, SSRIs don't have the same magical effect prior to ovulation, when a woman's hormones shift rapidly, estrogen levels peaking and LH (luteinizing hormone produced by the pituitary gland) surging. As Dr. Louann Brizendine, the founder of the UCSF Women's Mood and Hormone Clinic, told me, "Abrupt changes in hormones are like the rug being pulled out from under the brain." Because SSRIs don't work during this period, I relied on techniques learned in cognitive behavioral therapy and, when I found myself flinging my children's toys across the room or starting a social-media flame war, the occasional anti-anxiety pill. A chill pill, if you will.

Once I understood the cyclical nature of my sleeplessness, I could wean myself off sleeping pills, and throw away most of my pharmacopeia. For a while, I was far better able to control my moods. I still cycled, but because I could anticipate my rages and my periods of sadness, I was able to plan for them and deal with them. I monitored my calendar the way a pilot monitors her cockpit controls, not only to determine when to start taking my medication, but also so that I could schedule important meetings and events to coincide with less volatile days of the month. Dr. Brizendine requires her patients' partners to take the initiative during the premenstrual period, urging them to stop all arguments, jot down the subject on a piece of paper, and reintroduce it later in the month, when it can be dismissed without rancor. My husband kept track of my cycle and developed a bland and pleasant tone in which to ask the question "Do you think you might need an SSRI today?" I did my part by neither defenestrating nor decapitating him, but instead taking my pill.

For five years, things were predictable and peaceful. Then the inevitable happened. I entered perimenopause, and my period became irregular. Some cycles lasted thirty days, others twenty. Sometimes I'd skip a period or two altogether. With my period behaving like an ambivalent Victorian suitor who drops his visiting card rarely and on no discernible schedule, I could not time my SSRIs. My doctor convinced me to overcome my trepidation and try a low-dose estradiol patch to combat my shifting moods. The patch, however, did not provide the instant and profound relief I was used to. More troublingly, the use of unopposed estrogen—estrogen taken alone—is associated with an increased risk of endometrial and uterine cancer. This risk can be eliminated by adding progestin, but that's been associated with an increased risk of breast cancer. Furthermore, progestin has a marked negative effect on mood, especially in women with PMS or PMDD. Since the only reason I was wearing the patch was to ameliorate my low moods, I was not about to add a medication that would make me depressed and possibly give me cancer.

And then things took a turn for the worse. I found myself in a state of seemingly perpetual irritability. I seethed, I turned that fury on the people around me, and then I collapsed in shame at my outbursts. These alternating states of anger and despair came far more frequently than before, and made me feel hopeless. I couldn't seem to find pleasure in my life, or even contentment. I saw the world through a sad and dingy scrim. I knew there was light and love on the other side, but I couldn't manage to lift the grimy curtain of my unhappiness.

My husband, who had been dealing with my vicissitudes of mood for years, seemed finally to be exhausted by them. We fought, and we seemed to take far longer to recover from our altercations. Or perhaps that's more of my despondency talking. Perhaps he was no less patient than before, but my depression made me newly terrified that he would once and for all pack his bags and leave me alone with my ugly self.

It was in this state of mind that I stumbled across James Fadiman's book.

Before becoming a writer, I was a federal public defender and law professor with a particular interest in criminal justice reform. For many years, I taught a seminar called The Legal and Social Implications of the War on Drugs at the UC Berkeley

School of Law, and was a consultant to the Drug Policy Alliance, an organization dedicated to the reform of U.S. drug laws. However, though I have experience and expertise with drug-policy reform issues, I knew very little about psychedelic drugs. I had never taken LSD, and my experience with other hallucinogens began and ended in my freshman year of college, with a pleasurable but somewhat disconcerting few hours spent languidly spinning on a tire swing after consuming a very small quantity of psilocybin in the form of "magic mushrooms."* I have always been too afraid of enduring a terrifying bad trip or suffering lasting psychiatric harm to experiment further. But microdosing seemed different, less frightening. The doses Fadiman discussed were sub-perceptual, so small that there was no possibility of any kind of hallucination, positive or negative. Not so much going on an acid trip as going on an acid errand.

The individuals whose reports Fadiman presented in his book experienced "joy and gratitude," increased focus, better mood. I wanted that. They reported rarely losing their tempers, becoming more fun to be with. I really wanted that. They experienced that most seductive and elusive thing: a really good day. I needed that! None reported any negative experiences, but, then, the book was hardly a thorough research study. It provided, however, a glimmer of hope. With reservations, of course.

There has never been an officially sanctioned study of microdosing. The closest thing to research is Fadiman's anecdotal data collection, assembling reports from individuals who reach out to him. There is, however, a tremendous amount of data on LSD. Before the drug was criminalized, it was thoroughly studied. Thousands of doses were administered in therapeutic and research settings, with very few negative effects. LSD has a very low toxicity level and a large safety range.* This means that even massive doses are not physically dangerous. Microdoses have no discernible biological effects at all.

I contacted James Fadiman and received a memo entitled "To a Potential Self-Study Psychedelic Researcher." The document makes clear that it is not meant as an encouragement to engage in illegal activity but is, rather, a set of cautions and procedures designed to minimize harm, should you engage in illegal activity without the encouragement of James Fadiman.

The protocol is simple. To participate in the international selfstudy group on the effects of sub-perceptual doses of LSD on normal daily functioning, a "self-study psychedelic researcher" is to take microdoses of LSD on repeating three-day cycles. The suggested dose is ten micrograms, one-tenth or less of what a person would have to take in order to experience an altered state of consciousness. The idea is to take a dose so small that you don't actually feel anything unusual. Or at least nothing immediately tangible. On Day 1 of every cycle, participants are to take ten micrograms of LSD. They are to keep to their normal schedules of work, leisure, meals, coffee, naps, exercise, and social life. They are instructed to monitor mood, physical strength, symptoms, productivity, and the ease with which they do their work, and to "write a few notes about how [the] day went." On Days 2 and 3, participants are to take no LSD, but merely to continue monitoring and noting.

I read Fadiman's memo, I reread his book, I researched, and I considered. The idea of becoming a "self-study psychedelic researcher" felt ridiculous. I am the mother of four children. I am, to use my children's gibe, "totally basic." I wear yoga pants all day, I post photos of particularly indulgent desserts on Instagram. I am the mom surreptitiously checking her phone at Back to School Night, the woman standing behind you

in Starbucks ordering the skinny vanilla latte, the one getting a mammogram in the room next to yours, the one digging through her too-full purse looking for her keys while you wait impatiently for her parking spot. I am a former attorney and law professor, a law-abiding citizen. A nerd. If a cashier hands me incorrect change, I return the excess. I don't cheat on my taxes, don't jump the turnstile in the subway, don't park in handicapped spots. I write and lecture on the criminal justice system; I don't regularly commit crimes.

But I was suffering. Worse, I was making the people around me suffer. I was in pain, and I was desperate, and it suddenly seemed like I had nothing to lose. I decided to try a one-month experiment. I would follow James Fadiman's protocol, taking a microdose of LSD every three days. I would carefully track the results, keeping notes of the effects. Because I am a writer, I would write these notes up in a form that might be useful not just to myself or to Fadiman, but to others curious about the potential therapeutic uses of microdosing. I would also use this month to learn more about psychedelic drugs and to think deeply about what brought me to try something so unusual, so desperate. A single month out of fifty years. What harm—or what help—could there be in that?

*Lately, we've started going to a more traditional kind of couples therapy, in which we each try to recruit the therapist to take our side against the other. She's annoyingly neutral—Switzerland in sensible shoes.

†The single audience member, a malodorous gentleman slumped in a rear seat, woke up halfway through the reading, gazed at me with pity, and trundled his shopping cart heaped with beer bottles out the door.

*Other than the time I was fired for cursing out a sexist boss. But I'd waited until my last week of work before taking on the guy. He was such a complete and utter shiteel that I consider that experience an example of forbearance rather than (or perhaps in addition to) loss of control.

† Incidentally, alcohol seems to act on the same receptors, so a glass of wine can have the same effect. As appealing as was the idea of spending a week of every month in a mild state of inebriation, I opted for the pills.

*Or maybe the mushrooms weren't magic at all. I didn't hallucinate, and who wouldn't become dizzy spinning on a tire swing? It's possible that all I ate was a handful of dried shiitakes dipped in cow manure.

Based on some encounters of many people, it remains in reality that reading this **A Really Good Day: How Microdosing Made A Mega Difference In My Mood, My Marriage, And My Life By Ayelet Waldman** could help them making better choice and also offer even more encounter. If you want to be one of them, let's purchase this book **A Really Good Day: How Microdosing Made A Mega Difference In My Mood, My Marriage, And My Life By Ayelet Waldman** by downloading and install guide on link download in this website. You could obtain the soft file of this publication **A Really Good Day: How Microdosing Made A Mega Difference In My Mood, My Marriage, And My Life By Ayelet Waldman** to download and also deposit in your offered digital devices. What are you waiting for? Let get this book **A Really Good Day: How Microdosing Made A Mega Difference In My Mood, My Marriage, And My Life By Ayelet Waldman** on the internet as well as review them in any time as well as any kind of place you will read. It will not encumber you to bring heavy book **A Really Good Day: How Microdosing Made A Mega Difference In My Mood, My Marriage, And My Life By Ayelet Waldman** inside of your bag.