Psychedelic-supportive psychotherapy: A psychotherapeutic model for, before and beyond the medicine experience

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ABSTRACT

A renaissance is underway as research studies are substantiating psychotherapeutic and physiological benefits of psychedelic medicines, along with advancements towards legalization, expansion of professional training programs and a renewed cultural recognition of the healing qualities of the medicines. Pending legislation, a cadre of trained psychotherapists are poised to apply their expertise for those who might benefit however, they are currently largely blocked from doing so. There are also ranks of competent psychedelically informed psychotherapists who might provide support to clients engaging with the medicines but are lacking guidelines to do so.

‘Psychedelic-Supportive Psychotherapy’ is a proposed model which might be immediately implemented by qualified practitioners for working with clients adjacent to but not during a medicine experience without compromising ethical or legal risk. This model aimed at psychotherapists who are increasingly challenged to help clients already engaging with or considering psychedelics, draws from the current field of knowledge to respond to a moral imperative for practitioners to act in the service of client’s best interests and expand access for diverse communities. It balances psychedelic harm reduction perspectives with support for the emotional, psychological, and spiritual gains to be had when clients use psychedelics outside of therapy and can process the experience within their therapy. The model of psychedelic-supportive psychotherapy, is transtheoretical, its core premise being centrality of the therapeutic relationship as a change agent even as the therapist is not physically present in the client’s medicine journey. Here a foundational structure is presented along with criteria, parameters, and recommendations for practitioners in its application.

KEYWORDS

psychedelic, psychedelic-supportive psychotherapy, psychotherapy, therapeutic relationship, harm-reduction, psychedelic-assisted, integration

INTRODUCTION

Psychedelic medicine as a valid pathway for psychotherapeutic change is being rapidly embraced both within the field of psychology and within the general culture (Nichols, Johnson, & Nichols, 2017). The efficacy of psychedelic medicines in cultivating emotional, psychological, and spiritual growth and wellbeing including, healing from trauma, has been substantially demonstrated within research studies and professional literature. Clinical trials largely advanced by the Multidisciplinary Association for Psychedelic Studies (MAPS) and conducted within prominent research institutions have reached revolutionary milestones in validating the therapeutic effectiveness of psychedelic compounds. Alongside clinical trials involving standardized protocols, there is also a growing practice of “micro-dosing” psychedelics as an alternative to pharmaceuticals in offsetting depression and anxiety and in some cases in mitigating physiological pain (Fadiman & Korb, 2019; Waldman, 2018). Ketamine, a legally prescribed medicine and arguably, in its own category of psychedelic medicine due to its unique effects and short-lasting impact, has seen a surge in demand and...
new development of applications within established clinics. With decriminalization, groundbreaking legalization of therapeutic psilocybin, pending approval of MDMA for Post-Traumatic Stress Disorder (2003), and bills in progress legalizing personal possession and use, the expansion of psychotherapeutic approaches and applications of psychedelic treatments are widely anticipated. Once the floodgates of federal endorsement open, trained psychedelic practitioners will be in demand.

Currently, psychedelic medicines remain largely illegal in much of the world outside of approved research studies. A thriving “underground” community of shamans, sitters, and guides, has been operating for decades and informal as well as more formalized guidelines and Codes of Ethics can be accessed for ‘psilocybin guides,’ who may or may not be trained as well as for voyagers (Fadiman, 2011a, 2011b, 2022c; Haden, 2020; Jesse, 2001) At the same time, an undetermined number of licensed psychotherapists are providing some form of psychedelic related services, presented as ‘psychedelic integration’ or ‘integrative services.’ While the underground provides access, and professional “psychedelic integration” positions itself as preventing harm, there is little information available to practicing psychotherapists even as they are increasingly confronted with clients turning to psychedelics for psychotherapeutic gains.

Respected psychedelic-assisted therapy training programs are rapidly expanding however, most practice models draw from controlled research studies where rigorous operating procedures and behavioral benchmarks are standards for success. These approaches may ipso facto limit creative, experimental clinical applications in responding to the uniquely nuanced experience of individuals within diverse populations interfacing with the medicines. Additionally, the crucial component of experiential learning is missing from most psychedelic training programs due to legal constraints. Considering the established psychotherapeutic benefits of these medicines and that some independently practicing therapists are well-positioned to support clients engaging with the medicines, it is timely to consider new treatment models which may be legally and creatively applied now. Offered here is one model which may guide psychedelically informed, licensed psychotherapist in supporting clients who are choosing to engage with a psychedelic experience outside of the psychotherapy session.

There is considerable research discussing the function of therapists within psychedelic medicine sessions (Ardito & Rabellino, 2011; Bogenschutz & Forcehimes, 2016; Garcia-Romeu, Kersgaard, & Addy, 2016; Greer & Tolbert, 1998; Grinspoon & Bakalar, 1986; MAPS, 2010; Martin, Garske, & Davis, 2000; Passie, 2012; Wheeler & Dyer, 2020). While this is the accepted practice, it is important to note that a therapist’s presence during a medicine session has not yet been directly correlated with psychotherapeutic gain, nor has this question been substantially examined. Ambiguity regarding the locus of change remains along with consideration of an important question; what in psychedelic-assisted therapy most contributes to psychotherapeutic change?

In considering the terms “psychedelic psychotherapy,” “psychedelic-assisted psychotherapy,” and the proposed “Psychedelic-Supportive Psychotherapy,” it seems that no one term adequately depicts nor sufficiently illuminates that which is the primary change agent. Is the psychedelic assisting and supporting the psychotherapy or is the psychotherapy assisting and supporting the effects of the psychedelic? Does the essence of change lie within the interface of client and medicine or, within the relationship of client to therapist, or both? As language itself is linear and both psychedelic and psychotherapeutic processes are otherwise, these distinctions are effectively impossible to demarcate. It is perhaps best to simply recognize the dynamic interplay of each of the separate pairings as change agent; client/therapist, and client/medicine. The crucible for change might then be seen as residing within the triad of ‘therapist-client-medicine’ along with another critical component of ‘set and setting,’ ultimately forming a fourth field of transformation as described by Phelps

In intersubjective terms, these therapeutic alliances within the set and setting can be likened to a therapeutic fourth. The therapeutic fourth is the intersubjective field of set and setting that is cocreated by the influence of the therapists, the psychedelic medicine, and the person ingesting the medicine. (Phelps, 2017, p. 460).

Within this complex dynamic of relationality, it may be sufficient to state that the psychoactive potentialities of the medicine impacting any unique individual, in the context of set and setting, under guidance of trained psychotherapist are all interrelated agents of the process. The framework of ‘psychedelic-supportive therapy’ is gleaned from the professional fields of psychotherapy where the therapeutic relationship is positioned as a locus for change. More explicitly, when a trusting therapeutic alliance has been established it is internalized by the client, so that they feel supported throughout process even without the therapist’s presence in the medicine experience. To be clear, this is not to negate the potential benefit of a therapist’s participation in medicine sessions when legal access is expanded, but simply to present an alternative, immediately applicable model offering harm-reduction and psychotherapeutic benefit through a legal, clinically sound psychotherapeutic process.
THE MODEL: PSYCHEDELIC-SUPPORTIVE PSYCHOThERAPY

‘Psychedelic-Supportive Psychotherapy’ operates adjacent to a client’s engagement with psychedelic medicine while incorporating elements of the structure and practices presented within clinical research studies, professional literature, and training programs for psychedelic-assisted therapies. The key distinction is that in ‘psychedelic-supported therapy,’ the therapist is not participating in the medicine session itself nor advocating for its use but acting as an agent to help prevent harm and support potential psychotherapeutic benefits on behalf of the client. As the healing properties of psychedelics are being demonstrated, licensed, practicing therapists are increasingly confronted with clients engaging with psychedelics, while many lack information on how to best support them. While a rich future of evolving, creative psychotherapeutic applications of psychedelics is anticipated, this model offers an immediate, foundational starting point for licensed psychotherapists to legally and ethically support their client’s capacity not only to prevent harm but to also benefit.

‘Psychedelic-Supportive Psychotherapy’ builds on psychedelic harm reduction approaches and the model of Psychedelic Harm Reduction Integration (PHRI) presented by Gorman et al. in

…supporting exploration and enhancing understanding in patients who develop a relationship with psychedelics without encouragement to use psychedelics, the administration of psychedelics, or the providing of therapy during the psychedelic experience (2021, p. 4)

PHRI, itself is not a treatment modality or technique, but “serves as a perspective which therapists of all training backgrounds can incorporate into their practice (Gorman, Nielson, Molinar, Cassidy, & Sabbagh, 2021, p. 5). Similarly, “psychedelic-supportive psychotherapy” does not present any one theoretical approach but is a framework for therapist’s wanting to support clients seeking psychotherapeutic gains from their medicine experiences. While the model maintains an eye to harm reduction it also helps clients optimize that medicine experience in alignment with goals presented within psychotherapy. A central premise of the model is that an established safe and trusting therapeutic alliance which supports the client throughout the process before, during and beyond the medicine session, without the need of the therapist in the medicine session. Through this lens, it is suggested that the presence of the client’s therapist in a medicine session may be less significant than believed and may in some cases, detract from the client’s experience. Further, within an optimal therapeutic environment including sufficient preparation and the expectation of processing the medicine experience later with the therapist, the client feels ‘held’, irrespective of the therapist’s presence. This is especially likely if that therapist is psychedelically informed, has effectively communicated risks and benefits, has been attentive to the overarching process including all three components of preparation, medicine journey and integration and embodies the message that within the therapeutic container all processes are valid and welcome. To this end, guidelines are offered for therapists so they might best support client’s emotional, psychological, spiritual, and interpersonal growth within ethical and legal bounds even as legislation is pending.

Framework

The model is structured by the three segments of the experience: before, during, and beyond the medicine journey, typically referenced within the literature as a) the client preparation session(s); b) medicine experience or journey; and c) post-medicine processing or integration session(s). The number of pre- and post-medicine sessions may vary depending on what the client needs/wants and in tandem with recommendations made by the therapist. Here I will discuss a sequence of preparation, medicine journey, and integration as it unfolds within a ‘psychedelic-supportive psychotherapy’ with the understanding that this sequence might be repeated any number of times.

Criteria for therapist qualifications

While considering and standardizing therapist qualifications is a tricky endeavor in any context, it can only be more so for a model not yet developed within a practice not yet legal or endorsed by any traditional professional licensing or governing body.

Phelps (2017) specified criteria for psychedelic therapists derived from “fundamental agreement on the core knowledge, attitudes, and skills of a therapist in this specialization” as empathetic abiding presence; trust enhancement; spiritual intelligence; knowledge of the physical and psychological effects of psychedelics; therapist self-awareness and ethical integrity; and proficiency in complementary techniques (p. 450).

Alongside these criteria, the twelve domains for therapists delineated by Phelps are applicable to those working within the ‘psychedelic-supportive psychotherapy’ model. Whether therapists need to have had their own psychedelic experience to effectively do this work has not yet been systematically studied though there are strong arguments that having the firsthand experience is essential (Metzner, 2015, p. 13) and that there is need to study this requisite further (Nielson & Guss, 2018).While it is understood that therapists do not need to have experienced everything their client does, in order to be empathically attuned, it is possible that the experience of psychedelics is so ‘non-ordinary’ as to be unimaginable without having had the experience. In this regard, even if deemed not necessary it may be highly desirable (with caveats regarding legal and therapeutic risks of engaging in and/or disclosing such use). Given the depth and complexity reached within psychedelic induced non-ordinary states and potentially transformative processes, it is also advised that to be most effective, practitioners will have substantial clinical background. These suggested criteria
merit further exploration alongside considerations that profoundly gifted practitioners with more limited experience and sufficient understanding of psychedelics might be well equipped to support a client’s experience and goals. In any case, therapists wanting to support clients’ psychedelic experience should have some rudimentary understanding of the medicines as well as a basic familiarity with the structure outlined.

Psychotherapeutic structure

The structure of ‘psychedelic-supportive psychotherapy’ fundamentally distinguishes itself from “psychedelic-assisted therapy” insofar as the therapist facilitates two of the three segments of preparation and integration, excluding facilitation of the medicine session.

To be clear, in any cultural context where psychedelics are illegal, the discussion must emerge from a context in which the client raises the issue, whether it is because they have engaged with the medicines or are considering that engagement. Once a client expresses intention to pursue a psychedelic medicine experience it becomes part of the psychotherapy conversation, just as any client activity or action become “grist for the mill.”

In this model, “preparation” is not an encouraging of a client’s engagement with illegal substances but, should the subject of a client’s use or wish to use psychedelics arise within the course of treatment, it is the therapist’s duty to prevent harm and within the standpoint of clients’ acknowledged freedom to engage in activities (legally sanctioned or not) outside of treatment so long as there is not imminent harm to themselves or others. In this regard, the therapist accepts the client’s autonomy, and helps them prepare for the experience they are choosing including, anticipating potential consequences, and facilitating ways to resource and care for themselves as needed.

In that context, while presenting research-based evidence, a psychedelically informed therapist may offer perspective on how therapeutic processes and goals might be furthered alongside the explicit message that only legal medicines provided under the proper conditions are being recommended. Any conclusions regarding whether there may be compelling benefits to going forward is in the realm of client autonomy. If the client makes clear their intention to proceed, the conversation might move towards the concrete of how the psychotherapy can best support this choice. Caution is once again needed as the therapist cannot appear to promote the use of illegal substances and must consider legal risks. For example, any intervention that may be perceived as recommending illicit use of medicines or recommending a guide may jeopardize the practitioner under current legal conditions. As a rule of thumb, any psychotherapist providing professional services adjunctively to their client’s admitted use of illegal psychedelics should attend to federal and state laws and regulations of state licensing boards and seek legal expertise in advance (Jade, 2018).

In all cases, the therapist’s intent must be unconditionally focused on the best interests of the client with no personal investment in whether the client engages with psychedelics (outside of situations deemed harmful). Only upon reflection and clarity regarding this question and legal constraints, might the therapist embark on discussing what psychedelics mean to the client, their intentions for its use and enter into conversation about risks and benefits.

Beyond the medicine session, in what is typically referred to as “integration,” the client and therapist together will “unpack” all that the client has experienced in the journey including, associations, reflections, and interpretations arising and evolving as the client processes their medicine experience with the therapist.

Segment I: preparation segment of psychedelic-supportive psychotherapy

This segment to some degree, mirrors the current practices generally assumed by trained psychedelic-assisted therapists and practicing legal therapists, for example, Ketamine-Assisted Psychotherapy. In ‘psychedelic-supportive therapy,’ preparation might more explicitly focus on harm-prevention and will include tools for client self-care in the medicine session with the understanding that the therapist will not be present. At this initial stage, the therapist continues to explore the client’s motivations for seeking the experience and enlists the client in considering alternative choices such as breathwork, meditation, dance, music, bodywork. While it is the case that people use psychedelics for varied purposes, clients broaching this in the context of psychotherapy may well be pursuing forms of emotional and/or psychological growth, healing and/or wellbeing including, creative, professional, and/or spiritual growth. These are always valid and important areas of psychotherapeutic exploration meriting a mutual understanding of what these goals mean to that client. “Healing” is an example of a widely used term (particularly around psychedelic properties) which has only vaguely been defined in the entirely of psychological literature. One definition of healing emerging from a qualitative study of allopathic physicians, is described as “the personal experience of the transcendence of suffering.” (Egnew, 2005, p. 258). Another frequently used, ambiguous goal of clients seeking psychedelic therapies is that of “wellbeing,” perhaps generally defined as, “a state of happiness and contentment, with low levels of distress, overall good physical and mental health and outlook, or good quality of life” (American Psychological Association [APA], 2020). A related, recently emerging term (specifically as an outcome of the Pandemic) is that of “languisuing” or a “sense of stagnation and emptiness” (Grant, 2021). Not quite depressed and not quite flourishing, freedom from languishing may well be a common, not yet fully identified or established and yet, valid precipitant for those seeking psychedelic treatments (Keyes, 2002).

Whatever the stated goals, the therapist is tasked, as in most therapeutic processes, with exploring the particular meanings and manifestations unique to that person. Therefore, exploration and understanding the client’s perceptions, experiences, and subjective interpretations of their goals as they relate to intentions for engaging with the
medicine is important. This includes addressing the reality of those goals within the context of intrapersonal and interpersonal strengths, challenges, and limitations. Risks and benefits must be carefully assessed on all levels from a bio-psychosocial perspective including whether that client is physically, psychologically, and emotionally up to the potential demands of immersion in non-ordinary experiences and their unpredictability. Clients with risk factors such as suicidal ideation, psychosis, mania, dissociation, severe trauma, severe isolation, limited resources, addictions, medication interactions, and certain medical and situational stressors may not be appropriate to engage in a psychedelic experience for these purposes, or at all. While decisions about whether and how to proceed with using illegal substances rests entirely with the client, it is within the jurisdiction of the practitioner to explore risks and benefits (and referring elsewhere for medically related concerns) without encouraging the engagement. In addition to this kind of thorough assessment the therapist should ascertain the client’s expectation of the conditions (setting) of the planned medicine experience. The therapist must also authentically self-assess their own expertise and knowledge of the medicines with regard to their capacity to support the client’s experience. Most importantly, the therapist should investigate the legal and ethical regulatory constraints around psychedelics in the practitioner’s state or jurisdiction and continue to clarify to the client that even as they are exploring the risks and benefits of the client’s engagement with psychedelic medicines, they are not recommending their use.

The therapist’s overall task in this form of preparation with the client is to assess clients’ autonomous plan and address safety so that the client may make informed choices about curating optimal conditions and reducing potential for harm. If client or therapist have doubts about safety this is addressed in accordance with the understood protocols of the psychotherapeutic relationship meaning, the bounds of confidentiality remain firm except when “client’s actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others” or when there is evidence of “foreseeable, and imminent harm to a client or other identifiable person” (NASW, 1.02, 1.07.c). As legal constraints and permissions are principally consistent across the professional psychotherapeutic codes, the therapist is bound to those codes and the professional license under which they practice.

The value of respect for client agency aligns with the most fundamental premises of psychotherapy and of psychedelic healing as described by Nielson & Guss:

…”tools for healing are inherent in the individual’s mind and largely outside the control of the therapist” and “…the therapist is not constructed as administering the cure, instead the therapeutic encounter creates a set of conditions with lead to an alternative state of consciousness and an opportunity for the patients innate capacity for change to surface and unfold.” (2018, p. 5).

In sum, the action of promoting illegal substances is not being endorsed within this model, rather therapists should explicitly clarify their own position as neither advocating for nor judging any of those actions. While this nuanced approach to offering psychotherapeutic support adjunctive to the potential healing properties of medicines presents challenges, it is well understood that clients are free to pursue their own activities (excluding imminent danger to self and others) outside of sessions and all discussion is part and parcel of psychotherapeutic practice and standards of care.

The therapist’s curiosity and non-judgmental, supportive stance in this beginning exploration is the underpinning of establishing safety and trust and facilitating potential psychotherapeutic benefit. Depending on what is learned about the client’s knowledge and understanding of the medicines, the therapist might offer psychoeducation regarding what might emerge within a medicine experience (which may be dysregulating or beneficial) as related to the client’s purposes, including goals, fears, and fantasies along with strategies for harm-prevention, self-care, self-regulation, and resourcing.

With a thorough assessment of the client’s diagnostic functioning, capabilities, and resilience, followed by conversations around harm reduction and psychotherapeutic potentialities of medicines and having arrived at a basic mutual understanding and agreement of the conditions for continuing to offer support within the therapy, the fundamentals have been established. The process now moves into a more structured preparation which continues to balance attention to harm-reduction with support of psychotherapeutic goals.

Set and setting. Cultivation of “mindset/set” and “setting” are viewed as essential to outcomes of psychedelic experience insofar as

The term set includes the expectation, motivations, and intentions of the subject in regard to the session; the therapist’s or guide’s concept of the nature of the LSD experience; the agreed upon goal of the psychedelic procedure; the preparation and programming of the session; and the specific technique of guidance used during the drug experience. The term setting refers to the actual environment, both physical and interpersonal, and to the concrete circumstances under which the drug is administered. (Grof, 1980, p. 102)

In this regard any preparation conversation aimed at supporting the client should attend to the conditions of the environment including access to physical comforts and in some cases (with some medicines), elements of nature or safe access to nature are seen as desirable. Again, these elements are outside of the therapist’s control and yet, might be explored in advance with the client to the degree possible. Whether the client plans for a medicine session to be with a trained guide, or untrained person acting as “sitter” it is helpful and in the interest of harm prevention to ascertain that the client has an established, trusting relationship with this person. A client planning a medicine session on their own (without a guide or sitter) is less then optimal, and while continuing to honor the client’s free will, the therapist
might provide psychoeducation around what constitutes a
safe setting so that at the very least, a trusted responder
might be available as needed. If the medicine session is to be
conducted within a group the therapist should get a sense of
what -if any-group interaction is to occur, so that relational
and other group dynamics relevant to the client and their
process are meaningfully explored from a psychotherapeutic
perspective.

Anticipating, reflecting upon, and addressing the client’s
intentions for the medicine experience, contributes to the
cultivation of “mindset.” While the variables impacting
mindset are nuanced and complex, they share that same
territory of psychotherapeutic exploration and information
which tends to emerge from psychosocial assessment of
family background, race, religion, culture, history, health
and mental health history, intrapersonal and interpersonal
characters, personal narrative/sense of self (including body-
selves), activating triggers, and identified trauma(s). A client’s
familiarity with and previous experiences of psychedelic
medicines and other non-ordinary states will also influence
mindset.

In this form of preparation and with an eye to harm
reduction, the therapist may help the client anticipate and
normalize possible negative reactions including somatic
discomfort or emotional distress (aches, dizziness, nausea,
anxiety, agitation, sadness, anger, fear). The therapist would
want to learn about the nature of the client’s connection to
their own body, their degree of body attunement, familiarity
with how their body contains or expresses emotions as well
as how they regulate and engage in body care. Here the
therapist may suggest applied tools for self-soothing as
needed (breathwork, mindfulness, grounding, resourcing,
and other somatic techniques) and strategies for establishing
and securing safety and support within the medicine session
and from the guide as needed.

Supporting client’s resilience and access to tools for self-
care is an important component of this phase, involving
practices for awareness and openness to experience, medi-
tation, breathwork, attention to dreams, and health practices
around body care such as nutrition sleep, exercise, perhaps
involving yoga, massage, and other body work, connection
to nature, music, drawing, and journaling. Journaling in
particular, has been demonstrated to be a particularly
effective tool for integrating psychotherapeutic processes
(Kacewicz, Slatcher, & Pennebaker, 2007; Pennebaker, 1997)
in general and in medicine experiences in particular. One
comprehensive, holistic preparation tool which may be
particularly conducive for a deepening self-exploration and
which client and therapist might want to reference together
is a series of reflective questions designed by Bourzat and
Hunter (2019) examining the client’s relationship to their
own mind, body, spirit, environment, and community.

The concept of ‘mindset’ is widely discussed as a crucial
aspect of one’s psychedelic medicine experience. In this
regard, in preventing harm and supporting the client’s expe-
rience, the preparation is also an opportunity to facilitate the
client’s capacities for openness (rather than resistance) to
what might unfold during the medicine segment. If a
mindset of curiosity about what will happen has been
cultivated, and an attitude of mindful attention to the pre-
SENT moment experience has been encouraged, the client is
prepared to be unprepared, letting go of expectation and
trusting both the healing qualities of the medicine and their
(the client’s) own innate healing capacities.

While psychosocial assessment, attention to mindset,
conditions, expectations, and strategies for self-care are
Cruj elements in preparation, the therapist is also
modeling openness to these explorations establishment
conditions contributing to the client’s sense of being “held”
within the therapeutic container throughout the arc of the
experience irrespective of the therapist’s presence. Even if
the therapeutic alliance has been well established prior to
conversation about psychedelics, the therapist’s embodied
attitudinal stance regarding the client’s choice, their will-
ingness to engage from a perspective of harm-reduction,
support, and genuine interest in the client’s well-being all
contribute to sustained ‘felt’ presence of the therapist during
the medicine experience.

Segment II: medicine experience

In this segment of the client’s ingesting of and experiencing
the medicine, the therapist is not privy to direct experience
with the client. At the same time, having established a
trusting therapeutic ‘container’ formed through the ther-
pist’s open discussion of the client’s planned medicine
experience the therapist’s influence may be deeply and
meaningfully felt. Under these psychotherapeutic condi-
tions, the therapist’s unconditional regard has engendered a
therapeutic container which serves a “holding environment”
including the felt support of the therapist/love object even
when the therapist is not there (Winnicott, 1953). As psy-
chelic training programs are largely oriented to situations
in which the therapist is physically present in the medicine
session, there appears to be an assumption that the thera-
pist’s presence is a critical element of the client’s psycho-
therapeutic gain from the medicine journey. This
assumption has not however, been demonstrated or sub-
stantially investigated. It may therefore be valid not only to
reconsider those assumptions but to also, examine the ways
in which a therapist’s presence might interfere with the
client’s potential benefit from the experience. This alterna-
tive perspective aligns with current legal realities precluding
licensed practitioners from participating in medicine ses-
sions and, may also be clinically indicated in certain cir-
cumstances. For example, a therapist’s presence in the
medicine session (even under legally sanctioned conditions)
could trigger client self-consciousness, including the client’s
awareness of being witnessed and potentially judged by the
therapist. Many clients are interested in pleasing or gaining
their therapist’s approval, a dynamic which might confound
their medicine journey. In these examples, the pre-estab-
lished relational dynamic may have an effect of pressuring
clients to engage with or perform for the therapist, dis-
tracting the client from the benefits of being fully present
with and open to the medicine experience. Additionally,
some therapists (and particularly those lacking formal training in psychedelic-assisted psychotherapy), may be oriented towards the ways they typically work with clients perhaps, in problem solving, solution finding, providing directives or interpreting content, precipitating these interventions prematurely and distracting the client from relating fully and freely within the medicine experience. While these psychotherapeutic processes are all valid pathways for facilitating psychotherapeutic growth, psychedelic studies largely advocate against engaging in these processes during the medicine exploration in favor of going deeper into the present experience, with self-transcendence as both a goal and therapeutic benefit. In this light, the presence of the therapist and the familiarity of the established interactional style between client and therapist may challenge these very opportunities, dissuading the client from leaning fully into the present moment experience.

This is not to say that psychotherapists facilitating medicine sessions are unable to hold back from interpretation or that client self-consciousness and desire to share in the presence of one’s therapist is inevitable or blankly problematic. At the same time, there is considerable power in pre-established psychotherapeutic, relational dynamics including habitual ways of interacting, projections about therapist expectations, a pressure to be well-mannered, make observations and/or demonstrate insight. All of these might potentially interfere with and diminish the psychotherapeutic potential of the medicine journey itself.

Another consideration is that because medicine sessions digress from more traditional client-practitioner ways of relating there is a potential for permeation of well-established therapeutic boundaries. Historically, in psychedelic clinical trials, and in psychedelic-assisted therapy training programs, therapists are called upon to touch, hold, hug, and attend to clients’ physical needs (providing liquids, blankets, safety restraints, accompaniment to bathroom, blood pressure or other medical monitoring, etc.). While not necessarily unethical, these interactions do challenge the more familiar, boundaried models for psychotherapeutic practice and taboo against touch and assisting with bodily needs, to which many therapists and clients are accustomed. In this regard, the stretching or rupturing of boundaries could negatively impact therapeutic processes, muddying client-therapist roles, encroaching into the territory of dual relationships, and even undermine or threaten a client’s sense of safety. Additionally, licensed psychotherapists are rightfully trained to avoid medically oriented interventions which are outside their scope of practice. If a therapist (participating in a legally authorized medicine session) experiences discomfort around these non-traditionally ways of relating to their client, that discomfort is likely communicated to the client, potentially compromising their experience and the therapeutic relationship.

While the potential negative outcomes of a therapist’s facilitation of client medicine sessions have not been substantially researched, ‘psychedelic-supported therapy’ preserves the familiar dynamics and boundaries typically expected within the pre-established psychotherapeutic container. In this model, both client and therapist are freed from the potential constraints and complications of having the practitioner in the medicine journey.

On a practical level, a client wanting to share their medicine experience more extensively with their therapist, may choose to record or video themselves or, journal during the medicine experience in anticipation of sharing these materials later during the integration segment.

As illustrated in Masters and Houston’s comprehensive treatise (2000, pp. 3–36), the varieties of psychedelic experience can appear infinite, insofar as every unique individual with their embodied self and particular mindset encounters a specific medicinal effect at a singular moment of their development in time and within a particular setting. Most importantly, it is the client’s narrative of what transpired and what they make of their unique experience in the presence of the therapist within the safety of the alliance, which is the work of psychotherapy and “integrating,” the psychedelic experience.

**Segment III: post-medicine-integration**

What then is “integration”? Jung wrote of integrating the personality as a process of making oneself whole and fostering full connection with oneself including the shadow, or unacceptable, darker aspects of the self (1939). Presumably, the process was best fostered in the presence of the analyst, though Jung induced his own altered states as means of accessing unconscious and mystical experiences for self-integration. Humanistic-Existential perspectives link integration to: “self-actualization,” creativity, spontaneity, self-expression and “of the play back and forth between integration within the person, and his ability to integrate whatever he is doing in the world” (Maslow, 1968, p. 140). Early on, Watts referred to psychelics as offering “the sensation of being integrated, of being fully one with ourselves and with nature” (1962, p. 11).

In succinct terms, “Integration” within psychedelic medicine experience may refer to the “process by which the material accessed and insights gained in an entheogenic experience are incorporated over time into one’s life in a way that benefits the individual and community” (ERIE, 2022). Integration may interchangeably reference both that designated segment and process following the psychedelic experience as, “ongoing aftercare following drug sessions… considered a vital part of psychedelic therapy,” with the therapist acting “to provide ongoing clinical and emotional support in the wake of psychedelic sessions and monitoring of treatment progress” (Garcia-Romeu & Richards, 2018, p. 9). As the distinct segment, “integration,” is that time of contact with the therapist beyond a client’s medicine experience in which the client works with the therapist to understand the experience in relation to oneself and living one’s life moving forward. At the same time, it is impossible to segregate that phase of the work from anything which occurs in the client’s overall experience and in this context, from any aspect of what has transpired in the psychotherapeutic encounter as a whole.

In addition to the material (process and content) which emerges from the medicine session, a convergence of
variables drive the integration segment including mindset, setting, expectations, types of medicines, outcomes, client characteristics, needs and goals (García-Romeu & Richards, 2018). Bourzat (2019) views integration as an indelible, intrinsically connected part of the whole within “an arc of transformation, which includes all of the journeyer’s preparation, the actual journey, and finally the integration process, which invites the journeyer to engage with their own healing process” (p. 3).

From this perspective, integration incorporates all that transpires before, during, and beyond the medicine experience, in...

...the process of bringing separate elements together into a whole... the art of weaving the extraordinary into the ordinary-interpreting a journey’s mythical and symbolic layers, revealing its gifts and treasures, and anchoring them into our lives. (Bourzat, 2019, p. 2)

Viewed as a vital process contributing to the sustainability of the effects of the medicine, integration is seen as “supporting and reinforcing new healthy brain pathways and neural networks through committed intentions and practical actions” (Bourzat, 2019, p. 3).

In general terms, the process of integration involves attending to the thoughts, feelings, and activities occurring organically in congruence with and beyond the medicine experience. An engaged integration within the psychotherapeutic process, facilitates the client’s recollection of and reflection upon the medicine experience together with their therapist. The facilitated processing is itself potentially transformative, and may impact various arenas of the client’s life, including behaviors, decisions, world view, career, creative projects, interpersonal dynamics and/or the totality of lived experience. In this sense, all that occurs “beyond” the medicine experience is a culminating process of connecting what the client may have learned from the medicine into the future. How deep, far, and sustaining these changes might be, are determined by complex and crucial variables, including the client’s motivation, the practitioner’s skill and as in all psychotherapeutic process, the degree of safety established in the field of exploration. Attention to the client’s multi-dimensional sensory experience, associations and interpretations, insights, are to be facilitated in respect to the client’s willingness and capacity to do so and in relation to their goals. An important aspect of the integration, is the therapist’s demonstration of openness and curiosity with regard to the client’s narrative of the medicine experience, allowing for ample reflection and processing of the experience before attempting to interpret or translate the process into tangible life altering decisions. Here, as in all psychotherapeutic processes, attention is paid to what the client is ready, willing, and able to explore, with the therapist providing observations as indicated and appropriate.

The time frame within which integration takes place is entirely open-ended, depending on the client’s receptivity to the process. Richards (2017) reported spending “hours in the days and weeks after each psychedelic session dedicated to the initial integration of the experiential content that had occurred” (p. 325). Just as the psychotherapeutic alliance begins its formation with the very first contact between client and therapist, it may be said that the client’s integration is already in motion at the onset of any considerations around psychedelic psychotherapy. It is then furthered in formulating and articulating goals during preparation, carried into the medicine session, and expressively applied within the formal post-medicine session integration. It is important to address the reality and allow for integration to be unfettered by time, perhaps occurring over days, weeks, or months beyond the medicine experience, and on into the client’s life.

The timing of the initial ‘beyond’ integration segment with the therapist is crucial, optimally occurring within a day or so of the medicine session as the residue of psychic opening elicited by the medicine and the experience is fresh, (but not much sooner to also allow for psychic and physical rest). Subsequent integration sessions would ideally be scheduled within proximity to support the processing, interpreting, and threading together of what occurred while the client may still be in a state of active recall and connection to the experience. There are no maximum numbers of designated integration sessions as these would be driven by the client’s interests and needs. Within the context of an ongoing psychotherapy, integration can unfold in an open-ended manner through the course of the therapy as well as the client’s lifetime. From this perspective, even when therapist and client have scheduled integration sessions in advance, they should each hold awareness of the psychedelic experience as a shifting landscape.

**Beyond: psychotherapeutic approaches to integration.** Which psychotherapeutic approaches might then be considered as most effective within the integration segment of ‘psychedelic-supported therapy’ and for self-integration as a whole? A clear identification of best therapeutic approaches to integration and to psychedelic psychotherapy, as a whole has not been established in the field, although some approaches have been presented as being particularly well-suited. Because the nature of integration is that of a complex multi-layered endeavor with no specific timeline or definitive structure, identifying any best theory or approach may be impossible. If integration is viewed as a fractal of the altered medicine experience evolving into a process of reflecting upon, understanding, and implementing what has occurred, any attempt to overlay a formulative approach to the process may serve only to constrict it and the client’s capacity for psychotherapeutic gain. The complexity is particularly acute when the client has experienced unexpected openings into traumatic memory and/or creative, transpersonal, or mystical experiences. Given this, regardless of therapeutic orientation, the therapist’s deeply attuned presence and openness to whatever the client brings to the integration is vital. In this sense, a psychedelic-supported psychotherapy is conceived as one in which the therapist is not wedded to any particular theory or approach, but is curious and present to the client’s narrative of their experience in a way which might parallel that of the client’s encounter with the medicine experience. Meaning, just as it is believed that clients most benefit...
from being fully present to whatever the medicine might show (including all ‘parts’ of their embodied selves), without preconception or judgement, so too the therapist, invites the client to unfold whatever aspects of their experience they care to share, and the therapist maintains a position of openness to whatever the client brings. In this parallel process, the therapist assumes a beginner’s mind of curiosity, non-judgmental empathic listening, and compassionate responsiveness. Just as psychedelic therapy experts counsel the medicine journeyer to let go of expectation and trust the “inner healing intelligence” of the medicine, the therapist too lets go of any super-imposed, pre-conceived or formulaic psychotherapeutic approach in supporting the client’s experience.

In general, it may be said that integration is best served when the therapist is receptive to whatever the client brings, guiding while following the client’s narrative and nimbly drawing from those approaches which might best serve the client’s needs and objectives. The idea that therapists are called to mine a variety of approaches aligns with the MAPS (Mithoefer, 2017a, b) MDMA-Assisted Psychotherapy Treatment Manual advocating for therapists to draw from …widely recognized therapies such as Prolonged Exposure (PE), Cognitive Processing (CPT), Eye Movement Desensitization and Reprocessing (EMDR), and psychodynamic psychotherapy. In addition, there are other less widely recognized approaches that offer valuable experience for MDMA researchers. These include: Internal Family Systems (IFS), Voice Dialogue, Psychosynthesis, Hakomi, Sensorimotor Therapy, Holotropic Breathwork, Jungian psychology, Buddhist psychology, and Virtual Reality (2.0).

While the vast field of psychotherapeutic practice offers so much from which we might draw, it is suggested that some approaches might resonate well within the integration phase of ‘psychedelic-supportive psychotherapy.’ Here, I will name a few, while maintaining that the essential ingredient for positive psychotherapeutic outcome within this model lies in the strength of the established psychotherapeutic alliance which I will also address more expansively.

In positioning the client-therapist relationship at the center of healing activated by a medicine experience, the therapist’s attunement to what best serves the client is primary. In this regard, its underpinning is a person-centered, non-directive approach which postulates that “it is the quality of the personal relationship which matters most” (Rogers, 1962, p. 86). Additionally, as so many clients seek psychedelics not only to relieve suffering but also to further goals of self-actualization, creativity and enhanced well-being, a humanistic-existential perspective is imperative (Maslow, 1964, 1968; May, 2009). This perspective may well align with indigenous traditions insofar as, “much like humanistic-existential thought and counseling, curanderismo cannot be reduced to a single model or practice and varies with each healer–client relationship. Curanderas also emphasize humanity, matters of the heart, and the relationships that lay therein” (Chávez, 2016, p. 134). Additionally, the transpersonal and/or mystical experiences which can arise through psychedelics indicate the importance of therapist’s including transpersonal perspectives as clients integrate their “non-ordinary” experience into ordinary life (Vaughan, 2001).

An Internal Family Systems perspective has been compatible as it involves engagement with aspects or “parts” of the self which tend to surface in medicine experiences. An ACE model (Accept, Connect, Embody) trialed in psilocybin treatment for major depressions, suggests that psychological flexibility is key to change and that a therapist who incorporates this stance helps deepen and extend benefits (Watts & Luoma, 2020).

As psychedelic medicines often elicit heightened attention to interconnectedness of body-mind-spirit, a therapist’s familiarity with somatic approaches is invaluable. Somatic tools for relaxation and openness, in managing discomfort or releasing emotions in confronting challenging memories, associations and/or sensations as they arise are important components of self-care and healing accessed through the body and particularly with respect to trauma. Focusing-Oriented Psychotherapy is one approach, which helps call attention to the embodied felt sense of experience, enlarging the capacity to let go and integrate that which is beyond consciousness including the transpersonal (Danforth, 2009). Acceptance Commitment Therapy (ACT) has been positioned as a particularly effective cognitive-behavioral approach which facilitates client’s capability for openness to the medicine experience as it unfolds (Luomo et al., 2019).

In sum, while person-centered, humanistic-existential, transpersonal, psychological flexibility, focusing, and somatic are some orientations which may be well-suited to the integration segment of ‘psychedelic-supportive psychotherapy’ any and all of these approaches along with others not specified here, may be applied during the integration phase. This assumes that application is based on the unique needs, experience, goals, and interests of the client and is within the scope of the practitioner’s knowledge. Optimally, a therapist might draw from a substantial toolbox of theories and perspectives at any point in the treatment, and specifically during integration phases, based on their assessment of what will best support the unique needs and goals of their client. With these considerations in mind, and short of scientific data offering evidence of best approaches, a summary recommendation within this model is for the practitioner to hold a largely non-directive, person-centered perspective, supporting “self-actualization” with openness to the transpersonal and attention to the somatic, while flexibly, differentially applying other approaches. Most crucial is the therapist’s stance of embodied presence, curiosity, and openness to the client’s subjective narrative of their medicine journey and whatever meanings they might derive from that experience. As in dreamwork and particularly in ‘dream tending,’ interpretations offered by the therapist are subject to confirmation of resonance for the client and their felt experience of the medicine journey to be tended to as carrying …an inner knowing, an innate sensibility and an element of potency that affords each of us the capacity to open to the
depths of our own experience. When we tend a dream, images come “awake,” imagination is animated and we participate in life more fully rooted in the way of the dream (Aizenstat, 2001, p. 1).

The medicine journey, like a dream, offers inherent wisdom, and the narrative of the journeyer about their experience is to be cultivated within an integration process as it may relate to intentions and goals initially set forth and carried forward into the client’s future.

A question frequently posed by practitioners is how can a therapist know which approaches to apply in what instance? The MAPS manual asserts that these decisions will reflect “the sensitivity and talent of the therapist who employs [it]” (Mithoefer, 2017a, 2017b, 1.2), and that, “therapists are expected to draw upon their own training and experience in various models of psychotherapy to help them understand and respond to a participant’s process (Mithoefer, 2017a, 2017b, 1.5.1).” The answers to such questions as, which approaches to use, when to interpret and when to hold back, continue to be elusive and dynamic as are the nuances of interpersonal relating within the intersubjective field of therapist-client relationship. Recent developments within interpersonal neuroscience may offer some new insights to how practitioners do make these decisions, and involve consideration of the essential meaning and complex dynamics of “presence” within the psychotherapeutic encounter, which Siegel defines as when “we can freely move in and out of the open plane of possibility” (2020, p. 215).

The concepts of “clinical intuition” and “implicit relational knowing” presented by Marks-Tarlow (2014, p. 221) offers a window into how therapists make decisions, operating on many levels including a “fully embodied mode of perceiving, relating and responding” distinct from and alongside explicit processes such as thinking, analyzing, deciding (2014, p. 222). As Marks-Tarlow sees it, “This is precisely how clinicians tune into nuance, variability, and the full complexity of relationship as expressed moment to moment” (2014, p. 225).

Clinical intuition, abstract as it sounds, is grounded in the hard neuroscience of sensory experience operating in humans at all times, all at once. It may also well be the most potent, least understood and insufficiently valued aspect of how therapists make decisions (including decisions about interventions), while reflexively and often unconsciously, relying upon clinical intuition. Which theories, approaches, techniques, and interventions are to be applied at any particular time with a client, is always in some sense served by this dynamic (Geller & Greenberg, 2002; Messer & Wampold, 2002). The integration segment is the time when a client may also be in a supreme condition of openness induced by the medicine experience. The client and therapist together unpacking this experience signifies an encounter of two humans who are potentially both in a state of “fully embodied mode of perceiving, relating and responding” (p. 225).

Further exploration of this powerfully heightened state of receptivity within both participants in the process and how clinical intuition operates for therapists facilitating psychedelic medicine integration will likely prove elucidating.

As it is, this meeting space of both client and therapist in a fully embodied mode of perceiving, relating, and responding, parallels the client’s encounter with the medicine. It also encapsulates those qualities of the therapeutic relationship which best enhance a client’s post-medicine integration in the service of psychological, emotional and spiritual growth, and is the lens through which this model for ‘psychedelic-supported therapy’ is envisioned.

Summary

Here I have presented a ‘psychedelic-supported psychotherapy’ model aimed at both reducing harm and supporting psychotherapeutic benefit within the context of psychotherapy, while the medicine journey occurs outside this context. In positioning the therapeutic alliance as a central change agent insofar as the presence of the therapist has been internalized by the client, an argument is made for a supportive psychotherapeutic process leading to positive, potentially transformative, psychotherapeutic outcomes even when the therapist is not present during the client’s medicine experience. While conceivable risks have been generally mentioned and theoretical approaches gleaned from within the literature suggested, these elements merit further investigation. What I hope to have offered here is a compelling rationale and outline for implementation of a transtheoretical model of ‘psychedelic-supported therapy’ which places the centrality of the psychotherapeutic alliance as a primary and effective healing agent adjacent to, but not part of the client’s psychedelic medicine experience. Through this and other immediately accessible models of treatment complying with current legal and ethical regulations, significant gains are to be made in advancing the profession and most importantly, in furthering client access and supporting individual well-being and community healing.

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