VIEWPOINT

Extrapharmacological Safety Topics in Psychedelic-Assisted Psychotherapy

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The increasing popularity of psychedelic-assisted psychotherapy (PAP) has generated important discussions about the safety of psychedelic drugs. However, arguably the most important safety concerns arise from extrapharmacological factors. Treatment effects of these drugs notoriously depend on context, and they put patients in an unusually vulnerable state. Furthermore, the recent hyperbole surrounding psychedelic therapies has led to great expectations in both patients and therapists. These circumstances can make patients more vulnerable to therapist ineptitude or misconduct, as well as to disappointment due to unrealistic expectations.

In our view, these problems can be mitigated. Switzerland has a uniquely long history of legal PAP with lysergic acid diethylamide (LSD), psilocybin, and 3,4-methylenedioxy-methamphetamine (MDMA) through a restricted medical use program dating to 1988.[1] Licensed psychiatrists can apply for permission to practice PAP, then request allowances to use psychedelic agents for patients who do not respond to standard treatments on a case-by-case basis given at least preliminary evidence that the agent is effective in treating the patient's diagnosis. By describing the state of PAP in Switzerland, we hope to highlight some underdiscussed topics and provide insights into what future guidelines for safe PAP could look like. To further contextualize our comments, one of us (G.H.) has practiced PAP with ketamine since 2013 and with LSD, psilocybin, and MDMA since 2019, having treated 120 patients for mood disorders, posttraumatic stress disorder, and other indications. Both of us are members of the Swiss Medical Society for Psycholytic Therapy (SÄPT) and have experience with safely administering LSD to dozens of clinical study volunteers.

First, Swiss PAP practitioners must be licensed psychiatrists with additional psychotherapeutic training. Licensing allows for standards of ethical conduct to be formally upheld; it was an unlicensed therapist who was recently involved in abuse allegations following an MDMA clinical trial.[2] For this reason, PAP practitioners include licensed psychiatrists (because psychedelic agents are medications) and licensed psychotherapists (because these agents catalyze therapeutic processes). Both types of practitioners must demonstrate specific competency in PAP, which in the future will hopefully be achieved via evidence-informed training programs.

We also advocate that therapists work in teams or participate in professional associations of their peers. Intervision groups may be particularly beneficial because they promote discussing clinical cases and receiving guidance. In part, they are a solution to the possibility of some PAP practitioners developing unhealthy relationships with patients. Although this problem is not unique to PAP, we suspect that psychedelic medications can intensify the problem in therapists who are so inclined. Critically minded peer groups may help correct such a tendency, in addition to other benefits for patient care. In Switzerland, the SÄPT facilitates opportunities for both training and intervision.

We must also manage patients' expectations of PAP. On the one hand, unfavorable myths about psychedelic agents can adversely impact both acute experiences and the outcome of otherwise benign treatment effects.[3] On the other, highly optimistic media reports and overly confident therapists can give the impression that these agents are a miracle cure promising rapid recovery. The PAP practitioners in Switzerland recognize that this is the exception rather than the rule. Some patients require multiple psychedelic sessions with intensive psychotherapy over months or years, and some do not clinically respond at all. Patients who hope for a miracle cure may experience disappointment, hopelessness, or even guilt when this does not happen, potentially worsening their original symptoms. Thus, PAP professionals must realistically explain the potential risks and benefits of therapy to patients and set modest, if still somewhat hopeful, expectations.

It is also imperative to gather and share data on adverse effects, particularly postacute adverse effects, which have been only sparsely documented.[4] Data from both clinical studies and recreational users show that lasting adverse effects are possible, if relatively uncommon.[4,5] Systematically documenting these adverse effects, including how they were resolved, will help therapists and patients better weigh the risks of PAP and prevent and treat adverse reactions. There is still room to make serious adverse effects rarer, particularly when they are exacerbated by extrapharmacological factors. Because the impact of a psychedelic experience can unfold over many weeks or even months, long follow-up periods of 6 months or more are advisable.

Critical consideration should also be given to therapeutic techniques. Historically, PAP has been combined with various psychodynamic techniques,[6] with catharsis sometimes viewed as centrally important. However, modern psychotherapy research does not support this, and catharsis may be counterproductive if patients are pushed too far too quickly. Evidence-based therapies, such as variations on cognitive behavioral therapy, may be the most effective combinations with psychedelic medications, although this requires future study.[6] Additionally, psychedelic agents themselves are prone to catalyzing certain therapeutic processes. For example, MDMA and psilocybin can acutely[7,8] and postacutely[9] modify activity in the amygdala, lead-

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ing to a so-called helioscope effect that allows difficult feelings or memories to appear less threatening and easier to process.[10] In our experience, this treatment effect is best harnessed by allowing the psychedelic session to unfold naturally rather than attempting to force particular topics to emerge, which risks overwhelming or even retraumatizing the patient.

The role of physical touch in PAP is much debated. We have observed that appropriate physical touch (eg, hand-holding) can be extremely comforting to people who are in distress during PAP. Many therapists also see value in combining body-oriented techniques with PAP. However, touch can be a risk: when applied unskillfully or inappropriately, it can make people who are already in a vulnerable state feel uncomfortable or violated. In our view, relatively conservative guidelines on touch are safest if PAP is to become more widely used. If touch is an option, we recommend discussing it in detail with the patient before each PAP session and thoroughly documenting consent to different forms of touch to prevent accidentally violating boundaries. We would vouch that appropriate touch of the hands, arms, shoulders, or back is usually unproblematic, if consent is consistently respected.

Finally, psychedelic agents can occasionally cause people to misjudge the reality of events. Although people taking moderate doses of psychedelic agents usually maintain their grasp on reality, we have seen patients or study participants who truly believed that an illusory event was real (eg, they believed someone said something she plainly did not say, or they believed a psychotherapist sat next to them when he was actually across the room). While these examples are benign, this phenomenon presents 2 dangers regarding therapist conduct: a patient may mistakenly believe a therapist behaved inappropriately, or a therapist who did behave inappropriately may claim that this was only an illusion. As with physical touch, following clear and conservative rules could help clarify events in such ambiguous situations. Additionally, the risk of disputes can be mitigated by having a cotherapist in the room or allowing a family member or other loved one to attend PAP sessions. Videotaping sessions could also be allowed if the patient agrees. These approaches would protect both patients and therapists from misunderstandings, as well as reduce the risk of therapist misconduct.

Psychedelic medications have inspired earnest hope for mental health benefits and better outcomes for underserved patients. They are also capable of inspiring blind devotion, savior complexes, and abuses of power. As research and practice of PAP moves forward, it is imperative to advance the former and undermine the latter.

ARTICLE INFORMATION

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