

Psychedelic-Assisted Psychotherapy Practices and Human Caring Science: Toward a Care-Informed Model of Treatment

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Abstract

Psychedelic therapies intentionally combine a caring/healing environment, psychotherapy, and psychedelic medicine as a powerful means of treating intractable conditions of depression and posttraumatic stress disorder. This article utilizes the nursing theory of human caring science, as articulated by Jean Watson, to describe the essential and fundamental human caring qualities in psychedelic therapy. By mapping these qualities onto the traits of a psychedelic therapist, articulated by Janis Phelps and illustrating them with qualitative, exemplar data from a psilocybin assisted therapy study, we have created a nursing-informed philosophical theoretical framework with which to begin to examine questions related to trust enhancement between patient and therapist, therapeutic communication of openness to patient experiences, mutual learning between therapist and patient, the influence spiritual or psychedelic practices of the therapist on outcomes, optimizing

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therapeutic healing environments, and care of the physical body during psychedelic therapy sessions. This article is intended to identify themes and generate hypotheses for future nursing-informed psychedelic psychotherapy research.

Keywords

psychedelic science, psilocybin, existential therapy, qualitative methods, story

The Therapeutic Use of Psychedelic Medicines

Psychedelic medicines are experiencing a renaissance in research and various practice settings. Several psychedelic compounds have demonstrated safety and efficacy in a wide range of intractable mental health conditions, leading to clinical trials in preparation for FDA approval (Luoma et al., 2020). Nurses are well positioned to describe and study the care provided in psychedelic psychotherapy and were involved in psychedelic treatments before and after the cessation of early research (Ball, 1955; Parley, 1964). Moreover, in the past two to three decades nursing has been revising and articulating its philosophical–theoretical paradigm, leveraged to better understand future psychedelics studies. While nurse scholars have made preliminary inroads into describing psychedelic experiences (Berg, 1994; Denis-Lalonde & Estefan, 2020; Greer & Tolbert, 1998; A. Mithoefer et al., 2014; Ot’alora et al., 2018; Penn et al., 2018; Penn et al., in press; Rosa et al., 2019), the nursing-specific perspective on the psychedelic therapy process remains largely unarticulated. The purpose of this article is to begin to create a framework for a nursing-focused theoretical model to articulate, understand, and begin validating the philosophical/theoretical process of human caring that occurs during a course of psychedelic-assisted psychotherapy.

Johnson et al. (2008) described a common structure for safe delivery of psychedelic psychotherapy that has largely been followed by all studies in the modern era. Prior to drug administration, two clinicians meet with the patient for several hours for preparatory therapy. These visits begin to build the container in which the treatment will take place. The container is physical (session typically take place in a safe, comfortable, living room-like environment, vital signs are monitored), interpersonal (the medication session is with the same therapists who conduct the preparatory and integrative sessions), and psychological (these meetings allow for the subject to develop trust and rapport with the therapists and to begin to understand the emotional and autobiographical material that is likely to emerge during the psychotherapy).

The same clinicians remain with the person through the duration of the drug administration to ensure both physical and psychological safety and meet shortly after the session is complete to begin integration psychotherapy. Integration psychotherapy allows for experiences during the session to be examined, understood, and for insights attained during the session to be applied in daily life. Typically, the drug is delivered 1 to 3 times during the study protocol and is never administered at home, or outside of a supervised clinical setting.

Enter Nursing

Absent from the discourse about psychedelic therapy has been clear and detailed descriptions of the care delivered during psychedelic therapy sessions. Existing qualitative studies (3,4-methylenedioxymethamphetamine [MDMA]: Barone et al., 2019; Psilocybin: Belser et al., 2017; Noorani et al., 2018; Swift et al., 2017; Watts et al., 2017; LSD: Gasser et al., 2015; Ketamine: Lascelles et al., 2019) have focused largely on the subjective experience of the study participant and largely focused on the internal phenomenology of the patient before, after, and during the drug state. The actions of the therapists and the experience of receiving care by the patient from the therapists during these sessions has not been conceptualized through the lens of nursing theory.

The process of care is central to the declared ethos of nursing; nursing has contributed a substantial theoretical framework for understanding the relational ontology and expanded epistemology of caring science, creating a praxis for delivering and teaching authentic human caring science. The article synthesizes and adapts a description of psychedelic therapist competencies by Phelps (2017, 2019), informed by a philosophical, theoretical model that describes Caritas Nursing Processes by Watson (1979, 1999, 2008).

Our synthesis will be supported with findings from qualitative data from a study utilizing psychedelic-assisted therapy that illustrates the patient experience as it relates to human caring science and psychedelic therapist competencies. This particular study, described elsewhere (Ross et al., 2016), examined the effects of a psilocybin-assisted therapy session on measures of depression and anxiety; the participants were patients who had a life-threatening illness; data were analyzed in a qualitative studies of participants by Belser et al. (2017) and Swift et al. (2017).

It is through this descriptive theoretical framework that we create a lens for examining the shared phenomenon of human caring provided by practitioners of all backgrounds when delivering psychedelic-assisted therapy.

Table 1. The 10 Caritas Processes® (Watson, 2012).

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1. Practice loving-kindness and equanimity for self and other
 2. Be authentically present; enabling/sustaining/honoring deep belief system and the subjective world of self/other
 3. Cultivate one's own spiritual practices; deepening self-awareness, going beyond "ego-self" (Transpersonal)
 4. Develop and sustaining a helping-trusting, authentic caring relationship
 5. Be present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one being cared for
 6. Creative use of self and all ways of knowing/being/doing as part of the caring process
 7. Engage in genuine teaching-learning experiences within the context of caring relationship—attend to the whole person and subjective meaning; attempt to stay within other's frame of reference
 8. Create healing environment at all levels (including physical and energetic environment)
 9. Reverentially and respectfully assist with basic human needs with dignity
 10. Open and attending to spiritual, mysterious, unknown, existential dimensions of life-death-suffering; allow for a miracle
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The experience of human caring in medical or psychiatric treatment is often ineffable, implied, and expected, and as such, like the air we breathe, can go unnamed and unnoticed except when it is poorly delivered or is altogether absent. The constituent elements of nursing care are not often explicitly named. That which is not explicitly named cannot be examined or understood, and as such, goes unappreciated, or even unknown.

The profession of nursing, is oriented more toward a philosophy of caring rather than the curative mind-set characteristic of medicine and has attempted to articulate the core elements that comprise care. Nursing theorist Jean Watson has described these elements of caring originally as Carative Factors (Watson, 1979, 1985), later revised to 10 Caritas Processes (Watson, 2008, 2018). The 10 Caritas Processes describe the universals of human caring within a caring science framework (Table 1). These processes are transpersonal and transcend time, space, and physicality (Watson, 1985, 2008).

Consistent with Watson's human caring approach, Phelps (2017, 2019), a psychologist and educator of psychedelic therapists has advocated for specific psychedelic therapist competencies. Phelps (2017, 2019) described the six competencies of a psychedelic therapist (Table 2).

Even a cursory examination makes explicit the intersection, congruence, and convergence of Watson and Phelps' theoretical and philosophical orientation to relationship and consciousness of an intersubjective process between therapist and patient.

Table 2. Psychedelic Therapist Competencies (Phelps, 2017).

Therapist competency	Essential praxis
1. Empathic abiding presence	<i>The therapist maintains a calm, mindful equanimity to all that arises in the therapy.</i>
2. Trust enhancement	<i>The therapist engenders the trust of the patient and by doing so, creates a safe space for the patient’s innate healing capacity to emerge.</i>
3. Spiritual transpersonal intelligence	<i>The therapist is open to and invites the transpersonal, transcendent, and existential mysteries of the patient.</i>
4. Knowledge of the physical and psychological effects of psychedelics	<i>The therapist is aware of the potential effects of psychedelic drugs on the soma and psyche of the patient.</i>
5. Therapist self-awareness and ethical integrity	<i>The therapist maintains appropriate boundaries, uses power appropriately, and is aware of matters of transference/ countertransference that may arise in the therapy.</i>
6. Proficiency in complementary techniques	<i>The therapist brings a diversity of techniques to the treatment and creates a therapeutic environment, including utilizing other psychotherapy modalities, somatic techniques, and complementary practices such as art and music.</i>

The Psychedelic Therapy Approach

Psychedelic-assisted therapy has been described in manuals published by the sponsors of these studies (Multidisciplinary Association for Psychedelics Studies Investigators Manual; Mithoefer 2017; Usona Institute, 2018), and is largely nondirective. Patients are encouraged to relax, don eyeshades, listen to preselected music on headphones, and to turn their attention inward. Psychedelic therapies have also used elements of holotropic breathwork therapy (Grof & Grof, 2010), internal family systems therapy (Schwartz & Sweezy, 2019), somatic experiencing therapy (Levine, 1997), acceptance and commitment therapy (Carhart-Harris et al., 2018; Watts & Luoma, 2020), and exposure therapy (Young et al., 2017), but the specific therapy modality is largely driven by the needs and interest of the patient during the session and the skills of the therapist in a given modality, rather than following a specific therapy protocol. Meta-analysis of existing trials has shown a large effect size (Luoma et al., 2020).

In Phase 2 studies of MDMA-assisted therapy for posttraumatic stress disorder (PTSD), 54.2% of subjects treated with MDMA no longer met criteria for a PTSD diagnosis (vs. 22.6% of placebo treated subjects; M. Mithoefer et al., 2013, 2019) and that these improvements endured for months to years following the end of the study (Jerome et al., 2020). In a study of patients with life-threatening illness, patients treated with a single session of psilocybin-assisted therapy had significant reductions in measures of depression and anxiety (Ross et al., 2016) that persisted for at least 4.5 years following the treatment with no additional psychedelic treatments (Agin-Liebes et al., 2020). Carhart-Harris et al. (2016) demonstrated rapid antidepressant effects of a single psilocybin treatment in an open label trial that was recently replicated in a study by Davis et al. (2020) showing significant antidepressant effects of psilocybin assisted therapy at 1 and 4 weeks posttreatment.

While these results are impressive, the mechanism of how a combination of psychedelic medications with therapy are able to potentiate each other in such a way that these significant improvements can occur and be maintained for a lengthy duration after the end of treatment remains provocative and unanswered.

Integrating Psychedelics With Caritas Nursing

Watson has described an understanding of human caring that can be adopted by all disciplines delivering psychedelic psychotherapy; not just nurses, though nurses may find this approach most approximating the native sensibilities of their profession. However, for these Caritas Processes to be fully useful in the context of psychedelic therapy, a degree of adaptation is necessary, described below. These skills will require a translation into a teachable praxis to be included in the training of any psychedelic psychotherapist, regardless of professional background.

Trust, Presence, and Learning

The psychedelic psychotherapy process, like all nursing and all psychotherapy, is based on a trusting relationship. Psychedelics often reveal deeply held emotional experiences that are typically ensconced behind well-developed psychological defenses (Roseman et al., 2019). The sudden surrendering of these defenses in the psychedelic state, if not held carefully and thoughtfully by the therapist, can be traumatic. As such, it is imperative that these experiences of vulnerability be held in a field of authentic presence (Caritas Process 2), helping, trust (Caritas Process 4), teaching, learning, and meaning-making (Caritas Processes 7).

Many of Watson’s descriptions of a helping–trusting, authentic–caring relationship between nurse and patient could easily be applied to a productive therapeutic relationship between a psychedelic therapist and patient. A Bierer and Buckman (1961) article in *Nursing Times* about LSD therapy noted that

The way in which the nurse handles the individual patient while he is under the influence of LSD vitally affects the success of the treatment. A very special form of approach by a mature, sympathetic, understanding personality is essential.

This relationship was also historically described by nurse Kay Parley in a 1964 article on LSD-assisted therapy as

The nurse-patient relationship during LSD treatment is like that between partners on a mountain climbing team—warm, cooperative, intimate, and yet objective.

Examining the qualitative accounts of subjects with life-threatening illnesses who were treated with psilocybin-assisted therapy (Belser et al., 2017; Ross et al., 2016) begins to illustrate these experiences of care from the patient’s perspective. Participant 11 described her experience of trusting in the clinicians who were involved in her treatment:

I trusted Dr. Soros implicitly and Sally and Bridget . . . they were very professional . . . it’s not like it’s a couple of strangers watching you—it’s a couple of people that I had already opened up to, that already knew me and who I was, and that I felt comfortable with. . . . I was so protected—It couldn’t have been done better.

Participant 1 noted how this bond between himself and the therapists contributed to trust that endured through the therapy sessions:

They were . . . they were so exceptional in their care of me through the therapy sessions, and we developed a very close bond. I felt very comfortable with them—I felt I was in very good hands . . .

Psychedelic therapists engage in a process of learning about the patient and teaching the patient while at the same time, the patient learns about and teaches the therapist about herself and the commonality of the human experience. Watson (1985) writes,

We learn from one another how to be human by identifying our self with others, finding their dilemma in ourselves. What we all learn from this is

self-knowledge. The self we learn about . . . is every self. It is universal human self. We learn to recognize ourselves in others. [It]keeps alive our common humanity and avoids reducing self or other to the moral status of object.

This relationship, which exists wholly within the frame of the patient's experience and perspective, is the psychological-intersubjective landscape on which the therapeutic encounter occurs.

Participant 13 described this bidirectional learning process:

They were really, really significant in the session. Lisa (therapist) was really helpful (she) would listen and talk about and remind me of things that I had said . . . she would either ask a question or she would make a statement that would help me . . . I realized she really understood where I was coming from. (She asked) questions that got at the core of things for me . . . and she helped me to pull the threads together

Watson encourages the nurse to honor each person as they are and to suspend role and status so as to listen from a still and centered place without judgment. This is a relationship of shared humanity and intersubjectivity, described by Martin Buber (1923) as I–Thou rather than I–It, honors the experience of the other and avoids objectifying the patient.

Psychedelic therapists are called on to bring an authentic presence to support the deep belief system and inner subjective life of the patient. By seeking to understand what is important to the patient, we enable Watson (2008) calls capacity for “The body (having) the power at some deep intrinsic level to heal itself,” or what has been called the “inner healing intelligence” by Grof and Grof (2010) and M. Mithoefer and Mithoefer (2017). This drive toward healing oneself was noted by Participant 6 when she spoke about her experience with breast cancer:

Nathan (therapist) noticed whenever I talked about it (cancer) I would touch my breast, and he was like “how often would you do that?” And I think I said, “I do it a lot.” And I had pain in other places, but I don't touch them you know what I mean? . . . I had pain everywhere . . . and he was like okay well why are you touching it? And I was like I don't know I guess I'm trying to like rub out the cancer . . .

Nursing care supports the natural orientation of the human body and mind toward wholeness. The role of the psychedelic therapist is not unlike that of the nurse midwife or the hospice nurse—they permit a natural process and support the natural process of healing to occur (Taylor, 1995). Instead of tending to the unfolding birth or death process, in psychedelic-assisted therapy, the nurse-therapist is a focused attendant to the emotional–spiritual–psychological

healing of the patient, occasionally exerting gentle corrective action when impediments occur, but largely permitting natural emergence of a native process: our drive toward wholeness.

Psychiatric nurse and psychedelic therapist, Annie Mithoefer et al. (2014) likened this inner healing capacity to the innate capacity of a wound to heal when she said,

. . . we often use the analogy (in MDMA-assisted therapy) of a person with a wound. The doctor or nurse can help by removing obstacles such as gravel and debris and can create favorable conditions, but it is always the person's own healing intelligence that does the healing. A (doctor) can set a fracture but he cannot heal it. He can help but he cannot heal it. Our trust in each participant's inner healer allows us to be present as the healing process unfolds.

Loving-Kindness and Being Present and Supportive to the Expression of All Feelings

Phelps calls on the therapist to bring an abiding empathic presence to the psychedelic-assisted therapy encounter. This echoes Watson's edict for the nurse to practice loving kindness and equanimity for self and other (Caritas Process 1) and for the nurse to be present to and supportive of the expression of positive and negative feelings (Caritas Process 5).

Building on the trust established between patient and therapist, the therapist strives to be authentically present for whatever experiences the patient brings up during the psychedelic therapy encounter, as illustrated by the experience of Participant 12:

Oh my gosh! They were the best to speak to . . . in the beginning of the session, I felt that whole panic. But once I got past that, and to have them both there and to share that with them . . . they were absolutely amazing. I didn't feel judged; I felt so open to speak to them and tell them my life, and not feel, "Oh my god; what will they think of me?" I mean, there are some stuff that I've never spoken about. . . . They were amazing. They were very professional . . . very, very gracious.

Emotions, narrative, or thoughts arise that during the sessions are welcomed, without judgment, and permitted an unhurried exploration. The therapist is open and supportive to the expression of all the feelings of the patient, both positive and negative, and receives them with equanimity. The therapist takes on qualities of a bodhisattva, or one who holds open loving-kindness and compassion for another sentient being in the service of alleviating suffering. This was reflected by Participant 4 when he said,

I can't accurately tell you what Peter's intentions, or Doug's intentions (therapists) were except to be there for me and support me . . .

It is through this process of sitting with whatever arises in the patient, that the nurse models a willingness to patiently witness the unfolding from the inner world of the patient to the outer world. Kay Parley, a pioneering Canadian nurse who worked with Dr. Humphrey Osmond on LSD assisted therapy in the late 1950s wrote in her memoir,

We would sit for 8 hours a day, concentrating all our energy on someone who was uncommunicative. There was usually a gap of three or four hours when they didn't talk at all. . . . The sitter's interest and attention are the subject's lifeline. They have lost their ego. You are it. They have lost their sense of direction. You are their guide. They are drifting in space. You are there to bring them back to earth. It is a great growing experience for a sitter, if exhausting. It is the most intuitive and empathic relationship I have ever known . . . It's a state in which the world fails to intrude. (Parley, 2016)

Through whatever personal process the therapist has undertaken, be it meditation, yoga, psychotherapy, art, or their own psychedelic experiences, the therapist brings a capacity for stillness and witnessing. The experience of holding this space for the patient can be healing and deeply satisfying for both the patient and the therapist. Holding requires a subtle and attentive skill on the part of the therapist to track all that the patient is expressing and feeling, while simultaneously avoiding excessive guidance or direction. It is easy for a well-intentioned therapist to try to steer the patient toward an insight she is not yet ready to receive, or for a less self-aware therapist to insert themes from his own story into the patient's narrative. At the same time, sometimes the therapist is called to courageously advocate for the patient allowing the patient to experience his own emotions, even in spite of his resistance, as illustrated by these continued remarks from Participant 4:

. . . I felt pretty safe with Peter and Doug. I know that . . . as I was elevating into this experience, (there was a) temptation to be wisecracking. But really all I felt from Peter and Doug was kindness, and kind of a gentle but firm steering. There was one point where I just needed to get something expressed and Peter just said, "Listen . . . just listen." What he meant was, "Be quiet, and listen." Well, why's Peter bossin' me around? . . . And then I thought, he's telling me this for a reason.

This sensitivity experienced by the person on a psychedelic to the emotions of others in the room was noted in a 1964 report by Parley in an

article in *The American Journal of Nursing* on LSD-assisted psychotherapy, noting,

A patient under LSD is often very sensitive. He can easily suffer a sense of rejection or become suspicious. He requires expert guidance from an understanding companion. Also, he is apt to uncover deep emotional problems which can be endured better in the company of someone with whom he feels at ease.

LSD-assisted psychotherapy researcher Stanislav Grof (1980) reports that patients in the psychedelic state are often highly sensitive to the emotional state of the therapist, so it is important for the therapist to be both self-aware of their own emotional state, but also to be thoughtfully transparent and appropriately disclosing to the patient should the patient inquire about the therapist's feelings.

Integrating the Spiritual Practices and Experiences of the Therapist and Patient; Honoring Noetic Ways of Learning

Psychedelic medicines can occasion spiritual-religious-mystical experiences. Richards (2015) and Phelps (2017) emphasize that a psychedelic therapist must cultivate and possess a spiritual intelligence to attend to the spiritual/transpersonal/and mystical aspects of the therapy. This aspect of caring parallels Watson's (2008) encouragement for the nurse to "cultivate one's own spiritual practices: deepening self-awareness, going beyond ego-self" (Caritas Process 3) and for the nurse to be "Open and attending to spiritual, mysterious, unknown dimensions of life-death-suffering" (Caritas Process 10).

Mystical experiences during psychedelic sessions can be described as awe, and have been proposed as a possible mechanism of action for the benefits occasioned by psychedelic experiences (Piff et al, 2015; Hendricks, 2018). Psilocybin has been shown to increase the personality domain of openness (MacLean et al., 2011). Nurses should be open to their patients having mystical or even awe-inspiring experiences during psychedelic sessions. Watson's encouragement for nurses to have their own spiritual practices, and Phelps' encouragement for psychedelic therapists to do the same may seem unconventional, but this encouragement to explore the same territory in which the patient is about to embark is no different than the long tradition of personal psychotherapy and clinical supervision for those who are in training to become therapists. Nurses, when in training, are encouraged to engage in self-reflective exercises (Lauterbach & Becker, 1996), as part of their learning to have empathy for, and to be able to witness the suffering of the patient.

Psychiatric nursing (Peplau, 1992) has long emphasized that the primary tool for intervening with the suffering of a patient is the therapeutic use of self. Historically, therapists training to become psychedelic-assisted therapists were encouraged, if not required, to undergo their own psychedelic experiences in order to gain a better understanding of the experience of the patient, but also not to see the patient's nonordinary state of consciousness under the drug as pathological (Richards, 2015). This experiential component of psychedelic therapist training has been retained for clinicians learning to work with MDMA in the treatment of PTSD (Feduccia et al., 2018).

There is no one prescription for the spiritual practice of the psychedelic therapist. Membership in an organized religion is not necessary. Rather, any practice that encourages periodic attention to, and a mindful awareness of how one's self as part of a larger whole, however that may be defined, is likely to be a helpful skill for the psychedelic therapist. Practices that help decentralize the ego usually cultivate humility and a sense of connection of a larger whole. A personal spiritual practice, however defined by the clinician, also allows the nurse–therapist to remain open to mysteries that may arise during the psychedelic therapy experience.

These practices of the therapist need not be made explicit by the therapist to the patient, but will be evident by the way that the nurse–therapist conducts himself with the patient, as elaborated on by this account from Participant 7:

But, they weren't there to chitchat with me but to the extent we did chat I really enjoyed it. I also felt like there was like a . . . I really felt like there was a knowingness from Peter kind of like once I started . . . something about Peter like he just had a look on his face like he understood, it was kind of like maybe he understood because he has experienced himself but it was more than that it was like he understood . . .

Spiritual practice may help disentangle pain, that is, the nonnegotiable circumstances such as a life-threatening illness or a traumatic childhood, from the suffering results from our response to the painful event. Our relationship to the pain can be changed. Suffering is reduced through what has been called a psychedelic “meaning-making intervention” (Grob et al., 2011, 2013), that allows the story of the suffering that is embedded in the narrative of the illness, to be changed. Viktor Frankl (1946), in his seminal work, *Man's Search for Meaning: From Death Camp to Existentialism*, emphasized that if we can find meaning in our suffering, the suffering is lessened, when he wrote, “In some way, suffering ceases to be suffering at the moment it finds a meaning, such as the meaning of a sacrifice.”

The ability to encourage the patient to meet with the experience of suffering with equanimity is illustrated by this description from Participant 12 who had undergone cancer treatment:

(I went) from this really strong person to “this hurts right now.” So, it changes you so much. I went right into menopause overnight. It’s just completely . . . you’ve lost something. It’s like a phantom, like if you lose a limb, in a sense. It’s like that whole phantom limb feeling but it feels like your life is completely different. You walk differently; everything is different, and no one really tells you that. . . . I spent a lot of time being very depressed, very stuck, and not realizing what I was . . . feeling, or going through. This whole session of speaking with them (the therapists) . . . just speaking with them made me understand it and understand what I was feeling and going through.

Psychedelic experiences are often deeply autobiographical and provide an opportunity for such an examination of the suffering one is experiencing (Roseman et al., 2019). In order for the patient to feel permitted to make such an examination, the nurse–therapist must be open to what Watson describes as the spiritual and existential aspects of life–death–suffering. If the nurse–therapist is not open to such an exploration, this may be communicated to the patient that such questions are not welcomed, and at best, the patient may feel deterred from or even ashamed of such inquiries.

Patient 12 describes a moment in which the therapist’s ability to sit with suffering was therapeutic in that it allowed the emergence of a different perspective that created meaning:

. . . I remember talking to George (study therapist) for a while. I still had my eyes closed; . . . we lowered the music a bit. I was feeling his arm on me on this side, and it was just barely whispering and I remember us talking about the meaning of life, and how we take so much for granted and we get caught up in life, and we forget the meaning of it; we forget why we’re here. We forget what’s really important; we get carried away with work and making our money and paying our bills, and this is just not what life is about. It’s about enjoying what’s here, as well, and it doesn’t have to be extravagant—just these simple things in life. . . . That was just perfect.

Meaning can occur in a spiritual or mystical experience. A study of psilocybin in normal volunteers by Griffiths et al. (2006) reported that 67% of subjects reported that the psilocybin experience as the single most, or top five spiritually meaningful experiences of their lives. As such, the psychedelic therapist should be open and supportive to the possibility of a patient having a spiritual or religious experience.

This witnessing a spiritual experience of a patient, even if the experience is different than the spiritual/religious beliefs of the therapist, can be, as Watson describes it, an act of nursing that is an opportunity to embody a moral and human practice of bringing peace into the world through the act of service of witnessing another person.

We can see how this witnessing was received by the patient in this account from Participant 13:

Nathan and Aileen were definitely—I would call them my guides. They were my guides and both of them were just so helpful through the whole process. And they talked to me particularly about what to bring and how to prepare myself for the session to kind of set the stage for whatever was going to happen. . . . So, I did start to think about my life and think about things that were important to me that were meaningful, objects, things and such and such as that. I really thought about it and they encouraged me . . .

It is possible that this experience of finding meaning in suffering may be bidirectional. In a time where the demands of working in health care have exacerbated problems with burnout among nurses and other health care providers, it may be helpful to study if the hope engendered by seeing patient improvement during psychedelic therapy could provide meaning and purpose that improves the morale of those clinicians who provide the care.

Respecting the Experience and Frame of the Patient Through Ethical, Self-Aware Practice

Psychedelic therapy, like all therapy, needs to be conducted with the highest level of ethical conduct. It is incumbent on the nurse-therapist to both thoughtfully and ethically protect professional boundaries. The cautions against dual relationships that exist in the rest of nursing and therapist relationships remain the same. Because of the potentially boundary-blurring nature of egolytic medicines, it is important for the nurse-therapist to maintain a focus on the patient through the therapy. Phelps discusses the need for therapists to be irreplicable in their conduct with patients, particularly with regards to monitoring their countertransference responses. To ensure this occurs, it is important, as with all therapies, to have clear codes of ethics and conduct, and for nurse-therapists to seek regular supervision in order to remain conscious of feelings that may arise in the therapist toward the patient.

Watson speaks to the need for the nurse to remain within the patient's frame of reference to engage in whole person, and for that nurse to facilitate genuine teaching-learning experiences within the context of a caring relationship

(Caritas Process 7). The nurse also encourages the patient's creative use of self and all ways of knowing as part of the caring process (Caritas Process 6). Put differently, the nurse sees the world through the patient's eyes and remains attentive for opportunities where the patient can learn to see the world differently.

One role of the therapist is to track the narrative and to attend to the emotional valiances of the patient's words. Similarly, a psychedelic therapist can ask if an intervention can be understood within the frame of reference of the patient, and if the intervention is delivered with the spirit of a genuine learning-teaching experience for the patient. If this frame can be maintained, the patient may find the therapy as an experience of being deeply understood, as described by Participant 13:

And my trust became so much higher as she (therapist) would do—make these comments because I realized that she was really smart, she was really listening to me, she was really getting it and she was—and when she didn't, if she didn't get something she would ask me a question and I would explain. You see, and she helped me to pull the threads together . . .

The sometimes disorienting experience of the psychedelic session can require reorientation and redirection from the therapist. If the patient is able to fully trust the nurse-therapist, this can often be done with a minimum of resistance or confusion, as illustrated by Participant 3:

they were really good. . . . The way they talked to me . . . and the choice of their words . . . everything matters when you are in that state . . . they were very good at guiding me through it."

Self-compassion can be a teaching-learning experience within the frame of the patient's experience. A patient may be reminded that the struggles she has been experiencing may be a normal response to trauma. This perspective from the therapist may help the patient begin to hold more realistic, more compassionate expectations for themselves. Participant 4 who had endured multiple treatments for cancer made this statement about a remark made by Peter, a study therapist:

(Peter) said, "You've made an amazing recovery physically. That doesn't mean you don't have emotional and psychological needs that require space to recover. You're putting yourself right back in the very mundane and potentially dominating pressures of everyday life."

Understanding the Effects of Psychedelic Medicines and Creating an Optimum Environment for Healing

Phelps advocates for psychedelic therapists to have a clear understanding of the physical and psychological effects of psychedelic medicines before administering them to their patients. As previously discussed, some training programs suggest therapists have their own carefully controlled psychedelic experience to increase the capacity for empathy with the patient's psychedelic experiences.

Phelps also advocates for psychedelic practitioners to be conversant in complementary methods of enhancing healing. Watson encourages that nurse-therapists need to create an environment that is healing at all levels (Caritas Process 8), that is private, and feels safe and protected. In a psychedelic therapy environment, this would require the nurse-therapist to understand the effects of the medicines that are being administered. Additionally, Watson speaks to a function that is often unique to nurses, which is to administer sacred nursing acts of caring-healing by tending to basic human needs (Caritas Process 9).

Psychedelic nurse-therapists must be conversant in a number of complementary modalities and to understand how these techniques will influence the physical and psychological effects of different psychedelic medicines. Leary et al. (1964) noted that the largest two influences over the psychedelic setting are the "set and setting," stating that

The nature of the (psychedelic) experience depends almost entirely on set and setting. Set denotes the preparation of the individual, including his personality structure and his mood at the time. Setting is physical.

A century earlier, Florence Nightingale (1860) wrote of her environmental theory in "Notes on Nursing" that nurses utilize "the environment of the patient to assist him in his recovery."

Watson and Phelps speak to the need for nurse-therapists to create an environment that is healing at all levels, starting with physical safety, privacy, and for the setting to be aesthetic and pleasant. Psychedelic therapy rooms should be like a comfortable living room with comfortable seating, tasteful furnishings, softly lit, quietly set, and undisturbed by neighboring activities. Watson (2008) explains, in citing Florence Nightingale's teaching that this is more than just a pleasant façade, but rather that, ". . . beauty is healing. . . . Such efforts introduce these aesthetic dimensions as expressions of humanity and a way to preserve human and humane connections." When the patient is in a nonordinary state of expanded consciousness occasioned by a

psychedelic medicine, she is extraordinarily sensitive to her surroundings. Temperature should be able to be adjusted, clutter should be removed, and the décor of the room should be beautiful and encourage inward attention.

The room in which the psychedelic therapy takes place can take on its own significance, almost as if it becomes another presence in the room, a silent witness to the healing that is taking place in the field created by therapist and patient. Participant 10 described this association between the physical setting and the change that takes place in the context of the therapeutic relationship when she said, “I have wonderful feelings about this room . . . all the sessions that we had, talking. . . . There was real closeness there.”

Watson also notes that the physical environment extends to the nurse-therapist themselves, who become part of the “environmental field” that can be detected by the patient. Quinn (1992) spoke of the “nurse-as-environment,” stating that the nurse-therapist might consider,

If I am the environment for this client, how can I be a more healing environment? How can I become a safe space, a sacred healing vessel for this client in this moment? In what ways can I look at, into this person to draw out healing? How can I use my consciousness, my being, my voice, my touch, my face, for healing?

Sometimes, the nurse-therapist must use gentle, yet firm direction during a psychedelic session to be sure that bodily integrity is maintained, and that psychological safety is ensured. Participant 8 described a moment where he sat up early, thinking the psilocybin had left his system, but because of the waxing and waning nature of the drug at the end of the session, was encouraged by the therapist to continue to rest supine. He stated,

In hindsight, it was such a good recommendation I am so thankful that he was skillful in having me do that because it really changed the experience to the better and I think he had the insight to know that that was good for me.

Nurses bring a unique capacity in their role as psychedelic therapists, that Watson noted in Caritas Process 9 that nurses “Administer sacred nursing acts of caring-healing by tending to basic human needs.” The patient entrusts the nurse-therapist to assist with their bodily needs during psychedelic session. The simple human act of helping another person to get to the toilet, or to ensure adequate hydration can be experienced by a vulnerable patient as a profound kindness and experience of connection to another human being.

The nurse-therapist can also enhance the patient’s comfort and reduce anxiety by providing anticipatory guidance for the psychedelic session, as described by Participant 11:

They sat down and explained to me that I'd wear the headphones and (eyeshades). They gave me a blanket. They, of course, reminded me where the bathroom was and told me about how long it would last . . . they answered all my questions. I was very well-prepared.

Physical touch has always been a requisite component of nursing care. The trust patients put in nurses to care for their body during times of illness is one of the deepest covenants that exist in nursing. Appropriate therapeutic touch, such as reassuringly holding the hand of a patient is permitted but should always be agreed on in preparatory therapy sessions. Reassuring touch is always discussed as a possibility in preparatory psychotherapy sessions. Consent for holding a hand or touching the arm of the patient in a moment of emotional distress is obtained before the drug is administered and can be withdrawn at any time during the session. Touch between therapists and patients is always intended to steady and comfort and is never sexual in nature. Sometimes, in a moment of distress, it may be difficult for the patient to verbally express the wish for touch, so a gesture, such as reaching out a hand, may be agreed on in the preparatory sessions. The value of appropriate touch during a moment of emotional intensity was described by Participant 1 in the study:

They couldn't have been better. It was as though they were guides and at times when the emotion was becoming really intense, two or three times, they reached out and put their hands on me. One put their hand on my shoulder, another held my hand, and it was at the precise moment when I needed that contact. They could not have been better prepared, or done a better job, or shown greater care for me. It was incredible, it really was.

Participant 9 made a similar comment.

I remembered that Nathan and Michelle were right there and suddenly realized why it was so important that I get to know them and they to get to know me. And reached out my hand and just said I'm so scared. And I think it was Nathan who took my hand . . . and said "it's alright just go with it. Go, go with it . . ." and I did . . .

The same participant went on to discuss how her initial discomfort with having her physical needs attended to by the study therapist became a point of enhanced trust:

And Michelle walking me to the bathroom wow, and I was able to accept her going in there with me helping me which you know adults don't usually . . . I would not have been happy about a stranger having to help me with that but it was fine. It was Michelle.

Conclusions and Future Directions

This article initiates a qualitative examination of the quality of care experienced by the patient in psychedelic therapy and how it affects clinical outcomes. It is from this nursing-focused, theoretical–philosophical framework created by Jean Watson and synthesized with the core competencies of psychedelic psychotherapy as articulated by Janis Phelps, that a theoretical lens has been created, through which qualitative and quantitative inquiries can begin. It is critical that the process in the “black box” of psychedelic psychotherapy is examined in order to begin to demystify, describe, and study the mechanism of this powerful modality for psychological growth and healing. In the absence of being able to name and study this process, this care may remain invisible, and if unseen may be incorrectly assumed to be unnecessary. If this therapy is approved by the FDA, payors will undoubtedly be interested in limiting costs and reducing the number of therapist hours needed to deliver this treatment. Well-intentioned, but troubling proposals by one of the sponsors of the Phase 3 psilocybin assisted therapy for depression studies to move preparatory therapy sessions to an impersonal smartphone app (Goldsmith, personal communication, October 2017) are examples of how the care provided in the therapy may be eclipsed by a streamlined, reductionistic drug treatment, decontextualized from the care provided by the nurse–therapists.

Future studies should seek to study the quality of the relationship between patient and psychedelic therapy using this framework of Human Caring Science. Qualitative studies can describe the elements of care that are most important to patients undergoing this treatment while quantitative studies can begin to correlate specific aspects of care with outcomes. These studies should be informed by what is already known about the delivery of care in nursing science.

Nursing and psychiatry are primarily palliative in nature. While palliative care is often associated with life-threatening illnesses, its definition here is broader: it connotes the reduction of human suffering regardless of the cause or the trajectory of the illness. The categorical imperative of nursing is to reduce suffering through the science of human caring. Psychedelic-assisted therapy often succeeds, it appears, not through cure, but rather by changing the suffering experienced by the patient who is ill. Suffering is reduced and healing occurs in a sacred relationship between nurse and patient in where the patient is supported by a caring, empathic relationship. Nurse–therapists, delivering this care by acting as midwives and witnesses to this natural healing process, are well suited to this work.

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Authors' Note

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Janis Phelps, PhD, is a leader in the field as the Director of the California Institute of Integral Studies' Center for Psychedelic Therapies and Research. As the Center's founder, she developed and launched the first university accredited, postgraduate training program for psychedelic therapy and research. She is a board member of the Heffter Research Institute, which has conducted highly influential psilocybin-assisted psychotherapy research since the 1990s. Her 2018 *JHP*

publication, *Developing Guidelines and Competencies for the Training of Psychedelic Therapists*, describes best practices in the academic training of medical and mental health professionals in this field. These ideas are further developed in a 2019 chapter on "Training Psychedelic Therapists" in *Advances in Psychedelic Medicine*, edited by Michael Winkelman and Ben Sessa. A licensed clinical psychologist, she is a key contributor to the creation of a national certification board for psychedelic therapists. She is consultant on methods of scaling effective training programs to meet the burgeoning need for well-trained mental health and medical professionals in the field of psychedelic medicine. She maintains a private clinical practice in Mill Valley, CA.



Jean Watson, PhD, RN, FAAN, is known around the world for her Theory of Human Caring and scholarship in Caring Science. She is founder of Watson Caring Science Institute, a nonprofit organization working with nurses globally, implementing caring theory in education, clinical practice, research, and leadership. She is endowed professor/dean emerita of University of Colorado Denver, College of Nursing and holds 15 Honorary Doctorates, many which are international.

She holds the designation as a "Living Legend" by the American Academy of Nursing, its highest honor. Her work can be found at <https://www.watsoncaringscience.org/>.