Considerations in the Application of Psychedelic-Augmented Psychotherapy: A Commentary on Clinical Mechanisms

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1. Introduction

In this paper I outline some points of nuance central to the administration of entheogens and empathogens, with an emphasis on individual factors, therapeutic paradigms, and pathways toward combining psychological therapies with medical psychedelic intervention.

Combination of medical intervention with psychological treatment has proven efficacious for conditions such as depression and anxiety [1], often with multiplicative patient benefits. Such approaches typically involve grouping of anti-depressant drugs with cognitive-behavioral therapy (CBT) [2]. Neurological and psychological models of recovery can at times coalesce—in this instance, based on dopaminergic and/or serotonergic titration coupled with cognitive reframing of maladaptive schema [3]. Despite prior successes in treatment that combines therapy with medication, the state of dual therapies in psychedelic treatment remains somewhat nebulous [4] and thus calls for closer examination of augmented (psychedelics combined with psychotherapy), complementary (psychedelic administration pre/post psychotherapy, or a combination), and differential approaches (where specific psychopharmacology or psychotherapy is counterindicated). As an aside, there is a parallel debate materializing in the literature about the transformative function of phenomenology compared with the pharmacological mechanism of action in treatment. While such discourse is evidently irrelevant to prior treatment methods (i.e., selective serotonin reuptake inhibitors [SSRI] and serotonin and norepinephrine reuptake inhibitors [SNRI], neither of which stimulate a 'trip' component), it is particularly salient to the visionary and multisensory nature of experiences inherent in psychedelic treatment.

Notably, the schema-change model is merely one interpretation of how phenomenological aspects of a trip may translate to cognitive restructure and meaningful life outcomes. The reframing of maladaptive beliefs about self, others, and the world, either during a psychedelic experience or post-integration is concordant with established mechanisms in psychopharmacology (i.e., SNRI combined with rational emotive behavioral therapy [REBT], for instance [5]), but presents unique and novel opportunities due to the expedient mechanism of action in psychedelics. Formative models specific to psychedelic treatment, such as 'EMBARK' [6] have been put forth. EMBARK specifically centers on transdiagnostic criteria encompassing the dimensions of existential-spiritual, mindfulness, body-aware, affective-cognitive, relational, and keeping momentum, each of which presents axes in preparation, trip, and integration processes. It is anticipated that other clinical models will be developed as scholars continue to put forth scientific frameworks for psychedelic treatment and associated outcomes.

Past, Present, and Emerging Perspectives on Clinical Psychedelic Use

The first wave of psychedelic administration was largely experimental, with an examination of lysergic acid diethylamide (LSD) in myriad conditions potentially treatable, from post-traumatic stress disorder (PTSD) [7] to alcohol use disorder [8]. Psychedelic second wave, or 'psychedelic renaissance', signaled a renewed interest from the practitioner community in novel interventions. This resurgence was coupled with ongoing decriminalization and legalization efforts in many Western countries, thanks to the lobbying efforts of eminent practitioners such as David Nutt [9]. Over time, the weighted risks of recreational abuse could no longer be argued for, in favor of the sometimes immediate (i.e., ketamine; [10]) and often medium-term therapeutic and psychological benefits of psychedelics [11].

It is anticipated that a third wave of psychedelic treatments will turn attention to mediating factors such as individual, contextual, and tailored therapeutic approach. The latter of these is the key focus of this paper, with an emphasis on clinical frameworks and their underlying philosophies with respect to contextualizing psychedelics. Emerging frameworks that offer psychotherapy-oriented qualification and certification toward best practices in psychedelic administration have been proposed, and some of these are presently being evaluated within studies [12]. Perhaps the most widely applied to date is the Phelps six-principle model oriented on practitioner competency, which has been mapped onto best-practice outcomes with psychedelic administration and out-patient care (see [11]).

Wolfson [13] has highlighted that special competencies and training are required for practitioners endeavoring to provide complementary or augmented counseling in adjunct with psychedelic treatment (i.e., whether solely delivered or with the support of a psychiatrist). Pre-existing training frameworks in their respective fields (from psychoanalysis to psychiatric models) can at times lack sufficient education (both in soft competencies and conceptual breadth) necessary for the administration of psychedelics and supporting psychotherapies. This is likely due to the fact that such training programs have not traditionally been included in either medical or clinical psychology residencies, due to the prevailing legal status of psychedelics until recently. Still, today, few programs include elements of such training in core coursework, especially in the field of clinical psychology, where one could argue it is most critical in bridging the chasm between medical treatment and social support. A gap in training and best practices can appear glaring, but the current state of affairs also presents opportunities for the development of new guidelines and clinical standards in psychedelic-augmented therapies [14].

2. Psychedelic-Augmented Therapies

There is ongoing debate about which treatment modalities are well-suited to psychedelic administration. As canvassed in this paper, Rogerian-based principles that support patient-led 'integration' of a trip appear central in most earlier and contemporary approaches applied. Many modern psychotherapists incorporate Rogerian (or person-centered/humanistic) principles as a bedrock of practice, in which patients are approached from an empathic and open-minded perspective [15]. A receptive therapist attitude encourages the cultivation of meaning-making and can support patients in sharing deep-seated emotional experiences [16].

Specific techniques that can be applied to support the exploration, integration, and meaning-making aspects during and after a psychedelic experience ought to be considered in broader scope, building on the principles of person-centered care. Yet, clinicians should resist applying a one-size-fits-all metric to the evaluation of outcomes and instead consider individual factors in treatment regimens. Although it is common for researchers to examine pre/post-clinical significance measures, the dynamic nature of a psychedelic experience can often produce more subtle (i.e., not immediately

captured via quantitative means) or progressive (i.e., longer-term effect) benefits and impacts reported by patients, which should not be discounted nor undermined in research-evaluation metrics. In that sense, drawing upon a variety of counseling frameworks, ranging from constructionism traditions (i.e., meaning-making), to psychoanalytic work (i.e., transformation via realization and insight), as well as more widespread and established methods such as cognitive-behavioral treatment, will serve to round out a more balanced discussion.

While it is not my aim to address research methodologies underlying specific treatment approaches (for example, a cognitive therapist may evaluate efficacy in a rather different manner to the approach of a psychoanalyst), it is important to note potential sources of clinical bias. For example, Yaden et al. [17] have suggested that because pre-existing methods show well-established efficacy in other domains, those approaches should be considered as a default gold standard in psychedelic therapies. Yaden et al.'s [17] argument to adopt CBT as a universal treatment holds some merit due to the evidently robust and long-demonstrated outcomes with this therapeutic approach in non-psychedelic treatments. However, in my opinion, there are at least three treatment factors (not only at the patient level, but also more broadly culturally/socially) that are problematic with such a presupposition: (1) when studying a new area of phenomenology, prior clinical guidelines should not be applied de facto without exhaustive academic debate first; (2) many clients and client groups are implicitly excluded from an overly narrow therapeutic focus and practitioner suppositions about best standard care; and (3) practitioners from a variety of modalities (e.g., internal family systems therapy as well as religious/existential therapies, to name a few) have immense value to contribute to the discourse, whose voices might inadvertently be discounted from the conversation.

Studies centered on psychedelic treatment often apply a range of variables to examine outcomes, which can encompass more immediate efficacy (i.e., change in depression or anxiety scores [18]), often in addition to appraisal of metrics such as ego loss (i.e., mystical/unity encounters [19]), as well as alteration in existential attitudes (such as those applied in palliative care [20]). In future work, more stringent operationalization of specific psychotherapy modalities (i.e., as independent variables), such as one psychedelic treatment model compared with another in a controlled manner, would be fruitful. Decentering the perspective that psychedelics only provide mental health benefits within the treatment room may also be valuable in guarding against a one-size-fits-all bias, considering that various wellbeing measures outside of clinical sessions are also pertinent. Villiger and Trachsel [21] recently evaluated some of the core suppositions in psychotherapy (such as informed consent) and how psychedelic treatment presents novel hurdles and opportunities (for patients and clinicians alike) with respect to factors such as vulnerability and context (i.e., they outline specific differences of nuance compared to other more conventional methods such as the administration of psychotropics or electroconvulsive therapy). Therefore, while it may be tempting to search for a best-standard or universal model, we should instead embrace an exploratory attitude in the development of practices and techniques that support the application, integration, and referral processes which underlie psychedelic treatment.

Although this paper examines the question of which psychotherapy approaches may encourage optimal cognitive, affective, and behavioral well-being in conjunction with psychedelic treatment, there are a number of other important questions that are bracketed for the time being. For instance, the question of number, frequency, and intensity (i.e., dosage) of psychedelic treatments and how these factors weigh on the treatment experience and outcomes has been pondered at breadth in the literature [22]. Questions relevant to context (hospital settings vs. natural environments or out-

treatment) have been considered [23] but also require further thought. Additionally, while psychiatrists are best equipped to administer psychedelic treatments within the medical model, the broader role of psychotherapists, counselors, social workers, and other allied health professionals deserves more consideration.

One other question I have bracketed here concerns the combination and tailoring of psychedelics in augmentation with specific therapeutic strategies. Due to the broad mechanisms of action and thus the treatment potentials of many psychedelics, it can be rather reductive to draw prescriptive parallels between substance and condition, let alone therapeutic model and substance. Exemplified trends in literature show specific therapeutic benefits in the treatment of suicidal ideation with ketamine [24], improvement in interpersonal problems (and potentially intrapersonal/personality disorder spectra) after the administration of empathogens [25], and treatment of anxiety with atypical depressants such as kava extract [26]. For the purposes of this paper, more widely applied psychedelics such as ayahuasca, LSD, and psylocibin are considered in relation to a range of therapeutic frameworks. Although this is an admittedly convenient way of thinking about how psychedelics may fit into specific therapeutic modalities, the aim of this paper is certainly not to offer a deductive discourse. Instead, exploratory remarks are made about traditional, psychoanalytic/dynamic, and experiential/systemic therapies, with comment on their theoretical outlook toward, as well as clinical mechanisms in, psychedelic treatment.

3. Traditional Therapies

Treatment best practices have been put forth by organizations such as Mind Medicine Australia, which focus around three key parts of treatment: (1) preparation, (2) acute psychedelic experience, and (3) integration. The first part of the process can be preceded by various screening diagnostics, while integration may extend into follow-up as far as six months after the final counseling session [27]. The psychotherapy phase is generally centered on talk therapy, or a Rogerian approach, based on patient-led meaning-making. As described later, other methods such as meditation/mindfulness and somatic body-awareness may also be incorporated where applicable as part of a treatment regimen.

3.1. Humanistic (Including Attachment-Informed Models)

Foundational work on psychedelics (see [28]) applied clinical methods grounded in talk-oriented therapy principles, intended to summarize, and debrief on meaningful and significant aspects of one's experience. Other earlier approaches applied, such as psycholytic and anaclitic therapies, also examined ego-state changes and sub-threshold experiences of pre-egoic consciousness (i.e., implicative of pre-object relations) [29]. More recent work on psychoanalytic and attachment-based frameworks has reinvigorated discussion on the utility of such mechanisms in altered states [30]. Such considerations are consistent with trauma-informed practice.

As discussed earlier, the therapeutic relationship based in person-centered (i.e., Rogerian/humanistic) principles of respect, empathy, and therapist authenticity is well orchestrated to the set/setting components of psychedelic-administered therapies [30]. These principles allow a counselor to hold the required 'therapeutic space' to facilitate a patient experiencing potential moments of psychological transformation that arise within the context of psychedelics [31]. Open-ended and client-led dialogue about the experiential aspects of a trip, whether challenging or enriching to express, align with the Rogerian principles of self-awareness and self-actualization [16]. These principles are often regarded as crucial developmental and humanistic outcomes of counseling within

the person-centered model and are thus well-aligned with the transformational (or 'pivotal', to use Brouwer & Carhart-Harris' [32] wording) nature of the psychedelic state.

In much of the work on 3,4-Methylenedioxymethamphetamine (MDMA) in couples therapy, safety and a relationally comfortable environment have been shown to decrease anxiety and the fight-flight-freeze-fawn response [33,34]. In comparable medical models, bedside manner and positive relationship building (i.e., rapport) with patients is especially important when situated within the psychological framework of object relations and transference, carrying the notion that 'safe other' modeling will be later transferred to significant other relations (i.e., partners, friends, colleagues etc.). Such approaches are often concordant with patient-centered principles, incorporating clinician understanding around trauma, psychological vulnerability, and the interrelated potential of psychedelic experiences to mediate or, in some instances, exacerbate these factors [35].

3.2. Cognitive-Behavioral and Mindfulness-Based Therapies

The sensory-perceptual impact of the psychedelic experience can be significant, as recently articulated by the Qualia Research Institute model around hyperbolic imagery in experiences with N,N-Dimethyltryptamine (DMT) [36]. While traditional explanations discounted such fantastical visuals as hallucination or sensory aberration, recent work has examined the naïve realism hypothesis which presupposes 'deconstructed' reality, wherein top-down context cues are inhibited [37]. Theories such as the RElaxed Beliefs Under pSychedelics (REBUS) model are supported by Fristonian principles of the entropic brain, in which top-down (cognitive) malleability and bottom-up (sensory) cues coalesce [38,39]. Earlier work on LSD highlighted its potential to instill novel beliefs and perceptions at the top-down (i.e., cognitive) level [7], which is more modernly examined with the application of cognitive-based treatment approaches such as REBT, CBT, and schema-based therapies (all which hinge on belief alteration leading to healthier behavioral outcomes). Much of the present work on psychedelic-augmented therapies centers on traditional cognitive, cognitive-behavioral, and third wave (i.e., mindfulness-based CBT [MBCBT] and acceptance and commitment [ACT]) therapies [40]. Common applications in conjunction with psychedelic administration include the treatment of anxiety and depression disorders, as well as eating disorders and posttraumatic stress disorder (PTSD) [41]. See Yaden et al. [17] for a comprehensive table of potential therapeutic benefits of psychedelics coupled with traditional CBT and CBT-informed approaches.

Many researchers agree that approaches which facilitate mindfulness in combination with a cognitive and/or behavioral intervention (such as dialectical behavior therapy; DBT) may facilitate the reframing of negative, irrational, or maladaptive beliefs (e.g., schema relevant to over-vigilance or interpersonal rejection [42]). While it has been well-established that the schematic and/or relational reframing techniques underpinning these therapies are efficacious of their own accord, the altered state facilitated by psychedelics appears to further augment pivotal states of psychological flexibility that may arise [43,44,45]. Experiential avoidance may also be reduced (i.e., even further) in approaches such as ACT or DBT, which advocate for a behavioral re-engagement of the sensory system; an interesting subset of literature has examined the potential role of self-as-context in psychedelic-augmented therapy with ACT, with implications around facilitating a more complete absorption in one's visuospatial and sensorial experience during and after a psychedelic trip [46]. Notably, concepts comparable to 'experiential avoidance' overlap with related clinical constructs in other theoretical areas, including the notion of 'affect phobia' in intensive brief psychodynamic psychotherapy and layers of neurosis described in Gestaltist phenomenology (both of these are discussed in turn within the sections that follow).

4. Psychodynamics and the Unconscious Mind

Psychedelic treatment has traditionally been applied within the psychoanalytic tradition, with psychiatrists having received formative training during an era when the legality of psychedelics and the predominance of a psychoanalytic paradigm coalesced [47]. Notably, that training was clinically centered, and more modern evaluation of psychoanalytic models as a psychotherapy tool in the treatment of psychedelics is needed. As therapists in this tradition center their praxis on consciousness, the unconscious mind, and the intermediary threshold/barrier between both, this framework is ideally situated for psychedelic-related work, which often involves interoception and imaginal representation of unconscious materials [48].

Barrett [47] articulated three domains of psychanalytic work that lend themselves well to psychedelic treatment: (1) object relations, (2) access of unconscious contents, and (3) psycho-spiritual/psychosynthesis factors. Both pre-symbolic and transpersonal (i.e., archetypal in the Jungian sense) contents are therefore relevant to therapeutic contexts that combine psychedelic treatment with psychoanalytic work. Rosica and Suchet [48] noted that the transformative potential of psychedelics is compatible with core concepts of psychoanalysis such as therapist alliance (more specifically transference/countertransference) and could provide novel opportunities for making meaning of unconscious material, integrating ego-dystonic experiences, and facilitating healing/therapeutic processes, all of which may otherwise be less permeably afforded in ordinary states of consciousness.

Rundel [49] described specific implications of psychedelic use (via a case study with the dissociative, ketamine) in the psychodynamic concepts of attachment, familial issues, and countertransference. This particular case study shows promise in clinically supported treatment in which psychedelics were incorporated meaningfully and methodically during or in between sessions (for example, techniques such as journaling one's experiences for further reflection/integration was noted in this case). Other mystical and transcendent aspects of psychedelic use can bring to light new creative, restorative, and relational knowledge from the reservoir of the unconscious to the forefront of consciousness [48]. Notably, from the Jungian perspective, psychedelics offer a pathway to experiencing broader aspects of the Self archetype and therapeutic processes such as shadow work [50,51]. Although some hesitation may arise in stimulating unconscious contents in an expedited or premature manner, there equally exist opportunities to examine both the refinement of methods as well as the development of guideline indications (or contraindications) on spiritual emergence experiences such as the dark night of the soul [52].

5. Modern Approaches

As mentioned earlier, while more well-established clinical therapies may appear most amenable to psychedelic-augmented treatment at first glance, modern approaches from the positive psychology, somatic experiencing, and experiential schools of thought may offer novel techniques when applied in specific contexts. Although such modalities mightn't be at the forefront of mainstream psychological practice (i.e., common services offered in a hospital or clinic setting), they should not be discounted in potentially unique applications with psychedelic-combined therapy. As noted herein, some of these approaches are specifically helpful to both conceptualization and clinical treatment outcomes, while others require further work to consider their potential applications and efficacy.

5.1. Positive Psychology and the Cultural Perspective on Psychedelics

The positive psychology movement is important in the discussion of psychedelics because, as a clinical paradigm, it offers a novel means through which to consider mental health and wellbeing at a macro level. It is worth noting that achieving and sustaining peak/plateau states of consciousness is an aspiration that has informed much of positive psychology theory and praxis. Abraham Maslow's work on personality and human flourishing is instrumental to the overarching ideas of positive psychology, postulating the highest potentials of the human being (self-actualization and self-transcendence—both personal and communal facets [53]).

Interestingly, those who are part of the positive psychology movement have a fair bit to say about the psychedelic renaissance from a theoretical as well as contextual vantage point. St. Arnaud [54] discussed the prior negative framing around psychedelic use and considered public perceptions in creating a more empowering narrative, governed by psychoeducation. This is a point not to be dismissed lightly, as only mere decades ago, the discourse centered on psychedelics was a radically different one, causing significant polarization at both macro- and microsystems [55]. Specifically, perceptions held by one's family system, medical practitioners (e.g., family physicians), and within one's internalized autobiography (i.e., how one feels about psychedelics) can all weigh on the conceptual framing of illness, treatment, and recovery. In her dissertation on the topic, Eygoren [56] noted that the framing of psychedelic use as part of broader social discourse can have profound and meaningful impacts on the shaping of set/setting and the values inherent in given social attitudes towards their use. Therefore, how we may perceive the use and proliferation of these substances within varied contexts is of central interest in positive psychology discourse more broadly, as well as within the clinical setting.

At the clinical level, positive psychology is concerned with those epistemic components of tripping that may be positioned towards values of resilience, internal and external resources, as well as one's subjective definition of positive outcomes and wellbeing. Chen and Mongrain [57] noted that one of the least discussed but most important aspects of the psychedelic experience is the encounter with a state of awe and interconnectedness: the suspension of ego boundaries and cultivation of emotional states of gratitude, connection, and wonder intermingle in the promotion of social wellbeing. Jungaberle and his team [58] noted that positive psychology measures had been applied in 77 clinical trials on psychedelics and entactogens thus far. They derive that outcome-centric measures show pro-social benefits in the domains of empathy, creativity, personality, values, mindfulness, and wellbeing (all central to positive psychology intervention). Others (see [59]) have qualified claims around psychedelics and the potential harm of them being marketed as a 'catch-all' solution to mental health problems, calling for the need for more measured analysis and presentation of potential risk factors.

5.2. Somatic and Experiential Methods

Somatic approaches are well-suited to psychedelic therapies due to the fact that many psychedelics act at the biological-affective axis (often accentuating both physiological and emotional awareness). Further, body-centered approaches such as somatic 'focusing' and psychomotor methods are particularly accessible since the present-moment awareness of acute states can often be accessed as an 'embodied' experience (note: higher-dosages or dissociative substances may have the opposite effect, whereby one experiences separation from the body) [60]. Recent work on psychomotor therapies has illustrated the importance of somatic awareness in recovering from traumatic experiences and/or complex PTSD [61]. These techniques, which may encompass a variety of postural, movement, and embodiment practices, are amenable to psychedelic therapies, as affectively charged (or potentially trauma-isolated) experiences may arise. Scholars have posited that experientially

focused methods such as psychodrama and art therapy may also be particularly well-suited to psychedelic-supported approaches due to the embodied nature of these practices and techniques [62,63]; however, more controlled research is needed to examine this claim in clinical contexts.

An overarching approach that places an emphasis on somatic experiencing is Gestalt psychotherapy, which can be regarded as both an existential (focus on present sensory experience and environment) and relational (emotive-somatic awareness of affect and interpersonal experiencing) model [64]. 'Making contact' with the present moment is facilitated via a range of experiments, including parts integration, the empty chair, and embodied dreamwork; it's presupposed that this creative interplay facilitates a holistic re-experiencing of oneself and context. These 'experimental' (in the Gestaltist use of the word) methods could afford novel opportunities to facilitate psychedelic-augmented experiences which have thus not yet been explored/documented at sufficient depth [65]. Szummer et al. [66] noted that Gestalt philosophy relates strongly to the phenomenological ground described by Merleau-Ponty, in which the role of embodied cognition and experience is placed center-stage. The 'hyperassociative' nature of the mind on psychedelics is particularly amenable to novel and creative gestalts, as the geometric nature of visual phenomena often melds/merges various fractal and rhizomic materials [see 36].

Notably, while other clinical methods certainly incorporate comparable therapy techniques such as 'parts work' (e.g., internal family systems [IFS]) and 'contacting' the present moment (e.g., developmental psychology and counseling/psychomotor applications), the unique philosophical outlook of therapist, client, and overarching theory warrants consideration in any given modality. To further the former example, whilst Gestaltists are existentialist/phenomenological in their starting outlook, clinical mechanisms in IFS are hereditarily grounded in a systemic/cybernetic model where information flows between and within systems (e.g., familial dynamics), as scoped below.

5.3. Constructionism, Systemic, and Group Therapy Approaches

Modern constructionist approaches such as solution-oriented counseling and narrative practice may offer relevant techniques in the application of psychedelic therapy, but it remains nebulous whether the overarching framework (i.e., social constructionism) of these approaches is suitable within this context more broadly. The utilization of myth and storytelling in approaches such as narrative therapy [67] for instance, could potentially offer applications to the unique metaphorical/imagery-based landscape of many psychedelic experiences. Yet, I was only able to locate one paper positing such an application, and that was a hypothesis piece rather than validated experimental work. Delavan [68] proposed that psilocybin combined with narrative practice would assist patients to better 'externalize' (a technique applied in narrative practice) their symptomology related to depression; but was not able to test/publish the findings of this hypothesis. Narrative practice specifically may be worth investigating further for another reason, considering the long-rooted traditions of entheogen use in myth and mythology (i.e., the shamanic tradition), and thus may lend itself especially well to the social construction of meaning within modern contexts.

One semi-structured interview explored the potential of IFS therapy and psychedelics [69]. While family systems models initially may be regarded as counterintuitive in psychedelic-augmented practice, IFS is traditionally employed with individuals, with the consideration that various parts of 'self' are internalized as intrapersonal relational dynamics (i.e., with each a unique overarching role, such as 'exiles', 'managers', or 'firefighters' [70]). While other approaches may posit that these components of personality are best conceptualized as sub-personalities (in earlier psychoanalytic

thought) or disconnected elements out of consciousness (the Gestaltist view), the IFS view is one of an internalized relational family system. In the study, four therapists were asked how IFS supports psychedelic treatment, specifically focusing on the process of integration. Comments spanned skepticism of whether psychedelic use would enhance the process above and beyond traditional methods, while others qualified such sentiments with a call for therapist experience/expertise. One expert suggested that specific psychedelics, such as MDMA, which already shows good promise in couples counseling, could equally be be-neficial in IFS work.

Psychedelic treatment also offers opportunities in group therapy, with evidence of positive outcomes in both augmented and complementary r models. For example, Anderson and colleagues noted significant improvements in mental health outcomes of long-term AIDS survivor men in a group therapy intervention alongside a single administered dose of psylocibin [71]. Up to the point of writing this paper, one review [72] had previously been done systematically to examine the prospects of group psychedelic therapy, with studies ranging from 1959–1995. After this paper had been completed, Ponomarenko et al. [73] offered a timely update on the topic, suggesting that psychedelic-assisted group psychotherapy can support greater group connectedness and learning by leveraging the framework of Irvin Yalom's factors for effective group therapy. These authors evaluated three recent group-based psychedelic therapy studies which showed overall positive results. Parenthetically, their proposed approach was supported by effective clinical outcomes in a complementary case study. Notably, in some instances of group psychedelic therapy, participants essentially take part in the pharmacological component, while group counseling techniques are not necessarily employed in all studies (or only individual therapy is sometimes offered externally). The pathway forward is therefore open for future research to take place on specific group-work and/or social-work-oriented techniques for psychedelic-augmented treatment and support.

6. Substance, Technique, Individual

This commentary was intended as an exploratory examination of the status of the literature on clinical methods in psychedelic-supported therapy. It was set out to be neither exhaustive nor deductive and instead aimed to cultivate ongoing discussion, debate, and dialogue on some of the topics covered, especially with reference to novel and lesser-considered therapeutic approaches. There are many, many other therapeutic modes worth discussing in the broader conversation, notwithstanding other systemic methods, existential counseling, religious/pastoral care approaches, as well as adjunct techniques such as body/breathwork, hypnotherapy, and/or modern technology-focused methods, including the use of virtual and augmented reality [74].

As a final note, the consideration of individual differences (e.g., tolerance, personality, treatment preference) and therapist approaches (e.g., application of certain therapeutic techniques, support mechanisms at the clinic and government levels, including access to mental health support plans and rebates) also warrant consideration in broader scope. Potential mediators and moderators within the broad spectrum of set/setting, which can range from preparatory advice to pre-planning of environmental factors can all influence patient experiences and outcomes. These factors should receive more attention, especially as psychedelic treatment proliferates from a niche and focused approach with specific patient groups, to one that is embraced by the broader medical and psychological practice community worldwide. As demonstrated several times in this article, practitioners often hold particular presumptions, clinical preferences, and treatment biases in their approaches. Perhaps most importantly then, an objectively grounded clinical discussion on

psychedelics should continue to examine a range of voices and conceptual models of practice contextually, rather than converging on a key set of universal criteria.

7. Conclusions

I offered a clinically grounded perspective on psychedelic therapies based on a number of selected modalities and counseling philosophies. This was done in the spirit of exploratory navigation of psychedelic-augmented treatment rather than as a prescriptive remark about the benefits of one therapeutic model over another. As psychedelic treatment becomes more of a standard in supporting psychological wellbeing, it is important that practitioners recall that the administration of these substances originally occurred in very specific cultural contexts; therefore, the importance of an individual-centric and contextual approach ought to be maintained in modern treatments. Psychedelic-supported psychotherapy requires unique training and a combination of experience and expertise, yet practitioners may approach the prospect of psychedelic therapy from a pre-existing set of skills and qualifications in specific clinical foci. The unique expertise that psychoanalysts, psychiatrists, and other counseling clinicians (including, but not limited to, nurses, social workers, and other types of therapists) bring to the conversation will continue to enrich the developing discourse. All in all, we ought to exercise caution around potential monopolization or domination of particular 'gold standard' models, and instead invite broader discussion from crucial stakeholders, ranging from the perspectives of established clinicians as well as the lived experiences of their patients.

References

1. Gorka, S.M.; Young, C.B.; Klumpp, H.; Kennedy, A.E.; Francis, J.; Ajilore, O.; Phan, K.L. Emotion-based brain mechanisms and predictors for SSRI and CBT treatment of anxiety and depression: A randomized trial. Neuropsychopharmacology 2019, 44, 1639–1648. [Google Scholar] [CrossRef] [PubMed]
2. Månsson, K.N.; Lueken, U.; Frick, A. Enriching CBT by Neuroscience: Novel Avenues to Achieve Personalized Treatments. Int. J. Cogn. Ther. 2021, 14, 182–195. [Google Scholar] [CrossRef]
3. Liu, W.; Li, G.; Wang, C.; Yu, M.; Zhu, M.; Yang, L. Can Fluoxetine Combined with Cognitive Behavioral Therapy Reduce the Suicide and Non-Suicidal Self-Injury Incidence and Recurrence Rate in Depressed Adolescents Compared with Fluoxetine Alone? A Meta-Analysis. Neuropsychiatr. Dis. Treat. 2022, 18, 2543–2557. [Google Scholar] [CrossRef] [PubMed]
4. Richards, W.A. Psychedelic Psychotherapy: Insights From 25 Years of Research. J. Humanist. Psychol. 2017, 57, 323–337. [Google Scholar] [CrossRef]
5. Iftene, F.; Predescu, E.; Stefan, S.; David, D. Rational-emotive and cognitive-behavior therapy (REBT/CBT) versus pharmacotherapy versus REBT/CBT plus pharmacotherapy in the treatment of major depressive disorder in youth; a ran-domized clinical trial. Psychiatry Res. 2015, 225, 687–694. [Google Scholar] [CrossRef] [PubMed]
6. Brennan, W.; Belser, A.B. Models of Psychedelic-Assisted Psychotherapy: A Contemporary Assessment and an Introduction to EMBARK, a Transdiagnostic, Trans-Drug Model. Front. Psychol. 2022, 13, 866018. [Google Scholar] [CrossRef]
7. Grof, S. Theoretical and empirical basis of transpersonal psychology and psychotherapy: Observations from LSD re-search. J. Transpers. Psychol. 1973, 5, 15–53. [Google Scholar]
8. Smart, R.G.; Storm, T. The Efficacy of LSD in the Treatment of Alcoholism. Q. J. Stud. Alcohol 1964, 25, 333–338. [Google Scholar] [CrossRef]
9. Nutt, D.; Erritzoe, D.; Carhart-Harris, R. Psychedelic psychiatry's brave new world. Cell 2020, 181, 24–28. [Google Scholar] [CrossRef]

10. Kolp, E.; Friedman, H.L.; Krupitsky, E.; Jansen, K.; Sylvester, M.; Young, M.S.; Kolp, A. Ketamine Psychedelic Psychotherapy: Focus on its Pharmacology, Phenomenology, and Clinical Applications. Int. J. Transpers. Stud. 2014, 33, 84–140. [Google Scholar] [CrossRef]
11. Gukasyan, N.; Nayak, S.M. Psychedelics, placebo effects, and set and setting: Insights from common factors theory of psychotherapy. Transcult. Psychiatry 2021, 59, 652–664. [Google Scholar] [CrossRef] [PubMed]
12. Barber, G.S.; Aaronson, S.T. The Emerging Field of Psychedelic Psychotherapy. Curr. Psychiatry Rep. 2022, 24, 583–590. [Google Scholar] [CrossRef] [PubMed]
13. Wolfson, E. Psychedelic-supportive psychotherapy: A psychotherapeutic model for, before and beyond the medicine experience. J. Psychedelic Stud. 2023, 6, 191–202. [Google Scholar] [CrossRef]
14. Greenway, K.T.; Garel, N.; Jerome, L.; Feduccia, A.A. Integrating psychotherapy and psychopharmacology: Psy-chedelic-assisted psychotherapy and other combined treatments. Expert Rev. Clin. Pharmacol. 2020, 13, 655–670. [Google Scholar] [CrossRef] [PubMed]
15. Kirschenbaum, H.; Jourdan, A. The Current Status of Carl Rogers and the Person-Centered Approach. Psychotherapy 2005, 42, 37–51. [Google Scholar] [CrossRef]
16. Garcia-Romeu, A.; Richards, W.A. Current perspectives on psychedelic therapy: Use of serotonergic hallucinogens in clinical interventions. Int. Rev. Psychiatry 2018, 30, 291–316. [Google Scholar] [CrossRef]
17. Yaden, D.B.; Earp, D.; Graziosi, M.; Friedman-Wheel, D.; Luoma, J.B.; Johns, M.W. Psychedelics Psychotherapy: Cognitive-behavioral approaches as default. Front. Psychol. 2022, 13, 1604. [Google Scholar] [CrossRef]
18. Muttoni, S.; Ardissino, M.; John, C. Classical psychedelics for the treatment of depression and anxiety: A systematic review. J. Affect. Disord. 2019, 258, 11–24. [Google Scholar] [CrossRef]
19. Smigielski, L.; Kometer, M.; Scheidegger, M.; Krähenmann, R.; Huber, T.; Vollenweider, F.X. Characterization and prediction of acute and sustained response to psychedelic psilocybin in a mindfulness group retreat. Sci. Rep. 2019, 9, 14914. [Google Scholar] [CrossRef]
20. Dyck, E. Psychedelics and Dying Care: A Historical Look at the Relationship between Psychedelics and Palliative Care. J. Psychoact. Drugs 2019, 51, 102–107. [Google Scholar] [CrossRef]
21. Villiger, D.; Trachsel, M. With great power comes great vulnerability: An ethical analysis of psychedelics' therapeutic mechanisms proposed by the REBUS hypothesis. J. Med. Ethic. 2023. [Google Scholar] [CrossRef] [PubMed]
22. Leger, R.F.; Unterwald, E.M. Assessing the effects of methodological differences on outcomes in the use of psyche-delics in the treatment of anxiety and depressive disorders: A systematic review and meta-analysis. J. Psychopharmacol. 2022, 36, 20–30. [Google Scholar] [CrossRef]
23. Gandy, S.; Forstmann, M.; Carhart-Harris, R.L.; Timmermann, C.; Luke, D.; Watts, R. The potential synergistic effects between psychedelic administration and nature contact for the improvement of mental health. Health Psychol. Open 2020, 7, 2055102920978123. [Google Scholar] [CrossRef]
24. Wilkinson, S.T.; Ballard, E.D.; Bloch, M.H.; Mathew, S.J.; Murrough, J.W.; Feder, A.; Šóš, P.; Wang, G.; Zarate, C.A., Jr.; Sanacora, G. The Effect of a Single Dose of Intravenous Ketamine on Suicidal Ideation: A Systematic Review and Individual Participant Data Meta-Analysis. Am. J. Psychiatry 2018, 175, 150–158. [Google Scholar] [CrossRef]
25. Traynor, J.M.; Roberts, D.E.; Ross, S.; Zeifman, R.; Choi-Kain, L. MDMA-Assisted Psychotherapy for Borderline Personality Disorder. Focus 2022, 20, 358–367. [Google Scholar] [CrossRef]

26. Pittler, M.H.; Ernst, E. Kava extract versus placebo for treating anxiety. Cochrane Database Syst. Rev. 2003, 2010. [Google Scholar] [CrossRef] [PubMed]
27. Mind Medicine. What is Psychedelic-Assisted Therapy. 2023. Available online: https://mindmedicineaustralia.org.au/what-is-psychedelic-assisted-therapy/ (accessed on 17 January 2023).
28. Sessa, B. The history of psychedelics in medicine. In Handbuch Psychoaktive Substanzen; Springer: Berlin/Heidelberg, Germany, 2016; pp. 1–26. [Google Scholar]
29. Passie, T. History of the use of hallucinogens in psychiatric treatment. In Handbook of Medical Hallucinogens; The Guilford Press: New York, NY, USA, 2021; pp. 95–118. [Google Scholar]
30. Grob, C.S.; Bossis, A. Humanistic psychology, psychedelics, and the transpersonal vision. J. Humanist. Psychol. 2017, 57, 315–318. [Google Scholar] [CrossRef]
31. Walsh, R.; Grob, C.S. Early Psychedelic Investigators Reflect on the Psychological and Social Implications of their Research. J. Humanist. Psychol. 2006, 46, 432–448. [Google Scholar] [CrossRef]
32. Brouwer, A.; Carhart-Harris, R.L. Pivotal mental states. J. Psychopharmacol. 2020, 35, 319–352. [Google Scholar] [CrossRef]
33. Cherniak, A.D.; Brulin, J.G.; Mikulincer, M.; Östlind, S.; Carhart-Harris, R.; Granqvist, P. Psychedelic Science of Spirituality and Religion: An Attachment-Informed Agenda Proposal. Int. J. Psychol. Relig. 2022, 1–18. [Google Scholar] [CrossRef]
34. Stauffer, C.S.; Anderson, B.T.; Ortigo, K.M.; Woolley, J. Psilocybin-Assisted Group Therapy and Attachment: Observed Reduction in Attachment Anxiety and Influences of Attachment Insecurity on the Psilocybin Experience. ACS Pharmacol. Transl. Sci. 2020, 4, 526–532. [Google Scholar] [CrossRef]
35. Hutchison, C.; Bressi, S. Social Work and Psychedelic-Assisted Therapies: Practice Considerations for Breakthrough Treatments. Clin. Soc. Work. J. 2020, 49, 356–367. [Google Scholar] [CrossRef]
36. Gomez Emilsson, A. The Hyperbolic Geometry of DMT Experiences: Symmetries, Sheets, and Saddled Scenes. Qualia Comput. 2016. Available online: https://qualiacomputing.com/2016/12/12/the-hyperbolic-geometry-of-dmt-experiences/ (accessed on 17 January 2023).
37. Robbins, S.E.; Logan, D.R. LSD and perception: The Bergson–Gibson model for direct perception and its biochemical framework. Psychol. Consciousness Theory Res. Pract. 2022, 9, 305–335. [Google Scholar] [CrossRef]
38. Carhart-Harris, R.L.; Friston, K. REBUS and the Anarchic Brain: Toward a Unified Model of the Brain Action of Psychedelics. Pharmacol. Rev. 2019, 71, 316–344. [Google Scholar] [CrossRef]
39. Carhart-Harris, R.L. The entropic brain—Revisited. Neuropharmacology 2018, 142, 167–178. [Google Scholar] [CrossRef]
40. Walsh, Z.; Thiessen, M.S. Psychedelics and the new behaviourism: Considering the integration of third-wave be-haviour therapies with psychedelic-assisted therapy. Int. Rev. Psychiatry 2018, 30, 343–349. [Google Scholar] [CrossRef] [PubMed]
41. Kočárová, R.; Horáček, J.; Carhart-Harris, R. Does psychedelic therapy have a transdiagnostic action and prophy-lactic potential? Front. Psychiatry 2021, 12, 661233. [Google Scholar] [CrossRef] [PubMed]
42. Sloshower, J.; Guss, J.; Krause, R.; Wallace, R.M.; Williams, M.T.; Reed, S.; Skinta, M.D. Psilocybin-assisted therapy of major depressive disorder using Acceptance and Commitment Therapy as a therapeutic frame. J. Context. Behav. Sci. 2019, 15, 12–19. [Google Scholar] [CrossRef]

43. Wolff, M.; Evens, R.; Mertens, L.J.; Koslowski, M.; Betzler, F.; Gründer, G.; Jungaberle, H. Learning to let go: A cog-nitive-behavioral model of how psychedelic therapy promotes acceptance. Front. Psychiatry 2020, 11, 5. [Google Scholar] [CrossRef]
44. Qiu, T.T.; Minda, J.P. Psychedelic Experiences and Mindfulness are Associated with Improved Wellbeing. J. Psychoact. Drugs 2022, 1–11. [Google Scholar] [CrossRef] [PubMed]
45. Payne, J.E.; Chambers, R.; Liknaitzky, P. Combining Psychedelic and Mindfulness Interventions: Synergies to Inform Clinical Practice. ACS Pharmacol. Transl. Sci. 2021, 4, 416–423. [Google Scholar] [CrossRef]
46. Luoma, J.B.; Sabucedo, P.; Eriksson, J.; Gates, N.; Pilecki, B.C. Toward a contextual psychedelic-assisted therapy: Perspectives from Acceptance and Commitment Therapy and contextual behavioral science. J. Context. Behav. Sci. 2019, 14, 136–145. [Google Scholar] [CrossRef]
47. Barrett, K. Psychedelic Psychodynamics: Relational Knowing and the Unthought Known. Psychoanal. Dialog 2022, 32, 484–496. [Google Scholar] [CrossRef]
48. Rosica, K.; Suchet, M. Coda: Widening the Scope of Psychoanalysis. Psychoanal. Dialog 2022, 32, 497–504. [Google Scholar] [CrossRef]
49. Rundel, M. Psychedelic Psychoanalysis: Transformations of the Self. Psychoanal. Dialog 2022, 32, 469–483. [Google Scholar] [CrossRef]
50. Read, T.; Papaspyrou, M. Psychedelics and Psychotherapy—The Healing Potential of Expanded States; South Paris Park Street Press: Paris, France, 2021. [Google Scholar]
51. Swank, M. Mercurius Ubiquitous: A Jungian Approach to Psychedelic Therapy. Int. J. Jungian Stud. 2020, 13, 13–40. [Google Scholar] [CrossRef]
52. Bache, C.M. Mysticism and psychedelics: The case of the dark night. J. Relig. Health 1991, 30, 215–236. [Google Scholar] [CrossRef]
53. Venter, H.; Venter, E. Globalization and the Psychology of the New World Citizen: How the New Global Citizen Compares to Maslow's Level of Self Transcendence. Int. J. Interdiscip. Soc. Sci. Annu. Rev. 2010, 5, 29–36. [Google Scholar] [CrossRef]
54. Arnaud, K.O.S. Toward a positive psychology of psychoactive drug use. Drugs: Educ. Prev. Policy 2021, 30, 81–94. [Google Scholar]
55. Gorelik, G. Cultural cures for the disconnected mind. Cult. Evol. 2023. [Google Scholar] [CrossRef]
56. Eygoren, H. Psychedelics, Positive Psychology, and Positive Humanities; University of Pennsylvania: Philadelphia, PA, USA, 2022. [Google Scholar]
57. Chen, S.K.; Mongrain, M. Awe and the interconnected self. J. Posit. Psychol. 2021, 16, 770–778. [Google Scholar] [CrossRef]
58. Jungaberle, H.; Thal, S.; Zeuch, A.; Rougemont-Bücking, A.; von Heyden, M.; Aicher, H.; Scheidegger, M. Positive psychology in the investigation of psychedelics and entactogens: A critical review. Neuropharmacology 2018, 142, 179–199. [Google Scholar] [CrossRef]
59. Plesa, P.; Petranker, R. Manifest your desires: Psychedelics and the self-help industry. Int. J. Drug Policy 2022, 105, 103704. [Google Scholar] [CrossRef] [PubMed]
60. Phelps, J. Training Psychedelic Therapists. In Advances in Psychedelic Medicine: State of the Art Therapeutic Applications; Praeger Books: Santa Barbara, CA, USA, 2019; pp. 274–294. [Google Scholar]
61. De Winter, B.; Drožd, B. Psychomotor therapy: Healing by action. In Broken Spirits; Routledge: London, UK, 2004; pp. 415–432. [Google Scholar]

62. Satchell-Baeza, S. Psychedelic psychodrama: Raising and expanding consciousness in Jane Arden's The Other Side of the Underneath (1973). Hist. Hum. Sci. 2021, 34, 82–104. [Google Scholar] [CrossRef]
63. Labate, B.C.; Cavnar, C. The Therapeutic Use of Ayahuasca; Springer: Berlin/Heidelberg, Germany, 2014. [Google Scholar]
64. Woldt, A.L.; Toman, S.M. Gestalt Therapy: History, Theory, and Practice; Sage Publications: Thousand Oaks, CA, USA, 2005. [Google Scholar]
65. Naranjo, C. Experience with the interpersonal psychedelics. In Ecstasy: The Complete Guide; Park Street Press: Rochester, VT, USA, 2001; pp. 208–221. [Google Scholar]
66. Szummer, C.; Horváth, L.; Szabó, A.; Frecska, E.; Orzói, K. The hyperassociative mind: The psychedelic experience and Mer-leau-Ponty's "wild being". J. Psychedelic Stud. 2017, 1, 55–64. [Google Scholar] [CrossRef]
67. Bloos, I.D.; O'Connor, T.S.J. Ancient and medieval labyrinth and contemporary narrative therapy: How do they fit? Pastor. Psychol. 2002, 50, 219–230. [Google Scholar] [CrossRef]
68. Delavan, C. Narrative therapy-assisted psilocybin use for treatment of depression. In Proceedings of the 15th Annual SPFC Research Conference, Seattle, WA, USA, 31 May 2017. [Google Scholar]
69. Morgan, N.L. Integrating psychedelic experiences utilizing the internal family systems therapeutic model. Int. J. Soc. Sci. Manag. Rev. 2020, 3, 257–264. [Google Scholar] [CrossRef]
70. Schwartz, R.C.; Sweezy, M. Internal Family Systems Therapy; Guilford Publications: New York, NY, USA, 2019. [Google Scholar]
71. Anderson, B.T.; Danforth, A.; Daroff, R.; Stauffer, C.; Ekman, E.; Agin-Liebes, G.; Trope, A.; Boden, M.T.; Dilley, J.; Mitchell, J.; et al. Psilocybin-assisted group therapy for demoralized older long-term AIDS survivor men: An open-label safety and feasibility pilot study. Eclinicalmedicine 2020, 27, 100538. [Google Scholar] [CrossRef]
72. Trope, A.; Anderson, B.T.; Hooker, A.R.; Glick, G.; Stauffer, C.; Woolley, J.D. Psychedelic-Assisted Group Therapy: A Systematic Review. J. Psychoact. Drugs 2019, 51, 174–188. [Google Scholar] [CrossRef]
73. Ponomarenko, P.; Seragnoli, F.; Calder, A.; Oehen, P.; Hasler, G. Can psychedelics enhance group psychotherapy? A discussion on the therapeutic factors. J. Psychopharmacol. 2023, 02698811231155117. [Google Scholar] [CrossRef] [PubMed]
74. Sekula, A.D.; Downey, L.; Puspanathan, P. Virtual Reality as a Moderator of Psychedelic-Assisted Psychotherapy. Front. Psychol. 2022, 13, 813746. [Google Scholar] [CrossRef] [PubMed]