

Symptom-Specific Nuances in Psychedelic Integration: A Qualitative Study of Insights from Therapists Supporting Extended Difficulties in Naturalistic Settings

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Abstract

Background

Psychedelic consumption in naturalistic settings is rising, and a significant minority of users experience extended psychological difficulties. Yet, research exploring these challenges remains limited. Despite widespread endorsement of integration practices, little is known about how therapists approach integration for heterogeneous extended difficulties.

Methods

Nineteen therapists with experience supporting post-psychedelic extended difficulties participated in semi-structured interviews. Data was analysed using reflexive thematic analysis to identify core integration strategies and map symptom-specific adaptations.

Results

Nine themes of integration strategies were identified, organised into two therapeutic phases: stabilisation (grounding, psychoeducation, clinical safety) and processing (therapeutic alliance, client-led meaning-making, biographical contextualisation, symbolic framing and tolerance of uncertainty, pacing, and somatic anchoring). For each theme, symptom-specific adaptations were identified for six common post-psychedelic presentations. For ontological shock therapists emphasised somatic grounding to counter “philosophical spiralling” alongside client-led meaning-making. For anxiety, symptoms were framed as adaptive nervous-system responses requiring careful client-paced engagement. For dissociative symptoms, therapists prioritised safety planning to support daily functioning and approached traumatic content slowly and carefully. For self-perception disturbances, (ego inflation or deflation) therapists encouraged metaphorical exploration of psychedelic content. When resurfaced traumatic material, therapists highlighted memory fallibility and facilitated gradual exposure to reduce re-traumatisation. For disappointment and unmet expectations, therapists used retrospective psychoeducation and explored links to recurring patterns of unmet expectations.

Conclusions

Findings offer practice-informed insights into how therapists tailor integration across diverse presentations. These non-prescriptive findings represent a preliminary contribution to an emerging area of research. As psychedelic use expands outside of clinical trials, further development of clinical guidance, training, and service pathways is essential to support individuals experiencing post-psychedelic extended difficulties.

Introduction

Psychedelics are a diverse class of compounds that induce temporary alterations in consciousness, primarily through activation of the serotonin 5-HT_{2A} receptor [1]. Over the past three decades, scientific interest in psychedelics has undergone a marked resurgence [2], driven in part by findings suggesting their potential as transdiagnostic mental health treatments [3, 4]. This emerging evidence has led some researchers to describe the potential of psychedelic treatments as representing a ‘paradigm shift’ in mental health care [5, p.1]. This so-called ‘psychedelic renaissance’ [6, p. 1] has been accompanied by media coverage that often portrays psychedelics as a ‘magic bullet’ for mental health difficulties [7, p. 1370], often overlooking the highly controlled conditions of clinical trials, which may exaggerate perceived efficacy [8, 9, 11]. Together, these factors may contribute to an overly optimistic public perception of psychedelics, particularly in naturalistic contexts, where most use occurs [12], and many users report high expectations and limited awareness of potential adverse after-effects [13].

“Bad Trips” and Extended Difficulties

Challenging psychedelic experiences, often described as “bad trips”, occur in approximately 9–23% of users [14, 15]. Although distressing, these experiences are not necessarily pathological; many individuals later appraise them as meaningful or transformative [16, 17, 18, 19]. Outcomes appear to depend on how such experiences are navigated: acceptance, support, and skilled facilitation are linked to better outcomes [20]. The literature distinguishes these transient challenging experiences from “extended difficulties” that persist beyond the acute pharmacological action of the substance [21, 22]. However, these phenomena are interlinked: without sufficient containment and support, initial distress can consolidate into enduring psychological difficulties [22], which may last for weeks, months, or years [21]. Such prolonged difficulties have been observed in both trial and naturalistic settings. Up to 7% of trial participants, and around 9% of naturalistic users report challenges lasting beyond 24 hours [24, 25, 26].

Scholars suggest cases of extended difficulties constitute a ‘significant minority’ warranting further study [27, p. 2]. Carbonaro et al. [17] highlight the potential severity these challenges: among 1,993 psilocybin users reporting adverse after effects, 7.6% sought treatment for symptoms lasting over a year, 11% reported acute risk to self or others, and several cases involved psychotic symptoms or suicide attempts. As these risks remain only partially understood, particularly in naturalistic settings where a broader range of outcomes may occur than in controlled trials [28, 29], further investigation is critical for informing safe practice.

Psychedelic Integration

Given these risks, structured support is widely recommended [30]. Psychedelic support is typically divided into harm reduction and integration. Harm reduction is a pragmatic preparatory approach that includes risk assessment, planning and psychoeducation, intended to lower risks and increase benefits [5, 31]. Integration refers to post-experience practices that help individuals incorporate psychedelic

experiences into everyday life, to cultivate insight and support meaningful personal growth. It can be self-guided, community-based, or practitioner-led [32, 33, 34, 35]. Integration is widely regarded as central to accessing the therapeutic value of psychedelics [32, 36], with users often reporting it as beneficial [36], and engagement associated with improved outcomes [38, 39, 40]. However, despite consensus on its importance, integration remains conceptually diffuse and lacks clear operationalisation [32, 34].

Much of the existing integration literature is organised around specific therapeutic models, yet these frameworks remain insufficiently validated [41]. Some scholars have called for a shift in focus towards process-based approaches that examine how therapeutic change occurs [42], particularly regarding extended difficulties [43]. Several transtheoretical frameworks have been proposed: the Psychedelic Harm Reduction and Integration model recommends a compassionate, destigmatising, de-pathologising stance [31], while Frymann et al. [44] conceptualises successful integration as clients feeling “settled,” “harmonised,” and “improved”.

Qualitative research with practitioners offers practice-orientated insights. Greñ et al. [34] suggest optimal integration should be highly individualised and guided by the client’s cultural background, psychological history, social ecology, and goals. Their roundtable study highlights themes such as stabilisation and resourcing, therapist metaskills, grounding and embodiment, psychoeducation and normalisation, and collaborative sense-making. Chwyl et al. [45] conceptualise integration as relational process, emphasising attunement, presence, pacing, and sensitivity to cultural or spiritual frameworks. They also identify clinical challenges including destabilisation, heightened sensitivity, relational harms, cultural misattunement, loneliness, and disappointment. While these observations illuminate the complexities of post-psychedelic support, they are not focused specifically on extended difficulties or organised into symptom-specific approaches.

Much of the existing research on integration or coping strategies for extended difficulties draws on the accounts of affected individuals. Robinson et al. [15] mapped common post-psychedelic extended difficulties, their duration, and helpful coping strategies, and found that coping strategies varied by symptom presentation. For example, self-education was most commonly endorsed for existential struggle and derealisation, therapy for depression and low self-esteem, and social support for anxiety. Therapy showed relatively low endorsement for existential and dissociative difficulties, although the reason for this remains unclear. Despite these emerging patterns, only a small number of studies have explored specific extended difficulties in depth. Argyri et al. [27] provide a qualitative exploration of ontological shock and associated coping strategies. However, comparable in-depth work is lacking for other extended difficulties.

While these studies illuminate coping from the client perspective, far less is known about how practitioners conceptualise and respond to extended difficulties. Argyri et al. [30] surveyed psychiatrists, psychotherapists, integration coaches, and psychedelic facilitators to chart areas of consensus on the nature of extended difficulties and how best to support them. Across roles, individual therapy was seen

as the cornerstone of care, with differences largely reflecting professional orientation: psychiatrists tended to use diagnostic framing and pharmacological tools, whereas psychotherapists emphasised narrative processes and meaning-making. Practitioners across disciplines emphasised treatment centred on helping clients stabilise through regular contact, normalisation, and meaning-making.

Holmøy and Andersen's [46] qualitative clinical study offers rare symptom-specific guidance across post-psychedelic extended difficulties, organising extended difficulties into three categories: anxiety and unreality, persistent perceptual changes, and existential distress. However, these categories are derived from a narrative review and the authors' clinical experience, and are illustrated through fictional vignettes. While this study provides a valuable clinical sketch of common challenges and treatment needs, its framework is suggestive and not empirically grounded in practitioner perspectives. As such, their framework represents an important conceptual starting point, but does not examine how therapists implement interventions across diverse presentations.

Argyri et al. [30] provide one of the most detailed practitioner-derived taxonomies to date, identifying six high-consensus symptom profiles commonly seen after psychedelic use. These include:

Ontological shock and existential distress

Abrupt disruption of a person's assumptions about the self or the world, often accompanied by compulsive rumination and confusion about meaning.

Anxiety and panic

Persistent hyperarousal (dread, panic episodes, racing thoughts), alongside a felt loss of control and overwhelm.

Self-perception issues

Instability in self-representation, ranging from "ego-deflation" (self-doubt and shame) to "ego-inflation" (grandiosity or quasi-manic conviction).

Dissociative symptoms

Disconnection from thoughts, feelings, memories, or sense of self, including depersonalisation (self feels unreal) and derealisation (world feels unreal).

Resurfaced traumatic material

Emergence of trauma-related memories, affect or imagery, that may feel overwhelming or difficult to contain.

Disappointment and unmet expectations

Distress following a mismatch between curative expectations and the actual outcomes of psychedelic experiences.

This framework offers a structured way of categorising extended difficulties. However, the study does not examine how each of these diverse symptoms are addressed in practice.

Despite emerging clinician competency guidance [47], evidence suggests many therapists feel inadequately prepared to respond to psychedelic-related difficulties: 45% of psychologists and psychotherapists report lacking sufficient knowledge to advise clients about psychedelic use [7], and 84.3% of US clinical psychologists report that they would seek additional consultation if a client disclosed naturalistic psilocybin use [48]. These findings indicate substantial gaps in clinician knowledge and confidence, potentially leading to reliance on heuristics or media portrayals when making clinical decisions [49]. This is particularly concerning the context of rising naturalistic use, as therapists - whether or not they offer specific integration services - are increasingly likely to encounter clients seeking support after psychedelic use [50].

In the context of rising naturalistic use, reported gaps in clinician preparedness, and limited research examining diverse post-psychedelic presentations, a critical knowledge gap emerges: understanding how therapists sequence, tailor, and coordinate interventions for the heterogeneous difficulties that can follow psychedelic use. The present study addresses this gap by examining process-based, cross-modality therapeutic approaches and by delineating how strategies are adapted to specific symptom presentations.

Research Questions

1. What strategies do therapists report using to support clients with post-psychedelic extended difficulties?
2. How are these strategies adapted across the six symptom profiles identified by Argyri et al. [30]?

Methods

Participants and Recruitment

Participants were recruited through open-access registries of psychedelic integration practitioners (Institute of Psychedelic Therapy; Psychedelic Support Network), used as public listings rather than formal recruitment channels, alongside professional networking (LinkedIn), and snowball sampling. Inclusion criteria were: (1) licensed psychotherapist or clinical/counselling psychologist with membership in a recognised professional body; (2) experience supporting clients with post-psychedelic extended difficulties in naturalistic contexts. The final sample comprised 19 qualified therapists. Participant demographics are summarised in Table 1.

Table 1
Participant Characteristics (N = 19)

| Characteristic | n | % |
|--|----------|----------|
| Country of Practice (more than one choice permitted) | | |
| UK | 12 | 63.2 |
| Worldwide (Online) | 4 | 21.1 |
| Netherlands | 2 | 10.5 |
| Spain | 2 | 10.5 |
| Canada | 2 | 10.5 |
| Australia | 1 | 5.3 |
| Germany | 1 | 5.3 |
| Poland | 1 | 5.3 |
| Mental Health License (more than one choice permitted) | | |
| Psychotherapist | 17 | 89.5 |
| Clinical Psychologist | 2 | 10.5 |
| Counselling Psychologist | 1 | 5.3 |
| Psychiatrist | 1 | 5.3 |
| Years Working with Client who use Psychedelics | | |
| 1–4 | 5 | 15.8 |
| 5–9 | 10 | 52.6 |
| 10–14 | 2 | 10.5 |
| 15+ | 2 | 10.5 |
| Approximate Number of Clients with Extended Difficulties | | |
| 1–10 | 9 | 47.4 |
| 11–25 | 4 | 21.1 |
| 26–49 | 4 | 21.1 |
| ≥ 50 | 2 | 10.5 |
| Therapeutic Modality (more than one choice permitted) | | |
| Cognitive Behavioural Therapy (CBT) | 9 | 47.4 |
| Psychodynamic Therapy | 8 | 42.1 |

| Characteristic | n | % |
|--|---|------|
| Eye Movement Desensitisation and Reprocessing (EMDR) | 6 | 31.6 |
| Internal Family Systems (IFS) / IFS Informed | 6 | 31.6 |
| Psychedelic-Assisted Therapy | 6 | 31.6 |
| Person-Centred Therapy | 5 | 26.3 |
| Transpersonal Therapy | 2 | 10.5 |
| Acceptance and Commitment Therapy (ACT) | 2 | 10.5 |
| Existential Phenomenological Psychotherapy | 2 | 10.5 |
| Jungian Therapy | 2 | 10.5 |
| Humanistic Therapy | 2 | 10.5 |
| Hypnotherapy | 2 | 10.5 |
| Sensorimotor Psychotherapy | 2 | 10.5 |

Note. Additional modalities reported by 1 participant each (5.3%) are presented in Appendix.

Procedure and Data Collection

Data was collected through one-to-one semi-structured interviews lasting approximately 60 minutes. All interviews were conducted via Microsoft Teams by the lead author. The interview guide focused primarily on therapeutic strategies for specific categories of post-psychedelic extended difficulties. When time permitted supplementary questions explored broader topics, including therapist competencies and systemic considerations. Interviews were recorded and then transcribed verbatim.

Ethical approval

was obtained from the University of Greenwich Psychology and Counselling Research Ethics Panel. Participants received an information sheet and provided written informed consent. As qualified therapists, participants were not considered a vulnerable population, and any potential distress was expected to be manageable within their existing supervisory frameworks. All interviews were anonymised, and identifying information removed. Data was stored in accordance with GDPR and university policy.

Data Analysis

Data was analysed using reflexive thematic analysis [51, 52], which supported the identification of both shared patterns and divergences across accounts. Themes were understood as actively and interpretively constructed through data engagement, rather than simply “emerging” from it. Both participants’ accounts and researcher analysis were understood as acts of interpretation.

Coding was inductive with a reflexive, iterative orientation. Transcripts were read multiple times for familiarisation, and data was coded at semantic and latent levels using NVivo. Initial codes were collated into candidate themes, which were refined through repeated comparison within and across transcripts.

The first analysis stage generated master themes of integration strategies utilised across presentations. In a second stage, master themes were re-coded deductively by symptom category, treating symptom-specific analyses as adaptations of broader strategies. Analysis focused on intersections where therapists’ accounts meaningfully linked a theme, a specific presentation, and a therapeutic response. Findings are presented as practice-informed patterns.

The study was informed by a constructivist-interpretivist approach, recognising multiple realities shaped by participants’ professional training, therapeutic orientation, and cultural context. Findings are treated as situated interpretations co-constructed between researcher and participants. The study does not engage Indigenous knowledge systems, which offer alternative traditions for understanding psychedelic experiences beyond medicalised categories. Accordingly, Western clinical terminology (e.g., “symptoms,” “presentations”) is used pragmatically for analytic clarity. The authors acknowledge that alternative conceptualisations exist.

Researcher reflexivity

The lead author used reflexive journaling to track assumptions, and record evolving interpretations. A fuller account is provided in the Supplementary Materials.

Results

Analysis identified two overarching phases of therapeutic work: **stabilisation** and **processing**. Each phase contains recurrent themes reflecting common strategies across presentations. Figure 1 provides an overview of these two phases and illustrates how key integration strategies were adapted across symptom presentations. Table 2 summarises the themes and their symptom-specific adaptations in fuller detail. The results that follow elaborate these patterns and do not imply uniform application across cases.

Table 2
Integration themes and symptom-specific adaptations

| Phase | Theme | Symptom Presentation | Adaptation |
|-----------------|--------------|---|--|
| Stabilisation | Grounding | Ontological Shock/Existential Distress | Somatic grounding to counter “philosophical spiralling”; balance safety with existential questioning |
| | | Anxiety and Resurfaced Traumatic Material | Breathwork, nervous system regulation, present-moment anchoring |
| | | Dissociative Symptoms | Restoring psychological contact; reducing helplessness |
| | | Self-Perception Issues | Empathic presence and validation; relational containment |
| | | Disappointment/Unmet Expectations | Empathic presence and validation; relational containment |
| Psychoeducation | | Ontological Shock/Existential Distress | Normalising existential questioning; situating experiences in cultural/philosophical traditions |
| | | Anxiety | Framing as natural nervous-system response, not permanent damage |
| | | Dissociative Symptoms | Framing as natural, adaptive nervous-system response |
| | | Self-Perception Issues | Psychedelics as amplifiers of latent content; encouraging metaphorical interpretations |
| | | Resurfaced Traumatic Material | Discussing memory fallibility; cautioning against literal interpretations |
| Clinical Safety | | Disappointment/Unmet Expectations | “Reverse preparation” - reframing unmet expectation; highlighting psychedelic variability |
| | | Ontological Shock/Existential Distress | Psychiatric referral only for extreme loss of reality contact |
| | | Self-Perception Issues (Ego Inflation) | Psychiatric referral only for extreme loss of reality contact |
| | | Resurfaced Traumatic Material | Discouraging impulsive decisions; encouraging |
| | | | |

| Phase | Theme | Symptom Presentation | Adaptation |
|------------|---|--|---|
| | | | reflection before action |
| | | Dissociative Symptoms | Assessing safety beyond sessions; monitoring subtle dissociation; safety planning, with online contingency |
| | | Disappointment/Unmet Expectations | Managing despair, suicidality risk when psychedelics framed as “last chance” |
| | | Self-Perception Issues (Ego Deflation) | Suicidality Risk |
| Processing | Therapeutic Alliance | Anxiety | Distress tolerance; therapist regulation |
| | | Self-Perception Issues (Ego Inflation) | Empathetic containment; patience with provocative content; navigating rupture |
| | | Resurfaced Traumatic Material | Awareness of vicarious trauma; therapist regulation |
| | | Dissociative Symptoms | Maintaining psychological contact despite dissociation; working with disrupted presence in the therapeutic relationship |
| | Client-Led Meaning Making | Ontological Shock/Existential Distress | Meaning-making grounded in the client’s worldview; cautious collaborative exploration of alternative frameworks |
| | Biographical Contextualisation | Self-Perception Issues | Exploring identity history; challenge of self-referentiality |
| | | Dissociative Symptoms | Linking to trauma history |
| | | Disappointment/Unmet Expectations | Exploring unmet expectations as recurrent themes |
| | | Ontological Shock/Existential Distress | Anchoring abstract insights in personal context |
| | Symbolic Framing & Tolerance of Uncertainty | Self-Perception Issues (Ego Inflation) | Reframing grandiosity through metaphor; encouraging curiosity |
| | | Resurfaced Traumatic Material | Encouraging tolerance of uncertainty; treating memories as emotionally real |
| | Pacing & Gradual Exposure | Anxiety | Sequencing the experiences; slowing down to reduce |

| Phase | Theme | Symptom Presentation | Adaptation |
|-------|-------------------|--|--|
| | | | overwhelm |
| | | Dissociative Symptoms | Careful pacing; strong therapeutic container; building capacity |
| | | Resurfaced Traumatic Material | Client-led pacing; avoiding re-traumatisation |
| | Somatic Anchoring | Ontological Shock/Existential Distress | Avoiding over-intellectualisation; encouraging embodied presence |
| | | Anxiety | Breathwork; sensory grounding; co-regulation |
| | | Dissociative Symptoms | Gentle reconnection with bodily sensations |

Stabilisation

Across the dataset, most therapists recommended a period of stabilisation prior to moving into deeper exploration. Stabilisation was understood as a process of ensuring safety, containment, and resourcing. Three themes emerged in this phase: **grounding**, **psychoeducation**, and **clinical safety**.

Grounding

Therapists noted that deeper integration work could not proceed when clients were acutely destabilised. Grounding was therefore used to help clients feel less “at the mercy of these states” (P18). Techniques included breathwork, body awareness, nervous system regulation, and relational anchoring. Therapists emphasised that grounding should be individualised and non-prescriptive.

For clients with **ontological shock** or **existential distress**, therapists noted how philosophical spiralling could leave clients unembodied, and used body-focused grounding to restore presence:

‘People’s thoughts can go in all sorts of different directions when they’re experiencing existential crisis... get people to draw in awareness to the body...that’s a helpful place to start’ (P13).

Yet they stressed a balance between establishing safety and allowing space for existential questioning:

‘To make sure that my interest in creating a safe environment for them is not shutting down questioning. Because often this is something that needs to be gone through. So there needs to be space to explore it’ (P6).

With acute **anxiety** and **resurfaced traumatic material**, the emotional and somatic intensity often made it difficult for clients to reflect on, or even recount, their experiences. Therefore, therapists utilised

techniques that supported nervous system regulation and helped clients remain within a tolerable level of arousal:

'We might start to introduce specific techniques, practices that encourage the person to learn to regulate their nervous system, to cultivate emotional awareness, things that can bring them back to their senses' (P7).

For clients with **dissociative symptoms**, grounding focused more on restoring embodied presence and reconnection to the here-and-now:

'Really trying to arrive in the moment, trying to feel the body, to connect with the present moment.' (P11)

Across **self-perception issues** and **disappointment**, grounding relied primarily on relational containment. Therapists emphasised "staying with" clients in destabilised states, helping them feel heard without amplifying distress. In these presentations, grounding was enacted through presence rather than technique:

'Help making the person feel heard...validating their experience...gentle holding of what they're going through...grounding them as well' (P10).

Psychoeducation

Therapists used psychoeducation as a stabilisation tool, especially for clients unfamiliar with psychedelic risks. When symptoms were interpreted as irreversible damage, psychoeducation contextualised them as natural, albeit distressing, effects, often drawing on cultural, philosophical, or physiological frameworks to de-pathologise clients' experiences.

For clients experiencing **ontological shock** or **existential distress**, therapists used psychoeducation to normalise philosophical questioning, framing existential concerns as a valid part of the human condition:

'Questions around what reality is and what ontology is are entirely valid and don't need to be frightening. And maybe they're frightening because we can be othered' (P19).

Therapists found that offering clients' alternative cultural or philosophical frameworks helped them situate their experiences within long-standing traditions, validating their significance. This strategy reduced client fear by showing that these concerns have been shared across diverse contexts:

'This is a journey that people many before you have traversed...they're different maps or possible pathways through this...that often is...a great source of reassurance...when it's like actually...people have written about this kind of thing for millennia' (P17).

For clients with **anxiety**, therapists employed psychoeducation to reframe clients' symptoms as psychophysiological responses to nervous-system overwhelm, rather than signs of permanent damage. Anxiety was normalised as an understandable, often temporary reaction to excessive activation:

'Psychoeducation to formulate what's actually going on for that client...there's a physicality to it where they were probably totally overwhelmed, like over-served, and their nervous system has just been obliterated' (P17).

Similarly, in **dissociative presentations**, therapists explained symptoms in terms of nervous system functioning:

'It's quite common, they thought that they'd broken their brain in some ways, and so there was like an intense anxiety associated with that, and whenever this anxiety came up then the dissociation got worse, and so it was just really helpful for them to get reassurance around it' (P11).

Dissociation was also framed as a protective, adaptive response to stress, to be explored rather than eliminated:

'Dissociation is a resource, right? It's got a bad name, people see it as being a bad thing, but actually, you know, it's been a way of that person coping with a dysregulated nervous system and it's helped them survive to this point' (P15).

For clients experiencing disruptions in **self-perception**, psychoeducation was used to frame psychedelics as amplifiers of existing material rather than creators of new content. This helped clients make sense of grandiosity or self-loathing as unresolved issues brought into awareness:

'Reflect back that it was probably there in the first place...it's getting amplified' (P8).

This framing cautioned clients against literal interpretations, emphasising the symbolic or metaphorical nature of psychedelic material:

'Understanding that the psyche speaks to us in metaphors, and that there is some danger in a literal interpretation' (P17).

This was especially important in ego inflation, where psychoeducation helped calm grandiosity and foster curiosity:

'That psychoeducation part is probably the biggest one...to kind of just calm the ego' (P17).

For clients with **resurfaced traumatic material**, therapists used psychoeducation to stress the fallibility of memory in psychedelic states, managing expectations by clarifying that therapy could not establish their definitive truth:

'I always think it's really important for them to know that we're never going to get certain things and also for them to know that sometimes psychedelics can bring up things that are not meaningful or have never happened...relaying that in a way that's in no way...coming across as me being disbelieving of their trauma, but to inform...that we just we will never know' (P2).

Therapists noted that **disappointment** was often preventable with adequate preparation. When preparation was absent, psychoeducation was used retroactively to explore disappointing outcomes, contextualising them by explaining the variability of psychedelic effects. This helped clients understand their disappointing experiences as neither failure nor personal deficiency, reducing self-blame and confusion:

'We can do reverse preparation...speak about what an optimal preparation and conditions might look like and compare it to what actually happened for that person' (P14).

Clinical Safety

Several therapists stressed the need to assess clinical safety during stabilisation, evaluating whether therapeutic integration was an appropriate container and creating safety plans when necessary. In rare acute cases, psychiatric referral was required, though therapists emphasised this was a last resort, often driven by systemic gaps in care.

Ego inflation and **ontological shock** were seen as requiring careful safety monitoring. Most symptoms were manageable within the therapeutic frame, with grandiosity or existential questioning understood as normal, temporary responses, particularly among psychedelic-naïve clients. In rare cases, however, presentations escalated to extreme loss of contact with reality, and psychiatric intervention was deemed necessary:

'I've had one or two instances of...quite concerning delusions...that loss of contact with reality...where it kind of gets to the point of like, actually I think this has become more like a medical psychiatric intervention' (P5).

For clients experiencing **resurfaced traumatic material**, clinical safety often meant discouraging impulsive decisions, as some clients made sudden life changes or ruptured relationships in response to emerging memories. Instead, therapists encouraged reflection before action, aiming to prevent long-term harm from premature responses to destabilising material:

'It might be useful to discourage the person in going and taking some action because of that, and more like encouraging them to stay and focus on themselves' (P14).

For clients experiencing **dissociation**, therapists emphasised safety considerations both within and beyond sessions. Clinical safety meant assessing how symptoms affected daily functioning, responsibilities, and support systems:

'What are they engaging with in their life...are they going to start making life decisions, are they driving around in cars?...it's just checking in what they've got on, what they can clear in their calendar...making sure they've got support...it just always comes back to...how can they be safe?' (P13).

Practical resourcing and contingency planning were common strategies. Remote therapy sessions added challenges in this presentation, as therapists found it more difficult to employ grounding and

regulation techniques. To mitigate this, therapists created contingency plans for online settings:

'If you're working online, that can be really challenging. I find it's something that you have to set up a plan to support' (P2).

Several therapists cautioned that dissociation may present subtly and be overlooked by both client and practitioner, emphasising the importance of clinical sensitivity. They noted that subtle dissociation often revealed itself only through inconsistencies or a felt sense of disconnection:

'The biggest challenge is when the person doesn't even know about the dissociation...that can also show up in you as a practitioner, like a sense that something is not consistent' (P14).

Disappointment was also discussed as a clinical safety concern. Therapists saw clients who approached psychedelics as a "last chance" to address long-standing mental health difficulties, as particularly clinically vulnerable. In extreme cases, this escalated into crisis - several therapists described clients whose disappointment led to suicidal ideation:

'They start to have this false belief in a way that "I'm so broken that not even psychedelics can fix me"...well, then you're potentially going to get that person at increased risk of suicidality' (P17).

Similar concerns about suicidality were also present in **ego deflation** presentations.

Processing

Across the dataset, therapists described this exploratory phase of integration as dynamic, individualised, and non-linear. Therapists supported clients to explore the emotional, psychological, spiritual, and interpersonal impacts of their psychedelic experiences. Six core themes emerged in this phase: **therapeutic alliance, client-led meaning-making, biographical contextualisation, symbolic framing and tolerance of uncertainty, pacing and gradual exposure, and somatic anchoring.**

Therapeutic Alliance

Across presentations, the therapeutic alliance - the collaborative bond between therapist and client - was seen as a primary medium of integration. Therapists emphasised meeting clients with empathy, curiosity, patience, openness, and non-judgement. In acute presentations, therapists also spoke of the importance of distress tolerance, when they themselves remained regulated, they created the conditions for clients to regain regulation. Relational challenges included resistance, rupture, or the risk of premature termination.

When working with clients with acute **anxiety**, therapists noted that clients' distress could be particularly challenging. They emphasised the importance of regulating themselves first in order to provide a calm presence:

'The distress that can be there is quite hard to be with...the work for me is to be regulating myself enough that I can be with them, and they can start to accept their own lack of control' (P12).

Therapists found states of **ego inflation** could be particularly provocative, requiring patience and empathic containment:

'It can be tempting just to roll your eyes or be like this is too much, but that just doesn't help...you have to be willing to be with things that are potentially quite provocative for us' (P7).

Inflated states often created relational strain, as clients resisted therapeutic input. Further, confrontation risked rupture, sometimes leading to therapy termination:

'There's a risk of folks...not even wanting to be in therapy to begin with. And then if they are in therapy and there's a hint of accusation...they just shut it down. So the amount of tippy-toeing required...is phenomenal' (P3).

Therapists described relatively few structured strategies for navigating grandiose states. However, one therapist described utilising "empathic confrontation" to preserve the therapeutic bond while gently challenging grand narratives:

'There is this like empathic confrontation... it's like... "what a special thing to feel that kind of connection... there is an infinite number of ways that you can take that elixir into your own very real, very mundane, very beautiful life."' (P17)

Several therapists suggested that therapeutic work was often more productive after inflated states had naturally softened:

'It's usually like after that when you can support them, because during it it's like they don't want to hear it, but after...they realize that it was maybe like a polarization' (P8).

Therapists described the relational challenge of **dissociation**, which could disrupt psychological contact in the therapeutic alliance:

'It can be really hard to work with dissociation because the person isn't there with you in the room...when they're dissociating' (P2).

Therapists cautioned that when working with **resurfaced traumatic material**, particularly those that overlapped with their own histories, they could trigger vicarious trauma:

'Proxy trauma! And if any of your own overwhelm has anything to do with the client's category-wise, oh my goodness! Batten down the hatches! That's definitely happened for me with my own trauma' (P3).

Client-Led Meaning-Making

Therapists described meaning-making as central to integration. They consistently emphasised that this should be client-led, highlighting potential harms that arise from imposed interpretation. Practitioners framed meaning-making as a process of co-investigation, supporting clients to articulate what their

experience meant to them. Therapists suggested that this process should remain grounded in the client's worldview, values, and intentions.

Sensitivity towards clients' worldview was especially important for **ontological shock** or **existential disturbances**, as clients' recent radical shifts in perspective left them particularly vulnerable to external imposition.

'I'm trying to make sense of it from within his frame, I'm not trying to impose my own frame' (P4).

When clients lacked frameworks or "maps" to make sense of their experiences, some therapists did cautiously introduce alternatives. However, this was always done sensitively and collaboratively to ensure the process remained client-centred:

'I would help them figure out if they have any maps that would work to frame this... I'll go to their maps first...if they don't have a map, then I'll maybe co-investigate with them...maybe give a couple options' (P8).

Biographical Contextualisation

Therapists emphasised the importance of situating clients' symptoms within their personal histories, cautioning against viewing post-psychedelic difficulties as entirely drug-induced. They suggested that these challenges could be amplifications of long-standing internal and relational dynamics that shaped the meanings clients attributed to their experiences.

Therapists suggested that **self-perception issues** were often rooted in challenges in the clients' past, surrounding identity formation, interpersonal dynamics, and self-worth. However, addressing these difficulties was seen as particularly complex as their self-referential nature often trapped clients in the very patterns being explored. Therapists emphasised the slow, patient work required to understand clients' susceptibility to either pole:

'Identity is where these things get really sticky...the ego is always self-referential, right?...people bring their history, there will be underlying reasons or motivating factors for why somebody will be particularly suggestible in a certain direction, whether that is towards deflation or inflation...in my experience it takes a great deal of patience to get down to the nitty-gritty details of somebody's history where we can start to uncover what's actually going on. But that is what we have to do' (P7).

In **dissociative presentations**, therapists suggested that clients' vulnerability to dissociation was often connected to past trauma, rather than being solely induced by psychedelics. Therapists recommended working patiently and sensitively with clients to explore these biographical layers. As clients' capacity increased, therapists would encourage them to revisit traumatic memories, whether from the psychedelic session or earlier life events:

'Going back to either the moment of trauma in the psychedelic experience...working through that or working through whatever the thing was that maybe made them vulnerable to it in the first place' (P8).

Therapists often saw post-psychedelic **disappointment**, self-blame, or the acute sense of being let down, as echoing earlier experiences of unmet expectations or perceived failure. Therapists explored these challenges by shifting focus from the psychedelic event to broader life narratives:

‘What is disappointment for them? Do they have other experiences of unmet expectations?’ (P6).

In presentations of **ontological shock** or **existential distress**, therapists encouraged clients to connect their philosophical insights to their personal histories, cautioning against purely conceptual discussions that risked disconnection from lived reality:

‘There might be a tendency to be very abstract and philosophical and to omit the personal, emotional struggle’ (P14).

Symbolic Framing and Tolerance of Uncertainty

Therapists recommended exploring psychedelic material symbolically as well as literally. This enabled clients to engage with the emotional truth of their experiences without being constrained by factual reality. They also highlighted tolerating uncertainty as an important therapeutic task, particularly when clients faced unanswerable questions about what was “real”.

Symbolic framing was a central strategy for presentations of **ego inflation**. Therapists used metaphorical exploration to discourage over-identification with grandiose narratives. Instead, they invited clients to see how their psychedelic material connected with personal needs or values.

‘There’s a difficulty with understanding that the psyche speaks to us in metaphors, and that there is some danger in a literal interpretation...Mama Aya seems to tell everyone that they were a healer in a past life... but maybe there's an invitation to look at what my medicine for the world is’ (P17).

Similarly, with **resurfaced traumatic material**, therapists found symbolic framing useful when clients were uncertain about the factual accuracy of what had emerged:

‘My usual thing is... let’s just know that it’s real in the sense of it’s, like, it’s happening... I’ll usually say something like you know the psyche sometimes works in metaphor and so we don’t want to take it literally yet’ (P8).

Within this presentation, therapists highlighted uncertainty as a recurring theme, encouraging clients to attend to the emotional, relational, and somatic meaning of what had surfaced:

‘We’re not going to get in our head about is this real or not... what matters is, like, how the body’s responding in the moment’ (P8).

Some therapists adopted a “believing stance” by validating clients’ experiences and suspending judgment on literal truth. This strategy enabled clients to process the emotional and somatic consequences of their traumatic memories without becoming trapped in the binary of true or false:

'Suspend judgment as to whether or not it happened as a literal experience but instead adopt a believing stance and then rework it' (P15).

Ultimately, the work focused less on verifying memories and more on helping clients tolerate ambiguity, regulate emotion, and make sense of what had emerged:

'You just have to kind of stay in the doubt of it really' (P1).

Pacing and Gradual Exposure

Across therapists' accounts, the need for careful pacing was emphasised. Gradual exposure to distressing material kept clients within their "window of tolerance", reducing the risk of re-traumatisation. Material was explored fragment-by-fragment to help clients sequence and slowly make sense of their psychedelic experiences. This strategy was described as particularly important when clients' material was potentially destabilising, as it allowed emotions to emerge in a manageable and contained way.

For clients with acute **anxiety**, therapists used careful pacing sessions to slowly reconstruct the psychedelic experience, reducing confusion and making overwhelming reactions more comprehensible. They sought to gradually expose clients to emotionally intense material, rather than suppressing it:

'Really trying to help them understand like what happened first and what happened then...because especially in overwhelming situations, it can feel like everything happened at once...slowing it down, like giving them an understanding' (P11).

Dissociative presentations, often understood as a defence against overwhelm, were also seen as requiring patient exploration. They emphasised the need for a strong therapeutic container and attunement to prevent re-traumatisation:

'You need to know how to titrate things...if you ask too much about the trauma, too many details, it can be easily overwhelming...they're terrified of feeling all those emotions. So how do you make them feel safe?...very slowly they can open up...and just process the trauma, like fragment by fragment almost...making them realise that big difficult emotions are survivable...I'm there, we're doing it together' (P18).

Some therapists also supported clients in building the capacity to stay with dissociative states. When explored carefully, dissociation was seen as an opportunity to develop resilience:

'Often when you go to such a dissociative state, it's to come back to regulation, and then to work a little bit...I like to not stop at regulating...There is something that happened, you got over-activated and that activation was scary to you, it was dangerous, so let's learn to go into this activation' (P9).

For clients experiencing **resurfaced traumatic material**, therapists cautioned against moving too quickly into traumatic content. A central principle was allowing clients to set the pace, moving only as fast as they felt comfortable, so that engagement with traumatic material remained tolerable and contained:

'I find it very important to allow the client to be in charge of how fast they want to go about it...not to see them in new, overwhelmed situations. Within that frame, having them recount the memory several times with the goal of forming a narrative' (P11).

Several practitioners warned that rushing this process risked overwhelm or retraumatisation:

'Regulating all the way through it...so it doesn't become re-traumatising...really tuning into the client to make sure they're not becoming overwhelmed by even talking about it again' (P10).

Somatic Anchoring

Somatic approaches were described as central across presentations, with many therapists viewing embodiment as a core principle of integration. Practices such as breathwork and body scans helped to anchor abstract or overwhelming material in felt reality and re-establish clients' connection to their embodied experience. Somatic work was described as especially important in presentations marked by fragmentation or overwhelm.

For clients with **ontological shock** or **existential distress**, therapists cautioned against getting caught in over-intellectualisation:

'You gotta be careful with that...you can get drawn into all kinds of absolutely fascinating discussions. We have to constantly remind ourselves, you know, what does this serve?' (P7).

To counterbalance philosophical spiralling, therapists redirected attention to bodily sensations, inviting clients to reconnect with presence and emotion through somatic techniques:

'So a lot of philosophical wrestling...but really the experience of the sessions was inviting the client to turn towards their body and their emotions' (P3).

For clients experiencing **anxiety**, therapists described the body as both a site of dysregulation and a route back to calm. Somatic tools such as breathwork, co-regulation, posture, and sensory grounding were used to down-regulate heightened states:

'You have to work with the body because the best way to get out of your head is through the body...breathing exercises, visualization, posture, singing or humming, and touch...ways to connect with your body' (P18).

Co-regulation was seen as particularly powerful, with therapists modelling grounded presence and calm rhythms to help settle clients:

'A lot of co-regulation, so if I know someone's kind of all over the place, I will make sure to check I'm not over-synchronizing with them...most of the time it's about being as calm and present as possible with you just to help model that pattern' (P3).

This focus on the body was framed as a way to move past overwhelming cognitive loops:

'The key is to remind the person to ground themselves in their physicality...that gives you something more tangible to work with and by working on that level, the work of integration kind of bypasses all of the confusion of the mind' (P7).

For clients experiencing **dissociation**, therapists saw the body as central to re-establishing presence and safety. Somatic and nervous-system practices were used to help clients gently reconnect with fragmented or suppressed sensations:

'I guide them towards mindfulness and body-based techniques, so really trying to arrive in the moment, trying to feel the body, to connect with the present moment' (P11).

Discussion

The core integration themes identified in this study align closely with existing psychedelic integration literature [31, 34] and appear relevant across presentations. However, the novel contribution of this study lies in demonstrating how these shared strategies are adapted for diverse extended difficulties in symptom-specific ways, revealing important nuances in clinical application. Across six symptom presentations, the analyses offer real-world insight and draw attention to clinically prominent but under-theorised challenges. Findings are discussed in relation to prior psychedelic research; when such literature is limited, parallels are drawn from comparable presentations in broader psychotherapeutic and psychological research. These inferences should be interpreted cautiously, as aetiological and contextual differences may limit direct applicability.

Situating the Findings

Existing integration scholarship has largely articulated stance-level frameworks [31, 34], but seldom addresses the management of extended difficulties or explores tailored interventions for specific presentations. This study does not propose a new model or advocate for a standardised protocol; rather, it illustrates how clinicians adapt established integration strategies when working with heterogeneous post-psychedelic difficulties. These insights should be read as therapists' situated reflections rather than prescriptive recommendations.

Ontological Shock and Existential Distress

Grounding emerged as a key strategy for ontological and existential disturbances, consistent with qualitative accounts showing that individuals with ontological shock found grounding techniques helpful in reducing rumination [27]. Therapists in this study emphasised the importance of not shutting down philosophical questioning entirely, highlighting a delicate balance between stabilisation and exploration. Integration thus required a productive tension between grounding and meaning-making.

Psychoeducation aimed to contextualise clients' philosophical questioning as a natural part of human inquiry. Therapists drew on clients' preferred philosophical or cultural "maps" to de-pathologise their experiences. Robinson et al. [15] similarly found that participants with existential difficulties were often

stabilised by self-education material that offered normalising interpretive frames. Together, these findings suggest that worldview-sensitive psychoeducation may be helpful in this presentation, whether clinician-led or independently pursued.

Symptom-specific nuances of clinical safety were also evident. Therapists suggested that most cases of ontological shock could be managed within psychotherapy. However, in rare instances when clients lost touch with reality or developed psychotic symptoms, escalation to psychiatric services was considered. This caution aligns with research showing that, while uncommon, severe post-psychedelic adverse reactions, including psychosis or mania, do occur [17, 21]. Qualitative accounts also described the value of combining psychotherapy and psychiatric medication when psychotherapy alone was insufficient [30]. Greater clinical nuance may be required in this presentation, as some cases of ontological shock may be mistaken for psychotic or manic states due to overlapping phenomenological features [27, 46]. This is particularly concerning given therapists in the present study described instances in which psychiatric services were experienced as misaligned with the needs of clients struggling with psychedelic-related difficulties.

Integration in this presentation centred on meaning-making within the client's existing worldview, with alternative frameworks introduced only when none were available. This reflects recommendations that integration be client-directed and avoid imposed interpretations [31, 15]. Ontological shock and existential distress is often marked by confusion and destabilisation [27], and psychedelics may increase suggestibility [53]. Together, these factors may make clients in this presentation particularly vulnerable to adopting external explanations. Indeed, ontological disruptions have been conceptualised as crises of meaning [54], during which individuals may find offered interpretations especially attractive as they attempt to re-establish coherence and an inhabitable worldview. The present findings suggest that therapists recognised this increased vulnerability, and therefore recommended interpretive restraint more explicitly in this presentation than in any other.

Therapists' caution also extended to the metaphysical realm. As Letheby [55] argues, imposing metaphysical framings in psychedelic contexts risks epistemic harm by undermining autonomy and further destabilising identity and worldview. Yet, when handled sensitively, metaphysical exploration may be clinically helpful. Sjöstedt-Hughes [56] suggests that such metaphysical frameworks, used alongside psychological ones, can help clients situate ontological and existential experiences within long-standing philosophical traditions, reducing the risk that such experiences are dismissed as meaningless. Therapists in this study echoed this dual stance: metaphysics may offer guidance and scaffolding, but should not be imposed. Further, Cowley-Court et al.'s [13] "connection paradox" highlights how ontological disruptions can simultaneously expand new relational bonds and fracture existing ones, illustrating how worldview transformations may be both intra- and interpersonally disruptive. In this context, therapists' commitment to interpretive restraint, and to honouring both antecedent and emergent worldviews, may offer relational continuity amid instability.

Further strategies identified in this presentation - biographical contextualisation to anchor abstract questioning in clients' histories; embodied practices to interrupt philosophical spiralling - mirror Watts and Luoma's [57] Accept-Connect-Embody model, which emphasises diffusion from rumination, embodied present-moment awareness. Applied to ontological shock, the Accept-Connect-Embody model and therapists' accounts converge in redirecting clients from ruminative abstraction toward embodiment and personally relevant material.

Anxiety and Panic

In this presentation, grounding combined somatic down-regulation strategies with co-regulation to help clients return to a tolerable arousal level before deeper exploration. This approach aligns with Gorman et al.'s [31] emphasis on working within clients' "window of tolerance", and with Greñ et al.'s [34] view that present-moment grounding restores sufficient stability for therapeutic work. Consistent with Greñ et al. [34], therapists in this study also highlighted that these techniques were largely effective through their relational delivery, with moment-to-moment attunement especially pivotal.

Nuances in psychoeducation were also evident. Therapists often framed post-psychedelic anxiety as a normal, temporary response to nervous system overactivation, which appeared to reduce secondary distress. Although psychoeducation has not been studied specifically for psychedelic-induced anxiety, broader anxiety literature supports its value. Psychoeducational interventions have been associated with consistent reductions in anxiety symptoms across anxiety disorders and have also been shown to significantly reduce panic symptoms [58, 59]. These findings indirectly support our data's suggestion that psychoeducation may play a stabilising role in post-psychedelic anxiety by normalising symptoms and reducing fear.

Anxiety-specific adaptations in integration also emerged. Aligning with trauma-informed integration guidance [60], therapists suggested that anxiety-evoking material be approached gradually at the client's pace, with frequent reorientations to safety. Two strategies were particularly prominent: reconstructing the psychedelic event sequence to transform overwhelming memories into more coherent narratives, and exploring the experience while learning to tolerate uncertainty. These map closely onto Greñ et al.'s [34] two-step approach to integration of "organizing" and "analyzing" the experience. The present findings suggest that, in anxiety presentations, 'organizing' functions not only as a cognitive exercise but as a stabilising practice, while 'analyzing' requires careful scaffolding, so that clients can tolerate uncertainty and heightened arousal without re-traumatisation.

Previous literature has identified social support as particularly effective in post-psychedelic anxiety [15]. By contrast, therapists in this study did not emphasise this specifically for anxiety. Rather, they described it as a broader factor that both protects against post-psychedelic difficulties, and supports recovery from them, highlighting its role as an important component of wraparound care for those facing extended difficulties.

Self-perception Issues

Grounding in this presentation involved relational containment and co-regulation, positioning the therapeutic relationship as an important primary stabilising tool. This is consistent with psychedelic trauma-informed guidance that emphasises that when the sense of self is labile, relational safety enables clients to revisit overwhelming material and reorganise self-narratives without retraumatisation [60]. Therapists also emphasised clinical safety, including monitoring of suicidality in deflated states and occasional psychiatric referral for inflated states, underscoring the importance of robust risk monitoring [31, 41].

Metaphorical framing emerged as a key strategy in both psychoeducation and integration. Didactically, some therapists drew on Grof's [61] concept of psychedelics as "non-specific amplifiers", bringing latent material into awareness, rather than creating new content. This aimed to reduce literalism and foster curiosity. Within integration, the same stance was taken up experientially: self-revelations were explored as metaphors rather than truths. In inflated states, this allowed grandiose self-perceptions to be explored symbolically, connected to values, and reconstructed into more workable self-narratives. The present study adds nuance in two ways: it supports existing recommendations to de-literalise psychedelic content [60], and proposes that metaphorical framing operates dually, as psychoeducational and a mechanism of therapeutic change.

Several therapists noted that people with ego inflation were unlikely to seek therapy - "people have ego inflation, they don't come to therapy" (P8). In the rare instances this presentation was encountered, it was challenging and provocative, with relational ruptures and dropout common, particularly when grandiose claims were confronted too directly. Although psychedelic-specific data on rupture and termination is lacking, adjacent research on grandiose delusions in psychosis shows similar alliance difficulties and treatment disengagement [62, 63], suggesting that inflation carries comparable relational risks. Evidence that grandiose beliefs may be identity-defining [62] may help explain why, as therapists observed, direct challenges to such beliefs may be experienced as threatening.

Some therapists observed that inflation often softened over time, creating greater scope for intervention. This indicates that timing may be as critical as technique, with premature confrontation increasing the likelihood of rupture. However, few immediate strategies for working with clients with ego inflation were identified in this study. As such, focused research incorporating the perspectives of individuals who have successfully navigated ego inflation, is needed to clarify recovery processes and identify supportive interventions.

Across both poles, biographical contextualisation was pivotal. Therapists connected self-perception disturbances to long-standing identity and attachment patterns, and helped clients develop more workable self-narratives. Drawing on Whitfield's [64] Spectrum of Selves model, which frames grandiosity as a rigid "self-as-story," biographical contextualisation can be viewed as fostering "self-in-story," where psychedelic material is woven into personal context rather than treated as fixed identity truth. This approach also resonates with Modlin et al.'s [60] emphasis on reorganising self-stories through connection to personal history, values, and relationships. Notably, this study highlights biographical work

as particularly challenging in this presentation because of its self-referential nature: the therapeutic task was not only to interpret experience but to work with the very interpretive lens that was itself disrupted.

Aside from biographical contextualisation, no other symptom-specific strategies for deflation emerged. Therapists relied primarily on core relational competencies, such as patience, compassion, and non-judgement. This absence itself is noteworthy. It may indicate that existing psychotherapeutic repertoires are sufficient. Although this finding, or lack of, could point to deflation being clinically undertheorised, warranting further investigation.

Dissociative Symptoms

In this presentation, grounding incorporated nervous-system techniques and co-regulation to orient clients to the here-and-now. The aim was not to eliminate dissociation but to restore workable contact, so clients were no longer at the mercy of these states. This aligns with the Psychedelic Iatrogenic Structural Dissociation framework, which anticipates that psychedelic states may amplify latent vulnerabilities, such as dissociation, making early containment crucial [65]. Consistent with trauma literature [66], therapists suggested that dissociation could present subtly and be difficult to detect. It also disrupted therapist-client psychological contact, with clinicians describing clients as not fully “in the room” (P2). This mirrors accounts of dissociation as withdrawal from external contact, requiring the therapist to act as a “psychobiological regulator” through attunement and sensitivity to implicit cues [67].

In this presentation, clinical safety extended beyond the therapy hour. Therapists considered how dissociation affected daily functioning, such as driving, work, and social roles, and sought to reduce the risk of clients becoming stranded in dissociative states. They co-created safety plans with clients, incorporating grounding practices, practical resources, and online contingencies. Such approaches parallel dissociation research emphasising that safety planning must address everyday risks beyond clinical encounters [68]. The present findings, therefore, extend these principles into psychedelic integration, highlighting that supporting dissociative clients often requires scaffolding both inside and outside the therapy room.

Psychoeducation was used to normalise dissociation as an adaptive, trauma-linked, nervous-system response rather than a sign of drug-induced damage. This framing is supported by literature indicating that depersonalisation correlates more strongly with childhood-trauma severity than with recent psychedelic use [69], and by accounts that position dissociation as a protective state that may be inadvertently amplified by psychedelics [65]. Further, psychedelic users’ self-reports in Robinson et al. [15] show that self-education was the most common stabiliser for derealization. Taken together, these findings suggest that psychoeducation may help reduce secondary distress and enhance understanding.

Once sufficient presence and safety were restored, therapists eased into integration gradually to avoid overwhelm. This mirrors trauma-informed approaches in which fragmented material should be approached carefully, rather than pursued through exhaustive recall which may exacerbate fragmentation [66, 70]. Biographical contextualisation also appeared helpful in this presentation. Given

established links between dissociation and early adversity or attachment disruption [71], this strategy may help clients situate their emergent difficulties within their personal history and traumatic experiences. Overall, the present findings highlight the applicability of trauma-informed approaches when working with psychedelic-induced dissociation.

Resurfaced Traumatic Material

In this presentation, grounding focused on nervous-system regulation and containment. This aligns with research demonstrating that psychedelics can intensify autobiographical recall, sometimes surfacing overwhelming material [72, 73]. Therapists therefore emphasised clinical safety, cautioning clients against making impulsive decisions based on newly emerged content; mirroring the “no big decisions” window described by Chwyl et al. [45].

Therapists used psychoeducation to highlight memory fallibility, cautioning that memories emerging under psychedelics were not literal access to the past. They balanced validation with reminders of memory’s reconstructive nature, discouraging premature factual adjudication. This mirrors research showing psychedelics can increase memory distortion [74], and confidence in beliefs regardless of their accuracy [75]. Recent debate further cautions that clinicians should avoid positioning themselves as arbiters of truth, refrain from exerting undue influence over clients’ narratives, and should be cautious not to overemphasise memory fallibility in ways that invalidate clients’ lived experiences [76].

Accordingly, therapists framed the core task of integration as tolerating uncertainty. This echoes findings from Simon et al. [77], where participants reported that uncertainty over whether emerging material was “real” was itself distressing. Rather than focusing on factuality, therapists in this study explored traumatic material emotionally, somatically, and symbolically. This strategy is consistent with Simon et al. [77] and Rose [78] who propose that symbolic approaches can provide resolution and insight even in the absence of veridical memory.

Pacing and gradual exposure were central to enacting this stance. Therapists worked with resurfaced material incrementally, returning to grounding techniques to prevent overwhelm. This echoes psychotherapy literature, which suggests acceleration beyond the client’s capacity or seeking exhaustive recall can retraumatise clients [66, 79]. Consistent with Modlin et al. [60], effective integration appeared to depend on exposure being carefully paced, gradually building clients’ capacity to tolerate distress. Therapists emphasised that these experiences should be processed like any other traumatic experience, rather than treated as a uniquely psychedelic phenomenon.

From a conceptual perspective, it is important to note that the labelling of such experiences remains contested, particularly regarding terms such as ‘repressed’ or ‘resurfaced’ memory, and dissociative amnesia [74, 76]. In this study, the label “resurfaced traumatic material” is used for consistency with Argyri et al.’s [30] framework and the organising structure of the analysis. The focus here remains on clinical handling of these experiences, rather than endorsing a specific memory mechanism or ontological claim.

Disappointment and Unmet Expectations

Consistent with Argyri et al. [30], therapists in this study characterised disappointment following psychedelic use as a presentation in its own right. They described how unrealistic expectations, often shaped by media portrayals of psychedelics as miracle cures, could collapse into despair when outcomes were modest, slow, or confusing. These accounts echo concerns that media hype has amplified pre-psychedelic expectations in ways that complicate clinical outcomes [80]. For clients who viewed psychedelics as a “last chance” after unsuccessful treatment, the absence of breakthrough sometimes reinforced fears of being fundamentally “broken,” escalating into profound hopelessness or suicidality. Similar patterns are reported in the literature [45, 81]. In such cases, safety planning and, when necessary, escalation of care were prioritised.

Psychoeducation in this presentation was a central strategy, and often explored expectation management. Many therapists viewed pre-psychedelic preparation as the optimal time for psychoeducation, aligning with Gorman et al. [31]. However, when clients sought therapy after a disappointing experience, psychoeducation functioned as “reverse preparation”: retroactively countering narratives of immediate cures and reframing modest or confusing outcomes as valid experiences. This approach echoes broader recommendations to normalise the wide variability of psychedelic outcomes, including those that feel subtle or underwhelming [45], and calls to deconstruct media-driven hype [6, 11]. By normalising the nonlinear trajectory of psychedelic healing - described as “zigzag” or “spiral” processes by Chwyl et al. [45] - therapists helped clients remain engaged with integration when the short-term outcomes feel flat or confusing.

Therapists also emphasised the need to validate disappointment with attuned presence, with some conceptualising it as a ‘form of grief’ (P2). Approached this way, disappointment became workable material to therapeutically explore. Biographical contextualisation complemented this approach, gradually drawing attention to longer-term trajectories, situating disappointment within historical patterns of failure or unmet hopes. This strategy aligns with Dames et al.’s [82] suggestion that post-psychedelic disappointment often reflects underlying fears that require validation and collaborative inquiry.

Systemic and Cultural Gaps

While integration is often framed as a psychotherapeutic task, its success is shaped by the wider cultural landscape in which it unfolds. Cowley-Court et al. [13] argue that the socio-cultural framing of integration plays a pivotal role in its realisation. In this data set, many therapists discussed constraints beyond the therapy room - most notably the absence of suitable frameworks and services for supporting psychedelic experiences in Western settings. Without communal or spiritual containers, clients often returned to stigmatising or invalidating environments that amplified alienation. In the absence of alternative support, individuals were therefore vulnerable to medicalisation and were sometimes funnelled into psychiatric or hospital settings perceived as ill-equipped to address psychedelic-related

difficulties. As one therapist observed “these services aren’t set up to have an understanding of psychedelics” (P2). Consistent with the social cure model of psychedelics [84], integration is best understood not only as an individual process, but as embedded in broader cultural and systemic contexts where social infrastructures can constrain or potentiate its outcomes.

Psychedelic Exceptionalism

Alongside systemic factors, participants reflected on how integration is framed within psychotherapy, raising the question of whether it should be treated as a distinct practice - a debate closely tied to the concept of psychedelic exceptionalism. While much of the literature exploring psychedelic exceptionalism centres on the substances themselves - questioning whether psychedelics warrant special regulation, research designs, or prescribing frameworks [84] - the same logic extends to psychotherapy. If psychedelics are framed as exceptional drugs, the care surrounding them may likewise be cast as exceptional.

Yet, participants rarely saw integration as fundamentally different from psychotherapy. Therapists based their work in established psychotherapeutic competencies, sometimes describing integration as indistinguishable from therapy, or simply therapy “dialled up to maximum” (P4). Although distinctive elements were noted, consistent with psychotherapy research [86], participants repeatedly emphasised the therapeutic relationship as central to therapeutic change. One therapist described the alliance as “the main thing that gets the job done” (P7). This position closely aligns with Holmøy and Anderson’s [46] conclusion that neither clinical experience nor existing literature supports the notion that post-psychedelic difficulties require a unique form of psychotherapy.

However, some scholars do conceptualise psychedelic integration as a ‘specialist competence’ [87, p. 8]. Therapists in this study saw integration as part of the psychotherapy continuum, although they also described useful psychedelic-specific sensibilities, including comfort with altered states, knowledge of psychedelics, attunement to spiritual and metaphysical framings, and tolerance of uncertainty and the uncanny. Holmøy and Anderson [46] similarly argue that practitioners must understand the subjective phenomena experienced by clients during post-psychedelic extended difficulties. These findings suggest that extended or acute presentations may require both clinical expertise and psychedelic sensitivity, raising safety concerns when integration is delivered by providers with limited psychedelic literacy or without clinical training.

Ultimately, this study’s findings caution against framing integration as exceptional, instead situating it within the continuity of psychotherapeutic practice while recognising the important distinctive features it demands. In this sense, the data supports Villiger’s [88, p. 92] characterisation of integration as “same same but different”: familiar methods adapted to unusual conditions rather than a wholly separate paradigm.

Implications

The study's findings suggest that psychedelic integration is best approached not as a new paradigm but as psychotherapy under intensified demands. Core competencies remain central, yet additional psychedelic-specific sensibilities are also important, perhaps warranting their inclusion in training programmes. These symptom-specific accounts show how different post-psychedelic difficulties require nuanced applications of established principles, offering guidance for therapists working with common yet under-theorised presentations. At a systemic level, the findings highlight the absence of suitable cultural containers, often leaving individuals with extended difficulties reliant on medicalised pathways ill-equipped for integration. This underscores the need for advocacy and education to improve psychedelic literacy in healthcare and to develop complementary systems of care, including clearer service pathways to psychedelic-informed crisis support. As psychedelic use continues to rise in naturalistic settings, policy frameworks may need to develop clearer guidance and infrastructure to ensure that extended difficulties are met with timely and appropriate support.

Limitations

Several limitations arise from the study's methodological framing. By adopting a process-led, cross-modality perspective, the analysis highlighted general strategies for extended difficulties but did not explore modality-specific adaptations. Participants were also asked to speak in general terms about presentations, yet in practice these vary widely; strategies that stabilise one client may be ineffective or even counterproductive for another. As one therapist noted, "I'm aware again client to client is also going to be really different" (P4), underscoring that even within symptom categories, individual variability limits the generalisability of any single strategy. Although Argyri et al.'s [30] symptom framework provided a useful structure for organising analysis and enabling comparison across presentations, some practitioners noted that its categories did not always reflect clinical reality, as presentations frequently overlapped. This suggests that boundaries between presentations may be more fluid than existing frameworks imply.

Importantly, the findings reflect therapists' perspectives rather than evidence of therapeutic efficacy and rely on retrospective self-reports that may be shaped by recall or desirability bias. Future research should incorporate client accounts to assess the validity and impact of the strategies reported here. Finally, the study's Western framing of integration may limit transferability to contexts where integration is embedded in communal or spiritual containers.

Future Directions

Future research should examine each presentation in greater depth, and trace integration over time, ideally through longitudinal designs. Greater attention is needed for under-discussed self-perception disturbances. Currently, ego deflation appears clinically common yet remains largely absent from the literature, and ego inflation seems to present distinct relational and clinical challenges. It would also be valuable to include a broader range of professionals, such as coaches, psychiatrists, and psychedelic facilitators, whose differing training and approaches may shape integration practices. Finally, triangulating practitioner accounts with client perspectives and self-directed coping strategies would

help validate these findings, and provide a more comprehensive understanding of effective integration strategies.

Conclusion

This study shows how therapists adapt established psychotherapeutic integration principles to post-psychedelic difficulties, offering symptom-specific nuances that have so far been largely absent from the literature. These insights help bridge the gap between conceptual models and clinical realities. The study's contribution lies not in prescribing solutions, but in highlighting the tensions clinicians navigate - between grounding and exploration, validation and challenge, normalisation and risk monitoring - while recognising the complexity and individuality of post-psychedelic care. The findings are best read as situated and provisional rather than definitive. They serve less as protocols than as prompts for reflection, supervision, and dialogue, encouraging therapists to approach integration with curiosity, attentiveness to risk, and openness to diverse ways clients experience and interpret their post-psychedelic difficulties.

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the University of Greenwich Psychology and Counselling Research Ethics Panel. Participants received an information sheet and provided written informed consent.

Consent for publication

Participants provided informed consent for anonymised data to be used in publications.

Availability of data and materials

The interview data that support the findings of this study is available from the corresponding author upon reasonable request. Access to the data is restricted due to the sensitive nature of the material and the need to protect participant confidentiality. Data may be subject to redaction prior to sharing.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

AW and DL developed the research questions and study design. AW conducted all interviews with participants and led the analysis, with DL providing guidance on data organisation and application of the analytic framework. A.W. wrote the main manuscript text. DL, OR and JE contributed to the interpretation of the data and provided critical revisions during manuscript preparation. All authors approved the final version of the manuscript.

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Figures

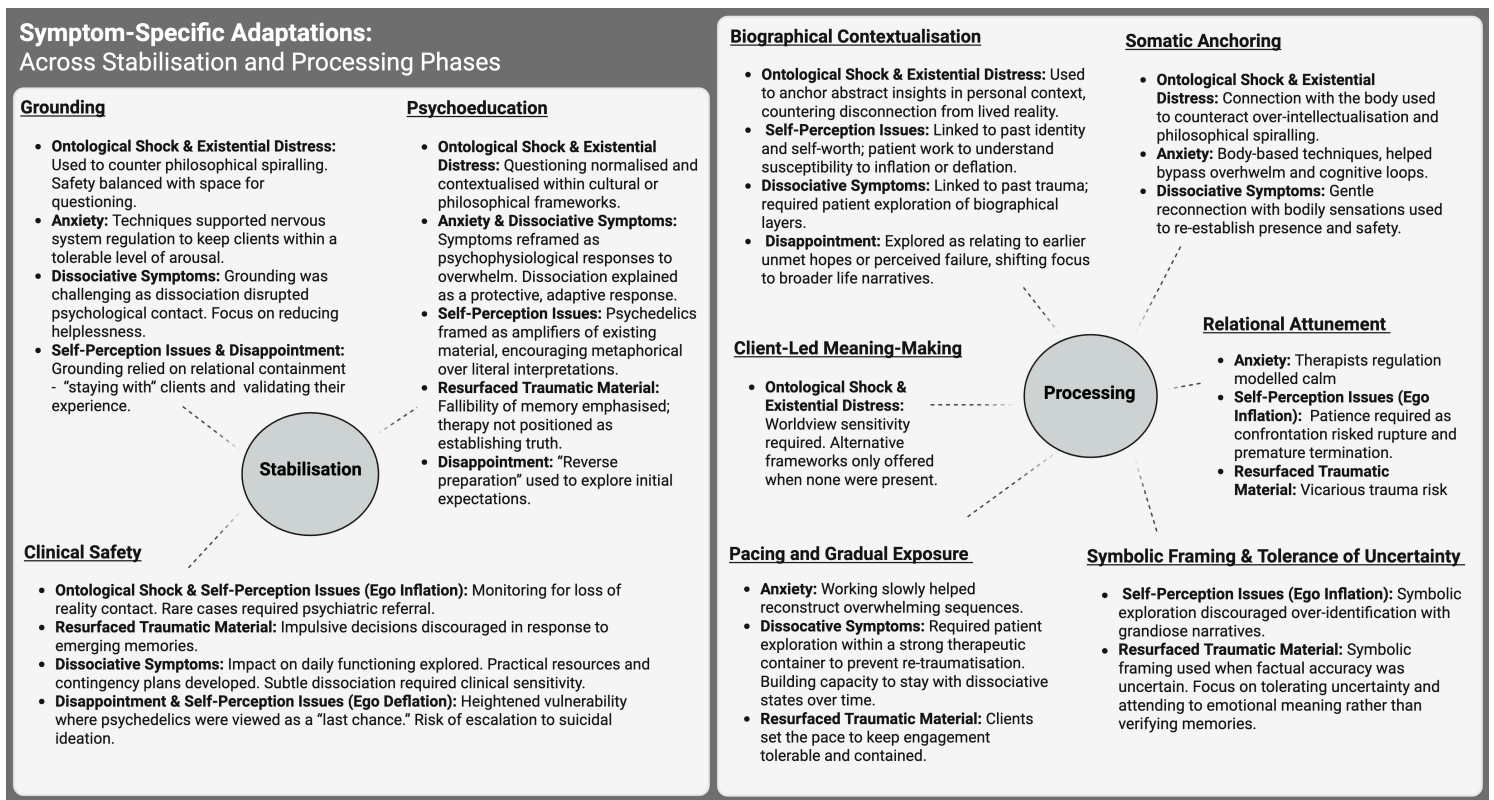


Figure 1

Overview of stabilisation and processing phases and their symptom-specific adaptations.

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