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PSYCHIATRY ACADEMY

Psychedelic-Assisted Psychotherapy

*Therapeutic work with altered states
of consciousness*

Roxanne Sholevar MD

*Staff Psychiatrist, Department of Psychosocial Oncology &
Palliative Care, Dana-Farber Cancer Institute*

Instructor in Psychiatry, Harvard Medical School



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I do not have a relevant
financial relationship with a commercial
interest to disclose.



Outline

- Review historical and contemporary models of support for psychedelic experiences
- Highlight conserved elements of psychotherapy across models
- Compare basic support vs evidence-based therapies
- Present therapy model from our research



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Historical & cultural context



Indigenous practices (pictured, ayahuasca ceremony)



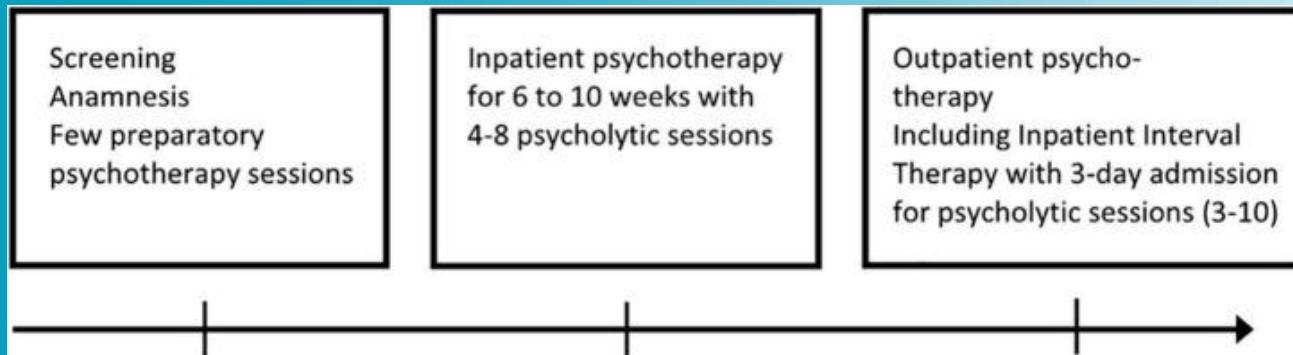
Non-psychedelic therapeutic approaches (pictured, psychoanalytic couch)



Early psychedelic-assisted psychotherapy research (pictured, Bill Richards at Spring Grove 1979)

Early clinical model: psycholytic therapy

Use of serial lower-dose LSD/psilocybin sessions in a psychoanalytical framework, practiced in the 1950s-60s



- Low dose: 75-125 µg LSD or 8-15mg psilocybin
- Indications: character neuroses, sexual disorders, psychosomatic conditions

Thousands of patients
treated in >30
treatment centers

TABLE 5

Treatment results for different groups of treatment-resistant patients with psycholytic therapy (62).

| Diagnoses | Number of studies | Treatment success rates |
|-------------------------------|-------------------|-------------------------|
| Anxiety disorders | 9 | 70% |
| Depressive neuroses | 4 | 62% |
| Personality disorder | 10 | 61% |
| Sexual disorders | 7 | 50% |
| Obsessive-compulsive disorder | 7 | 42% |
| Hysteria and conversion | 2 | 31% |

Mascher E. Psycholytic therapy: statistics and indications; 1967



Psycholytic therapy principles

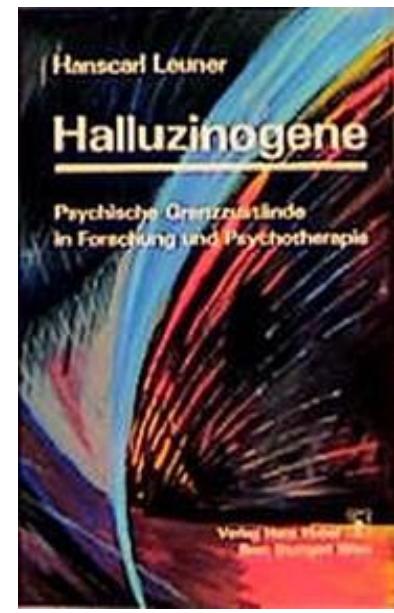
- Activation of affect and sensory perception
- Loosening of psychological defenses
- Personally meaningful symbolic visualization of affects
- Therapeutic splitting of ego functions with a preserved “reflective ego capacity”
- Broadening of associations
- Exceptionally vivid reliving of disavowed conflicts and memories
- Age regression with great depth of experience
- Pronounced affective abreaktions
- Intensification of transference experienced and observable in the here and now on the therapist
- Spontaneous introspective insights



Ronald Sandison MD, Britain



Hanscarl Leuner MD, Germany





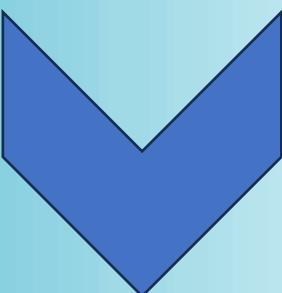
Contemporary research models

Systematized Review of Psychotherapeutic Components of Psilocybin-Assisted Psychotherapy

2021

David M. Horton, M.S., Blaise Morrison, Ph.D., Judy Schmidt, Ed.D.

- 11 studies, n=275, from 2011-2021
- Psychological outcomes in:
 - Substance use (alcohol, tobacco)
 - Depression (TRD, MDD)
 - OCD
 - Medical illness (palliative care, older long-term AIDS survivors)
 - Healthy participants



Models of Psychedelic-Assisted Psychotherapy: A Contemporary Assessment and an Introduction to EMBARK, a Transdiagnostic, Trans-Drug Model

William Brennan^{1,2*} and Alexander B. Belser¹ 2022

Included other psychedelics:

- MDMA (PTSD, n=2)
- Ayahuasca (MDD, TRD)
- LSD (anxiety in serious illness)

Common and variable elements



Key points

- Psychedelic-assisted psychotherapy consists of **three stages**: pretreatment, treatment, and posttreatment sessions
- The **purpose** of each stage was **consistent** across studies; the **content** of these stages **differed**
- The **role of therapists** during treatment sessions was "inner-directive" and supportive; therapists had a more direct role during the pretreatment and posttreatment sessions

PAP consists of three stages



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Pre-treatment, “preparation”



- Prepare participants to receive psilocybin safely
- Help them feel supported while under psilocybin's effects

Support during administration, “dosing”



- Participant lie down & wear eyeshades, music
- Non-directive & supportive, inner-focused

Post-treatment, “integration”



- Review of experience and resulting effect of previous psilocybin treatment sessions



Content: preparation & integration

Preparation and integration psychotherapy vary in
number of sessions, modalities, and techniques used

Number of sessions:

Preparation: mean hours 6.06 ± 1.70 ;
mean sessions 3.31 ± 1.44

Integration: mean hours 8.72 ± 5.96 ;
mean sessions 6.71 ± 4.61

Modalities:

Basic support vs. evidence-based therapy interventions

Basic support & inner healing intelligence

- Concept that an individual has the innate capacity to heal; referenced in Buddhist meditation and somatic therapies
- Role of the therapist is to provide a safe structure for this process to unfold and provide encouragement and grounding, "bear witness"
- Therapist creating opportunities for experiential processing and self-directed inquiry



"The body initiates a remarkably complex and sophisticated healing process and always spontaneously attempts to move toward healing. The psyche too exhibits an innate healing intelligence and capacity"- MAPS MDMA Therapist Manual



Evidence-based therapy models

- Incorporation of EBT, depending on indication
- Most commonly variation on supportive/expressive therapy or group psychotherapy
- Motivational enhancement therapy (MI + CBT): AUD
- CBT: smoking cessation
- Cognitive-behavioral conjoint therapy (CBCT): PTSD (MDMA)
- ACT & ACT (+embody): depression
- Modified supportive-expressive group therapy: older long-term AIDS survivors
- Existential approaches: psycho-existential distress related to serious illness
- Eclectic: supportive, psychodynamic/analytic, narrative

Internal Family Systems (IFS) and parts work



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Techniques

- Music
- Therapeutic relationship/person centered
- Body scanning: increasing somatic attunement
- Journaling
- Guided imagery
- Meditation: encouraging daily practice, offering pre-post dosing

PAP is delivered by 2 trained therapists

- At least 2 trained therapists present at dosing
- At least 1, usually 2, present at pre- and post-treatment phases
- Therapist dyads
- Therapist training



TABLE 2. Credentials of therapists in psilocybin clinical trials

| Study | Psychiatrist | Psychologist | Master's-level social worker or counselor | Other licensed professional | Bachelor's-level staff |
|---------------------------------|--------------|--------------|---|-----------------------------|------------------------|
| Anderson et al., 2020 (9) | 5 | 5 | 2 | 2 | 1 |
| Bogenschutz et al., 2015 (10) | 2 | 1 | | | |
| Carhart-Harris et al., 2016 (3) | 2 | | | | |
| Davis et al., 2021 (11) | 2 | 3 | 1 | | 4 |
| Griffiths et al., 2016 (12) | | 1 | 2 | 1 | 1 |
| Griffiths et al., 2018 (13) | | 2 | 2 | 1 | |
| Grob et al., 2011 (14) | 2 | | | 1 | |
| Johnson et al., 2014 (15) | | 2 | 2 | | 2 |
| Moreno et al., 2006 (16) | | | | | |
| Nicholas et al., 2018 (17) | | 2 | | 4 | |
| Ross et al., 2016 (4) | 6 | 2 | 6 | 1 | |



Our approach: PATH study

- Interdisciplinary therapist team (MD- HPC, psychiatry; PhD- music therapist, SW)
- Collaboration with hospice clinical care teams
- Two 1-hour preparation sessions, one dosing day (at hospice house), two 1-hour integration sessions
- Basic support model with existential themes (demoralization outcome)
- Therapists' individual styles
- Hospice informed: relational, patient-centered
- Group supervisions



Building a frame: the pain study

- 3 preparatory sessions
 - Session #1: collecting history, exploring participants' experience
 - Session #2: psychoeducation on psilocybin effects, dosing day experience
 - Session #3: experiential exercise (music listening, guided meditation, practicing grounding techniques)
- Covered and revisited at each session
 - Intention
 - "Four agreements" (safety)
 - Relational elements (including therapeutic touch)
 - Invitations to deepen (somatic experiencing)



References

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