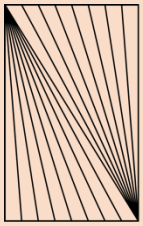


NUMINUS

Fundamentals of Psychedelic-Assisted Therapy

WORKBOOK

MODULE 1

INTRODUCTION AND FUNDAMENTALS

Numinus Care Model

An integrative and transformative mental wellness approach has a focus on whole-person health, including lifestyle and behaviour changes in which physical and mental health are deeply connected–not existing in isolation. This is at the heart of the Numinus Care Model.

TRAUMA- AND VIOLENCE-INFORMED CARE

Trauma is a transdiagnostic risk factor for mental and physical wellbeing. Informed professionals understand the types and physiological, psychological, and behavioural impacts of trauma.

CULTURAL SAFETY AND HUMILITY

Cultural humility is an ongoing process of self-critique in order to achieve a culturally safe environment. Cultural safety allows Indigenous Peoples to live their full sense of self and identity when accessing services.

JUSTICE, EQUITY, DIGNITY, & INCLUSION

Health professionals must prioritize dignity and human rights in the face of injustice. Services should be equitable and inclusive. Health professionals must commit to ongoing learning about oppression, racism, and discrimination.

HARM REDUCTION

Harm reduction is any program, policy, or intervention that seeks to reduce or minimize the adverse health and social consequences associated with certain behaviours such as substance use.

CONNECTION

This approach recognizes the importance of relationship-building in healthcare to create meaningful opportunities for people to connect with each other throughout their healing journey.

MINDFULNESS

Mindful awareness encompasses contact with all available modes of sense perception (vision, sound, interoception, etc.), as well as awareness of arising and passing emotions and phenomena (thoughts, images, embodied experiences, etc.).

EMBODIMENT

Embodied awareness provides access to one's present truth and past as it shows up through embodied implicit memory. Embodiment includes interoception which allows us to feel and relate to what is going on in our bodies.

Justice, Equity, Dignity, and Inclusion Exercise

Why are justice, equity, dignity, and inclusion (JEDI) important in psychedelic-assisted therapy? What can you do as a health professional to uphold JEDI in psychedelic-assisted therapy? When prompted, please copy and paste your responses in the chat in Zoom.

INDIVIDUAL RESPONSE

NOTES FROM SMALL AND LARGE GROUP SHARING

Indigenous Perspective on the Importance of Guiding Principles

While watching the video with Elder Duncan Grady, please use this space to take notes and reflections. You're encouraged to share some of your reflections with the larger group.

Vignette Case

PART 1

Julie is a 50-year-old woman struggling with alcohol use. She is a successful professional and is married to a successful professional. They have a teenage daughter. Family life can have its ups and downs as she and her husband experience high levels of stress at work and their daughter struggles with anxiety.

She has been coming to therapy on and off with you for many years for help with stress management, but she recently started talking about her alcohol use.

She drinks at least a bottle of wine every night and has been doing so for many years. She is increasingly concerned about the negative impact on her life, including being dysregulated and impulsive at the end of the evening (often having arguments with family members), feeling tired and sluggish in the morning, and not being fully present for her daughter. She is also concerned about the potential long-term effects on her physical health.

She has tried many times to slow down or stop drinking, but the habit typically returns when she feels stressed. She feels a sense of shame that she is unable to solve this problem.

What are the key considerations of Harm Reduction that would guide your therapy with Julie?

PART 2

After exploring Julie's drinking problem further, she is keen to pursue psychedelic-assisted therapy and asks you if you would support her with psilocybin. She has also contacted an underground therapist working with psilocybin and is eager to get started either way.

N.B. Psilocybin is not legally accessible in your jurisdiction, but you do offer ketamine-assisted therapy (for depression, substance use disorder, and PTSD) at the clinic with which you are affiliated.

How does harm reduction inform how you respond to her interest and request?

MODULE 2

THERAPEUTIC STANCE

At Numinus, we have identified particular elements that define an optimal 'therapeutic stance' for delivering psychedelic-assisted therapy. We encourage all health professionals, regardless of prior training, to develop this common language and understanding. Health professionals must *embody* these elements in order to show up well for their clients; they cannot remain merely abstractions or ideas as this will not create a fertile intersubjective field between health professional and client for integrative and transformative healing and learning to take place.

INNER DIRECTED THERAPY

Health professionals should relax into uncertainty of what is unfolding, or about to unfold, within a client's present moment process in psychedelic-assisted therapy, and to support this appropriately. Needs and opportunities for healing and learning are met skilfully as they arise emergently, rather than through pre-planned processes.

UNCONDITIONAL POSITIVE REGARD

This involves showing abiding recognition of a person's inherent human worth irrespective of the person's values and actions. When one is fully acknowledged and supported as they are, without judgment, resistance to change lessens (Rogers, 1942). With less resistance, one can more readily step into the change process.

APPRECIATION FOR HUMAN SUFFERING

This appreciation recognizes suffering is part of the human condition (Cooper, 2016). Health professionals should trust the client's inner healing process by refraining from attempting to 'help' by palliating their experience. Instead, encourage them to lean into the experience while providing skillful and loving support.

EMPATHETIC ABIDING PRESENCE AND LISTENING

Demonstrable components of empathetic abiding presence include evenly suspended attention, mindfulness, empathetic listening, “doing by non-doing,” and responding to distress with calmness and equanimity (Phelps, 2017). A nurturing, safe clinical context is essential for healing.

BEING GROUNDED, SELF-REGULATED, AND ALIGNED

Being physiologically and energetically grounded, self-regulated, and aligned is essential when working with individuals in altered states of consciousness and with those who have experienced significant traumatic stress. Health professionals should self-monitor and self-regulate.

ORIENTATION TOWARDS PHENOMENOLOGY

A phenomonological orientation concerns itself with unfolding the subjective “inner” experience of the client, including their thoughts, emotions, body sensations, behaviours, or impulses to act. Questions asked and language chosen invite client self-exploration.

RELATIONSHIP-CENTERED CARE

Attention to the quality of the therapeutic relationship is always prioritized with an understanding that desired therapeutic outcomes will naturally follow, in keeping with the contextual model of psychotherapy. Relationship-Centered Care also acknowledges that all relationships have power dynamics.

LOVE

Health professionals should have lived experiences with agapic love (also known as altruistic or selfless love) to be able to empathically resonate and meet a client in that state and to be comfortable experiencing this natural human state within frameworks of professionalism as love is commonly encountered in this modality.

TOP-DOWN AND BOTTOM-UP PROCESSING

Using the model of the brain as a hierarchical information processor, top-down or long-route processing versus bottom-up or short-route processing refers to the area (or level) of the brain which is dominant in guiding the processing that is occurring in the client’s experience.

SELF-AWARENESS AND ETHICAL INTEGRITY

Psychedelic-assisted therapy has unique ethical risks. Self-awareness includes investigating and challenging one’s implicit biases, establishing a strong and trustworthy therapeutic relationship, maintaining appropriate boundaries, and identifying and managing countertransference.

Attachment Styles

Attachment Style	Parenting Style	Corresponding Adult Attachment Characteristics
Secure	• Connected and attuned to the child's emotions and needs	• Ability to empathize with others and set boundaries • Tendency towards stable and meaningful relationships
Avoidant	• Emotionally unavailable or tendency to reject the child's emotions and needs	• Tendency to avoid close relationships or emotional connection • Rigid, critical, or intolerant
Ambivalent	• Inconsistent parenting • Intrusive or harsh communication	• Anxious and insecure • Controlling • Blames others • Unpredictable • Charming at times
Disorganized	• Ignored or oblivious to child's needs • Parent's behaviour was frightening or traumatizing	• Chaotic, explosive, or abusive • Insensitive • Lack of trust even when seeking closeness to others
Reactive	• Extremely unattached or dysfunctional	• Cannot establish positive relationships • Frequently misdiagnosed

Secure Attachment
(Adult attachments – comfortable)

Positive Thoughts of Self

Positive Thoughts of Others

- High Self Esteem
- Able to set appropriate boundaries
- Accepting
- Able to be vulnerable
- Creates meaningful relationships
- Comfortable with intimacy
- Learning
- Parent to child: aligned and attuned
- As an adult: empathetic, responsive, engaged and responsible
- "I am worthy of love" and "I am capable of getting the love and support I need" • "Others are willing and able to love me"

Ambivalent Attachment
(Adults attachments – preoccupied)

Negative Thoughts of Self

Positive Thoughts of Others

- Low Self Esteem
- Overly concerned about other's thoughts
- Clingy
- Seek validation and approval
- Wants excess intimacy
- Grasping
- Parent to child: inconsistent
- As an adult: controlling, blaming, erratic, unpredictable
- "I am not worthy of love" and "I am not capable of getting the love I need without being angry or clingy"
- "Others are capable of meeting my needs but might not do so because of my flaws."

Avoidant Attachment
(Adult attachments – dismissive)

Positive Thoughts of Self

Negative Thoughts of Others

- High Self Esteem
- Independent
- Doesn't show emotions readily
- Uncomfortable with intimacy
- Avoids closeness
- Blaming
- Parent to child: unavailable or rejecting
- As an adult: distant, critical, rigid, intolerant, frustrated
- "Others are either unwilling or incapable of loving me." and "Others are not trustworthy; they are unreliable when it comes to meeting my needs."

Disorganized Attachment
(Adult attachments – fearful)

Negative Thoughts of Self

Negative Thoughts of Others

- Low Self Esteem
- Dependent
- See self as helpless
- Fearful of intimacy
- Expects to be hurt
- Ruminating
- Parent to child: parent is either scared or scary to the child – child experiences dysregulated inconsistent caregiver
- As an adult: chaotic, explosive, abusive, untrusting
- "Others are unable to meet my needs." and "Others are not trustworthy or reliable." and "Others are abusive, and I deserve it."

Attachment Style	Patient's attitude to care seeking and the 'sick role'	Impact on doctor-patient relationship	Pitfalls for the doctor	Predicted patient outcomes
Secure style	Trusting, collaborative, positive towards seeking help, comfortable with 'sick role' as appropriate	Patient is collaborative, confident, values help and advice Doctor feels sympathetic to patient's needs, valued, confident that advice will be followed May challenge some doctors by being assertive	Problems are uncommon. However, because these patients tolerate uncertainty and ambiguity the doctor may not attend enough to providing clear and consistent advice and recommendations, or miss problems in service delivery that need to be addressed	These patients work most comfortable with doctor and the clinical team(s), maximizing the chance of good outcomes
Insecure styles				
Preoccupied style	Low trust in own worth and decision-making, preoccupied with relationships and pleasing others, show high emotional reactivity, seek reassurance from others, presents as 'anxious', 'needy'	Doctor feels a need to reassure patient, but this can lead to exasperation if repeatedly asked for reassurance on same matters	Patient expresses anxiety, may ask doctor to make decisions – 'I can't... you know best, you decide,' which leads to overriding patient in interests of time.	Patient is needy but co-operates after reassurance. They may show resistance ('yes, but...'), increased anxiety ('you don't understand...'), leading to helplessness, loss of confidence, patient may give up, leave
Dismissing or Distrustful Style	Wary, distant, does not trust clinician, misses appointments	Patient appears to display a lack of involvement, lack of engagement, unreliability, or can be avoidant because of a tendency to show themselves in a good light, minimize problems and need for treatment	Doctor may become frustrated override patient when thy repeatedly state: 'I can't...', 'I forgot...', or 'I don't need to do anything... it's not that bad really'	Increased withdrawal from care, bottling of problems and emotional issues, possibility of crises when strategy of self-reliance breaks down
Derrogating Angry-Dismissing Style	Denigrates help offered, nothing good enough. If extreme, distant, disdainful, nonengaging due to hostility about being dependent.	Doctor feels 'put down', unappreciated for clinical input, angry. If extreme, doctor can lose patience and confidence, find ways to avoid patient, may see patient as 'hateful'.	Doctor can get angry and confront, challenge patient who says 'What's the use... you can't help me anyway...' Doctor and team may decide to walk away.	Anger/resistance, low frustration tolerance, tends to storm out, make complaints, threats, including self-harm. May sabotage treatment, drive clinicians away by hostile attitude.
Fearful Style	Low trust in self and others, afraid of intimacy, expect rejection, but high emotional reactivity. Present as wary, testing out doctor and relationship, ambivalent style.	Doctor feels confused by alternation of approach and avoidance, patient's unpredictability	Doctor may get upset with patient's inconsistency and pulling away when help is given.	Increased anxiety, depression, threats of self-harm, may withdraw, miss appointments or leave.
Disorganized Style	Typified by low trust and tendency to become disorganized when in stressful situations.	Patient may be frightened by doctor and treatment, may also re-experience other earlier traumas. Doctor may become fearful for patient, panic about ability to contain patient's overwhelming emotions.	Doctor may feel a failure, keep trying harder, doing more, go beyond professional boundaries. The seemingly overwhelming nature of patient's problems can split or fragment clinical teams.	Patient and doctor may reinforce feelings of being overwhelmed, loss of personal control, leading to poor outcomes, chaotic care provision and medical and mental health crises.

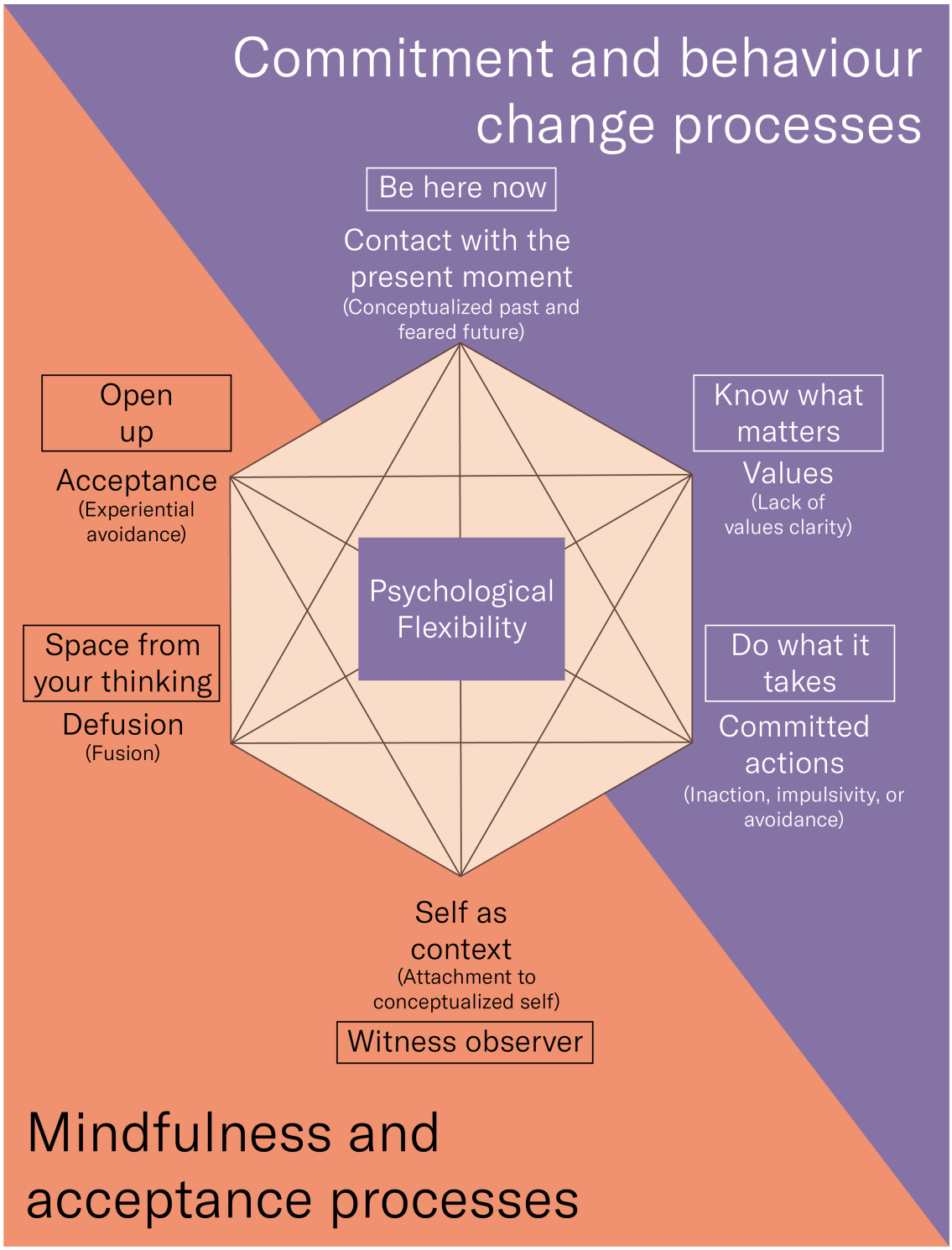
ADAPTED FROM LARGE & NIELSSEN, 2016.

MODULE 3

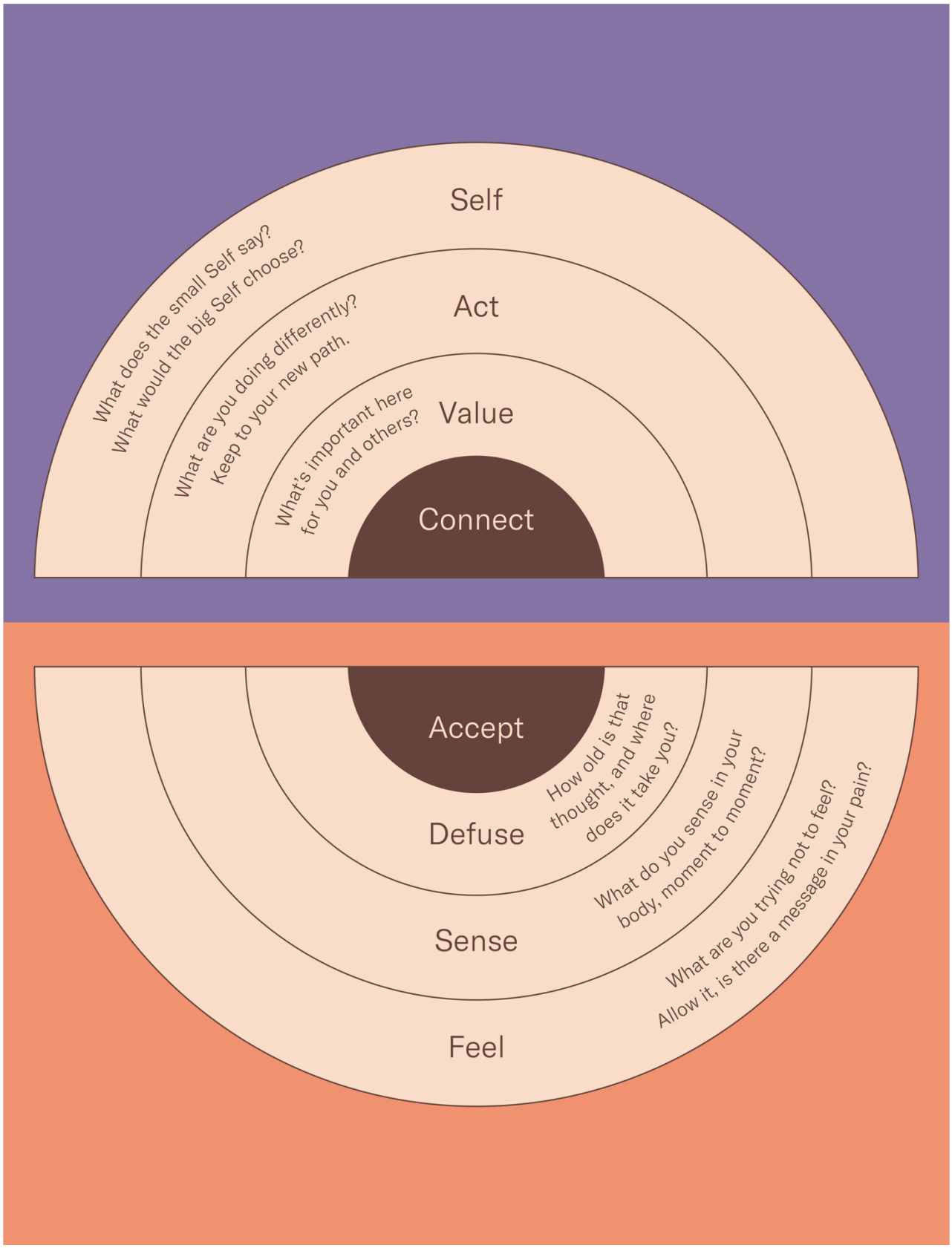
CORE THERAPIST SKILLS

Psychological Flexibility

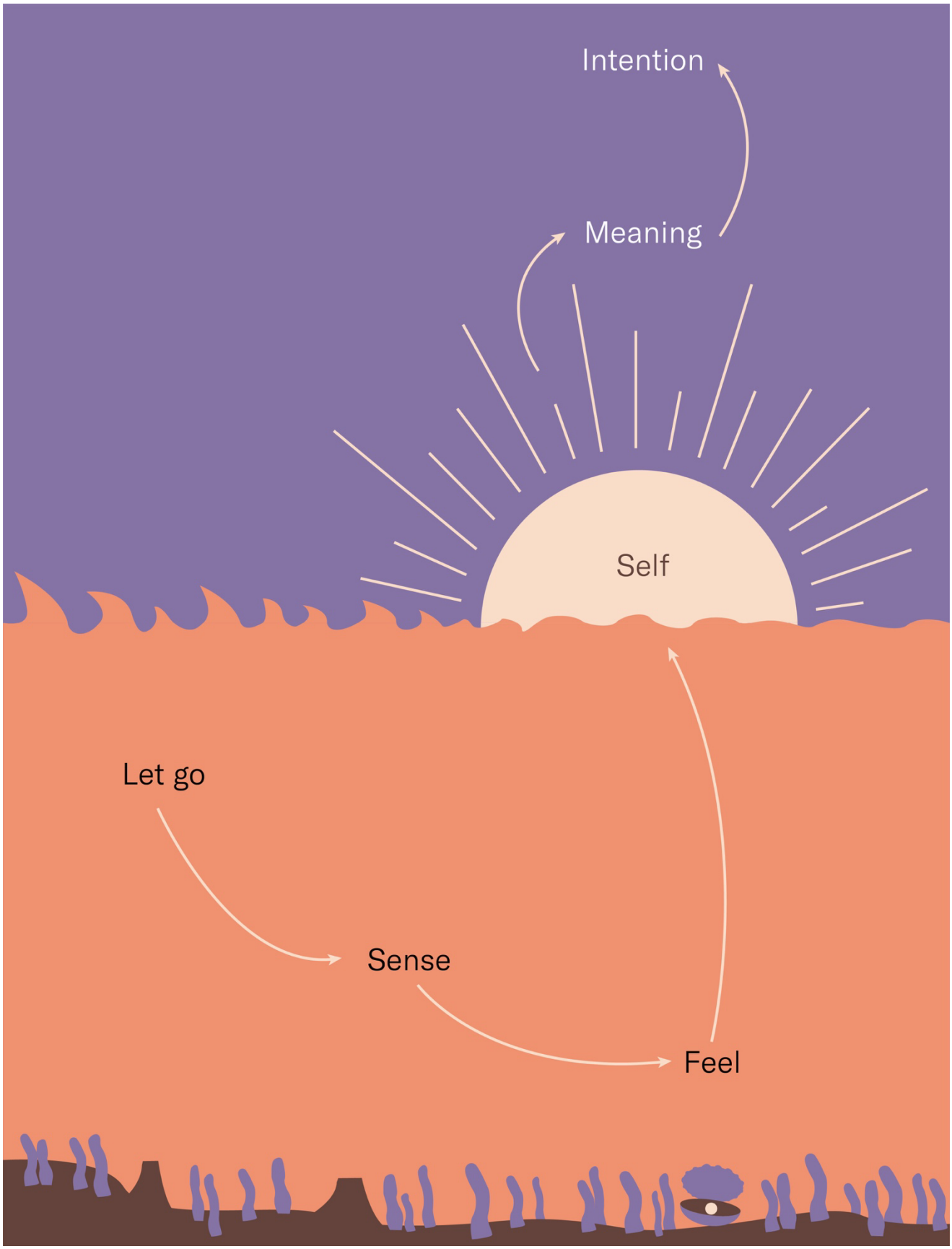
ACT HEXAFLEX MODEL



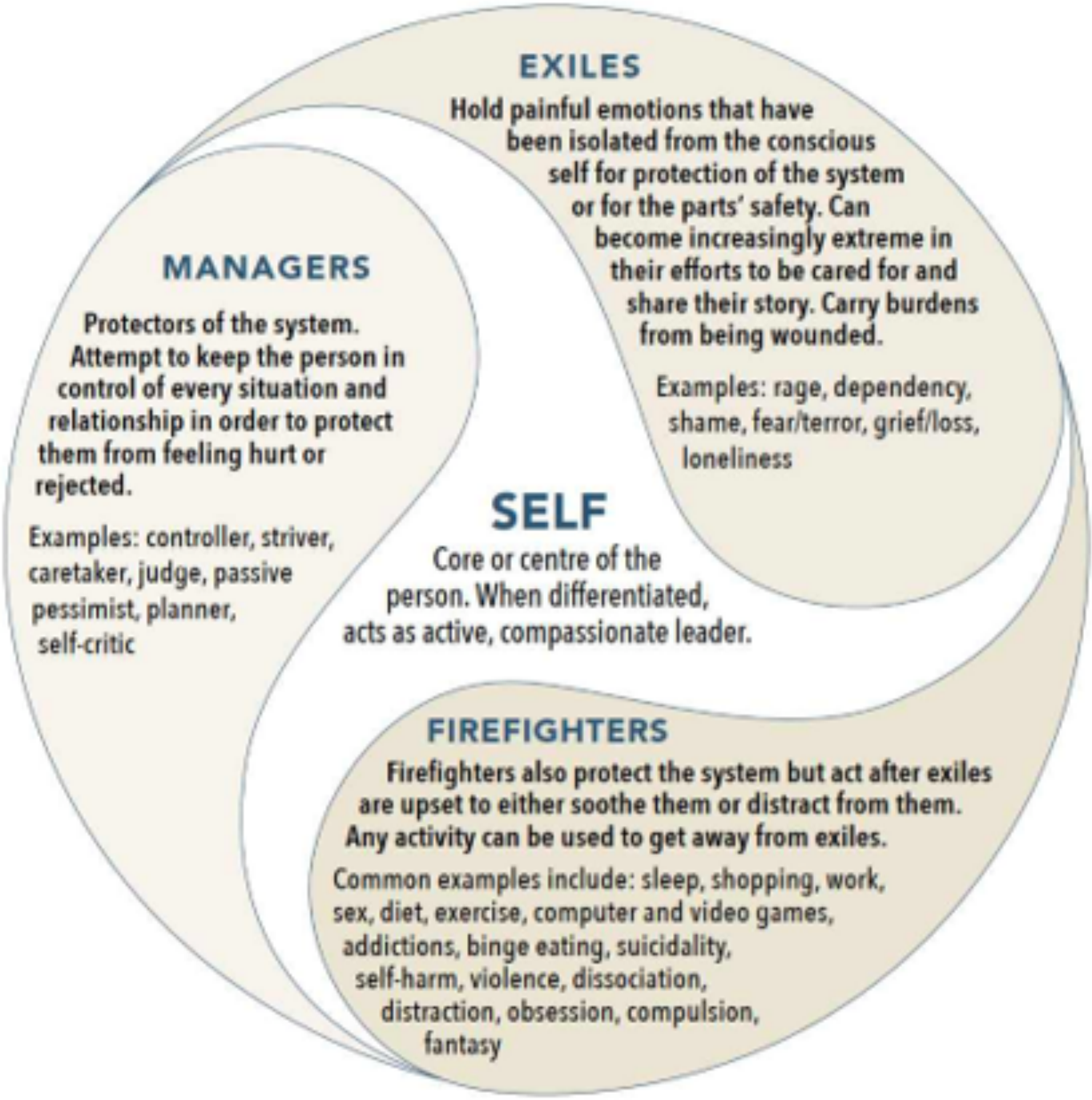
ACE MODEL


Self
What does the small Self say?
What would the big Self choose?
Act
What are you doing differently?
Keep to your new path.
Value
What's important here
for you and others?
Connect
Accept
How old is that
thought, and where
does it take you?
Defuse
What do you sense in your
body, moment to moment?
Sense
What are you trying not to feel?
Allow it, is there a message in your pain?
Feel

ACE BODY SCAN



Internal Family Systems



MODULE 4

CORE FACILITATION SKILLS

Regulation Activity

In your breakout room, please answer these questions:

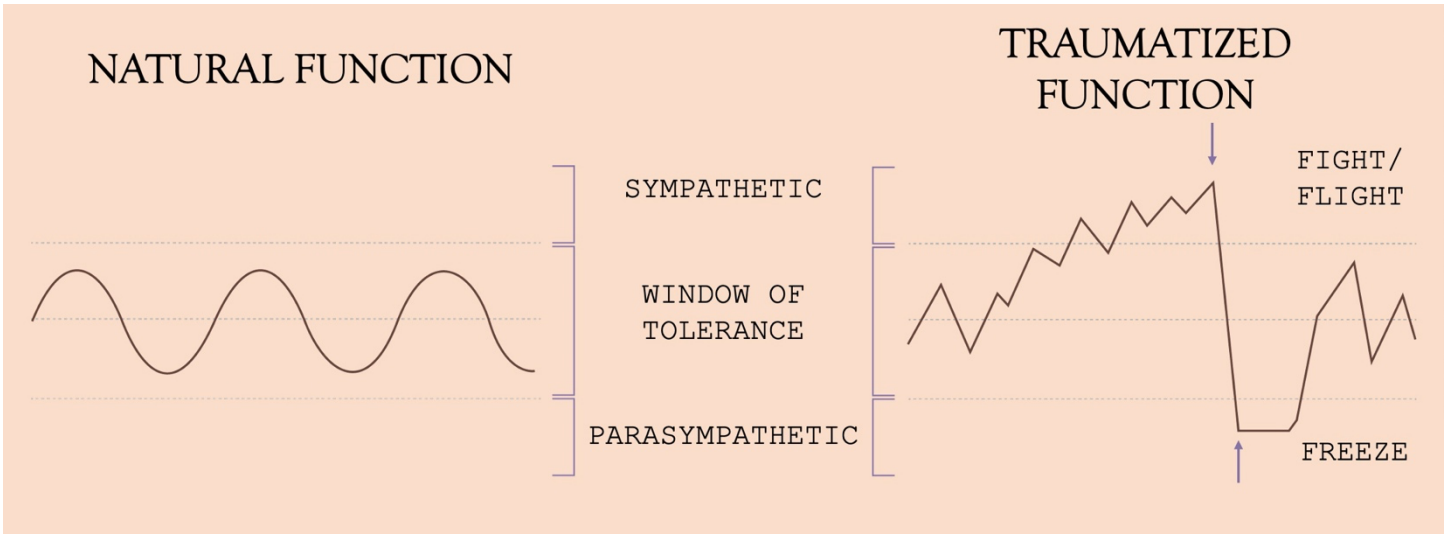
- What is *self-regulation* and why is this important as a therapist?
- List ways you self-regulate
- What is *co-regulation* and how do you use it?
- How do they apply to PAT and why are they important?
- If time left over, teach each other some techniques you use - (15 min)
- Small breakout group activity: key diagrams from the slide deck

Stress and Survival Physiology

Recall that the components of the autonomic nervous system.

- Peripheral Nervous System:
    - Somatic system (voluntary control)
    - Autonomic system (ANS) (unconscious control)
        - Parasympathetic nervous system (PNS): Rest, digest, freeze, collapse
        - Sympathetic nervous system (SNS): Tend, befriend, fight, flight

Also consider an individual's window of tolerance when in natural function compared to traumatized function.



Trauma and Healing Vortex

Trauma Vortex	Healing Vortex
• Represents the activation of the sympathetic nervous system • Can be a downward spiral into the trauma - often associated with being “stuck” or “trapped” • Inability to control sensations, images, feelings, thoughts, and behaviors	• Essential in allowing the body to move through the sympathetic activation in the system (TV) • Places in the body what feel neutral, good or pleasurable • What is working for a client • The witness/observer is online - important for whole treatment • Places of coherence in their system • Resourcing & Resources

Demonstration

While watching the demonstration, please track the following:

Resourcing	
Titration	
Pendulation	
Healing Vortex / Trauma Vortex	
Language Used	
Self-Regulation / Co-Regulation	

MODULE 5

PREPARATION SESSIONS

Intention Setting Aims

- Clarify and reflect on motivations for seeking psychedelic assisted therapy
- Think about how the client would like to be feeling, behaving, and thinking at the end of the PAT process
- Overarching goal – realistic – session intentions ultimately relate to this goal
- Serves as a clearly defined intention for the medicine session, that relates to the client's therapeutic process and their overarching therapeutic goal
- Encourage turning toward experiences versus avoidance
- Anchor for the psychedelic experience
- A lens to process the experience during integration

Intention Setting Principles

- Simple, clear, and concise
- Therapist supports discovering and distilling main themes and patterns
- Encourage the client to imagine more possibilities for themselves and their lives
- Intentions can change and are an ongoing exploration
- Reflect values, areas of suffering, and desired changes
- Use the client’s language
- Can look different in reality to what was imagined
- Serve as an integration tool
- Intentions are distinct from expectations
- Can be both an anchor but also held loosely to be open to the experience that arises

Intention Setting Activity

Reflect on something you are working on in your own life. Describe one goal. If you were going to do a psychedelic Medicine Session, what would be your intention as it relates to this goal, using the *Show me, Teach me, Help me* framework?

MODULE 6

MEDICINE SESSIONS

CO-THERAPY DYAD ACTIVITY

You are about to engage in a medicine session with a co-therapist. Discuss and answer the following questions.

1. What do you need to do to ensure this process is as smooth as possible?

2. What agreements do we want to have before working together with our client?

3. What are your markers of stress?

4. What helps you to come back to yourself and to therapeutic presence?

5. What other questions would you want to discuss together? Brainstorm a list so you can enter them into chat box.

Here are some additional questions that support co-therapy team building that we recommend you consider taking time to answer together, when establishing a working relationship with a co-therapist:

- Do you have any insecurities related to this work, or working together?
- What, if any, aspects of your social identity/intersectionality might establish implicit power dynamics in our co-therapy relationship, or in our relationship with our client, that we should be aware of?
- How do you respond to and manage conflict when it arises (and how can we do this skilfully, both inside and outside of client sessions?)
- Are there any pieces of your life that are currently tender that the other should know about?
- What, if any, past experiences or wounds could get activated through vicarious trauma that would be helpful for the other therapist to be aware of?
- What are the behaviours you exhibit when you start to become triggered/activated? (e.g. checking out, talking more, becoming dominant or withdrawing?)
- What are some ways we can help resource each other in those moments?
- What are your greatest resources?
- What interests or inspires you about this work?

CO-THERAPY CASE STUDY

Emily and Jake are two mental health professionals who were hired to provide co-therapy for a clinical trial of a psychedelic-assisted therapy protocol for a treatment-resistant condition. Emily had been involved with this study for several years and had some additional responsibilities in this particular case. Both had full-time jobs but did their best to carve out time to fulfill their roles in the study. They met for the first time just before the participant was going through the screening process. They enjoyed meeting each other and noted that the differences in their training backgrounds had the potential to offer the participant a rich diversity of perspectives to draw from.

The study protocol was very demanding for both Emily and Jake. Emily was able to prioritize the study and work extra hours during the week and so took on more of the work. Jake has small children at home and had more difficulty managing the workload. The assessment revealed that the participant was really struggling with her symptoms and had limited support in her life. In fact, there was some discussion the study team about whether she was stable enough to be admissible. In the end she was enrolled but ultimately required a high level of support from the therapists.

The Preparation Sessions went smoothly. The co-therapists and the participant were all excited about the opportunity to participate in the study, and all were feeling confident about the healing potential of the intervention. Emily took the lead in facilitating the sessions but left plenty of space for Jake to contribute. The therapeutic alliance appeared to be strong. Under the circumstances, Emily and Jake did not think it was necessary to debrief in any detail from these initial sessions, despite some seemingly minor disagreements about things like the optimal length of sessions and how closely to stick to the protocol. Meetings with their supervisor were uneventful.

The dynamic changed significantly over the course of the Medicine and Integration Sessions. The participant had big, mind-manifesting experiences with the medicine and transference & countertransference emerged as the central material for processing. These sessions were also destabilizing and exhausting and the participant needed time and support to recover each time. Emily tended to create more space in her schedule to be available for the participant, while Jake felt it was safer to maintain the boundaries of the protocol. For example, in an Integration Session towards the end of the study, the participant expressed some concern about separating from the therapists at study termination. Emily responded that she was open to staying in contact with the participant, whereas Jake, who felt this was an opportunity to work through the difficult feelings associated with the separation, did not make this commitment.

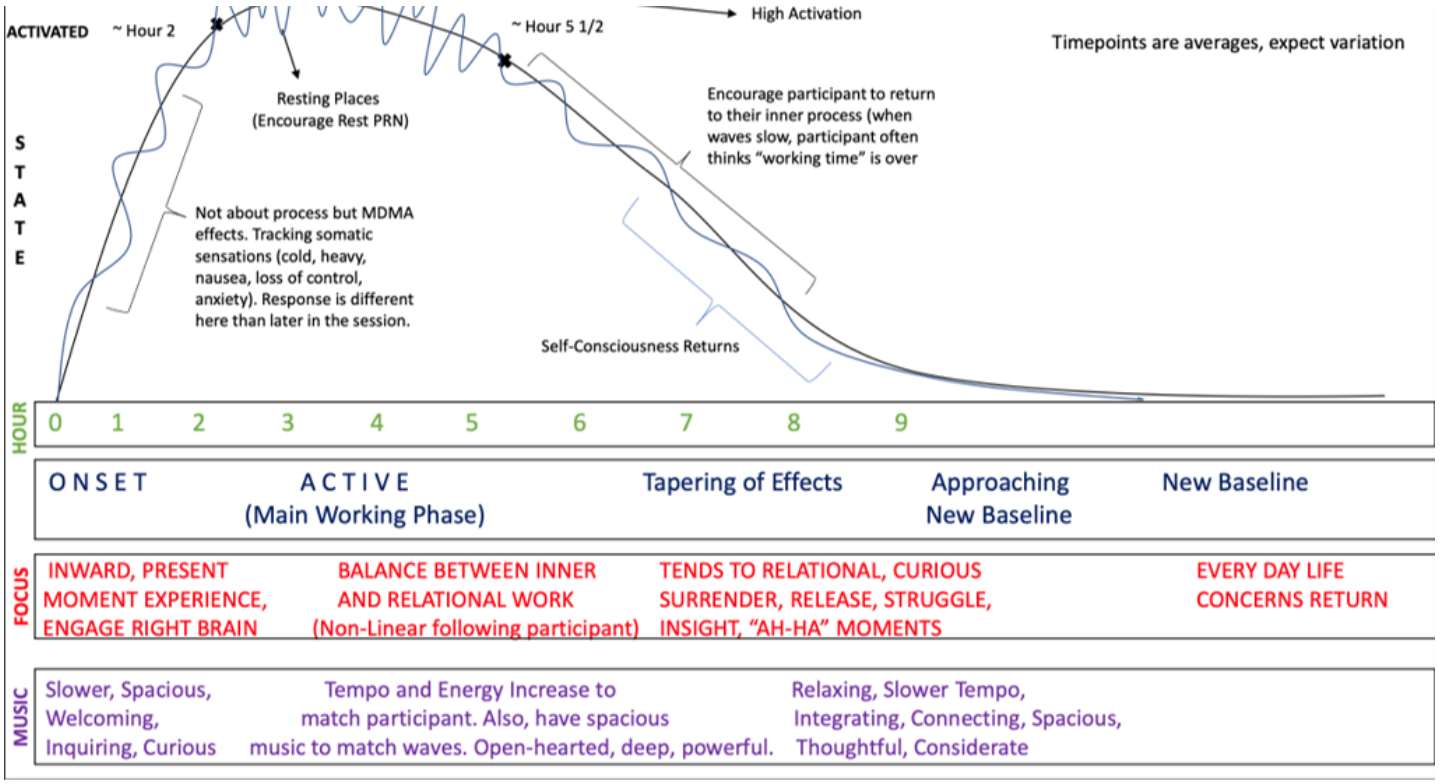
The differences between Emily and Jake's approach created some confusion for the participant and lead to several ruptures with Jake and closer alignment with Emily. Emily began to resent Jake for the imbalance in the workload and Jake was frustrated by the fluid boundaries and triangulation. Both were beginning to feel overwhelmed by the intensity of the participant's distress and close to burnout. They managed to book some time for debriefing but not enough to get fully aligned on their approach with the participant. Supervision meetings began to feel like couples counselling, as both therapists were looking to the supervisor to validate their views and settle the disagreement. The study team contemplated terminating the study early because of the participant's distress, her limited support outside the study and the friction between the co-therapists.

In the end, the study was completed. The participant did some healing and transitioned to a new therapist in the community. She maintained a supportive connection with Emily but is not in touch with Jake. Jake and Emily had a final debrief after termination and have not spoken since.

DISCUSSION QUESTIONS

1. What problems arose that may have impacted the participant?
2. What could have been done differently?
3. What could have helped to mitigate or prevent this situation?

THE ARC OF AN MDMA MEDICINE SESSION



MEDICINE SESSION ARC GROUP EXERCISE

We will be looking at the following overarching questions:

- What elements are important to include during each phase of the medicine session arc?
- What is your focus as a therapist in each phase?

Phase	Elements to include during each phase	What is your focus as a therapist (guiding principles, therapist competencies)
Arrival		
Initiation and onset		
Peak effects		
Taper		
Integration and closing		

SUMMARY OF GUIDING PRINCIPLES, THERAPIST COMPETENCIES, AND THERAPEUTIC STANCE

You may find it useful to reference the summaries below when completing the table above.

Guiding Principles

- Justice, Equity, Dignity, and Inclusion
- Cultural Safety and *Humility*
- Embodiment
- Mindfulness
- Harm Reduction
- Trauma- and Violence-Informed Care
- Connection: Relationship-Centered Care and Community

Therapeutic Stance

- Inner-directed therapy
- Unconditional positive regard
- Love
- Empathetic abiding presence and listening
- Being grounded, self-regulated, and aligned
- Orientation towards phenomenology
- Relationship-centered care
- Appreciation for human suffering
- Therapist self-awareness and ethical integrity
- Top-down versus bottom-up processing

Therapist Competencies

- Interoceptive awareness
- Awareness of embodied oppression
- Embodied communication
- Embodied inquiry
- Dual awareness: tracking and working in two time zones
- Therapeutic supportive touch
- Movement in therapy
- Working with the psychological flexibility model
- Working with parts and internal family systems
- Trust enhancement
- Spiritual intelligence
- Experience with altered states of consciousness
- Perspectives on healing

MODULE 7

INTEGRATION SESSIONS

Cases

Please review the following integration needs, therapist tasks, cases, exercises, and role-plays. You will have 20 minutes to work with each case. Please prioritize the role-plays and engage in these for up to 10 minutes each. Then, choose 1-2 other items to discuss within the time remaining. Select one person to summarize the learning or what stood out from working with each case. After the small group breakouts, we will engage in a large group debrief.

REGULATION

We can think of regulation as primarily associated with managing emotion and tracking the nervous system. Down-regulation refers to reducing the intensity of activated states, while up-regulation may be necessary when more energy (nervous system arousal) is required. If a client is very dysregulated and out of their window of tolerance, meaningful processing on a cognitive level can be compromised or challenging.

Several strategies can be used to manage dysregulation, and these include but are not limited to orienting mindful attention to the environment, to associated or pleasant/neutral bodily sensations, working with the breath, rhythmic or other movement, a willingness to have, or acceptance of what is present, re-directing one's attention, re-appraisal or changing the situation.

NORMALIZING

Normalizing speaks to the client's need to make sense of their experience. This can be an essential part of integration, particularly when they have no, or little frame of reference for what they experience during and following the session(s). Such experiences may include intense emotional states, conceptualizing content from the experience, extreme reactivity, insomnia, vivid dreams, changes in relationships, persistent changes in perception, and so on. For many, psychedelics involve stepping into a new world and it is essential that there be some context setting for, and translation of, the experience as part of its integration. This is where psychoeducation for the client, practitioner experience, and knowledge of the substances and their range of effects can be essential.

THERAPIST TASKS

Regulation

- To track the client's nervous system and ensure they can move in and out of different nervous system states (trauma and healing vortex)
- To regulate when higher levels of dysregulation are present and to intervene with down and up regulating strategies
- To practice and elaborate resources from experiential sessions
- To attune to the client, mirroring, tone, etc.
- To know when to refer or know when someone might need more acute or emergency care

Normalizing

- To provide the frame of reference for clients by understanding the normal range of impacts and effects of psychedelics
- To provide psychoeducation where applicable
- To recognize when someone is experiencing effects of the substance outside of what is expected and needs acute support.

CASE

Assessment & Integration

Rebecca is a 42-year-old, queer, and assigned female at birth (AFAB) who works in the trades and has been questioning their gender. They use she/her pronouns. While they don't have an official diagnosis, they present with PTSD or even C-PTSD symptoms. They have low moods with both depression and anxiety symptoms and currently work outside the home and then mostly isolate in their off time. They are currently single and have cut off connection with their family. They have had problems with addictions in the past however now they drink socially on occasion and use cannabis. They are feeling isolated socially because many of their friends still use substances and they find it hard to be around them.

They have come to you for integration support because they went to Peru for a two-week Ayahuasca retreat where they said they did not have much of an experience. They said their biggest realization was how unsafe they felt in their body and the world. After this insight, they said, "the medicine finally opened," and they had some experience although overall they said it was mild. For a few weeks after, they talked about having high emotions and a volatile mood.

A few months later, they found an underground therapist with whom they did a one-to-one MDMA-assisted session.

They establish their intentions with difficulty: "Help me feel safe in my body."

Medicine Session

During the Medicine Session, Rebecca spent much of the time talking about other people and recognized this was an effort to avoid their own experience. The therapist encouraged them to go inward. They began to feel shame about their childhood, who they are, and that, as a child, they weren't allowed to have their own needs and were profoundly neglected by their father and mother. They recognized that they didn't trust others and found it difficult to let the therapist in because they didn't feel safe. When the therapist encouraged them to turn their attention to the body, they started to cry and became overwhelmed by shame, and self-loathing. They realized how they had internalized their father as their inner critic.

Integration

Rebecca is agitated during the session and feels ashamed that they were so vulnerable while taking the MDMA. They had some profound insights during the MDMA session but as with the Ayahuasca experienced the effects of the medicine as mild and doubt the benefit of the experience. They feel disappointed by their psychedelic experiences and compare themselves to others who have been able to gain important insights. They dismiss this comparison and their doubts, brushing them off as not important and then have an intense wave of emotion. They cry and tell you they have been extremely angry toward their father and have been lashing out at others since the MDMA.

Group Work

How would you address the gap between the client's expectations of the medicine and the actual outcome? In addition, consider how the experience is discounted, denigrated, or dismissed (rubber band effect) commonly due to shame that it is discordant with their beliefs and/or due to the activation of protector parts.

- Discuss this in your small group and come up with a process for managing these.
- Consider how you would inquire into Rebecca's view in order to elicit rather than explain.
- How might you suggest or collaborate with Rebecca to come up with alternative perspectives to continue normalizing and broadening their view?
- Role-play this discussion as therapist collaborating with one of your group members. Another person is the client, and another observes, providing feedback.

How would you explain to and/or explore with Rebecca the seemingly mild effects of the medicine and Rebecca's interpretation of that as compared with their actual experience (emotions, realizations, behaviours etc.)? **Role-play this discussion as therapist and client. Be sure to attend to normalizing and regulation.**

Consider the following to assist your inquiry:

- If the dysregulation isn't present now, identify a recent time when it occurred (bring it to mind)
- If it is present, regulate and resource – Remember an identified resource and bring attention here or recall a time when you felt safe/supported and bring this to mind.
- For tracking dysregulation or a state of resourcing, how do you know? What do you notice? Body (describe), emotions, thoughts....
- If the experience is manageable (body, thoughts, emotions), can you turn toward these? Name the emotions. Describe the sensations with curiosity and kindness – stay with these.
- What might help you stay with this?

METABOLIZING

How one works with difficult experiences can be viewed as a process of metabolizing, as the digestion of emotions, their physical correlates, and other sensations. We might argue the more effective this process is, the greater the client's wellbeing. Metabolizing experience in integration refers to how effectively one can identify, attend to, be curious, turn toward, stay with (often through somatic experience), and allow whatever arises to come and go. When unable to do that, this can be recognized and the therapist can then determine what needs to change, if anything, and how. Alternatively, one may be able to be with things as they are. This process is active and, at the same time, requires discernment around what is a most helpful response. Psychedelic experiences can be conceived of as metabolized when the client has established a different relationship with, or perspective about, what has arisen. If needed, they have processed challenges and/or have moved into meaning-making or recognition of how their new understanding may be applied to daily life.

MEANING MAKING

Because psychedelics are disruptive and result in a period of neuroplasticity, they can allow for significant shifts in one's view of self and others, leading to enhanced psychological flexibility and healing. Deriving meaning from the psychedelic experience can be a significant part of what is to be learned from the integration process. It assists in optimizing the utility of the experience and is related to the client's intentions, values, and future wellbeing.

KEEPING IT ALIVE

Following the psychedelic experience, clients often report that they want to continue to stay connected and engaged with what has often been a transformative experience. Keeping it alive refers to an active engagement with the content and ongoing exploration and meaning making, as needed, of content from the session. This can allow the experience to continue to expand, transform their lives and assist with loosening from a rigid identification with the self. Continuing to benefit from the experience often requires the development of concrete behaviours or actions. Reflective activities could include journaling, meditation, movement, being in nature, creative endeavour, social activities.

THERAPIST TASKS

Metabolizing

- To assist the client to somatically, emotionally, and cognitively process the experience as fully as possible
- To follow the client's lead during this process, intervening only when needed

Meaning Making

- To recognize and reinforce meaning making that is in the service of the client's intentions and wellbeing as needed
- To assist the client to make links between meaning arising from the Medicine/Integration Sessions that can be applied to the client's life

Keeping it Alive

- To assist in creating time and ways to engage with the experience
- To promote different activities and/or create rituals to stay engaged with their process

CASE

Assessment/Preparation

Ellen is a 45-year-old woman with depression in a long-term relationship of 10 years that she has been considering leaving. She has had multiple recurrences of depression since the age of 25 and has tried several anti-depressants. These have put her into remission for periods but then stop being effective. She was in psychoanalysis from the age of 35-40 years old and has been in couples therapy for the last two years.

She has no significant medical history, is currently on no medications, drinks socially but does not use other substances. She works as an artist, has one adult child from a previous relationship, and a couple of good friends.

She was recently referred for Ketamine-assisted therapy as the next step in her treatment to see if her mood will benefit. Her current score on the PHQ-9 is 16 (moderately severe).

Ellen reports that she feels overly dependent on her partner to meet her needs and finds it difficult to motivate herself to make change. She tells you she is not happy in the relationship but is scared to leave. She feels stuck and hopeless at times but is not and never has been suicidal. She is somewhat hopeful that a course of ketamine-assisted therapy will help her to make some changes and improve her mood. She tells you that she wants to face her fears and wants to feel more secure in herself.

She establishes her intentions to be: **Show me: fear; Teach me: safety; Help me: to be secure**

Medicine Session

Ellen's ketamine session takes place with an underground therapist. During the initial onset of the medicine, Ellen feels scared and wants her partner to be present. In fact, during the trip, she sees him for a moment, but then he fades away. As her medicine session progresses, she finds herself in a dark room in which her awareness enters the body of a huge mechanical black cat. She experiences being embodied in this cat and walks around the room freely in this 3-meter-high mechanical creature making hissing noises and making lithe movements. Later in the session, she becomes a huge diffuse sparkling white monolith, shooting into the sky and traveling through space. In both these scenarios, she is alone. She also has a thought toward the end of the session that there is no such thing as safety or security.

Integration Session

During this first integration Session, Ellen is excited and tells you that she is full of energy, feels tremulous, and feels strong. She also felt very powerful during the session, and this was a very new experience for her. She expected to be frightened during the ketamine session and is surprised that she was not.

Group Work

A) Given Ellen's intentions and goals, what aspects of her experience would you want to inquire about? Choose three.

1	
2	
3	

B) How will you help Ellen make meaning of her experience? What kinds of questions might you ask her?

C) What might be a reflection exercise or home practice task you might ask her to consider for the next Integration Session to keep the experience alive?

COMMITTED ACTIONS

Committed actions are those that enable the client to behave in ways that are consistent with their values and intentions. Integration can be a time to explore how we may bring behavioural change into alignment with them. This is a stage when concrete tasks may be developed collaboratively between the client and practitioner to optimize the client's desired outcomes. Developing such a behavioural plan is a way to continue to take advantage of what has been gleaned from the psychedelic session and then apply these learnings to everyday life. Some of the ways of working with committed actions involve identifying important values to the client that have become salient from the sessions and supporting them to establish relevant goals with which work. Identifying behaviours that are inconsistent with values or impulses to avoid discomfort rather than engaging with what is important to the client can also be part of this work. Lastly, eliciting what is motivating for the client and describing behaviours or tasks in positive terms will enhance the likelihood of their occurrence.

SPIRITUAL NEEDS

One of the reasons clients may take psychedelics is a need for meaning or connection. Sometimes this is expressed as a spiritual need. The Psychedelic experience is often unusual, and the client may view it as a spiritual event or crisis. The word spiritual has different meanings for different people. It may be defined within a religious context, concerned with what one considers sacred. It may be tied to seeking a purpose or meaning in life that is greater than the mundane aspects of being human. It may relate to themes of life and death, and one's relationship to death. For others, it may be linked to the idea of awakening or liberation, freedom from suffering or being attached to worldly things.

Commonly, clients can enter a peak or mystical state during the Medicine Session that they then feel the need to integrate into everyday life. For some, this is extremely challenging if such an experience is discordant with their view of self and previous or current religious beliefs about spirituality. Integration then is aimed at how the client comes to terms with such a challenge and reconciles their previous beliefs with what has been perceived as profound, unusual, and mysterious.

*Note - The therapist can conceive of spiritual beliefs as consistent with working with any other belief or view. Should the client wish to put these new beliefs into practice, part of the practitioner's work will be to support this process in cognitive, emotional, and practical ways.

CONNECTION TO OTHERS AND THE NATURAL WORLD

Psychedelics or other altered states may reveal an increased need for relationships, connection to the environment, and community. There are different elements to consider regarding connection. These may include sharing the experience with others (determining who and how much), ending or reflecting on existing relationships, seeking new relationships, seeking a community with shared psychedelic experience, and/or a desire to have an increased relationship with nature.

THERAPIST TASKS

Committed Actions

- To articulate values and support the client behaviours that are aligned with those values and intentions
- To identify behaviours that are no longer serving the client and explore the purpose of those behaviors and alternative ways to meet that need

Spiritual Needs

- To explore with the client mystical or spiritual experiences, their meaning and integrate these into their current beliefs and daily practices, if the client desires
- To attend to and explore discordance between old and new belief systems

Connections to Others/ Natural world

- To promote finding safe places and people to share experiences with others
- To help navigate client changes in relationships – losses and gains

CASE

Assessment/Preparation

Will is a 58-year-old married male who works in finance. He has no children. He has been struggling with low mood, feelings of hopelessness and a lack of meaning. He tells you that he thinks he may be going through a "mid-life crisis." He is nearing the end of his career, is not engaged in volunteer work, and has few hobbies. He has no religious affiliations. He has no diagnosed history of depression, although he suffers from generalized and social anxiety; and while he has friends, he tends to avoid most social situations. He is a long-distance runner and expresses that running decreases his anxiety.

His medical history consists of an MVA in which he experienced a concussion 10 years ago. He also was a heavy drinker when he was in his 30s but now only drinks socially. He does not use other substances although he used cannabis recreationally, on occasion as a teenager. His GAD-7 score = 15 (moderate to severe).

He tells you that he is hoping the psilocybin assisted therapy will get him out of his "rut" and help him with his anxiety. He realizes he is isolated. Will is anxious about taking the medicine but is motivated because he feels lost.

His intentions are: Show me: Hope; Teach me: Openness; Help me: Find a direction

Medicine Session

Will takes 4 grams of cubensis mushrooms. During his session he finds himself in a forest. He explores the trees and eventually is absorbed into one, experiencing union with it. His awareness moves into the earth surrounding the tree, its roots, the tree trunk, branches, and leaves. He experiences himself growing out of the ground as the tree and as if this is happening for centuries. His wife and a female friend become one with him and the tree. He experiences both fear and profound joy. The fear fades and what arises for him is a sense of overwhelming awe, and love of all things – plant, animal, human and that he is a part of everything, and everything is a part of him.

Integration Session

During the Integration Session, Will feels hopeful, disoriented, and confused. He has always been somewhat of a loner and doesn't know what to make of his experience. He tells you he doesn't believe in God but doesn't know how to explain his experience or how it might help him. He hesitantly asks you if you think this was a spiritual thing. He asks you what you think it all means.

Group Work

A) Therapist task: Reflect and record for 5 minutes your own beliefs and views of spirituality and how you approach the topic with clients. Consider how you may have some biases towards client beliefs that are different from yours. How might you recognize these? How will you avoid imposing your own beliefs or opinions onto the client? (e.g. slow down, notice extreme reactions that arise) Discuss this with your small group.

B) In your group of 3, choose one person to be the client, one the therapist, and another the observer. The observer will pay attention to how the therapist embodies mindful caring attention and the kinds of questions they ask.

Use SIBAM to unpack Will's experience as well as the other Inquiry questions below as needed. If Will expresses this material on his own, there is no need to ask more about it unless there is utility on amplifying or reinforcing the experience to help him meet his intentions. See the following examples of potential SIBAM questions. The following questions are meant to be a guide:

S – What did you notice in the body, if anything during this experience and how did you meet or relate to those sensations?

I – Tell me more about the images of the tree and what happened?

B – What did you do during this period while you were part of the tree?

A – What emotions (affect) came up? How did you experience those? And then?

M – What might this experience say about you or mean for you?

Inquiry:

- When did you notice this experience arising?
- How might you think about this experience?
- What happened that you interpreted this as a spiritual experience? How do you define spiritual? (If needed) - How might you reconcile your views of spirituality with this experience?
- How did you know? And then?
- What might be the advantages or disadvantages of seeing this experience this way?
- What from this experience might you be able to take into your regular life? How might you do that? What may get in the way?

C) Given Will's intentions and concerns, help him identify 2-3 values and how he has been or has not been behaving in ways that are consistent with these. Help him to come up with associated relevant and manageable tasks that he can commit to doing as home practice for the next week.

D) Discuss with Will how he might experiment with connection to others and the natural world in concrete ways. Make sure to elicit this from him.

MODULE 8

THERAPIST SELF-CARE AND PERSONAL DEVELOPMENT

Group Burnout Activity

In what ways have you been impacted by burnout (your own, or others)?

When we talk about therapist “personal development and self-care" what comes up?

What is helpful about this for you?

What might be missing or frustrating?

What other ways of thinking about “self” might inform a new or different way forward? E.g. anything from Elder Duncan’s share; other frameworks?

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