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Therapist, Trip Sitter Or Guide? A Second-Person Perspective on Psychedelic-Assisted Psychotherapy

Introduction

In conventional neuropharmacology, drug effects modulate neurochemical signalling and downstream processes to reduce symptoms of mental illness. Psychotherapy, on the other hand, is an extra-pharmacological intervention that is focused on the therapeutic relationship between patient and therapist. While psychopharmacology is often combined with psychotherapy,[1] the effects of substances like antidepressants or antipsychotics on the neural system function parallelly and rather independently from the psychotherapeutic work.[2]

Psychedelic-assisted psychotherapy (PAP) is an innovative approach to addressing mental health conditions, blending psychotherapeutic practice with the controlled administration of substances like psilocybin or MDMA. Following this model, a perceptible dosage of a psychedelic drug is used in very few sessions, typically preceded and followed by drug-free psychotherapeutic sessions known as preparatory and integrative phases, with the guidance of a trained psychotherapist.[3] Unlike conventional psychopharmacology, however, this model postulates that psychopharmacology and psychotherapy do not work independently from each other; instead, the drug effects on conscious experience open a therapeutic window that enables individuals to confront and revise harmful beliefs during psychotherapeutic sessions, with the help of a therapist.

In this chapter, we argue that PAP poses unique ethical challenges related to the second-person interaction between patient and therapist, and in particular the second-person perspective adopted by the therapist. The philosophical concept of “second-person perspective” refers to the ability to attribute mental states to others by carrying out simulations based on the ascribing agent’s spectrum of mentalistic states.[4] In regular psychotherapy, the second-person relationship occurring between

psychotherapists and their patients is primarily driven by the therapist's interest in understanding the patient's mental states, including their thoughts, emotions, and experiences. This process necessitates the therapist to engage their imagination and empathy, drawing upon their own thoughts, feelings, and experiences to arrive at conclusions about the patient's mind. These conclusions are continually refined through efforts to confirm inferences with the patient, aiming to better appreciate what is transpiring in their mind and to collaboratively work towards modifying it based on mutual understanding.5

In PAP, the second-person interaction not only is central to the psychotherapeutic process but also modulates the drug-related effects. Psychedelic substances are highly dependent on context: the altered state of consciousness that is exploited for therapeutic purposes emerges from the complex interaction between the neuropharmacological effects, the mental state of the patient, and the immediate environment. The therapist is able to manipulate two out of these three variables in their second-person interaction with the patient: during the preparation sessions, they can manage the patient's expectations, fears, and intentions around the psychedelic experience; by being present and offering support to the patient during the psychedelic experience, and by making conscious choices about the room decoration or music, they are an important part of the immediate setting. Therefore, the interaction between therapists and patients in PAP has a double role: to provide professional psychotherapeutic guidance, and to facilitate their psychedelic experience. This poses the question of whether the role of the therapist and the role of the accompanying figure during the psychedelic experience are aligned,or whether they might sometimes carry different goals, require different practices, or be in conflict with one another in some way.

While the first is a regulated practice with clear guidelines and defined boundaries, the second is a lot more nebulous. Psychedelics have been used by different communities in very different contexts, and while a second-person interaction is at the core of most practices, there is a lot of variability in what this interaction can look like. Some indigenous communities take psychedelics under the spiritual guidance of a shaman; underground practitioners of "psychedelic healing" call for the importance of physical touch during the psychedelic experience; psycare projects

offering psychedelic peer support prefer a more passive role, sitting though the experience together with the person rather than trying to guide it.

In this chapter, we will provide a philosophical analysis of how the involvement of psychedelic drugs impacts the second-person relationship between patient and therapist, giving rise to ethical issues that are new to both psychedelic use and the psychotherapeutic context. In order to do so, we will first look at the role of the therapist within the therapeutic relationship according to different schools of psychotherapy: behavioral, psychodynamic and humanistic (Sect. 2). In Sect. 3, we will turn to the role of the second person in different contexts involving psychedelic use for therapeutic purposes, broadly intended: indigenous communities, underground psychedelic healing, and psychedelic peer-support projects. Finally, we will offer a conceptual comparison between these two roles, clarifying differences and commonalities, and opening ethical questions on novel aspects in the therapeutic relationship between patient and therapist in PAP (Sect. 4).

The Second-Person Interaction in Psychotherapy

In traditional psychotherapy, encompassing the most influential therapeutic practices of the twentieth century such as psychodynamic psychotherapy, (cognitive) behavioral therapy, and humanistic psychotherapy, various perspectives on the therapist's role in the therapeutic endeavor have been articulated. In the following we shall focus on widely accepted and shared attitudes prevalent in the therapeutic communities. This exploration will set the stage for a meaningful comparison between these conventional perspectives and the evolving considerations surrounding the therapist's role in psychedelic-assisted therapy.

Ethical Guidelines and the Therapeutic Alliance

A common ground assumption shared between therapists of all schools is the relevance of establishing a good therapeutic alliance as psychotherapists. The concept of psychotherapeutic alliance introduced by Sigmund Freud[6] and worked out in more detail by other psychodynamic psychotherapists[7] quickly became crucial to the profession.[8] Today it is a school agnostic concept—that is, the idea that therapeutic alliance is central to therapeutic success is accepted in virtually all schools of psychotherapy.[9]

Broadly speaking, therapeutic alliance is understood as the bond existing between the therapist and patient during the therapeutic work.[10] Although different authors have conceptualized this bond in different ways, today there are three recurring features that are generally considered to create a bond beneficial to therapy: (1) the establishment of common treatment goals, (2) the establishment of a cooperative atmosphere in the relationship, as well as (3) a positive affective bond between patient (e.g., feeling understood, having sympathy for the therapist) and therapist (e.g., being empathetic with the patient, having sympathy for them).[11]

The rationale for establishing a stable therapeutic alliance is rooted in its pivotal role in treatment outcomes. Research consistently indicates that a strong therapeutic alliance, characterized by the elements mentioned above, is highly correlated with positive treatment results[12] and is widely acknowledged as a significant mediator of treatment success.[13] Given the paramount importance of a robust alliance, the initial establishment and ongoing maintenance of this connection constitute key responsibilities for therapists. Therapeutic alliances are susceptible to potential threats and declines, commonly referred to as “alliance ruptures.”[14] Ruptures may arise due to various factors, including errors on the therapist’s part (e.g., forgetting patient information, missing sessions, and making inadequate interventions), as well as the patient exhibiting maladaptive interpersonal behavior styles harboring negative feelings towards the therapist or the therapy itself. This might be because of lack of apparent progress or challenges to long-held beliefs and behaviors.[15]
In order to avoid ruptures and harm, it is important to ground the therapeutic relationship with strong ethical boundaries and guidelines. This ethical conduct includes understanding that the positive professional relationship between therapist and patients has its limits: patients and therapists are required (at least as long as the treatment is ongoing, and usually even in the following years) to not have a private relationship that may interrupt the therapeutic process or allow the therapist to take advantage of the patient’s dependency on them. This advantage could be in the form of favors and additional financial gain, or in emotional or sexual capacities. The treatment itself usually follows a standard format that ensures boundaries are not easily crossed. For example, it may be established at the beginning that the patient and therapist shake hands at the beginning and end of each session, sit in the same chairs, and meet for the same amount of time at the same time every week. Any

change in the treatment setting and boundaries usually has to be discussed between therapist and patient, and explained so that professional care can be provided, a safe positive therapeutic alliance can be developed, but at the same time no uncertainty about the professional service character the therapy has may become relevant.[16]

Another ethical challenge is transference or countertransference, a conceptualization of interpersonal phenomena in therapy that was first addressed by psychodynamic therapists, but also plays a crucial role in contemporary CBT.[17] One might understand transference as affective and cognitive attitudes of patient towards the therapist, evoked in the context of the therapy which reiterates stereotypical emotion-- cognitive patterns learned by the patient in earlier social interaction, perhaps early on in life with significant others such as especially primary care takes. These patterns thereby are habituated so that they usually escape the explicit notice as being such reiterations.[18] Moreover, the criterion to judge a patient's behavior or experiences to plausibly be a product of transference depends on the observer's (usually the therapists') judgment, whether the behavior of patients seems to be inadequate to the therapeutic relationship and the previous interactions taking place in it. Such interpersonal ruptures in the context of transference are considered to appear as the emotio-cognitive patterns that are "based on a past interaction with a unique individual and is being forced onto new relationships with different unique individuals,"[19] which is not the original individual who supported the development of this pattern that is activated in the current context-distorted interaction. From this assumption, it is a small step to the understanding of countertransference: the complementary reaction of the therapist directed at the patient that is influenced by the therapist's own transference dispositions deriving from their experiences activated by aspects of the patient's overall presentations, especially their transference behavior.

Cooperative Exploration

A common thread across various therapeutic modalities is cooperative exploration: the therapist's active role in engaging with the patient to support them in making sense of their experiences, behaviors, and mental distress. This engagement is a shared element in cognitive behavioral therapy (CBT), psychodynamic therapy, and humanistic therapy. In CBT, the therapist takes an empiricist standpoint, collaborat-

ing with the patient to investigate and examine the factors contributing to their problems. The therapist adopts a Socratic dialogue approach, asking questions and supporting the patient in analyzing their own mental life. The emphasis is on empowering the patient to explore and understand their thoughts, emotions, and behaviors within a structured, collaborative framework. In Psychodynamic Therapy, the therapist actively engages in exploration, pushing towards the explorative end of the explorative-supportive spectrum. Similar to CBT, the therapist collaborates with the patient to deepen their understanding of the conflicts and suppressed attitudes that may underlie their suffering. The focus is on uncovering unconscious dynamics and working towards resolving internal conflicts through increased self-awareness. In humanistic therapy, engagement in cooperative exploration is fostered through empathy and positive regard. The therapist endeavors to be fully present in the patient's world, expressing recognition for the patient's experiences. By doing so, they motivate the patient to join in the exploration, deepening their understanding of themselves and potentially discovering avenues for change and personal development.

While the specific techniques and interventions may vary, the overarching goal across these therapeutic approaches is to facilitate a collaborative process where the therapist and patient work together to gain insights, understand patterns, and ultimately navigate a path towards positive change and growth. The therapist's role as a guide and facilitator in this journey is a fundamental aspect of effective psychotherapeutic practice.

The crucial role of cooperative exploration in therapy has been acknowledged in various philosophical debates, as exemplified by Gupta et al.[20] in their discussion of how psychiatrists approach patients' mental suffering. They argue that it is a necessary aspect of the therapist's role to engage in what Gallagher termed "participatory sense-making."[21] According to Gupta et al., therapists play an active role in guiding patients through their experiences, seeking to understand what it is like for the patient to have these experiences. This participatory understanding, often referred to as a second-personal perspective ("what it's like to be you"), informs the therapist about the right questions to ask and the inconsistencies in the patient's reports to

address. This idea aligns with the approaches discussed earlier across various therapeutic modalities, emphasizing the importance of exploration and understanding the patient's unique perspective.

For instance, consider a patient reporting extreme workplace humiliation without expressing anger or sadness but experiencing subsequent sleep disturbances. Regardless of therapeutic orientation, a therapist would likely explore this situation in-depth. Questions may include: Why no anger or sadness? Do these emotions not matter to the patient, or is there an underlying emotional response being suppressed? What are the patient's thoughts on this situation, and how did they physically feel during and after the humiliation (psychophysical response)? Have similar situations occurred before, and did they correlate with sleep problems? Can the patient experience anxiety or anger in other contexts related to humiliation? The therapist would approach these questions through exploration in psychodynamic therapy, Socratic dialogue and empiricist investigation in CBT, or empathetic understanding in humanistic therapy. The goal is to develop an inner diagnostic model of the patient.[22] Another philosophical approach aligned with this perspective is Stanghellini's PHD Model of therapy, where PHD stands for Phenomenological Unfolding, Hermeneutic Analysis, and Dynamic Analysis.[23] Phenomenological unfolding involves cooperation between the patient and the therapist to uncover implicit, automatic, and forgotten sources and processes that give rise to the patient's emotions, habitual behavior, and ways of thinking. Hermeneutic analysis focuses on the active role the person takes towards their abnormal experiences, highlighting the patient's unique strengths, resources, needs, and difficulties in shaping their symptoms, course, and outcome. Dynamic analysis is the engagement where therapist and patient seek to understand the patient's mental situation in the meaningful context of their life, considering experiences that have contributed to their life history and shaped who they are today. These philosophical perspectives offer nuanced ways of articulating the therapist's role in achieving a participatory understanding of the patient's experiences and fostering therapeutic exploration and growth.

Model Learning

Model learning is considered a form of social learning, and it involves acquiring new knowledge, behaviors, or skills by observing, reflecting upon, and possibly

cooperatively interacting with other individuals. This learning process can be conscious, such as when we intentionally think about and analyze another person's actions to solve a task or handle a particular situation. However, model learning also often occurs unconsciously, with our observations subtly influencing our beliefs and behavioral tendencies without explicit awareness.

Learning from role models is a specific type of social learning, where individuals observe and emulate the behaviors of others whom they consider to be trustworthy sources of knowledge. This trustworthiness may stem from the belief that the observed individuals possess the skills and expertise needed to navigate and handle certain situations effectively. Model learning is a powerful mechanism that allows individuals, including humans and various animals, to acquire and adopt complex behaviors, adapting to and managing intricate environments based on the knowledge gleaned from trusted role models.[24] In essence, model learning provides an alternative to other learning strategies, such as trial-and-error learning. It capitalizes on the capacity to learn from the experiences and expertise of others, leveraging the social aspect of learning to efficiently and effectively navigate a wide array of challenges. Considering this understanding of model learning in light of what has been said about the therapy schools' understanding of the role of the therapist, it appears that at least two therapy schools, CBT and psychodynamic therapy, assume that one important task of the therapist is to serve as a model from which the patient can learn or further develop existing capacities.

In CBT, we see this in the ideas articulated regarding empiricism and the Socratic dialogue, which are initially demonstrated and introduced to the common endeavor of therapy by the therapist and intended to be adopted more and more by the patient, explicitly (e.g., by being guided to think about certain things in a certain way or consider a certain question) and implicitly (e.g., by picking up on certain turns in thinking the therapist takes and starting to copy them), learning from the example of the therapist. The end goal of this social learning process is to build up the relevant mental tools and capacities used by the therapist and being able to employ these approaches in the absence of the therapist to achieve lasting improvement and resilience against future problems. Plausibly, this component will also be present in humanistic therapies, as we can hardly prevent learning from the example of the

therapist; however, this component is not at the center of the humanists' agenda regarding the role of the therapist.

Now that we have an idea of what the role of the therapist in classical psychotherapy is, let us turn towards how this role may differ once psychotropic drugs are involved. McMillan25 argues that bioethicists dealing with normative questions in psychedelic-assisted therapy should tune in to the voices of psychedelic-using communities, namely communities with lived experiences of psychedelic practice. This is because,in addition to being affected directly by the legal framework deriving from such questions, these communities have acquired a degree of epistemic expertise through their experience with psychedelics. According to McMillan, their practical and theoretical knowledge can and should aid decisions about research and clinical use of psychedelics.

In what follows, we will share some considerations about three communities with lived experiences of psychedelic practice that share values, norms, and epistemic stances regarding psychedelic use. It is important to note that these three communities are not uniform: each one includes a wide spectrum of smaller communities with distinct practices and philosophies. However, we believe it is possible to identify each of these three as having a distinct stance on the second-person interaction in their practice, which differentiates them from the others. The first one is the ceremonial use, which tends to involve the guidance of a religious and spiritual figure and that comes with a metaphysical stance about psychedelics revealing the true nature of reality and the spiritual world. The second one is the psycare and peer-support community, which follows the principles of harm reduction. The third one is psychedelic practitioners, who work with clients in extralegal, or "underground," healing contexts.

Ceremonial Use

Ceremonial use of psychedelics has a long tradition in many indigenous populations: most notably in the Amazon but also in other parts of America and in Africa. While such use is very heterogeneous and substances and rituals vary widely between different communities,26 some commonalities can be noted.

First, it is important to note how the second-person interaction is at the center of

this ceremonial use as much as it is at the center of the therapeutic practice. The ingestion of psychedelic substances is not typically a solo activity, and many psychedelic practitioners would discourage from embarking on this journey without expert guidance. This guidance includes adopting a second-person perspective—attributing mental states to the patients in order to heal them.

However, such mental states are not seen only as psychological. Hallucinations, emotional reactions, and other mental states that come up during the psychedelic experiences are understood as external forces: attacks to be faced or divine knowledge to be witnessed and brought back to the community.27 The guide's job is to safely navigate their patients through a very real journey through the spirit world, filled with physical and metaphysical dangers, powerful sorcery and magical entities.28 The reasons why one might choose to embark into this journey are also often of a metaphysical or existential nature, rather than of a merely psychological one. For this reason, the second person in this interaction is often represented by a shaman: a religious, spiritual, or moral leader.

This difference in ontology is mirrored by a different role of the second-person perspective. The shaman is not assisting the patient in their exploration of their inner world but is fighting evil forces side by side with them. In some cases, the shamans will drink the brew together with their patients, or even be the only ones in the ceremony ingesting the psychedelic substance.29 Furthermore, shamans do not shy away from heavily influencing the subjective experience through the manipulation of extra-drug variables: Peruvian leaders sing icaros, wave leaf fans called chacapas, and blow smoke from Peruvian tobacco. 30

Psychedelic Peer Support

Psychedelic peer support initially emerged in the 1960s within the festival scene, due to a lack of compassionate assistance from emergency and law enforcement services for individuals experiencing altered states of consciousness induced by substances. The high levels of drug consumption in psychologically unsafe environments such as big music festivals created the need for a safe space where individuals could go in case of challenging or difficult experiences with psychedelic substances and receive support without judgment from their peers.31

These initially spontaneously emerging bottom-up communities formalized later into specialized teams, trained to offer support during challenging psychedelic experiences and turning them into opportunities for development and self-- discovery. Some examples of such groups are the Zendo Project, born at Burning Man in 2012 and sponsored by the Multidisciplinary Association of Psychedelic Research (MAPS), the Kosmicare Project, born from Boom Festival in 2016, and the Fireside Project, a free psychedelic peer-support hotline launched in 2021 that offers remote assistance through text and phone call. These projects advocate for the strategies and ideas of harm reduction, a movement aimed at reducing negative consequences associated with drug use rather than ignoring or condemning their use. They also centrally stress the value of being assisted through difficult experiences from peers that have first-hand knowledge of psychedelic experiences rather than from a medical professional who might not understand what it is like to be in a psychedelic state. In time, psychedelic peer-support projects developed a series of very specific guidelines to train their volunteers. An example of such guidelines that have largely influenced other psychedelic peer-support projects can be found in the training manual from the Zendo Project.[32]

What emerges from these guidelines is that the figure of the peer-support volunteer is not intended as a guide, but as a trip sitter: instead of trying to change the trajectory of the psychedelic experience by taking action, volunteers are advised to take a back seat and simply offer a calm presence and a safe space for whatever emotions might emerge. A more active role might be warranted if the individual tries to engage in conversation or attempts something potentially dangerous, but it is not the default. Unlike in psychotherapy, there is no clear goal to steer the person towards—the only aim is to offer unconditional support during the challenging experience, whatever that may look like. Sitters are trained to “avoid rushing the experience, trying to fix the scenario, or find a solution.”[33]

Unlike shamans, however, trip sitters are encouraged to steer away from epistemic guidance. From the training manual: “Allow and encourage the individual to come to their own insights or conclusions. It is ok to provide your perspective on their experience, but focus should be more on helping them come to their own insights and conclusions through compassionate inquiry. Let go of your agenda and

try not to get ahead of the process."[34] Regarding ethical boundaries on touch and sexual contact, the training manual includes some forms of potentially appropriate touch, like a hand on the shoulder,or assistance in getting up or sitting down. However, all forms of touch need the person's explicit permission. Sexual engagement between sitter and guest during or after the peer-support session are considered unacceptable.

Underground "Psychedelic Healing"

Even though psychedelic-assisted therapy is still undergoing trials, there is a long and widespread tradition of underground work with psychedelics for therapeutic purposes. A study by Brennan et al.[35] collected qualitative data from underground psychedelic practitioners.

Among the descriptive themes that were highlighted by the interviews, many suggested that accompanying someone through a psychedelic experience requires a more flexible role of the practitioner in comparison to the strong boundaries required by regular therapeutic work: practitioners are often more widely available outside of the therapeutic sessions, they see the role of touch as more central than in regular therapy, and they recognize that the intensity of the experience creates a greater intimacy than the one usually present between a therapist and a client.
At the same time, this blurring of boundaries can pave the way to ethical transgressions. One notable risk is a greater transference and countertransference than in regular psychotherapy: particularly relevant is the risk that the patient might attribute whatever emotions elicited by the psychedelic experience to the person who gave them the drug. This can result in "guru-projections,"[36] in which clients transfer the awe caused by the psychedelic drug to the practitioner, rendering themselves extremely vulnerable to voluntary or involuntary manipulation, abuse of power, and harm.

Most practitioners highlighted the importance of having had psychedelic experiences before embarking into this type of work, in order to better understand what their clients are going through and be more aware of the risks involved.

Novel Ethical Questions

in Psychedelic-Assisted Psychotherapy

In the rest of the chapter, we will argue that psychedelic-assisted psychotherapy should inherit insights from more traditional schools of psychotherapy, while also honoring lessons from psychedelic-using communities about the role of the second person during the psychedelic experience. When comparing the role of the second-person interaction in psychotherapy and in psychedelic communities, new ethical questions and complexities emerge.

Lessons from Psychedelic Using Communities

PAP was first developed between the 1950s and the 1970s, when great hopes were placed in its therapeutic potential. These hopes were never realized, and the substances were placed under strict international control. Since the 1990s, however, they have again become the object of scientific studies, clinical trials, and, in some states, clinical practice. Such clinical context typically involves three phases: preparatory, medication (comprising one to three sessions with moderate to high psychedelic doses), and integration sessions. In the preparatory phase, a therapeutic alliance is built between the patient and a male-female therapeutic team: the therapists engage patients in exploring their life history, symptoms, and intentions, and manage their expectations around the medication sessions. In the medication sessions, patients are given the drug and explore their altered state with the support of a psychotherapist. In the integration phase following the medication session, therapists collaborate with patients to interpret the psychedelic experience, extracting insights and thoughts for meaningful, lasting change.

It is important to note how some of the psychedelic-using communities analyzed in this chapter have clearly different goals from psychotherapy. As noted by Langlitz and Gearin26 shamanism is a distinct form-of-life from psychotherapy: while the latter has to do with looking into one's psychological reality in order to facilitate emotional wellbeing, the first is an act of spiritual, moral, and metaphysical guidance and protection against evil forces. Psychedelic peer support is more aligned with psychotherapy in terms of not endorsing a particular ontology, but with an important difference: Zendo volunteers are not trying to get to the bottom of their guests' psychological problems or to facilitate long-term improvement, but their primary aim is to safely accompany them through a situation of crisis and reduce potential harm. Underground healing is more similar to psychotherapy in terms of goals, with notable overlaps in methodology—more than half of the practitioners

interviewed in the study by Brennan et al.36 had undergone formal psychotherapeutic training at a graduate level.

A lot of the difference in practices can be attributed to these different goals. Shamans do not shy away from using music, words, or even physical means to direct their patients' journey in a desirable direction, because they see their role as one of moral and spiritual guidance; peer-support volunteers, on the contrary, will avoid inserting themselves into their guests' experience because they see do not see their roles as guides, but only as trip sitters.

While this difference in goals needs to be taken into consideration when making comparisons, it does not mean that the exchange cannot be fruitful. Some elements that were originally present outside of the psychotherapeutic practice have already been integrated into the medical context. For example, the shamanic use of music and other immersive practices to shape the psychedelic experience has inspired early psychedelic researchers like Timothy Leary to coin the famous expression "set and setting."36 This was then translated into psychotherapeutic practice as the recognition of the opportunity to influence subjective effects through the manipulation of extra drug variables. Psychotherapists do not chant, blow smoke, or wave leaves to influence their patient's experience, but they might integrate soft, calming music and add warm, inviting elements to the room, such as reclining chairs, soothing decor, and music options. (Reiff 2021). Similarly, other insights from psychedelic-using communities may be adapted to the medical context to improve our understanding of how to use psychedelics for psychotherapy in a safe and effective way. In what follows, we will analyze three aspects of the therapeutic relationship through this lens: cooperative exploration, prior psychedelic experience, and the enforcement of strict boundaries in the therapeutic relationship.

Cooperative Exploration and the Therapeutic Relationship

In regular psychotherapy, the emphasis is on building a strong therapeutic alliance between therapist and patient in order to work together towards the goal. Through cooperative exploration, the therapist has an active role in helping the patient to gain insights, understand patterns, and ultimately navigate a path towards positive change and growth. Patient and therapist are meeting halfway: questions from the therapist

direct the self-exploration of the patient, and the answers from the patient correct the therapists' second-person perspective on them, which subsequently informs further dialogue. However, the capacity to meet halfway presupposes a high degree of autonomy from the patient side: while an imbalance of power is present and recognized, it is assumed that the patient will stand their ground if they feel like their emotion or mental processes are not being correctly understood. Take the example cited in Sect. 2.2, where a patient reports extreme workplace humiliation without expressing anger or sadness and the therapist investigates, through tools like participatory sense-making and Socratic dialogue, whether the patient might be processing suppressed emotions. A successful dialogue is only possible if the patient is able to think of their experience through the lens of the questions that they are being asked without being excessively influenced in their recollection of the experience. All three psychedelic-using communities share the insight that ideas or personal beliefs of someone perceived as a guiding figure might disproportionately influence their interpretation of the external world or their own self-model or life events. While in some traditions shamans use this feature of the psychedelic experience to their advantage, peer-support organizations warn their volunteers from involuntarily nudging their guests towards a certain interpretation of their psychological states. This suggests that, while cooperative exploration can still be a valuable tool in psychedelic-assisted therapy, it might be wise for the therapist to adopt a more passive standpoint during the dosing session, and use the tools of participatory sense-- making or Socratic dialogue more liberally during preparation and integration sessions, when the patient is sober and their autonomy is not impaired. The role of the therapist during the psychedelic experience may end up looking very similar to that of a peer-support volunteer: making sure that patients are able to safely navigate their new state of consciousness without harm, without trying to steer the experience in a desired direction. This is already partially the case: especially when classic psychedelics like psilocybin or LSD are involved, medication sessions are centered on encouraging the patient to focus inwards, possibly with the aid of eye shades, as therapists maintain a supportive, neutral stance. However, other psychoactive substances like MDMA tend to induce talkativeness and a desire to communicate and connect, which could make it harder for the therapist to refrain from accidentally stearing the experience. A fruitful exchange of perspectives between professional therapists and psycare organizations could there-

fore lead to valuable insights.

The discussion of cooperative exploration also raises broader ethical questions regarding the therapeutic relationship. In regular psychotherapy, the therapeutic alliance can only happen within the strict limits of a professional relationship, in order to avoid boundary crossing and damaging consequences of normal phenomena that patients might experience during the psychotherapeutic process, such as transference. This seems confirmed by psychedelic-using communities: both the Zendo manual and the psychedelic practitioners interviewed in the study recognize that the risks of ethical misconduct is high, due to increased vulnerability during the acute phase of the psychedelic experience. Furthermore, there is an increased tendency of patients projecting the intense emotions caused by the drug onto the therapist, which is a type of transference that might be specific to the psychedelic experience.

Despite this, many psychedelic practitioners argue that the boundaries between patient and therapist require more malleability than regular psychotherapy: while they widely agree that any kind of sexual or romantic interaction is unethical, many advocate for the beneficial effects of a broader availability outside of sessions, for the use of therapeutic touch, and for a greater intimacy and recognition of each other as multifaceted individuals outside of the therapeutic relationship.36
At the moment, it is yet unclear whether a closer relationship between therapist and patient can increase treatment effectiveness. Therapeutic touch is already being discussed in the context of clinical trials37 However, it is certain that blurring boundaries in the therapeutic relationship carries high potential for harm, misconduct, and ethical breaches.

This raises the question of how much risk might be acceptable in order to increase treatment effectiveness. It is possible that, as further data on clinical trials emerges, psychedelic-assisted psychotherapy might face a conflict between treatment success and safety. If clinical trials showed that the use of touch, for example, increases the effectiveness and leads to greater symptom reduction for a majority of patients, while at the same time leaving patients more vulnerable to abuse and (voluntary or involuntary) harm, should it be approved as a common

practice in psychedelic-- assisted psychotherapy? Such questions deserve attention and careful analysis by philosophers and therapists, in order to draft guidelines for therapists that honor the safety of the patients and the ethical code of psychotherapists, while at the same time recognizing the unique elements that are introduced by psychedelic consumption.

Model Learning and Previous Psychedelic Experiences

Model learning is a form of social learning where individuals acquire knowledge, behaviors, or skills by observing and reflecting upon others, consciously or unconsciously. This mechanism enables individuals to adapt to complex environments by leveraging others' experiences. Model learning is an integral part of CBT and psychodynamic therapy. Model learning seems to seamlessly fit practices of psychedelic-using communities. For example, the Zendo manual highlights the importance of grounding clientsby modeling calm behavior, through deep and slow breaths, slow movements, and relaxed tone of voice.

A topic that seems to be related to model learning is the suggestion, highlighted by many psychedelic practitioners interviewed by Brennan et al.,36 to include psychedelic experiences into the training of practitioners. The reasoning is that by understanding the experience better from a subjective perspective, practitioners can understand the mental state of their patients and model behavior that can help them navigate difficult experiences in an altered state. Timmerman et al. suggest a framework of psychedelic apprenticeship, based on the idea that therapists should receive psychedelic-assisted therapy as part of their training, or be otherwise experienced with psychedelic states of consciousness.38 Such experiences, according to Timmerman, would equip therapists with empathic resonance and accumulated know-how, allowing them to better guide patients through altered states.

There are valid reason to be skeptical about this suggestion. The underlying assumption is that a therapist's experiences with psychedelics can help them model their behavior in a way that will be helpful for patients during their psychedelic experience. However, it is important to remind ourselves that, while some themes and guidelines can be generalizable to most psychedelic experiences, different people can react in vastly different ways due to factors such as their expectations, past experiences, background beliefs, and current environments. Consequently, one per-

son's experience with a psychedelic journey may not always serve as a reliable model for someone else. Additionally, the psychedelic state is highly suggestible; strong expectations from the therapist's own experiences with psychedelics can influence the patient's experience, steering it towards the therapist's expectations. Moreover, prior experiences with psychedelics might impair one's ability to remain objective about their efficacy, potentially leading to conflicts of interest that could compromise research integrity.

There is merit in the idea that firsthand experience of an altered state of consciousness can help develop skills to guide others through similar states. However, it is crucial for therapists practicing psychedelic-assisted psychotherapy to acknowledge the potential biases that might arise from those experiences, and the ways such bias might affect patients. The therapeutic effects of PAP seem to emerge from the combination of two elements: psychotherapy and the psychedelic experience. Throughout the process of PAP, which includes preparation, dosing, and integration sessions, patients are at the same time undergoing a psychedelic experience and receiving psychotherapeutic treatment.

In this chapter, we analyzed both psychotherapy and the psychedelic experience through the philosophical lens of the second person perspective. We argued that the second person interaction serves two separate roles in traditional psychotherapy and in psychedelic use, and that the challenge for a psychotherapist working with PAP is to adequately represent both roles.

What are the implications? First, it might be needed to differentiate the role of the therapist and the ethical guidelines that they should follow during preparation and integration sessions, during which patients are sober, and from dosing sessions, during which they are under the influence of psychedelic substances. Practices that work well for sober patients might incur additional complications when dealing with people in altered states of consciousness. Second, introducing the psychedelic element to psychotherapeutic practice might raise the need to rethink some elements of the relationship between therapist and patient, and this rethinking should take into serious consideration practices surrounding psychedelic use outside of the clinical context. The psychedelic renaissance is not just a matter of data and clinical

trials: a responsible and careful implementation of psychedelic substances in psychiatry is going to need collaborative efforts from anthropologists, therapists, bioethicists, and philosophers.

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C. Caporuscio and A. Kind529
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