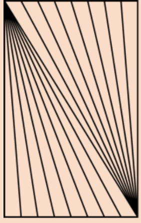

NUMINUS

Embodied Inquiry for Psychedelic-Assisted Therapy

WORKBOOK

ALL SESSIONS

Inquiry Cheat Sheet

Embodied Inquiry is an approach to working with psychotherapy clients in psychedelic-assisted therapy (PAT). The embodied inquiry approach is grounded in mindfulness-based and somatic modalities, third-wave behavioural approaches such as Acceptance and Commitment Therapy and the extensive experience of the clinicians involved. As PAT is evolving, the ways in which we support clients is also evolving. This is in part a function of the clients that often seek out PAT: as this population frequently has a history of trauma or has been shown to be refractory to other forms of treatment. We believe that process-based therapies that employ bottom-up and experience-based processing are better suited to those with a trauma history and/or engaging in PAT than other psychotherapeutic models that emphasize top-down verbal/cognitive forms of meaning making.

Remember: The process of embodied inquiry begins as soon as client and therapist enter a relationship with each other. This process is used to establish rapport, the therapeutic relationship, and to begin clarifying the client intentions.

ASSUMPTIONS OF EMBODIED INQUIRY

- Psychological flexibility is an essential quality of mental health and well-being
- Experiential avoidance is a limited way of coping that can maintain suffering. Reducing experiential avoidance leads to increased self-determination and positive outcomes
- Identifying, enhancing, and utilising one's resources is a foundation and support for working through dysregulated states
- Turning toward and bringing kind attention to challenging and unwanted experiences can increase agency and one's capacity for moving through difficulty
- Experiential, somatic, and phenomenological ways of working support processing difficult or traumatic experiences
- Identification with thoughts and emotions can increase reactivity and rigidity. A more de-centered perspective enhances regulation and flexibility of responding, reducing fusion with a fixed sense of self
- Self-compassion is a tool for enhancing psychological flexibility (kind, loving attention) and reduces poor outcomes
- The process is primarily client-led unless they request assistance or become stuck in countertherapeutic states or processes (e.g. the client is dysregulated, tangential, caught in narrative)
- Unfolding present-moment experience anchors and drives the therapy session
- The inner-directed process of embodied inquiry trusts the client's inner healing intelligence or innate healing capacity

- The client is the expert of their experience, and healing happens in them; embodied inquiry intends to expand awareness, options, opportunities for this to occur
- The body holds both the imprints of the past, and the truth of present moment experience. As the past is resolved, trust in the body as a reliable source of truth in the present moment can increase
- The therapist's embodied attitudes (e.g., curiosity, kind attention, empathy, compassion) can facilitate a client's capacity to access, be with, and process experience
- Therapist and client are exploring together, this can be playful, light, "don't know" mind, working collaboratively, misattunements and rupture/repair cycles are part of healing

STEPS FOR EMBODIED INQUIRY

The following steps outline a systematic approach to inquiry. This is meant to be a guide and know that it is not always a linear process.

1. Bring attention to direct experience – inquire
2. Elaborate a resource
3. Track and describe dimensions of direct experience: sensations, emotions, thoughts, images, impulses (behaviours)
4. Listen and reflect (verbal and somatic)
5. When possible, stay with, welcome, and bring kind attention to difficult states
6. Recognize when directing and resourcing (client or self) is required, using trauma-specific techniques as needed
7. Support opportunities for more functional meaning to emerge as needed
8. Reinforce and integrate the learning beyond the session

INQUIRY SAMPLE TYPE QUESTIONS

- Present Moment orientation (often use present participles)
  - What are you noticing now? In the body? What is coming up?
- Invitational
- Open ended
  - What, where, how questions (rarely why questions)
  - Staying close to direct experience: *Where* do you notice this? *How* do you know ...? *What* [aspect of your felt experience] is telling you?
- Tracking questions/reflections that mirror the client experience

    - Using the client's language, not presuming to know
- Questions that enhance the client's ability to describe and flesh out their experience
    - Can you tell me more? Name emotions, identify statements as thoughts. Use descriptors and imagery to describe inner states
    - Ask about the client's relationship to what they are speaking about
- Meaning/Integration
    - What does that say about your life? How does that impact you? What does that mean for your day-to-day experience? How does this relate to your intention? May involve specific themes and insights.
- Questions that enhance one's reflective capacity and the movement from direct experience to meaning; learning to first describe, then abstract, and apply what has been learned
    - Addressing what is still alive for the client – both reflection experience and what is unfolding in real time.

THERAPIST ESSENTIAL SKILLS

The following skills are essential for health professionals when working with their clients:

- Resource oneself – self-efficacy and self-care
- Training the ability to direct attention (place, explore, shift, disrupt)
- Fluency with embodied self-awareness as an orientation to the present moment – cultivated interoceptive awareness and ability to bring language to experience
- Building a present moment orientation and the ability to articulate or describe experience (an experiential vocabulary)
- Genuine curiosity, patience, and acceptance
- Enhancing the capacity to turn toward, be with, stay with challenging states, using the body as a source of information
- Be able to attend to and parse different elements of experience (e.g. SIBAM)
- Maintain compassionate attention in the presence of difficult experience
- Be aware of the signs of dysregulation and know how to regulate the client pendulation/titration – expand the window of tolerance
- Help the client to externalize, decenter, and engage in meaning-making aligned with their values
- Applying skills, resources, and tools to assist the client's well-being

The Three Characteristics: Imperfect, Impermanent, Impersonal

INQUIRY GUIDE - PATRICIA ROCKMAN

SUFFERING	EASE	PERMANENCE	IMPERMANENCE	SELF	NON-SELF
• Discontent • Wanting/not wanting/wanting things to be different • Aversion • Resistance • Avoidance • Preferences – liking/not liking	• Acceptance • Patience • Open to what is • Bringing curiosity • No attachment • Trust • OK with uncertainty	• Seeking certainty • Wanting to know • Always • Never changing	• Everything changes • Everything comes and goes • Witnessing the arising, persisting and passing of experience • (Internalizing that things do pass – having the bodily experience)	• Personalization – It's all about me • Why me? • I, me, mine • Story telling** (Narrative self-referencing)	• Commonality • Universality • Interconnected • Impersonal • Interdependent • Self not fixed – also always changing • Self as process
HOW IT SHOWS UP IN INQUIRY					
• I don't like • This should not be • It's too much • I don't want it • I won't • If only • It doesn't work • Doubting – it or me • Frustration	• Observing Describing • Tracking • Surprise • Not as expected • Noting a shift • Allowing • Accepting • Willing to have	• Predictions or fixed view - implications • This is how it is • I'm just like that • It's always like that	• Tracks experience • Noticing shifts • Belief in thoughts changes • Emotional tone changes • Attitude changes experience • Like/dislike-contingent	• Perfectionism – having to get it right • Negative self-importance (I'm so awful) • Comparing • Identifying with-fusion with thoughts, emotions	• Good enough • Neither so good nor so bad – ordinary • Loosening from it's about me • Decreased identification • Decentering

*Characteristics that increase suffering and limit our view, responses, options vs. the other end of the continuum of characteristics that we are highlighting

**Negative, narrative self-reference is the default vs. Experiential self-reference that we are cultivating

ABOUT THE THREE CHARACTERISTICS

The Three Characteristics are a Buddhist concept that we have adapted to assist our inquiry. These characteristics are typically referred to as Suffering, Impermanence, and No-Self. These refer to the fact that life is imperfect (there is suffering), impermanent and insubstantial. When we want things to be other than they are or do not accept this imperfection – we suffer. When we cling to certainty or do not recognize the impermanent nature of existence, we also suffer; and when we are too attached to a sense of self or a fixed view of self, we also suffer versus when we can relate to self as process or see the insubstantiality of all things.

Here we have developed a table for the teacher to use as a guide for inquiry. Listening for how suffering – ease; permanence – the recognition of impermanence and a fixed sense of self – self as process (non-self) show up in practice.

CAN YOU THINK OF OTHERS?

Feel free to add other thoughts, emotions, sensations, or behaviours in the empty columns when you notice ones that are relevant.

SESSION 1

Participant Introductions

After being placed into small breakout groups, please ask each other the following questions:

- What is your occupation?
- What do you hope to get out of this course and how will you know if you receive it?
- How do you imagine inquiry informs PAT?

Inquiry Practice 1: Using the Three Layers

Following the demonstration and after being placed into dyads, take turns practising inquiry.

Ask the "client" to bring into awareness a low-level difficulty or difficult emotion attached to a concern and then go through an inquiry process. Try to go through the layers as listed below:

- Layer 1: Noticing
    - "What are you noticing?"
    - Naming, tracking, and describing the experience
- Layer 2: Decentering
    - "How are you relating to this experience?"; "What's it like to notice…"?
    - Abstracting and shifting perspective
- Layer 3: Integrating
    - "What does this mean for you and your wellbeing?"
    - Meaning making, application of learning

Inquiry Practice 2: Responsive Breathing Space with SIBAM

Following the demonstration and after being placed into triads, assign the roles of "client," "therapist," and "observer." Then, the "therapist" uses the script to guide the "client" in a responsive breathing space; this is followed by practicing using embodied inquiry, using SIBAM to help formulate questions for naming/describing direct experience (layer 1) decentering (layer 2) and integrating (layer 3).

Observer – taking note of the following

- SIBAM (Sensations, Images, Behaviours, Affect, and Meaning) questions used
- Noticing the layers: describing/tracking, perspective taking/de-centering, and integrating/applying

Responsive Breathing Space[1]

The Three-Minute Responsive Breathing Space is taught as a formal practice to give the client the opportunity to work with challenging situations in a relatively benign, safe, and manageable context. They have the choice regarding the intensity and duration of challenge with which they want to work. It is recommended that a challenge of relatively low intensity is initially chosen. One may experience an amplification of the sensorial nature of the experience, a dissipation, or even very little. Insights around the situation may arise, as may knowledge of what it is like to observe the experience (be with it).

SCRIPT

Now, coming into a comfortable position, one that embodies a position of being alert and awake, closing your eyes if that's comfortable for you or taking a soft, receptive, half-open gaze a few feet in front of you on the floor. Then turning your attention to the body. Becoming aware of your posture, the front body, the back body, and everything in between.

(silence for 15 seconds)

Now, turning attention to the sensations of breathing in the abdomen, noting the expansion of the abdomen on the in-breath and its deflation on the out-breath.

(silence for 15 seconds)

Now, bringing to mind some difficult situation, some worry, some concern or troubling thought or image.... something manageable, versus the greatest stressor you have ever experienced. Noticing what arises in thinking, emotions, and sensations.

(silence 10 seconds)

If there is an emotion or emotions naming it or them... perhaps saying sadness is here, or irritation, whatever it is...

(silence 15 seconds)

and then bringing attention to any attendant sensations and focusing here, exploring them, investigating them, being with whatever is here as best you can, exploring them, getting curious about them...

(silence 30 seconds)

Saying to yourself, "this is a moment of distress, let me feel this, it's ok whatever it is, it's already here. I can be with this." And if they are particularly challenging note that. If needed, breathing with these sensations, perhaps expanding into them on the in-breath and softening on the out-breath, staying with these sensations for as long as they are capturing your attention.

(silence 15 seconds)

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[1] Segal, Z., Williams, M., & Teasdale, J. (2018). Mindfulness-Based Cognitive Therapy for Depression (2nd Ed.). The Guilford Press.

And when you’re ready, letting go of attending to the sensations in the body and returning the attention to the lower abdomen, being with the body breathing, in and out.

(silence 45 seconds)

Now, expanding or widening attention to the entire body and all sensations, inside the body, and at the surface of the skin, bringing a more spacious attention to experience and your next moments.

(silence 45 seconds)

And now letting go of this practice and opening the eyes, looking around the environment and moving the body in any way that is needed.

Adapted from Segal Z. et al. (2002, 2013).

SIBAM QUICK REFERENCE

EXPERIENCE	DESCRIPTION	QUESTIONS
Sensations	Location, qualities (soft, hard, fluid, heavy, light, etc.), temperature	"As you notice sadness, what sensations are present for you, if any?" (A-->S) "As you talk about that situation, I'm curious what you notice if you pause and check if there are any sensations?"(M-->S) "Where do you notice it? What's it like?" (menu: is it heavy? Light? Hard? Soft?...)
Images	Spontaneous memories/scenes/imaginings To further describe sensations: colour, texture (e.g. smooth, porous), material (e.g. metal, wood), size, shape	"Tell me more about the scene – who else was there? Can you describe the room/environment?" (I-->I) "That heavy tightness in your belly, does it have a shape or colour? How big is it? (S-->I)
Behaviours	Movements, gestures, impulses, facial expressions, sounds Often arise spontaneously; may gently bring attention to them and make links	"Is there a gesture that could express that joy you're feeling?" (A-->B) "If that black heavy anvil in the chest had a facial expression, what might it be?"(S/I-->B) "I noticed your shoulders tensing as you were telling me about that memory; I'm curious if you're open to exploring if there are any movements in the shoulders or arms that might feel supportive? Or, "What would it be like to exaggerate that and make it even bigger?" (B-->B)
Affect (Emotion)	Big 4: fear, anger, sadness, happiness Others: shame, repulsion, bliss, peace, tranquility, frustration, curiosity, pride, etc.	"I'm curious if there's any emotion present as you are telling me about this?" (M-->A) "When you see that image, what emotion is present, if any?" (I-->A) "I noticed your posture just changed: you sat up more (mirroring offered) - as you notice your posture now, I'm curious if there's any emotion present for you?" (B-->A)

Meaning (Layer 3 inquiry)	Cognitive interpretations, associations, narratives Often arise spontaneously	"As you see yourself leaning against the tree, and as you're describing the feeling of it's firm support at your back, I'm wondering if there's any meaning in this for you?" "If that nervous energy in your belly could speak, what might it say?"

SESSION 3

Embodied Inquiry IFS Demo Checklist

This exercise is intended to increase attention to the interactions that take place during inquiry. The following list of items is not complete but is meant to provide a focus for your observations of the process.

During the Internal Family Systems demo, please attend to both the “client” and “therapist” interactions. Record any relevant questions and reflections by the therapist and client that you think reflect the items below:

THERAPIST	EMBODIMENT	CLIENT
	Empathic Abiding Presence	
	Curiosity	
	Kindness	

THERAPIST	ATTENTION	CLIENT
	Present Moment	
	Orienting to the body	
	Tracking experience	

THERAPIST	PROCESS	CLIENT
	Approaching difficulty	

	De-centering	

Embodied Inquiry Worksheet

You can use this worksheet to guide your inquiry. The inquiry dialogue will vary depending upon where in the PAT you are working:

Determine whether you are working with reflective, future, or present moment (real time inquiry). This will be dependent upon whether you are working with

- Preparation: intentions, hopes, ambivalence etc.
- Medicine Session (mostly present moment inquiry)
- Integration: working with dysregulation, establishing the meaning of the experiencing, generalizing, and applying what has been learned for the future

In order to enhance an embodied experiential orientation, the emphasis will be on open ended questions: how, what, where, when (rarely why).

1. Identify and elaborate a resource to help create a container and strengthen the ability to work through trauma (growing the healing vortex) – as needed
2. Recognize and notice what is arising – images, sensations, impulses, thoughts, images
3. Impulses (behaviours): attending to direct experience
4. Track and describe present moment experience and nervous system states
5. Identify parts of self and the components of experience (e.g. sensations, thoughts, images, emotions, impulses)
6. When possible, stay with, welcome, and bring lovingkindness (compassion) to difficult experience
7. Recognize when self-care and resourcing are required and use pendulation and titration when helpful
8. Support opportunities for more functional meaning to emerge
9. Reinforce and integrate the learning beyond the session (e.g. using meaning making, tasks, daily rituals).

Embodied Inquiry Cases

You will be working with the following cases during live session 3. Please use this workbook to guide your preparation, roles, and inquiry during the role plays especially the Inquiry cheat sheet found at the beginning of the workbook. You will be rotating through each case as therapist, client, and observer. The facilitators will be moving in and out of the breakout rooms to provide assistance and feedback where needed.

CASE DEMONSTRATION

Listen for and record questions that reflect the embodied inquiry process as you listen to the case demonstration.

EMBODIED INQUIRY STEPS/PROCESS	QUESTIONS IN DEMO THAT REFLECT EACH STEP
IDENTIFY AND ELABORATE A RESOURCE	
BRING ATTENTION TO WHAT IS ARISING	
TRACK & DESCRIBE PRESENT MOMENT EXPERIENCE AND NERVOUS SYSTEM STATES	

IDENTIFY PARTS (IFS LANGUAGE)	
BRING LOVING KINDNESS AND COMPASSION TO DIFFICULT EXPERIENCES	
HELPING CLIENT TO REGULATE - USE OF PENDULATION AND TITRATION	
SUPPORTING MEANING MAKING	

INTEGRATION AND APPLICATION OF LEARNING	

CASE 1 - PREPARATION SESSION CASE

ASSESSMENT	We are assuming that an in-depth assessment has already been completed including symptoms, safety concerns, previous medications, and treatment.
DEMOGRAPHIC INFORMATION	Leo is a 45-year-old Caucasian man. He is married and lives with his wife and their two young children. He previously worked in IT at a reputable company, but he is currently on disability.
RELEVANT HISTORY	Leo has a history of trauma. When he was in elementary school, he was sexually assaulted by an older boy. His parents refused to talk about it with him, and he felt significant confusion and shame about the experience. There was a typical pattern of unavailability in his relationship with his parents who did not want to be burdened by his emotional difficulties. He struggles with significant sleep issues and is overweight. His diet is unhealthy, and he exercises very little. He has experienced varying degrees of depression most of his adult life, his mood ranging from anhedonic (unable to experience pleasure) to highly irritable, self-critical, and hopeless. On his better days, he can help with the morning and evening routines at home, spend some quality time with his extended family and occasionally go out with friends. He nonetheless spends a lot of time in bed and on his computer in the basement of the family home. When in a depressive episode, he has difficulty getting out of bed, is exhausted, lacks motivation, and withdraws almost completely from the external world. He regularly contemplates self-harm when in these moods. Leo takes several antidepressant medications and has had several therapists in recent years. He is bright, insightful, and curious about mental health. He has tried psychedelics on his own and sought out ketamine infusions and ketamine-assisted therapy in clinical settings. Many of these interventions (especially ketamine) produced positive but temporary relief to his depression. He feels more energetic, clear, and hopeful when he believes he has found a solution to his problems. He relapses each time and typically ends up feeling vulnerable, angry, and discouraged.
PRESENTING CONCERN	Leo has sought out an underground therapist to pursue psilocybin-assisted therapy.
PREPARATION	In the first Preparation Session, he presents as a little nervous and disconnected but grateful the treatment is finally under way. He is speaking about some very difficult experiences in his life but expresses little affect.

He is hoping that the psilocybin will finally break through his chronic mood problems, but also afraid that it won't work, and that he will be disappointed and out of options. Before the end of the session, the therapist guides Leo in a body scan, and he slowly relaxes and opens up. He appears calm but deeply sad as he leaves the session.

Small Group Practice Instructions

Please assign the following roles: therapist, client, and observer. Note throughout the day you will switch roles. The therapist will focus on preparation with the client in the case described above. The role play will put an emphasis o**n getting informed consent,** if possible, from all parts and will use the inquiry model during that session. The client should enact their role as authentically as possible (without being overly challenging). The observer should take notes around what they observe elements of the inquiry process.

Please be sure to address the client's intentions and expectations. Make sure you cover section 5, working toward consent from all parts. Note that this may not achievable. It is the process that is most important. The following questions can be used as sample inquiry questions for this exercise. Please focus on the consent exercise, number four and five, although you are welcome to address the other areas if you have time.

Embodied Inquiry Sample Questions

<table>
<tr><td>INTENTIONS AND GOALS</td><td>Clarifying intentions and potential outcomes (important for Preparation, for guiding the Medicine sessions, and Integration) – What are you hoping for? What would it look like?</td></tr>
<tr><td>CLARIFY EXPECTATIONS</td><td>What they are? What would be the worst thing that would happen if you didn't meet them? Listen for how this shows in the body, emotions etc., and track this. (Expectations and openness to the psychedelic experience are significant predictors of positive outcomes)</td></tr>
<tr><td>EMBODIMENT</td><td>Consider orienting to the body through a meditative state for this client (enhancing attention to the body – direct and immediate experience – disrupting cognitive elaboration and rumination common in maintaining depressive states)

Consider how disappointment or sadness is showing up – body, emotions, thoughts (track this)

REFLECTION

• Oh – so you are noticing disappointment or sadness.
• How is that showing up in the body? Can you describe it? And then what happens as you attend in this way?
1. Identifying parts that are keen and those that are ambivalent
2. Identify sensation(s) – What does it/they want you to know? How do you feel toward that sensation? Or how are you relating to that sensation (Rejecting/Accepting)? (If rejecting then this is indicative of another part. Need to address that one).</td></tr>
</table>

READINESS	Are you ready for this psychedelic experience? – catalogue all the sensations, thoughts, and emotions that come up. Then inquire about them. There may be parts that are ready and those which are not. Assume that different parts have different feelings about going ahead with the experience.
CONSENT	Ask to get consent from all the parts on a scale 1-5 (assume it's informed) • 5 fingers – hell no! • 4 fingers – leaning toward no but open to discuss. Probably no • 3 fingers – on the fence. I'm interested but I have questions and concerns • 2 fingers – probably yes but I have questions • 1 finger – hell yes! **Don't proceed with the Medicine Session unless all the parts endorse 3 or higher.** Consider the need to utilize questions like "what would have to happen to move you up the scale toward consent even just a little bit?"

CASE 2 – MEDICINE SESSION CASE

ASSESSMENT	We are assuming that an in-depth assessment has already been completed including symptoms, safety concerns, previous medications and treatment.
DEMOGRAPHIC INFORMATION	Jane, 37, is a single Latina female. She defines herself as spiritual but non-religious. She is an interior designer financially supported to do PAT by her ex-partner who is a strong friend and supportive. Her twin brother and friends are also supportive. Her father is absent, and mother is dependent on her.
RELEVANT HISTORY	Symptoms of depression, alcohol use disorder, and borderline personality traits. She is currently on medical leave from her professional design firm. Her mother was recently diagnosed with Parkinsons' disease and lives 1 block away, and Jane serves as her primary support. Born with twin brother. She has a brother 5 years her senior (later diagnosed with schizophrenia). Jane moved overseas twice during her lifetime. She had an unstable childhood, many moves, no close friendships or sense of belonging, some bullying. She denies any shock traumas. Childhood essentially characterized by severe emotional neglect, never soothed, leaving her with chronic sense of emptiness in adulthood, often feeling 'defeated', and need to use management strategies of dissociating. She began using alcohol at age 17. Her parents had an unhappy marriage, both engaging in infidelity. They divorced when she was 10. Father was "absent", mother "depressed", and narcissistic. She has felt responsible for her mother her entire life - relational/developmental trauma. Her older brother died 10 years ago and was found in a river.
PRESENTING CONCERN	Self-medicating with wine at night (1-2 glasses, most nights); feeling 'asleep' to life, not connected or in good relationship with herself; emotional lability and challenges regulating and orienting around how to behave. Jane lacks self-confidence and trust in herself and what is right/true for her.
TREATMENT GOAL	To stand on my own two feet, to feel fully alive and confident in myself, my choices, and my ability to handle my emotions and challenges.
MEDICINE	Ketamine IM 1.1 mg/kg
SESSION	Set and setting, the medicine, the client response – consider using inquiry to help the client process a challenging or other state using their direct experience as it is unfolding. Consider inviting skills of titration and pendulation during this process.
SETTING	Numinus clinic PAT room; Wavepaths music, reclined with eyeshades, blankets

Under effects of ketamine, she is quiet, and the therapist provides attuned, supportive presence throughout. Once ketamine effects began to wane the client reports that during her experience she connected with painful memory from grade school regarding disruption of her only supportive friendships at the time, due to moving back and forth from Vancouver to Belgium and back again in grade 8. Prior to leaving, she was very close with two other friends from grade 6-8, who were both also 'different', so they banded together. Upon return in grade 8, one friend had moved out of the country, while the other turned away from her. She pinpointed this as a significant painful moment, where pain of loss, instability, loneliness fortified a protective mechanism and fortress around her heart – she realizes she has felt frozen alone in pain since that time. Today brought that pain back to be witnessed.

During the Medicine Session with some guidance and by placing her awareness on the fortress around the heart, it transformed into a porous cocoon. She described it as a milky golden colour, very light, wrapped around her softly, and held her. She said it has edges, but that she can see through it too. It felt nurturing and motherly for her. In the cocoon she felt protected and had the sense that it was sending her grade 8 self-loving energy and that she was held.

During the transition from the session to going home you inquire into her experience.

Small Group Practice Instructions

Please assign the roles of therapist, client, and observer (switch roles from previous role play). This inquiry focuses on Jane's parts (getting acquainted with them) and their relationship to her Self-Energy adult part and building a nurturing relationship between them.

Note: Client should listen to music for 2 minutes and bring up this "memory," as well as the images of the fortress and its transformation into a porous cocoon. You will receive a link to the music during the live session.

THERAPIST TASKS	CLIENT
• Inquire into experience – awareness – **images, sensory experience** • Work with the fortress and trapped girl – bring supportive inquiry to it – connection to these images • Elaborate the resource of the cocoon and how to integrate into the different channels	• Bring up a challenging memory – loss of supportive friendship – teen • Realizes frozen, alone, and in pain since then • Images of the trapped girl, fortress around her heart and its transformation into a porous cocoon – describe cocoon

• Inquire into the relationship between her (*self*-energy/wise/adult part) and the young hurt part – how can the former work with the latter when she goes home (beginning integration – keeping it alive)	• Identify how from her wise adult/self-energy she will continue working with this after the session

Embodied Inquiry Sample Questions

Pick a few of the sample questions below and then use your own inquiry questions with the content that arises.

- Consider inquiring into the fortress around the heart – size, shape, texture/material? How are you experiencing this? Can she stay with what is arising even just a little bit? What is it like to do this? (making the image of the fortress clearer; locating the experience somatically)
- Consider asking if she could connect with this fortress with her inner healing intelligence, to learn a little bit about what it's trying to do, what it's afraid of?
- Ask if she can sense how the little girl inside the fortress is feeling?
- When she thinks about the trapped little girl what emotions or sensations arise? Can she connect with this part anywhere in the body? (relational dialogue; anchoring to this part)
- How and where can she connect with the cocoon and nurturing presence? How can you (therapist) elaborate that resource? (kind and loving attention)
- Ask what does she need? Can she show you or tell you? How is she (in *self*-Energy/wise adult part) relating to the little girl? How might she (in *self*-Energy/wise adult part) explore this relationship with this part, help her now and when you go home? (unblending, integrating)
- Ask any other questions that arise out of the dialogue.

CASE 3 – INTEGRATION SESSION CASE

ASSESSMENT	We are assuming that an in-depth assessment has already been completed including symptoms, safety concerns, previous medications, and treatment.
DEMOGRAPHIC INFORMATION	Rory is a single, black gay male, in his mid-thirties. He is a professional performer and artist. He lives alone and frequently travels for work.
RELEVANT HISTORY	He has no formal mental health or medical diagnoses.
PRESENTING CONCERN	He decided to go to a psilocybin retreat abroad. He has a history of alcohol misuse and feels like something is missing in his life. While he is high functioning and relatively content in his life, he said he has always felt a deep sense of loneliness and often feels empty. He suffers from existential anxiety which he describes as related to a lack of deeper meaning and purpose in his life. He is coming to see you to resolve some concerns that arose during one of his medicine sessions.
INTENTION	Rory's intention was help me connect with a sense of deeper belonging.
MEDICINE	Psilocybin
MEDICINE SESSION	Rory had several Medicine Sessions during his retreat. He said a lot of it was easy for him to relate to and understand. There was one ceremony in which he felt significantly confused. He tells you that he has always been called 'gay' and other similar names since he was six years old and was bullied because of how he presented socially. He is prominent in the queer scene and his art and identity are rooted in this identity as a gay man. He tells you that he had a vision during one of the ceremonies in which he saw his life play out as he is currently living, and it was very dark, isolated, and lonely. He then had a vision of a life and family with one woman he knows and admires. He is deeply confused about this and wonders if, in fact, he is straight. He said in the vision this life was full of colour, love, meaning, and connections. He has been struggling since the retreat to make sense of the experience because it has deeply challenged his sense of identity. It has brought up many difficult feelings and thoughts for him. He has been feeling extremely vulnerable and lost. He asks for your support.

Small Group Practice Instructions

Assign roles: therapist, client, and observer. Please be sure to address, using inquiry, the client's relevant integration needs. Integration needs are reviewed below:

REGULATION	Helping the client move out of or manage dysregulated states as needed
NORMALIZING	Making the experience understandable and congruent with the client's frame of reference, view of self, culture, etc.
METABOLIZING	Processing the experience somatically, emotionally, and cognitively (SIBAM)
MEANING-MAKING	Making coherent sense out of the experience
KEEPING IT ALIVE	How to take the experience forward
CONNECTION TO OTHERS	Relationships and community
COMMITTED ACTIONS	Behaviours/actions consistent with one's values
SPIRITUAL NEEDS	Meaning/purpose greater than the self (may/may not be religious)

Embodied Inquiry Sample Questions

Use one or two of the following sample inquiry questions to start your inquiry process to explore and unpack the confusion surrounding this one ceremony. What are the most important integration needs for Rory, and how can you use the inquiry process to elaborate and open his exploration? You can also use inquiry questions that invite what has been learned to be applied in daily life.

- When you think about the woman from the vision, what do you imagine she represents for you (qualities, desires, longings)?
- If we did not take this at literal, what other interpretations could be there? When you think about this, what do you notice in your body? Associated emotions? Thoughts?
- When you think about the darkness of your current trajectory, what do you notice (sensations, images, feelings)?
- Feel free to add any other questions and reflections that arise out of your conversation and reinforce the application of what is being learned going forward.