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Developing Guidelines and Competencies for the Training of Psychedelic Therapists

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Abstract

Research since the 1950s has shown that psychedelic-assisted psychotherapy has had significant positive effects in reductions of specific clinical symptoms and increases in quality of life as measured on a variety of indices. The intensity of focus on evidence-based outcomes, however, has resulted in a paucity of active discussions and research on the core competencies of the therapists themselves. The context of the history of psychedelic research reveals how this neglect of therapist variables occurred. With current discussions of Phase 3 and expanded access research programs for psilocybin-assisted and MDMA-assisted psychotherapies, there will be a great need for competent therapists trained in this clinical specialty. This is particularly the case if less restricted, legal medical use is approved within the next 6 to 10 years. This article is the first review and compilation of psychedelic therapist competencies derived from the psychedelic literature. These six therapist competencies are empathetic abiding presence; trust enhancement; spiritual intelligence; knowledge of the physical and psychological effects of psychedelics; therapist self-awareness and ethical integrity; and proficiency in complementary techniques. A further contribution of this review is a delineation of the 12 fundamental curricular domains of study for the training and development of these therapist competencies. As current legal restrictions evolve, aspects of these training guidelines will develop accordingly.

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Setting the Stage for Psychedelic Research

The evolution of psychedelic psychotherapy in the 20th and into the 21st century has been both furthered and stymied by the cultural backdrop against which these substances were being explored at the time. When research into psychedelics, known collectively as hallucinogens, was underway in the early 1950s in clinical and laboratory settings, they were viewed as tools that could be used to better understand how the brain itself works (Abramson, 1960; Grob, Greer, & Mangini, 1998). From 1950 to the mid-1960s, there were more than 1,000 clinical papers published about the sessions of some 40,000 patients, scores of books and six international conferences on psychedelic-assisted psychotherapy (Grinspoon & Bakalar, 1979). A core question underlying psychedelic-assisted therapy surfaced in those early years, well stated here by conference panelist, Robert Murphy:

> Is LSD [lysergic acid diethylamide] a therapy in itself, with the therapeutic relationship functioning merely for support? I believe this is so. Or is the essential therapeutic process the sort of thing Dr. Abramson described, in which the therapeutic relationship is the essence of the therapy, and LSD simply facilitates or catalyzes it? These questions underlie a good deal of the discussion here, and are perhaps of more importance than we have recognized. (Lennard & Hewitt, 1960, p. 219)

There are references in the research literature to the hypothesized effects of therapist competencies and therapeutic alliance-building on clinical outcomes, but these variables have gone relatively unsystematized and unresearched due to changes in the political climate in the United States. Any discussion of therapist skill bases and the training of therapists for this research requires a historical contextualization within the ebb and flow of the 60-year-old psychedelic research field itself.

In the clinical setting, these substances were initially of interest based on a belief that they could induce elements of psychosis (an effect often termed psychotomimetic) and could reveal underlying psychodynamic processes (Eisner & Cohen, 1958; Grob, Bossis, & Griffiths, 2013). However, soon interest shifted to their potential as catalysts for therapeutic healing in the

clinical setting, particularly with the classic psychedelics, mescaline, and LSD (lysergic acid diethylamide). In a therapeutic model known as psycholytic therapy, low- and mid-dose applications were administered over an extended period of time in conjunction with psychoanalytic psychotherapy (Grof, 1968; Naranjo, 2013; Passie, 2012). Alternatively, high-dose applications were used and limited to a handful of significantly longer sessions followed by psychotherapeutic integration work (Gasser et al., 2014; Osmond, 1957).

During this cornucopia of research, some clinicians posed optimal qualities for therapists. Early researchers suggested that therapists should have a mix of empathy and "objectivity," which they variously defined as "being as normal as possible" and "balanced" (Lennard & Hewitt, 1960). Others remarked that therapists needed to be calm and composed (Blewett & Chwelos, 1959), aware of the effects of their reactions on the research participant (Buckman, 1967), and keenly capable of transference analysis (Hoffer & Osmond, 1967). While direct research on therapist variables was proposed during this period, there exist only clinical case studies and self-reported, anecdotal, and sparse discussion of qualities, skills, and competencies for therapists.

Researchers in the 1950s and 1960s who pursued psychedelic-assisted therapy quickly discovered psychedelics' mysticomimetic potential—their ability to catalyze transformative, breakthrough experiences (Abramson, 1960; Eisner & Cohen, 1958; Riedlinger & Riedlinger, 1994). The promise of psychedelic-assisted therapy was considered so great that psychiatrists and psychologists began convening conferences where researchers could share their findings and discuss the potential implications of them. For example, international conferences on the use of LSD in psychotherapy were held in Princeton, NJ, London, and Long Island, NY, in 1959, 1961, and 1965, respectively (Pahnke & Richards, 1966). In April of 1969, the American Association for Humanistic Psychology and the Menninger Foundation cosponsored an invitation-only conference in Council Grove, Kansas, dedicated to the topic of altered states of consciousness, which counted among its participants "national and international therapists working with psychedelics" (Fadiman, 1969, p. 135).

The Dark Ages and the Renaissance in Psychedelic Research

They would not be able to publicly voice their enthusiasm for psychedelic-assisted therapy much longer, however. In the face of widespread use deemed unmanageable by the federal government, President Nixon in 1970 signed into law the Controlled Substances Act, which made any use of the specified

psychedelic substances illegal. Then the entactogen MDMA (3,4-methylenedioxymethamphetamine) was introduced to the therapeutic world by several therapists, most notably by Leo Zeff, in the mid-1970s (Stolaroff, 1997). Entactogen, it should be noted, is a term coined by chemist David Nichols referring to those psychedelic medicines found in the MDA (3,4-methylenedioxyamphetamine) and MDMA family (Shulgin & Nichols, 1978; Nichols, 1986). MDMA was viewed as a "penicillin for the soul" by therapist guides for enhancing empathy, creativity, and team building (Shulgin, 2001), but along with its researched pharmaceutical analogues stayed largely under the radar of the mainstream culture until they, too, were placed on Schedule I status in 1985 (Dass, Metzner, & Bravo, 2010; Degenhardt & Hall, 2010; Nutt, King & Nichols, 2013).

In 1986, Rick Doblin founded the Multidisciplinary Association of Psychedelic Studies (Emerson, Ponté, Jerome, & Doblin, 2014). In 1993, the Heffter Research Institute was cofounded by David Nichols, George Greer, Dennis McKenna, Mark Geyer, and Charles Grob (Nichols, 2014). In the meantime, in the fall of 1990, the federal hold on psychedelic-assisted research had loosened enough to allow Rick Strassman to conduct clinical trials with the psychedelic DMT (N,N-dimethyltryptamine) (Strassman, 2010; Strassman & Qualls, 1994; Strassman, Qualls, Uhlenhuth, & Kellner, 1994). In one of the few other reports in this time period, Liester, Grob, Bravo, and Walsh (1992) published positive data gathered from the subjective experiences of 20 psychiatrists who took MDMA as part of their study. In these years of the early 1990s, both the National Institute on Drug Abuse and a Food and Drug Administration (FDA) Advisory Committee recommended that clinical research on psychedelics could be resumed, "subject to the same regulations that the FDA used to review research with all other drugs" (Nichols, 2014, p. 22).

But in the wake of both Strassman's research approval coup and the pivoting of the two federal agencies, it took the collective efforts of MAPS and Heffter and the largesse of their respective donors to get psychedelic research programs started up again in earnest. This time around, researchers were learning from the mistakes of the past, pursuing work with those substances that had both the greatest chance of clinical efficacy and, from a cultural standpoint, the fewest negative associations (Tupper, Wood, Yensen, & Johnson, 2015). For MAPS, that meant a focus on MDMA for the treatment of posttraumatic stress disorder (PTSD; Emerson et al., 2014) and for Heffter, psilocybin for the treatment of anxiety in patients with advanced-stage cancer (Grob et al., 2011). These organizations continue to work closely with researchers at University of California, Los Angeles; New York University (NYU); Johns Hopkins; University of New Mexico; University

of Wisconsin; and other centers in order to conduct clinical research on psychedelic-assisted therapies. The research agendas have specifically followed the FDA protocols for drug development in three phases: In Phase 1, evidence for safety of the medicine is gathered; in Phase 2, findings are sought that show the medicine is efficacious for medical condition(s); and in Phase 3, researchers attempt to show that the drug is as effective or more effective than currently available medicines in existing treatments. The empirical findings from the FDA-approved clinical trials in the past 20 years have been so positive that there are current applications to the FDA for permission to step into Phase 3 clinical trials for MDMA for treatment-resistant PTSD and psilocybin for end-of-life distress and major depressive disorder (Doblin, 2015; Nichols, 2014).

Present-Day Research With Psychedelics

The momentum of the current renaissance period has occurred through the dedication, persistence, and wisdom of several dozens of researcher clinicians, many of who have sacrificed some portion of their careers for this work. MAPS and Heffter are not the only not-for-profit organizations partnering with academic institutions to conduct and underwrite clinical research of psychedelic-assisted therapy. The three organizations of note in this regard are the Council on Spiritual Practices (CSP), convened in 1994 under the impetus of Robert Jesse; the Beckley Foundation, founded in 1998 by Amanda Feilding; and the Usona Institute, started by William Linton in 2014. All of them help financially support clinical studies evaluating the role of psychedelics in a therapeutic environment (Feilding, 1998; Jesse, 1994; Linton, 2014). Indeed, without the tireless efforts of all these organizations (particularly by CSP in the early 1990s), it is unlikely that research in this field would be remotely as far along as it is now. And with their help, the cultural tides have turned to greater interest in this field, as evidenced by the publication in the past 5 years of the publicly acclaimed New Yorker article, *The Trip Treatment*, by Pollan (2015) and the publication of such books as *Healing with Entactogens* by Passie (2012), *Manifesting Minds* by Doblin and Burge (2014), *Sacred Knowledge: Psychedelics and Religious Experiences* by Richards (2015), the second edition of *Zig Zag Zen: Buddhism and Psychedelics* (Badiner, 2015), *Allies for Awakening: Guidelines for Productive and Safe Experiences with Entheogens* by Metzner (2015), and *Altered States: Buddhism and Psychedelic Spirituality in America* by Osto (2016).

To contextualize the reasons for a lack of direct research on therapist qualities and competencies, a focus will be made on the highlights of recent research data on the medicines poised to move into Phase 3 drug trials: psilocybin and

MDMA. The influence of therapist variables that we commonly see in therapy outcome studies has not been the focus of this era of research, however, because the work within the structure of FDA-approved clinical trials necessitates controlling for differential therapist effects. This contemporary research has sought to delineate the role of the therapist as a deliverer of a safe and consistent set and setting within consistent protocols across conditions.

Current Psilocybin-Assisted Therapy Outcomes

Beginning in 2006, researchers at Johns Hopkins University began publishing results from the first of a series of clinical studies looking at the potential of psilocybin-assisted therapy to induce mystical-type experiences. In the first study, psilocybin-assisted therapy was found to occasion such experiences and 2 months later, the study participants rated the experience "as having substantial personal meaning and spiritual significance and attributed to the experience sustained positive changes in attitudes and behavior" (Griffiths, Richards, McCann, & Jesse, 2006, p. 268). In follow-up interviews conducted 14 months later, 94% of the volunteers rated at least one session in the top five spiritually significant experiences and in the top five personally meaningful experiences of their lives (Jesse & Griffiths, 2014).

In a psilocybin-assisted therapy pilot study on smoking cessation, Johnson, Garcia-Romeu, Cosimano, and Griffiths (2014) reported remarkable findings at 6 months' follow-up: 12 of the 15 participants were abstinent from tobacco (based on physiological indices). These outcomes were significantly correlated with reports of mystical experience, experience of increased meaning, and spiritual significance. Johnson, Garcia-Romeu, and Griffiths (2017) and team found that at 12-month follow-up, 67% of these participants remained smoking abstinent. This is a remarkable finding in the field of tobacco addiction. Bogenschutz (2015) is currently conducting an NYU double-blind study on the effects of psilocybin-assisted psychotherapy on alcohol dependence. Members of the Hopkins research group are also conducting a study on the effects of psilocybin on the psychology of long-term meditators and brain function, as measured by functional magnetic resonance imaging (Griffiths, 2015b). And NYU and Johns Hopkins are in the midst of a study focused on the effects of psilocybin on religious leaders' experience of mystical-like states (Griffiths, 2015a).

In a pilot study of patients with anxiety as a result of advanced-stage cancer, a team of researchers at University of California, Los Angeles–Harbor Medical Center led by Charles Grob found no adverse physical or psychological effects (Grob et al., 2011). But despite the relatively low dose of psilocybin administered to the patients, the study yielded a statistically significant reduction in anxiety. They note as well that the quality of the

experience of psilocybin supports the development of strong therapeutic bonds and the lessening of demoralization. Griffiths et al. (2016) reported results on a very low dose psilocybin session versus a high-dose psilocybin session for 51 participants with life-threatening cancer. With 5 weeks between sessions and 6-month follow-up, the high-dose condition resulted in decreases in anxiety, death anxiety, and depressed mood with concomitant increases in life-meaning, optimism, quality of life. Clinically significant changes remained for 80% of participants at 6-month follow-up, with more than 80% endorsing the effects of the high-dose session to be moderately or greater increased life satisfaction/well-being.

In a related study Ross et al. (2016) measured the effects of psilocybin-assisted therapy for 29 patients with cancer-related psychological distress on pain perception, depression, anxiety, existential/psychospiritual distress, quality of life, and spiritual/mystical states of consciousness. The research team found that single moderate-dose psilocybin-assisted psychotherapy produced rapid, robust and enduring anti-depressant and anxiolytic effects. Psilocybin-induced mystical experience mediated the therapeutic effect of psilocybin on their depression and anxiety.

Current MDMA-Assisted Therapy Outcomes

In 2011, Mithoefer, Wagner, Mithoefer, Jerome, and Doblin published the results of a Phase 2 clinical trial examining the effectiveness of MDMA on treatment-resistant PTSD. They found that 83% of those who received MDMA in conjunction with psychotherapy no longer qualified for a PTSD diagnosis two months post-treatment compared to 25% of other participants who only received a placebo (Mithoefer et al., 2011). All of the study participants who received MDMA-assisted therapy were found to have maintained both statistically and clinically significant symptom relief in a comprehensive follow-up study (Mithoefer et al., 2013). Michael Mithoefer (2014) and Annie Mithoefer are now conducting an MDMA study with veterans, firefighters, and police officers with treatment-resistant PTSD and are overseeing studies on MDMA in Boulder, Colorado, Vancouver, B.C. and Beer Yaakov, Israel. Also of note is the on-going study looking at MDMA-assisted therapy for the treatment of social anxiety in autistic adults. (Danforth, Struble, Yazar-Klosinski, & Grob, 2015). Recent research has shown MDMA use to be correlated to self-compassion (Kamjol et al., 2015), generosity toward close friends (Kirkpatrick, Delton, Robertson, & de Wit, 2015), and increases in emotional content in speech about a significant other during a talking task (Baggott, Kirkpatrick, Bedi, & de Wit, 2015).

Subjective Experiences of Participants in Psilocybin and MDMA Clinical Trials

The following discussion focuses on the primary clinical results regarding relationship and quality-of-life improvements for the research participants and reflects on some interesting parallels between participant outcomes and desired therapist characteristics. These highlighted clinical results are: occasioned mystical states and experiences; openness; improved quality of life; and enhanced experiences of love, empathy and meaning-making. Among the clinical outcomes briefly mentioned in the previous section are mystical states of consciousness or what is often referred to as the mystical experience. Pahnke and Richards (1966) divided the features of the psychedelic-induced mystical experience into nine categories, which Richards (2009) subsequently narrowed to six variables: unity; transcendence of time and space; intuitive knowledge; sacredness or awesomeness; deeply-felt positive mood; and ineffability and paradoxicality. Not only have researchers found that these mystical experiences occasioned by psychedelic- and entactogen-assisted therapy can count among the most spiritually and personally significant of patients' lives (Jesse & Griffiths, 2014), they have observed that such experiences produce increases in openness. "Importantly, participants who had a complete mystical experience during their high-dose session, but not others, showed enduring increases in openness, suggesting that other mystical experiences could occasion similar change" (MacLean, Johnson, & Griffiths, 2011, p. 1456).

As such, a psychedelic- or entactogen-derived mystical experience can actually improve the quality of life to a notable degree for an addict, a traumatized person, or someone who is dying. As Bossis (2014), an investigator for NYU's end-of-life psilocybin clinical trials, writes,

> Enhanced spirituality and existential well-being derived from a mystical experience offers distinct opportunities for cancer patients to foster a sense of connectedness with the sacred, to enhance loving relationships with family and other significant persons in their life, and to live fully, in the moment, with equanimity and acceptance. (p. 266)

A pilot study looking at psilocybin for the treatment of tobacco addiction found a significant correlation between mystical experience measures and smoking cessation outcomes (Bogenschutz & Johnson, 2016; Johnson et al., 2014). Indeed, the mystical experience that LSD catalyzed was recognized by none other than Bill Wilson, founder of Alcoholics Anonymous, as having a potentially profound impact on addiction (Richards, 2009).

Also of interest is the finding that the experience of love can be facilitated by both MDMA and psilocybin. With the lessening of fear and anxiety, feelings of love can come to the surface, allowing patients to examine their lives from a more secure place, which is one of the core reasons that MDMA is so effective in facilitating therapy (Greer & Tolbert, 1990; Mithoefer et al., 2011). For patients with terminal illnesses, the experience of love can be especially transformative (Grob et al., 2013; Roberts & Hruby, 2002). Bossis (2014), in recalling clinical studies using psilocybin with advanced-stage cancer, noted that patients reported experiences akin to what would be considered agape, or universal love.

Another important clinical outcome facilitated by psychedelic- or entactogen-assisted psychotherapy is the experience of greater empathy (Riedlinger & Riedlinger, 1994). In clinical trials focused on psilocybin and mystical experiences, Griffiths et al. (2011) found that a significant increase in empathy during the study remained stable for a majority of the participants at the follow-up assessments 14 months later. In a recent analysis of MDMA research on empathy, Jerome, Schuster, and Klosinski (2013) propose that the empathy engendered by MDMA could also play a role in the treatment of addictions, as it could allow patients to acknowledge to a greater degree their substance abuse, the effect it has on others, and the corresponding need to change their behavior.

Finally, there are predominant and positive outcomes regarding the increased capacity to make meaning of one's experience after psilocybin-assisted therapy (Griffiths et al., 2011; Grob et al., 2013; Jesse & Griffiths, 2014; Richards, 2014). The ability to make new meaning from old experiences can catalyze the healing process (Echenhofer, 2011). Rev. Mike Young, one of the divinity students who participated in Pahnke's Good Friday Experiment in 1962, expressed this sentiment 30 years later:

> The drug experience can evoke a reordering, a reframing, of the experiencer's meaning and meaning-making. . . . This reframing and re-connecting, this re-membering of ourselves, is what pushes and pulls us to be more than we are. (Young, 1995, p. 38)

The Competencies of the Therapist Guide for Psychedelic-Assisted Psychotherapy

The benefits of psychedelic-assisted therapy have become clear with each successive study, and with them, the best practices needed to elicit positive therapeutic outcomes. But discussions about the desired qualities and competencies of the therapists themselves have remained limited. Clinicians have

typically pointed out therapist competencies when sharing case study observations, while research-based descriptions of therapist competencies have primarily taken place within the parameters of treatment manuals and protocols. The MAPS manual for MDMA-assisted PTSD therapy stands as an exemplar (Mithoefer, 2016). If Phase 3 studies get the go-ahead soon from the FDA and if those clinical trials are deemed by the FDA to be successful in comparison with results of current treatments for the medical conditions studied, there will be decidedly broader scopes of practice for therapists in psychedelic-assisted therapy and research. The time has come to have serious conversations and inquiry dedicated to psychedelic therapist competencies and training in anticipation of these developments. The psychedelic therapist guide competencies that follow are described using the usual terminology of mental health and medical professionals' competencies in three functional areas: knowledge and understandings; values, attitudes and dispositions; and skills.

There are references in contemporary discourse to three terms used to describe a mental health or medical professional who is present and facilitating a psychedelic therapy session: a sitter (Greer & Tolbert, 1998; Grof, 1980; Taylor, 2007); a guide (Cooper, 2014; Jesse, 1995; Pahnke & Richards, 1966); and a therapist (Abramson, 1956; Eisner & Cohen, 1958; Noller, 2009; Walsh & Grob, 2005). A review of the psychedelic literature shows that the preferred term by psychedelic scholars is "therapist" and the role is associated with that of being a "guide," with these two terms sometimes used interchangeably. A cogent description of the therapists who act as guides in psychedelic research is from Mithoefer (2016):

> The therapists act as empathic listeners, trustworthy guides, facilitators of deep emotional expression and catharsis, and supporters of the participant's own inner healing intelligence. . . . The therapists' role is often to follow, rather than guide, the participant, as she/he explores new and unexpected perceptions and realizations. At other times it may be helpful for the therapists to remind the participant that facing painful experiences is actually a path toward healing. . . . In this situation, it is valuable for the therapists to intervene and guide the participant back to her/his internal experience. In this case, guidance should be offered as a possible choice without implying that it is expected or is the only correct course to follow. (pp. 29, 30, 38)

This witnessing and acknowledgment by the therapist facilitates in the participant a sense of trust, safety, encouragement, and fortitude, as is true in the various models of psychotherapy. At the same time, it solidifies the therapeutic relationship through the ebb and flow of challenges and releases during psychedelic preparation, sessions, and integration periods. The therapist

helps the participant move through three phases of treatment: preparation for the medicine-assisted session, the medicine session itself, and integration of the psychological material that arises during preparation and the medicine session. The context within which this therapeutic process occurs is referred to as set and setting (Grof, 1980):

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

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

This review and compilation of the extant, but sparse, literature on specific competencies of the psychedelic therapist guide reveals fundamental agreement on the core knowledge, attitudes, and skills of a therapist in this specialization. Most clinical scholars in the field have at least touched on the question of therapist competencies if only in an oblique manner. Most often we hear in the literature that such description is beyond the scope of the paper or book. Where it is published, both the psycholytic and client-centered researchers and thinkers suggest the following primary therapist qualities: an empathetic abiding presence; trust enhancement; spiritual intelligence; knowledge of the physical and psychological effects of psychedelics; therapist self-awareness and ethical integrity; and proficiency in complementary techniques. Many of these desired competencies are characteristic of all psychiatric and psychological treatment. However, there is a specificity to the competencies that is unique to the field of psychedelic-assisted psychotherapy and requires specialized training. Each of the six competencies serve as umbrella terms under which reside several unique components that are closely related to one another.

Competency 1: Empathetic Abiding Presence

One of the hallmarks of humanistic therapies, the therapeutic capacity for empathy (Bugenthal, 1978; Maslow, 1970; Rogers, 1961), is a universally agreed-upon quality of a properly trained psychedelic therapist. This is not surprising, given that empathetic skills are foundational to the training of

practitioners within the mental health, medical, and religious professions. In addition to the traditional understanding of empathy as key in facilitating positive therapeutic outcomes, empathy in the therapist guide takes a particular bent in psychedelic-assisted therapy (Grof, 2005; Mithoefer et al., 2011). Current thinking in this field embraces a particularity in the qualities of desired empathy from the therapist: an empathetic responsivity that has been leavened into a cultivated embodiment of a calm, abiding presence during psychedelic therapy. This empathetic abiding presence is a capacity evidenced in the therapist during preparation, the session itself, and integration meetings. The term "abiding" here is purposely used to convey aspects of a witnessing of the mystery of life in action during psychedelic-assisted psychotherapy. Richards (2015) likens this to the ability to be present with qualities of patience, openness and trust in the processes of unfolding. Mithoefer (2016) and colleagues determined that empathetic presence was one of seven unique therapist skills for adherence raters to assess when reviewing archival videos of sessions, which include: verbal communication; establishing rapport; communicating safety and support; eliciting pertinent information; addressing questions and concerns; empathetic presence; and non-directive approach.

Components of empathetic abiding presence range from composure, evenly suspended attention, mindfulness, empathetic listening, "doing by non-doing", responding to distress with calmness, and equanimity. Buckman (1967) reports that the quality of empathy with presence and demeanor is crucial in this work because "the patient is very susceptible to mood and voice tone of therapist, nurse and other people in the treatment unit" (p. 89). Strassman (2010), Johnson, Richards, and Griffiths (2008) and Grof (1980) have shared similar clinical observations. "We have repeatedly observed that LSD subjects were able to tune into the inner feelings of the sitters with great accuracy" (Grof, 1980, p. 89). Taylor (2007) speaks of this presence as a capacity for a "widening the focus of awareness" and "doing by non-doing" during processes of Holotropic Breathwork, the widely known form of non-psychedelic means of inducing a non-ordinary state of consciousness (p. 21). Stan and Christina Grof (2010) developed Holotropic Breathwork as a method of inquiry and transformation based on elements of yogic breathing practices. Naranjo (2006), a contemporary advocate of psycholytic psychedelic therapy, conceives of the complementarity between love and non-attachment when the therapist practices mindfulness in sessions. Several researchers have commented that ways of listening, with empathy and presence, are much more impactful than engaging the participant in dialogues and inquiry (Naranjo, 2013; Stolaroff, 1997; Richards, 2009). "Dialogue between client and therapist, which most therapies view as central, appeared less

important. Indeed, in high-dose sessions, it sometimes seemed more distracting than beneficial" (Walsh & Grob, 2006, p. 440).

An aspect of empathy is likened to being balanced and aware of the multiplicity of what unfolds moment to moment for the volunteer (Richards, 2003; Sherwood, Stolaroff, & Harmon, 1962). This specific quality of empathy can be seen as akin to the stalwart analytic practice of evenly suspended attention (Epstein, 1984). Strassman (2002) reports that "our research nurse and I did our best to practice meditation while with our volunteers: watching the breath, being alert, eyes open, ready to respond, keeping a bright attitude, and getting out of the way of the volunteer's experience" (p. 117). Of note here is the empathetic skill of being attentive, supportive, and becoming ground to the figure of the participant's own process. In the MAPS manual for treatment of PTSD, Mithoefer (2016) states that

> therapists should have a client centered orientation and should have done sufficient inner work themselves so they are comfortable following and supporting whatever course the participant's own emotional process takes, rather than trying to impose upon it a predetermined course or outcome. (p. 11)

Thus, therapists practice to "learn when [their] prior training can be helpful and when it needs to be set aside and just be a good listener, compassionate observer and caring supporter" (Fadiman, 2011, p. 77).

Another component of empathetic abiding presence is the therapist's equanimity and natural comfort in listening deeply and moving gracefully with the ebb and flow of each unique psychedelic session. This abiding ease is crucial when challenging and difficult moments arise for the participant during the session. This equanimity can be seen as consistent with Taylor's (2007) statement that a guide develops the skills for "a balance of protection, permission and connection" (p. 133). The therapist guide's knowledge of the interaction of the effects of the medicine, the setting, and the trust in the wisdom of the healing process is paramount for ease during sessions and for potentiating a corrective emotional experience for the participant (Bache, 2000; Richards, Grof, Goodman, & Kurland, 1972). Grof (1980) adds that a therapist's confidence and competence can be increased through observation of the participant's patterns of movement into, through, and beyond overwhelming difficult affect: "Witnessing positive resolutions of such states and seeing the same subjects only a few hours later radiant and joking, the therapist gradually develops equanimity, confidence and tolerance in regard to the entire spectrum of psychedelic phenomena" (p. 101).

In addition to these above qualities, therapists are seen as best suited to this work if they themselves have experienced a fair share of transformative,

nonordinary, or alternate states of consciousness (the latter term coined by Richards, 2003). This criterion has clear face validity, given the clinical set and setting within which they provide therapy (Blewett & Chwelos, 1959; Fischer, 2015; Grob, 2002a, 2002b). While not a consensus, there is a vein in the limited discourse on therapist skills and training that suggests the need for psychedelic therapists to be versed in a meditation or contemplative practice (Pahnke, 1963; Richards, 2005; Strassman, 2010). Possibly they have experienced and integrated mystical states of awareness and have found the experience of value (Roberts & Hruby, 2002). Such experiences of alternate states can serve to help therapists embody the empathetic abiding presence called for in this work, as well as tolerance for moments in psychedelic sessions in which the participant is experiencing paradoxical, intense emotional and physical states. Indeed, this competency is reflective of the common psychedelic outcome in which volunteers can find themselves capable of greater empathy and openness, with concomitant trust in the unfolding process of psychological transformation.

Competency 2: Trust Enhancement

Related to an empathetic abiding presence, the therapist is skilled in enhancing trust in three arenas: the volunteer's view of the therapist as a trustworthy guide; the participant's trust in their own inner healing capacity; and the ability to reliably normalize for the participant that paradoxical transformations and radically unexpected moments in sessions are to be expected, and thus trusted as part of the process. These aspects of trust enhancement capacities enable the therapist to support the participants' engagement in making meaningful sense of their lives and inner healing processes. As with Rogers's (1961) model, current researchers see the quality of trustworthiness as key to creating safety in the treatment sessions (Johnson et al., 2008; MacLean et al., 2011); building the therapeutic relationship (Greer & Tolbert, 1998; Grob, 2002; Jerome et al., 2013); and supporting the participant's increased trust in others and their trust in self, which can be experienced in sessions as "a unity with oneself" (Passie, 2012). One component skill needed is to be knowledgeable about the types of subjective states that participants may experience and adroitly convey normalization of these states during preparation.

> Participants will be reminded that difficult emotions, including grief, rage and fear or panic, may arise during MDMA-assisted psychotherapy sessions, and that sometimes the process can produce surprising and profound experiences even in people without any psychiatric conditions. (Mithoefer, 2009, p. 32)

This latter point is a key consideration for psychedelic therapists since part of their work in optimizing the set and setting is to consistently respond in ways designed to enhance the participant's trust in their own inner healing process. This capacity is embodied in the therapist who is a role-model for the participant in terms of her or his own trust in the unfolding process within the sessions. This necessitates a welcoming attitude and openness toward the full range of emerging affective experiences (Grof, 1998; Lennard & Hewitt, 1960; Richards et al., 1972). In MDMA therapy with trauma, the "therapists work with the participant to establish a sense of safety, trust, and openness, as well as to emphasize the necessity of trusting the wisdom of the participant's innate capacity to heal the wounds of trauma" (Mithoefer, 2016, p. 5). The qualities of therapist openness to various ontologies and a personal embodiment of multiple ways of knowing are foundational for the development of this trust enhancement competency. As an example of these therapist qualities, Maté (2010) observes that trustworthiness as an addiction therapist entails the practitioner's full acceptance and honoring of addicts, particularly while the patients are in altered states of consciousness. Stanislav Grof (1980) draws out the connection among a trust in oneself, the therapeutic relationship, and trustworthiness in the therapist:

> A good therapeutic relationship helps the patient to let go of psychological defenses, surrender to the experience, and endure the difficult periods of sessions characterized by intense physical and emotional suffering or confusion. The quality of the therapeutic relationship is essential for working through on of the most crucial situations in psychedelic therapy, the crisis of trust. (p. 90)

Being consistently trustworthy as a guiding therapist during psychedelic-assisted therapy research contributes to the participant's felt sense of a stable and safe set and setting.

This trustworthiness is essential for a participant's willingness to endure the challenges of making meaning of the broad ranging material emerging from psychedelic sessions. This capacity to normalize unfamiliar or challenging material is augmented by therapeutic skills in the facilitation of an enhanced meaning-making capacity within the participant (Bugenthal, 1978). The journey of making meaning from psychedelic sessions is paramount in positive therapeutic outcomes and the concomitant increase in a sense of quality of life (Griffiths, Richards, Johnson, McCann, & Jesse, 2008; Savage, Savage, Fadiman, and Harmon, 1964). Bossis (2014) observes that "if the search for meaning is successfully accomplished, patients may experience a sense of renewal, greater self-awareness, personal growth, and an enhanced appreciation for life, nature, and greater compassion for others" (p. 252).

Carhart-Harris et al. (2017) and Preller et al. (2017) have recently shown breakthrough findings of neural correlates to cognitive fluidity in attributions of relevance and to meaning-making capacity in relation to psilocybin and LSD ingestion, respectively. In Preller et al. (2017), enhanced meaning making and relevance attributions were most the highly weighted subjective variables in a path analysis of outcome. The trust-enhancing therapist is competent in helping the participant cultivate multifocal viewpoints for making sense of what may reveal itself as meaningful during psychedelic-assisted therapy.

Competency 3: Spiritual Intelligence

Therapists who are competent in psychedelic-assisted therapy have knowledge and values that can be described as a spiritual intelligence that "goes beyond conventional psychological development. In addition to self-awareness, it implies awareness of our relationship to the transcendent, to each other, to the earth and all beings" (Vaughan, 2002, p. 18). One can liken this intelligence to a deep understanding and embodied experience of entelechy, which is

> a philosophical term, referring to a meaningful process of psychological and/or spiritual content emerging from within the field of consciousness in a wise and orderly manner. I have come to believe that each person 's psyche is infinitely wiser than the egos of the patient and therapist (or traveler and guide) and, if trusted, will manifest the experiential sequences of imagery, memories, emotions, revelations and insights needed to facilitate conflict-resolution, communication with the sacred realms of the Self, and healing. (Richards, 2003, p. 33)

Spiritual intelligence is evidenced by knowledge of the process of entelechy, having existential meaning-making capacities (Emmons, 2003) and familiarity with mystical states of consciousness (King & DiCecco, 2009).

Careful considerations of the descriptions by Passie (2012), Bossis (2014), and Richards (2014) of the qualities of experiences within transpersonal and mystical realms of consciousness reveal descriptors of spiritual intelligence in the competent therapist. Passie (2012) describes a set of six characteristic elements of transpersonal experience with MDMA, which are aspects of spiritual intelligence: (a) ability to open up toward inner awareness, (b) feeling free to accept oneself, (c) feelings of relaxed detachment to an extent that everything appears safe, (d) a felt contact with an inner core, (e) a feeling for what love is, and (f) awareness of nonmaterial aspects of being and happiness. Competent therapists with spiritual intelligence have knowledge and

values related to what Bossis (2014) describes in his derivation of four themes of experience from psilocybin in end-of-life anxiety research: (a) transcendence into the nature of self, (b) cultivation of equanimity, (c) acceptance of change and impermanence, and (d) the experience of love (p. 267).

Therapist guides with this competency have the awareness of what Richards (2014) describes as truth claims that are resultant from mystical experiences: (a) the primordial reality of the spiritual dimension of consciousness, (b) the indestructible nature of this form of consciousness, (c) interrelatedness within the great unity of all human beings and perhaps all life forms, (d) agape as the ultimate energy at the core of reality, and (e) the incredible, awesome beauty of these states in design, visuals, wisdom and meaning. These qualities of psychedelic therapists' spiritual intelligence are best described as an "embodied knowledge." "All the researchers therefore ended up at least sympathetic to and, in several cases deeply committed to, a spiritual worldview" (Walsh & Grob, 2006, p. 438).

Competent psychedelic therapists embody spiritual intelligence, which is woven with an appreciation of the mystery of realms of transpersonal consciousness (Vaughan, 2002) and of one's own being and suffering (Richards, 2015). Correlations of clinical outcomes of such values held by the therapist, and skillfully applied in psychedelic-assisted psychotherapy, will be a fruitful line of future empirical inquiry. These therapist sensibilities are akin to participants's subjective mystical experiences which are significantly correlated to the positive outcomes on many clinical variables in psychedelic-assisted therapy research.

Competency 4: Knowledge of the Physical and Psychological Effects of Psychedelics

The components of this expertise range from knowledge of the anthropology of shamanism; neurobiology, neuropharmacology, and drug dispositions; skills in the creation of safe and artful sets and settings; and optimally, knowledge from subjective, phenomenological experience of personal psychedelic-assisted therapy. The work of contemporary psychedelic therapy and research has benefited from knowledge of ancient and contemporary indigenous practices of ceremonial use of plant medicines, which have time-honored sets and settings. Psychedelic scholars have noted the need for guides in psychedelic-assisted therapy to have in-depth, theoretical, and experiential knowledge of the cross-cultural roots of the global use of plant medicines (Bravo & Grob, 1989; Grob & Dobkin de Rios, 2013; Metzner, 1998; Narby, 1998; Smith et al., 2004). Schultes (1979) contributed to this discussion early in the past

century when describing the dedication and skill of leaders in guiding inquiry and healing with peyote in southwestern and Mexican indigenous communities. Expertise in this area can range from the therapeutic application of the anthropology of shamanism, knowledge of ethnobotany, and skillful, artful inclusion of ceremonial aspects of healing within community (Davis, 1996; Furst, 1976; Labate, 2014; McKenna, 2007; Schultes, 1979; Smith, 1988; Wasson, Hofmann, & Ruck, 2008).

Researchers have reiterated that therapists need to be thoroughly knowledgeable in all aspects of current best practices for creating appropriate set and setting for safe and optimal outcomes. These skills include competence in the thorough assessment for eligibility of candidates for psychedelic-assisted therapy; informed knowledge of contraindications for such participation; and experience in building rapport while working closely with a cotherapist, as well as with a multidisciplinary treatment team (Greer & Tolbert, 1998; Johnson et al., 2008; Passie, 2012). The authoritative compendium of safety procedures for psilocybin-assisted therapy from Johnson et al. (2008) is an oft-referenced summary of the wisdom on safety procedures and ethical practices. Knowledge is necessary regarding risk assessment and mitigation for acute, difficult effects, such as the potential overwhelming distress of dysphoric somatic, emotional, and existential experiences in a session. The therapist "should be knowledgeable about the medical and psychological markers of potential adverse reactions to the drug" (Johnson et al., 2008, p. 610). Knowledge of hallucinogen persisting perception disorder, preexisting conditions, and clinical reports of unusual drug reactions is of key importance in this competency.

Psychedelic therapists need to be astute in theories of child and adult development, as sessions of psychedelic-assisted therapies often reveal the participant's current developmental challenges and accompanying life narratives. A related skill is the requirement that the therapists successfully know how to persuade the volunteers to stay onsite, to refrain from destructive acts to self, other, or property; and from sexual activities; and to follow therapists' instructions for safety (Greer & Tolbert, 1986; Harmon, McKim, Mogar, Fadiman, & Stolaroff, 1966; Shulgin, 2001). Therapist guides in double-blinded comparison treatment groups need to understand all the nuances and limitations to their behavior in order to keep the integrity of the blind intact through the duration of the study (Griffiths et al., 2006). In terms of creating an artful and aesthetic physical environment for the session, there are excellent and thorough references on the use of music, flowers, art, lighting, chalices, the décor, furniture, and a personal altar for the participant (Bonny & Pahnke, 1972; Cooper, 2014; Grob, 2002; Kaelen et al., 2015; Mithoefer, 2009; Fadiman, 2011; Metzner, 2015; Richards, 2009).

Psychedelic therapist guides should be competent in their knowledge in anatomy and physiology; neurobiology; pharmacology; drug disposition and interactions; and neuropharmacology of psychedelic drugs (Grob et al., 2013; Hoffer & Osmond, 1967; Nichols, 2004; Pahnke & Richards, 1966; Walsh & Grob, 2006). Familiarity with clinical narratives on the normative effects of different psychedelic drugs at varying dosages in a variety of sets and settings is highly instructive as well (Abramson, 1956; Fadiman, 2011; Metzner, 2013, 2015; Stolaroff, 1997). Related to these drug-related knowledge base competencies is an issue in the field that is agreed on in principle, but became illegal to enact after MDMA was deemed a Schedule I drug by the FDA in 1985. Since the 1950s, there has been agreement about the essential need for any medical personnel and therapists working with psychedelic-assisted therapies to have personal experiences with the drugs in a safe set and setting (Grof, 2005; Hoffer & Osmond, 1967; Metzner, 2015; Mithoefer, 2009; Sherwood et al., 1962). In his recent book, Richards (2015) echoes the perspective of many scholars and therapists that the capacities of therapists are enhanced when they are experienced themselves with the psychedelic medicine(s) with which they are conducting therapy and research:

> Besides gaining knowledge of the different terrains within the mind, which is likely to increase the practitioner's empathy and effectiveness when working with future patients, sensitivity to the potency of factors such as trust, honesty, courage, and openness is likely to be enhanced. (p. 148)

In the 1990s when research began again under FDA approval, the discussion among scholars in the field revolved around the dilemma of promoting this valuable competency-based training when it had been deemed illegal for everyone except participants in the approved clinical trials. Grof (1980) states that from his viewpoint "it is impossible for the future LSD therapist to acquire deeper understanding of the process without first-hand exposure" (p. 101). Shulgin (2001) reiterates that with psychedelics the therapist themselves "MUST have had this kind of emotional and spiritual journey, if [he or she] asks a client to undergo it" (p. 201, emphasis in original). Earlier, Hoffer and Osmond (1967) observed that when having a psychedelic therapeutic session, if a therapist "has had a psychedelic reaction he will understand a similar reaction in his patients and if he has a psychotomimetic reaction he will sympathize with this kind of reaction in his patient" (p. 109). Swiss and German health authorities have actually required that therapists in a psychedelic study first take that drug as specified by the protocol with which they are working (Strassman, 2010). The Czech model in the 1950s required five personal sessions and 30 sessions as a guide as a requirement in a therapist's

training (Grof, 2005). Researchers at MAPS successfully gained FDA approval to allow training therapists to be participants in a Phase 1 study with healthy subjects (Mithoefer, 2009). This unique and strategic protocol has allowed for the personal experience of MDMA for the MAPS fully trained therapists.

Competency 5: Therapist Self-Awareness and Ethical Integrity

This competency relates to six components of the therapist's acumen related to: self-awareness of personal motives for this work; integrity in protecting boundaries with the volunteers; well-developed capacities for building therapeutic alliances; skills in attachment theories, and transference-countertransference analysis; and personal self-care (which protects both the therapist guide and the volunteers). A core component of this competency is a capacity to wisely reflect on one's motives when conducting psychedelic therapy while simultaneously working with participants' attachment and transferential processes (Fisher & Martin, 1969; Grof, 1968; Sherwood et al., 1962; Strassman, 2001). The consensus is that psychedelic therapists should work closely with a clinical supervisor on these issues that invariably occur. Transferential issues have been seen to arise more often in higher dose treatment, depending on the emerging unconscious processes (Grof, 1980; Lennard & Hewitt, 1960; Strassman, 2010; Yensen & Dryer, 1992), but are not likely to lead to idealization of the therapist (Cohen & Ditman, 1963; Passie, 2012). In sessions in which transference is triggered, "there is little doubt that a Jungian analyst will find many archetypes nor will Freud's disciples lack early memories of Oedipal conflict" (Hoffer & Osmond, 1967, p. 109).

Researchers have highlighted the need for therapists to scrutinize their responses in countertransference with participants in each step of the treatment, particularly during the psychedelic sessions. Given the intensity of affect that can emerge, "the therapist can all too easily be drawn into acting out with a patient, actually preventing the patient from gaining insight" (Buckman, 1967, p. 90). Fadiman (2011) reports clinical findings that the participants "became distressed when the guide had become unsettled, uncertain or upset" (p. 21). Learning to not directly enact roles in response to the participant's unconscious material during sessions is a key skill in this competency (Blewett & Chwelos, 1959; Greer & Tolbert, 1986; Passie, 2012; Strassman, 2010). Sherwood et al. (1962) reported that psychedelic therapy "tends to discourage any sort of long-term dependency or transference relationship with the therapist" (p. 72). In a unique balance that characterizes psychedelic therapy, this special quality of the transference analysis "is

indispensable and the nonreinforcing and nonresponding attitude of the therapist is a necessary prerequisite enabling the patient to reach the core experience" (Grof, 1968, p. 465).

> The client sets the goals for himself, the therapist accepts those goals and accepts the fact that only the client can achieve them. A dependency transfer relationship to the therapist is not sought, but rather the dependency is placed on that source of information *within* the client which is made accessible by the drugs so that the client develops a reliance on those aspects of his own *developing* states of consciousness. (Fisher & Martin, 1969, p. 69)

These aspects of the therapeutic alliance building are thoroughly supported, of course, by first four competencies of the therapist guide: empathetic abiding presence; trust enhancement capacities; spiritual intelligence; and knowledge of and skills in safe, informed sets and settings. The field of psychedelic research "demands very high requirements in the training and experience of therapists, who must always comport themselves with good psychotherapeutic skills and a high degree of personal integrity" (Passie, 2012, p. 67). Grof (1980) recommends the cultivation of thorough self-reflection and becoming conscious of impulses to act impressively and to demonstrate power or authority with participants. Metzner (2015) cautions therapists to be ever aware of the potential for their own grandiosity and the overidealizing of their perceptions of what is meaningful in states of consciousness associated with psychedelic-assisted therapy.

Self-awareness of power dynamics is very important when supporting the sense of safety felt by participants from underrepresented populations, such as people of color and LGBTQ (lesbian, gay, bisexual, transgender, and queer) identified persons. Competency in these regards can avert ethical pitfalls that might otherwise be at risk during the psychological activation by the medicine (Dahlberg, 1967; Naranjo, 2013). An adjunct to this ability to self-reflect is the guide's self-care skills, so as to avoid compassion fatigue and to process what happened in sessions with her or his research team (Cooper, 2014; Eisner & Cohen, 1958; Smith, 1988). "It is important that therapists continue doing their own inner work and that they take time for regular debriefing with the co-therapist" (Mithoefer, 2016, p. 57). These skills of integrity and ethical behavior protect both the volunteer and the guide from relational outcomes that could hamper the effectiveness of psychedelic-assisted therapy. The last component of this competency is an adoption of and acting within guidelines in relevant ethical codes (in addition to the ethical guidelines of one's profession).

For further consideration, there has been fruitful work on the creation of ethical guidelines specific to guiding people who are on spiritual paths, guiding

in Holotropic Breathwork, guiding psychedelic-assisted psychotherapy, and working on collaborative multidisciplinary teams. The *Code of Ethics for Spiritual Guides* from the CSP (Jesse, 1995) is a milestone in the crucial period of the FDA's agreement for psychedelic research to begin anew in the 1990s. The collective collaboration of psychedelic elders and scholars within CSP was seminal in catalyzing the heft of the current renaissance in psychedelic research. CSP regarded ethics as foundational for its subsequent work, which encompassed matters of religious freedom and instituting university research with psilocybin, particularly when given experimentally to healthy volunteers. The CSP code of ethics has nine foci: intention, serving society, serving individuals, competence, integrity, quiet presence, not for profit, tolerance, and peer review. The code was developed by CSP for "guides" to be inclusive of, but not restricted to, community members who "feel called to assist others along spiritual paths, and who are known as ministers, rabbis, pastors, curanderas, shamans, priests, or other titles" (n.p.). Given that many psychedelic therapists see their work as potentially aiding people on their spiritual paths, this code is an invaluable resource.

Cooper (2014) and her team have adapted aspects of the CSP code and professional codes for the *Usona Guide Manual* for an FDA-approved study on the pharmacokinetics of psilocybin. As part of that manual, the *Usona Code of Ethics for Entheogen Guides in a Research Setting* contains guidelines for therapist guides in the areas of intention, integrity, competence, health and safety, healthy boundaries, service to individuals, and service to society. (The term "entheogen," translated as "the eliciting of the divine within," is a newer word used by a growing number of scholars and researchers instead of the term "psychedelic", translated as "mind-manifesting.") A third set of relevant ethical guidelines, *Ethics for Holotropic Breathwork Practitioners* (Grof Transpersonal Training [GTT], 2016a), outlines ethical behavior in the areas of commitments, confidentiality, safety, boundaries, peer review, community, and dual relationships. Finally, members of the Interprofessional Professionalism Collaborative, representing national associations in psychology and medical specialties, have created a list of values and ethical behaviors for use in multi-disciplinary care-giving teams in medical settings (Hammer, et al., 2012). The Interprofessional Professionalism Collaborative delineated 43 attitudes and valued behaviors, such as respect for colleagues in other disciplines, collaboration and team-building skills, and values that are client- and family-centered. In sum, any therapist guide needs to adhere to the ethical competencies outlined by their profession, their practice/research protocols in their professional setting(s), and would do well to adopt relevant sections of these four sets of ethical and values-based guidelines for their research and practice setting.

Competency 6: Proficiency in Complementary Techniques

The primary components of this competency are skills and knowledge that form a toolbox of complementary therapeutic methods to use in various phases of the therapy and research. Many types of complementary therapeutic skills have been explored for the early preparation phase, to bring closure within the psychedelic session itself, or for use during integration sessions (Grob, 2002). These additional skills and therapeutic methods used by guides include somatic-oriented techniques such as Holotropic Breathwork (Grof, 2009; Mithoefer, 2009; Taylor, 2007); stress inoculation, therapeutic body work, and touch (Cooper, 2014; Eisner & Cohen, 1958; Johnson et al., 2008; Mithoefer, 2016); techniques of eye-gazing at a mirror or with the therapist (Abramson, 1967; Eisner & Cohen, 1958; Grof, 1968); felt sensing and focusing (Danforth, 2009); and somatic experiencing and sensorimotor therapies (Dahlberg, 1967; Mithoefer et al., 2013; Taylor, 2007).

Other competencies that have been found to be useful are guided affective imagery (Bonny & Pahnke, 1972; Leuner, 1969; Richards, 2015); meditation during integration periods (Griffiths et al., 2011; Watts, 1970); psychoanalysis (Grof, 1968; Naranjo, 2013); the Bonny Method of Guide Imagery and Music and expressive arts therapy (Bonny & Savary, 1973); logotherapy, existential, and narrative therapy (Bossis, 2014); posthypnotic suggestions (Hastings, 2006); family-oriented techniques with photos or analytic inquiry such as Internal Family Systems work (Mithoefer, 2016; Stolaroff, 1997); hakomi, gestalt, voice dialogue, and psychosynthesis (Cooper, 2014; Mithoefer, 2016); and shadow work (Grof, 1968; Shulgin, 2001). Depending on the particular protocol and therapeutic issues, a multivaried skill-set in these types of methods is called for in a proficient psychedelic therapist.

Horizons of Psychedelic Therapist Training

With rare exception, there is a consensus that there needs to be specialized training for professionals to be proficient in psychedelic-assisted psychotherapy (Cohen & Ditman, 1963; Kurland et al., 1973; Mithoefer, 2016; Pahnke & Richards, 1966; Strassman, 2010). Clearly, the clinical results are profound and more professionals should be trained to support it. Further evidence of need for skilled therapists, clergy, and medical professionals is found in the 2015 national survey data that that 1.2 million people over age 12 reported taking a hallucinogen in the past month (Center for Behavioral Health Statistics and Quality, 2016). This group represents a much larger population that would immediately benefit from a significant rise in the availability of clinical expertise for helping with risk mitigation and the after-effects of such

experiences in less than ideal sets and settings. Additionally, after Phase 3 trials are sufficiently underway, drug researchers can seek FDA-approval for what are known as expanded access programs: research and clinical programs serving patients who are deemed to have "a serious or life-threatening disease or condition and no other comparable or satisfactory therapeutic options" (FDA, 2013, p. 6). If this happens with MDMA and/or psilocybin, then there will be further need for therapeutic services from properly trained medical professionals, therapists, clergy, and chaplains to work in clinics and centers that have expanded access programs.

The charge of academic professional programs in psychedelic therapy and research is to do justice to the training of expertise in the six therapist competencies. Through the work of MAPS, Heffter, Usona, the GTT, and the California Institute of Integral Studies (CIIS), there are well-established and newly developed psychedelic-assisted therapy training programs (or in Holotropic Breathwork, as is the case of GTT). The leadership of Michael and Annie Mithoefer has been profoundly effective in the development of the MAPS training program for future MDMA-assisted research therapists (Mithoefer, 2009, 2016). The training involves didactic, practical, and experiential training (as mentioned earlier, their trainees may receive MDMA-assisted psychotherapy as part of their training in an FDA-approved protocol). In a well-organized mentoring program, senior Heffter researchers in clinical trials conduct the training for each new medical team receiving Heffter funding for psychedelic research. They provide continuity in terms of supervision, mentoring, and guidance in all aspects of the Heffter-funded psilocybin-assisted research.

The Usona Institute has created a thorough and astute *Guide Manual* for training therapists in research on the pharmacokinetics of psilocybin (Cooper, 2014). The Usona manual is applicable to other psychedelic-assisted research as well. The CIIS (2014) pioneered the first academically accredited certificate program in Psychedelic-Assisted Therapy and Research for training clergy, medical, and mental health credentialed professionals. This postgraduate certificate program is currently training the second cohort of licensed physicians, clinical psychologists, nurses, clergy, and masters level therapists for advanced professional development at psychedelic-assisted therapy centers for FDA-approved research and future expanded access programs. The 6 competencies and 12 curricular domains of study, which follow, are central to the learning outcomes and goals of the innovative CIIS training program. The Psychedelic Psychotherapy Training of the Orenda Institute (2015) in British Columbia is a cohort-based program of theory and practice for professional therapists who wish to learn psychedelic-assisted psychotherapy. In a related area of training, Stan and Christina Grof founded GTT and conducted

Holotropic Breathwork training with the wisdom of set and setting learned when Stan Grof was engaged in LSD research (GTT, 2016b). The multifaceted GTT training enables students to learn competencies to be sitters in breathwork sessions (Grof & Grof, 2010; Taylor, 2007).

Twelve Domains of Training in Psychedelic-Assisted Therapy

The following curricular areas of study are foundational for any training program designed to educate psychedelic therapists. Each of these 12 domains will enhance the development of several of the six therapist guide competencies. Future benchmarks of success in training, derived by each unique training program, can be evaluated based on a coherent linking of competencies and their components to the goals and learning objectives, and to the areas of study that are emphasized in that program. A training program's emphasis on each of the 12 areas will uniquely depend on the intended scope of practice of their graduates (e.g., for Phase 3 research, for expanded access research programs, or in future clinical, palliative, and pastoral care in clinics and perhaps, community-based centers). Trainees should be licensed medical and mental health professionals or ordained/commissioned clergy and chaplains who have had sufficient psychiatry, psychology, and psychotherapy or pastoral counseling training and experience. This includes clinical psychologists, clinical social workers, marriage and family therapists, as well as physicians and nurses, ordained clergy, and commissioned chaplains who are well trained in psychotherapeutic methods. The instructors should be recognized scientists, clinicians, members of the clergy, and elders who have a demonstrated expertise in one or more of the domains. The 12 curricular domains of study for training in psychedelic-assisted psychotherapy are the following:

1. The history of clinical research and current legal status of psychedelic-assisted therapy
2. Neurobiology, neuropharmacology, drug disposition, and drug interactions
3. Best practices in sets and settings: preparation, psychedelic session, and integration
4. Psychedelics and therapeutic relationships: transference, boundaries, ethics, and self-care
5. Supervised observation of psychedelic session videos
6. Variations in therapeutic models: client-centered and psycholytic psychedelic therapy
7. Complementary therapeutic techniques in psychedelic-assisted therapy

8. Co-therapy methods and interprofessional skills for working on multidisciplinary teams
9. Current models of consciousness, spiritual intelligence, and mystical experiences
10. Ceremonial use of psychedelics in religious and community settings
11. Individual and group clinical supervision during an internship as a psychedelic therapist in FDA-approved clinical trials or expanded access clinical research programs
12. Personal experience of being guided as a research participant in an FDA-approved study

Regarding the last domain of study in the absence of or as an adjunct to the legal use of psychedelics in preparing competent therapists, training programs can improvise many sources of inductions of nonordinary, alternate states of consciousness in their curriculum. These include Holotropic Breathwork; drumming and rattling inductions; solo wilderness journeys; isolation tank immersion; participation as a church member in ceremonies with the União do Vegetal, Santo Diame, or Native American Church; prolonged meditation retreats; work in harm reduction or medical centers at events and festivals; and experience healing sets and settings in countries where usage of a particular psychedelic is legal. The fourfold purpose of such experiential training is to support trainees to develop the following: (a) skillful means of personal healing practices that foster spiritual intelligence and empathetic abiding presence; (b) personal knowledge of the primacy of the inner healing capacity and the secondary impact of the guide on psychedelic-assisted corrective emotional experiences; (c) personal knowledge and attitude of appreciation for numinous qualities of the mystical realms of consciousness; and (d) a comfort with unexpected and difficult experiences in induced alternate states.

Much fruitful discussion and debate can emerge regarding questions of training in these 12 areas of study, in light of the scope of practice toward which the programs are training. This would include such questions as the following: Which of the areas of study are or are not essential for particular a competency? What are the best practices for educating trainees in these areas of study and in what kind of learning environment(s)? How should the progress of the trainees be assessed as they move through the program? In what ways should the training program's effectiveness be evaluated, based on its scope, goals, and learning objectives? CIIS is conducting a program evaluation of our first year of training in order to address questions such as these. The established training programs of Heffter, MAPS, GTT and CIIS have much to teach us about these questions as they also continue to evolve their curricula.

Renewed Psychedelic Therapy Training Conversations

As more training programs are developed in this current flux in the scope of practice, these six core therapist guide competencies will be essential in the expansion into areas of new research designs, clinical methods, and pastoral care in medical and community-based centers. Pahnke and Richards (1966) suggested long ago that such centers could include psychiatrists, therapists, and professional religious personnel. Increasing interest of clergy and chaplains in being guides and becoming psychedelically experienced would create welcome discourse about both how to train guides who are clergy and about how clergy are trained (Richards, 2009; Roberts & Hruby, 2002; Vaughan, 2001). Should the future come to include possible applications of psychedelics for "the betterment of well people" (Jesse, 1994), the scope of practice and guide training programs may begin to include people respected in their community due to their therapeutic capacities. Work in ketamine-assisted therapy (Wolfson and Hartelius, 2016; Zarate et al., 2006) will bring about more opportunities for trained therapist guides to use these competencies.

There is no doubt that, during expanded access periods and beyond, some of the most interesting work will be done by therapists who will utilize and adapt wisdom both from the analytically-oriented, psycholytic research and from the more humanistic, client-centered frames of current clinical trials. There is an urgent need to address the issue of more diversity among therapists in terms of increasing the participation of women, people of color, and those who are LGBTQ-identified. A fruitful renewal of exploration on the enhancement of creativity, art, problem solving, and team building with psychedelics (Harmon et al., 1966; Krippner, 1968; Savage et al., 1964) will require the training of guides to meet different needs of set and setting.

Conclusions

The trajectory of psychedelic-assisted psychotherapy has been inextricably linked to the social and political forces within which it has been pursued. The research programs in the early decades of the 1950s and 1960s enjoyed flexibility in the exploration of many variables thought to be associated with therapeutic effectiveness (Grinspoon & Bakalar, 1979). The outcomes of this research in the early years and in the past 25 years have been significant, iterative, and profound. Findings indicate that psychedelic-assisted psychotherapy can significantly increase capacities for coping and making meaning, increase empathy, lessen anxiety and other symptomologies, evoke life-affirming transpersonal/mystical experiences, and enhance the quality of life. The contributions these researchers have made to the betterment of mental

health and our understanding of healing in such a short period of time is laudable. The federal restrictions on psychedelic research since the 1970s and 1980s have had far-reaching effects on the types of therapeutic variables studied. Unfortunately, therapist effectiveness and competence variables have not been a contender as an area of focus in the required context of double-blind clinical trials with treatment manuals. In order to demonstrate efficacy of the psychedelic medicine, therapist variables have often been seen as intervening variables that are necessary to control for in the research design.

Therapist competencies have been discussed only sporadically in the wider psychedelic literature, but this review has compiled and elucidated identifiable trends in terms of 6 core competencies. The importance of 12 curricular domains of study and guidelines for therapist training was explicated. Should this renaissance continue apace, this compilation of core competencies and training areas of study can serve as a vehicle for philosophical debate, research, and the refinement of the competencies and domains of training elucidated here. Of course, there are reasons that this work is important beyond the tidy design of training programs for therapist guides. Freedom of religion and spiritual practices utilizing psychedelics has been suppressed in the United States. And people with critical medical conditions cannot derive the benefit of accessing the psychedelic medicines. What we may well be preparing for is a redemptive developmental stage in the life of the psychedelic research field, in which perhaps:

> Interdisciplinary research and retreat centers could someday be established at which volunteer subjects who pass medical and psychological screening could receive entheogens. Some might apply to come to such centers for personal, spiritual reasons alone, and have little interest in research. Others might be willing to contribute to research. (Richards, 2005, p. 386)

The healing and transformational experiences to be found in psychedelic-assisted exploration in therapeutic and supportive sets and settings are a birthright. The diligent and devoted work of the scholars and researchers in this field will be looked on by future generations as absolutely heroic.

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