

When Therapy Falls Short: A Qualitative Study of Psychotherapy After Challenging Psychedelic Experiences

Guy Simon

Bar-Ilan University

Nir Tadmor

Impulse - Integrative Clinical Center

Jules Evans

Challenging Psychedelic Experiences Project

David Luke

d.p.luke@gre.ac.uk

University of Greenwich

Jason Luoma

Portland Institute for Psychedelic Sciences

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Abstract

Background

Psychedelic substances are increasingly used outside clinical trials, yet individuals seeking support after challenging experiences often report that available services are inadequate or misaligned with their needs. While prior research documents both beneficial and adverse outcomes of naturalistic use, less is known about how such experiences are received and interpreted within routine psychotherapeutic care.

Methods

We conducted semi-structured interviews with 48 adults reporting significant psychological or functional difficulties following naturalistic psychedelic experiences, of whom 35 had subsequently engaged with professional psychotherapy and formed the analytic sample for the present study. Data were analyzed using reflexive thematic analysis, informed by a phenomenological epistemology, with attention to participants' accounts of therapeutic encounters, meaning-making processes, and trajectories of distress and recovery.

Results

Four interrelated themes were identified. Participants described: (1) therapeutic encounters experienced as misaligned or invalidating, characterized by reductionist or pathologizing interpretations; (2) unmet needs for therapeutic knowledge and relational competency regarding altered states, ontological ambiguity, and non-linear change; (3) the development of self-directed or informal support strategies when professional care was perceived as unavailable or unsafe; and (4) temporal mismatches between participants' recovery trajectories and clinicians' expectations of symptom stabilization. Across accounts, these dynamics frequently co-occurred with concealment of distress and erosion of therapeutic trust; delayed help-seeking was described by a smaller subset of participants, primarily those who reported shame or anticipated incomprehension as barriers to accessing care.

Conclusions

Findings highlight structural and epistemic tensions between dominant mental health frameworks and the forms of distress reported after challenging psychedelic experiences. Rather than isolated clinical failures, participants' accounts suggest systemic mismatches across ontological, temporal, and relational dimensions. These findings contribute to the emerging concept of "psychedelic-informed therapy" — a clinical orientation that may help mental health professionals work with clients who have had psychedelic experiences outside clinical settings. The themes identified point toward competencies including ontological flexibility, temporal sensitivity, and attention to the relational dynamics of

disclosure and concealment, though further research is needed to develop and evaluate these as formalized clinical practices.

Introduction

Psychedelic substances have garnered significant attention within the mental health field, accompanied by emerging training guidelines and competency frameworks for practitioners [1], as well as a growing body of clinical trials and reviews demonstrating their potential to alleviate depression, post-traumatic stress disorder, anxiety disorders, substance use disorders, and other conditions [2, 3]. This literature frames psychedelics as promising adjuncts to psychotherapy, positioning them within contemporary debates on mental health innovation [4].

Nevertheless, psychedelic use extends far beyond the controlled contexts emphasized in academic and clinical discourse [5]. Psychedelic use is rising globally and occurs predominantly in naturalistic, unsupervised settings [6, 7, 8]. Surveys spanning multiple countries indicate that personal growth is among the most commonly cited motivations for use [9, 10].

Psychedelics have been shown to potentially induce prolonged difficulties post-experience, including ongoing anxiety and fear, existential struggle, social disconnection, and depersonalization/derealization, with ontological disruptions — shifts in one's understanding of reality and existence — reported by half of those experiencing such difficulties in one large mixed-methods study [11, 12]. These difficulties can persist for months or years; Evans et al. [11] found that approximately one-third of their sample experienced difficulties lasting over a year, and one-sixth beyond three years. Preliminary findings from the Global Psychedelic Survey 2025 indicate that 8% of respondents reported clinically relevant difficulties — defined as lasting at least a month and causing disruption to daily life — across their lifetime of psychedelic use, of whom 42.4% sought external support, and 79.1% found that support to be effective [13]. More broadly, individuals navigating post-psychedelic challenges frequently rely on self-education and peer support rather than professional care due to limited access to clinical resources [14], though psychotherapy has been perceived as helpful when accessible, particularly for addressing existential struggles [15].

The dominant clinical framework for engaging with psychedelic experiences is psychedelic-assisted therapy (PAT). While PAT has shown efficacy in treating conditions such as PTSD, treatment-resistant depression, and addiction, the underlying trials are also characterized by important methodological limitations [16, 17]. However, clinical trials typically focus on narrowly defined diagnoses within medicalized environments [18, 19], and PAT offers limited guidance for mental health professionals encountering clients who have used psychedelics in unsupervised settings [20, 21, 22, 23]. Notably, guided settings have been found to predict a narrower range of post-psychedelic difficulties [11], highlighting how little structured support exists for the majority of users whose experiences occur outside such settings.

There is scholarly debate on the extent to which post-psychedelic difficulties require new diagnostic categories or treatment modalities. Grof and Grof [24] introduced the category of "spiritual emergency," a form of psycho-spiritual crisis precipitated by methods like meditation and psychedelics, sometimes involving quasi-psychotic symptoms that they argue should be distinguished from standard psychosis. While the concept has gained traction within psychedelic culture, and some individuals find the term helpful in framing their difficulties, others do not [14], and it remains largely unrecognized as a diagnostic category outside of alternative spirituality and transpersonal psychology [25]. At the other end of the spectrum, Holmøy and Andersen [26], drawing on their clinical experience treating post-psychedelic difficulties, suggest that standard evidence-based psychotherapy is effective for such challenges and that a specialized form of therapy is not required, though they note it is helpful if the therapist is familiar with psychedelic experiences. This tension — between calls for entirely new frameworks and arguments that existing approaches suffice with modest adaptation — marks the conceptual space into which the present study intervenes.

In this paper, we use the term "psychedelic-informed therapy" to refer to an emergent clinical orientation — developed in part through the present study's findings — that draws on trauma-informed care, harm reduction, and integration frameworks [27, 28] to support clients navigating post-psychedelic difficulties. While these traditions differ in their epistemological commitments, their convergence here reflects a shared concern with meeting clients where they are rather than requiring conformity to a single clinical model — foregrounding the need for training that enables clinicians to recognize diverse post-psychedelic phenomena, including existential and ontological disruptions [29], while respecting clients' autonomy in making sense of their experiences [30]. We introduce this term here as a conceptual frame to orient the reader, with its full elaboration developed through the findings and discussion that follow.

The present study contributes empirical evidence toward a psychedelic-informed therapeutic paradigm by examining the experiences of individuals who navigated challenges both during and after naturalistic psychedelic experiences while engaging with professional psychotherapy. The study pursues two primary aims: first, to investigate the qualities, skills, and practices that participants identify as characterizing adequate support during the integration of destabilizing psychedelic processes; and second, to examine participants' accounts of inadequate or harmful support, exploring the alignment between integration needs and the therapeutic approaches encountered.

Methods

Design and Approach

We employed a qualitative design grounded in a phenomenological epistemology to explore the subjective nature of participants' post-psychedelic experiences [31, 32, 33]. Given the analytic sample ($N = 35$) and the objective of identifying shared patterns across a diverse cohort, the specific analytic method employed was Reflexive Thematic Analysis [34, 35]. Our application of thematic analysis

attended to participants' subjective accounts and their descriptions of lived experience, while simultaneously identifying structural patterns across the sample.

Participants and Recruitment

Participants were recruited from a larger mixed-methods study on extended difficulties following psychedelic use [11]. From the original survey cohort of 608 respondents, 48 individuals agreed to participate in a follow-up qualitative interview as part of a broader study on extended difficulties following psychedelic use. The present paper focuses on 35 participants (18 women, 16 men, 1 non-binary; ages 21–58) who reported engaging in psychotherapy following a challenging experience. The sample reflected high heterogeneity in both the substance involved (46% psilocybin, 27% ayahuasca, 25% LSD, among others) and context of use (e.g., ceremonial, recreational, solo, and other non-trial settings). Participants consulted various providers, most frequently psychotherapists or counselors trained in modalities including cognitive-behavioral therapy, psychodynamic or analytic therapy, Internal Family Systems, and somatic approaches. Recruitment relied on voluntary opt-in; no financial incentives were provided. The Bar-Ilan University Institutional Review Board approved the study protocol.

Data Collection

Semi-structured interviews were conducted between August and September 2023 via secure video or voice call, lasting 60 to 90 minutes. The interview guide was exploratory rather than confirmatory, utilizing open-ended prompts (e.g., “How did you make sense of what happened in the weeks that followed?”) to elicit rich, dense descriptions. Interviewers were trained to adopt an empathic and curious stance, minimizing evaluative responses to facilitate the disclosure of stigmatized or experientially complex material.

All interviews were audio-recorded and transcribed verbatim. To ensure anonymity, names and identifying details were replaced with alphanumeric codes (e.g., P1, P13), which are used throughout this report.

Data Analysis

Data management and coding were facilitated by MAXQDA 2022 software, following the six-phase process of Reflexive Thematic Analysis [34, 36]. The research team first engaged in repeated readings of the transcripts to achieve immersion, noting preliminary observations on narrative patterns. Subsequently, two researchers performed systematic line-by-line coding. Codes were primarily semantic, describing explicit content, and later evolved into latent codes capturing underlying conceptual dynamics, such as “Epistemic Friction.” Consistent with the reflexive orientation of this analysis [36], coding was understood as an interpretive act shaped by each researcher's disciplinary positioning. Two researchers coded independently, then engaged in structured analytic discussions to surface divergent readings, challenge assumptions, and deepen interpretive nuance. Where interpretations differed, these

differences were explored as productive tensions rather than errors to be resolved, and the final coding reflected the lead analyst's interpretive judgment informed by these exchanges.

Codes were then collated into candidate themes, seeking central organizing concepts that captured recurring patterns and structural relationships among disparate data points. For example, codes regarding "judgment," "fear of disclosure," and "therapist conflict" were grouped under the organizing concept of incompatibility in the therapeutic process. Candidate themes were reviewed against the coded extracts and the entire dataset to ensure they accurately reflected participants' accounts. Theme boundaries were refined to ensure distinctiveness and coherence, and final themes were defined to capture the data's overarching narrative.

Trustworthiness and Rigor

We drew on Lincoln and Guba's [37] criteria for trustworthiness as a general framework, while recognizing that these criteria were developed within a post-positivist tradition and do not map seamlessly onto the reflexive thematic approach employed here [36]. We therefore applied these criteria selectively, emphasizing those most compatible with our epistemological commitments. Credibility was enhanced through researcher triangulation, involving multidisciplinary perspectives from clinical psychology and sociology, as well as prolonged engagement with the data. Dependability was maintained through a detailed audit trail documenting the evolution of coding and thematic mapping. Confirmability was supported by an independent review by three qualitative researchers, who examined the codebook and a subset of transcripts to provide critical feedback on the relationship between codes and participants' statements.

Researcher Reflexivity

The research team approached this study with specific theoretical sensitivities, including background knowledge of psychedelic science and psychotherapeutic practice. While clinical training informed our attunement to participants' descriptions of therapeutic encounters, the analytic framework drew primarily on phenomenological and existential perspectives to examine how individuals made meaning of their experiences. Before analysis, researchers documented their assumptions and prior beliefs—particularly regarding the value of integration or the efficacy of therapy—to maintain reflexive awareness throughout the interpretive process. All participants provided informed consent for both the interview and the publication of anonymized data, and ethical safeguards included a distress protocol with trained interviewers attentive to signs of re-traumatization, as well as the provision of integration and mental health resources following participation.

Results

All 35 participants in the analytic sample expressed a desire for therapeutic support from clinicians knowledgeable about psychedelic experiences to help them safely interpret their experiences. Some participants also reported consulting psychiatrists, mainly during early stages of distress; however, these

interactions were more often related to medication management than ongoing therapy. Of the 35 participants who sought professional help, 15 (42.9%) described therapy as supportive, finding it helpful for stabilization, understanding, or integration. Meanwhile, 20 participants (57.1%) reported that therapy was either unhelpful or only partly helpful, often citing a mismatch between their experiences and the interpretive or relational frameworks available within therapy.

While participants reported both supportive and insufficient encounters, the analysis that follows focuses specifically on therapy experiences perceived as unhelpful, constraining, or insufficiently responsive to their needs. These themes do not represent the prevalence or objective effectiveness of therapeutic approaches but instead illuminate how participants experienced and made sense of therapeutic encounters.

Theme 1: Friction in Standard Therapeutic Settings

Participants described encounters with mental health care that felt ill-equipped to engage the ontological and psychological complexity of challenging psychedelic experiences. This theme captures reports of dismissal, judgment, reductionism, and silence when bringing these experiences to clinicians whom participants experienced as lacking familiarity with psychedelic-related challenges.

Biomedical and Diagnostic Framing

A central pattern involved clinicians interpreting psychedelic phenomena primarily through biomedical or pathologizing frameworks that participants experienced as constraining. P1 described the dissonance of working with a Cognitive Behavioral Therapist who viewed his experience as a cognitive error:

One of them was a kind of cognitive behavioral therapist, and she had an approach that I disagreed with, which was to try to convince me that, you know, my new kind of beliefs were just wrong.

This friction often centered on meaning-making. P2 described how his therapists focused on biological explanations rather than exploring the significance he attributed to the experience:

I was seeing several therapists already at the time. They were not psychedelically informed. It was their position that I should get back on my antidepressants, which I declined to do... their attitude was like it was a drug experience, not more. It didn't have any meaning. So maybe I'd fried my brain, they said. I'd done damage, maybe, I don't know.

P3 articulated this disconnect most sharply, noting that he experienced the medical paradigm as ill-suited for the experience he was enduring:

The mental health system in itself, I think, is totally wrong... effectively, what they're doing is they're sort of taking a medical paradigm and applying it to you. It really doesn't apply... really, what I needed was someone to... guide me out of my fantasies rather than pump me full of drugs and give me a diagnosis.

Evaluative Stances and Constraints on Disclosure

Therapists' perceived evaluative stances toward psychedelic use shaped disclosure practices and, in some cases, contributed to strain or rupture in the therapeutic alliance. Several participants sensed shifts in tone, facial expression, or atmosphere after disclosing psychedelic experiences, which they experienced as judgment. P4 described a subtle but palpable shift in her therapist's demeanor:

I feel like, yeah, I felt like I'm being judged because you did the drug. You know, you are the one who tried something else, and then now you pay for it... I even think it was a bit of a let-down by him because he's such a great therapist. But when it comes to this, the judgment came in unconsciously, consciously. And I then feel like I'm being rejected and abandoned in some way.

P5 described how a moment of perceived judgment led her to terminate therapy:

She claimed to be very understanding until I came back from an experience and explained to her the shift in my well-being. I could see the judgment on her face at that time. I was like, 'I'm done. I can't see her anymore.'

In these accounts, participants described withdrawing or ending therapy when they felt that their psychedelic use was being evaluated rather than explored.

Concealment, however, did not arise only in response to perceived disapproval. Participants also described situations in which therapists appeared to adopt an uncritical narrative of psychedelic healing. In these cases, participants described experiencing pressure to sustain a narrative of transformation rather than disclose ongoing struggle.

P6 described how his therapist quickly concluded that he had “cured” himself after a ceremonial experience. Feeling invested in maintaining the image of a successful and insightful traveler, P6 chose not to contradict that interpretation:

I came back, I kind of... I bullshitted to my therapist that I felt better... because I just... You know, I want to... and this is one of the things that I think is really dangerous... Like, I'd been seeing this therapist for a little bit, and he was really impressed by me and my story too, and he was like, Oh, it sounds like you went and did this, had this ceremony, and cured yourself. He told me I cured myself. And I didn't. That wasn't true.

P6 later reflected that this dynamic involved both his own desire to be seen as transformed and the therapist's readiness to affirm a narrative of cure; rather than exploring ongoing difficulties, the interaction stabilized around a shared narrative of improvement. This account introduces an important variation: concealment here was not driven by fear of pathologization but by a relational pull toward confirmation. The therapist's enthusiasm created a context in which disclosing ongoing struggle would have disrupted not only the clinical narrative but also the interpersonal bond P6 valued. In this sense, affirmation and pathologization may function as symmetrical constraints on disclosure — both representing predetermined stances that narrow the space for authentic communication.

Across cases, participants described adapting their self-presentation when they experienced therapists as holding predetermined stances toward psychedelic experiences. This adaptation took two distinct forms: concealing use or distress in the face of anticipated judgment, and presenting narratives of recovery in response to affirming enthusiasm. While the former has received more attention in the psychedelic literature, the latter may be equally consequential for clinical practice, as it can mask ongoing difficulties behind an appearance of therapeutic success.

Shame and Protective Silence

Participants reported that anticipating incomprehension prevented them from seeking help at all. P7 described how shame acted as a barrier, preventing disclosure even to a trauma specialist she was already seeing:

I felt so embarrassed by that experience that it stopped me from getting help. I didn't want to talk about it... I was seeing my trauma specialist. But again, I didn't engage him because I was embarrassed. What was I going to say? Oh, I'm the idiot who did this.

In a variation of this pattern, P8 described withholding information to protect her therapist from worry, managing disclosure based on her assessment of what the therapist could handle:

I obviously went to therapy, but I don't tell my therapist that I do this, so she doesn't know. ... Because I think she would be worried. It's not legalized here. That's for starters. But it's also... I think after everything I've been through, she would be worried about me, I think.

Theme 2: Desired Therapeutic Qualities and Knowledge

Participants wished for clinicians who were familiar with altered states and capable of engaging with their experiences without premature diagnostic interpretation.

Navigating Questions of Reality and Meaning

Participants frequently expressed a wish for a clinician who could help them make sense of experiences that challenged their understanding of what is real and what such experiences might mean—questions that are ontological and epistemological. P9 articulated why she felt standard therapy fell short; she described needing assistance discerning whether her visions held validity or significance:

I really would have loved to have had somebody knowledgeable as a therapist and also had first-hand knowledge of psychedelic use, and could help me sort out one from the other in a way, you know, because I did doubt how much I trust these visions if I'm often having them through, with the aid of consciousness-altering substances, you know.

P8 noted that without this specialized knowledge, she felt the therapeutic work stalled, as the inability to share this part of her life limited the depth of the therapeutic bond:

It would be really nice to have someone guide you through these things and help you integrate... And it's also like, for the purpose of healing, I haven't held back on anything I've told my therapist, because what would be known if I want to integrate everything is that I need to be open to everything. It's really a pity that I cannot share this part, as it would strengthen our bond as well.

The Value of Shared Experience

While not universal, several participants stated that a therapist's personal familiarity with altered states would serve as a crucial tool. This was rarely described as a desire for a "peer," but rather as a safety mechanism to ensure the therapist would not pathologize the territory. P2 hypothesized that such shared ground would have transformed his recovery:

I think if I had a therapist who had taken psychedelics or who was familiar with this, that would have probably been a very powerful integration tool.

P7 contrasted the well-meaning love of her friends with the relief of speaking to someone who "knows":

It would have been phenomenal if I had a community, but I didn't know anyone, so I was isolated in the experience. That would have been really big to have someone who knows. Instead, I had a lot of friends who were like, "I love you," but they didn't have any experience. So they weren't like, This is normal or This is not normal.

P10 extended this personal wish to a broader critique, calling for education within the mental health profession:

And then, if there is a challenging experience, there's enough education, perhaps in the psychotherapy world, to support people with that. In the absence of spiritual leaders or shamans in my country, we don't have access to these supports.

Theme 3: Self-Directed and Informal Support Pathways

Participants described developing self-directed, informal support strategies when professional care was unavailable or perceived as inadequate.

Informal Networks as Substitutes

In the absence of informed professionals, participants described leaning on partners and friends.

P2 described his husband's support as a substitute for the therapy he could not access:

But because I didn't [have a therapist], I mean, I had my husband, who had gone through the same things. It was kind of like informal therapy, almost.

P11 highlighted the limits of peer support when peers had not shared similar experiences, describing a sense of isolation even among friends who used psychedelics recreationally:

As I said, my friends who introduced me to the drug itself, who take acid all the time, they couldn't relate to the experience I had, it's just not the experience they have, right? ... So I had no support there.

For some, perceived gaps in care not only led to informal coping but also to vocational imagination. Rather than withdrawing from therapeutic systems, they described aspiring to become the kind of practitioner they had needed. P12 described a fantasy of becoming the professional who could provide the non-pathologizing care he had been denied:

I often fantasize that it would be quite good to have sort of professionals, if you like, who are like me. Know and understand what's going on when someone's going through a break like that, and can help them without the use of drugs.

Theme 4: Non-Linear Recovery and Therapeutic Fit

Participants often described recovery as temporally non-linear, involving periods of destabilization or intensified affect that they experienced as not aligning with improvement-oriented assumptions in therapeutic settings and shaping their sense of therapeutic fit.

Destabilization and Reorganization

Participants such as P13 described trajectories in which periods of decreased well-being preceded subjective improvement, patterns that later shaped how their progress was interpreted within care settings. She retrospectively framed these periods as integral to her process, though she described others as potentially perceiving this as a decline:

In the short term, it decreased my well-being because I had to deal with the things that it brought up for, you know, months at least... but I think that was necessary. It was part of the healing... even though sometimes at the beginning, that growth looked like decreased well-being.

P13 described this destabilization as preceding a sense of reorganization:

It felt as though the blocks in my mind had been shaken about a little bit and settled in a slightly different way. So then it also felt like the carpet had been pulled out from underneath me...

Similarly, P14 highlighted how increased anxiety was not a symptom to be suppressed but a signal of returning sensation:

Previously, I wouldn't feel anxious. ... Now, you know, I feel anxious like it's in my chest. ... Maybe I'm actually just more aware of a previous anxiety.

Such experiences of destabilization were not inherently framed by participants as regression. However, when situated within therapeutic contexts that emphasized symptom reduction or observable progress, these phases sometimes generated uncertainty about whether change was occurring in the “right” direction.

Tensions Between Recovery Trajectories and Therapeutic Models

Participants described instances in which divergent timelines generated uncertainty within the therapeutic relationship. P15 described a scenario where her therapist, uncertain about P15's response to therapy following an ayahuasca experience, sought consultation on whether to continue their current approach:

She had recently sought consultation on whether it is useful to continue the same style of therapy we are doing. Actually, I wasn't responding to therapy.

P15 interpreted this not as a lack of capacity to heal, but as a limitation in the therapeutic model's capacity to accommodate a period of non-linear stagnation or reorganization.

Revising Expectations of Recovery

Participants described revising these expectations not only regarding psychedelics themselves but also in relation to how change was discussed and anticipated in therapy. They also described how non-linearity prompted them to abandon expectations of a “quick fix,” often bringing them into tension with cultural narratives that had shaped their initial hopes. P16 described realizing the “magic pill” narrative was false:

But I realized that wasn't the case... I thought that psychedelics would fix everything. You know, one session and I'd be okay. ... It's not urgent, but it's not going to get better unless you look at it. So it's there, and it has to be dealt with.

For some, the value of destabilizing experiences became evident only retrospectively, complicating binary distinctions between “good” and “bad” outcomes commonly used in clinical evaluation. P17 described how an experience of extreme fear later reshaped his professional practice.

I just kept feeling like I was being drowned... I was being told to give up and surrender, and it felt as if I did give up and surrender; I would die... And then, all of a sudden, I was on the other side... And I remember reciting that poem and being like, I can understand it now. Like, I have this new vision, this new understanding of what that meant.

For P17, the meaning of the experience emerged only over time, reshaping his understanding of suffering in his professional role.

Synthesis

Across these themes, participants' narratives converged around a recurring pattern. Many accounts highlighted perceived mismatches between participants' needs and available forms of care, particularly involving experiences participants described as dismissive, pathologizing, judgmental, or constraining open disclosure (Theme 1). These encounters reflected not only interpersonal difficulties but broader perceived misalignments between participants' needs and the forms of care available—particularly regarding specialized competencies (Theme 2) and the difficulty of integrating destabilizing, nonlinear recovery processes within therapeutic frameworks oriented toward observable improvement (Theme 4). In response, participants described developing self-directed or informal support strategies when professional care was experienced as insufficient or unsafe (Theme 3).

The Discussion below interprets these themes through complementary conceptual lenses to clarify how these tensions may be structured within routine therapeutic care.

Discussion

As reported in the Results, while some participants described psychotherapy as supportive — particularly when characterized by relational safety, emotional containment, and interpretive flexibility — more than half described therapy as unhelpful or only partially helpful, reporting mismatches between their needs and the frameworks available within therapy. This contrasts with preliminary findings from the 2025 Global Psychedelic Survey, in which 79.1% of those who sought external support for disruptive difficulties found it effective [13]. However, this discrepancy should be interpreted cautiously. The GPS captures a broader population and a wider range of support types (including peer and community resources), while the present sample was pre-selected for extended difficulties following psychedelic use [11]. The divergence may therefore reflect differences in both the severity and chronicity of participants' difficulties and the specific dynamics of professional psychotherapy, where prevailing frameworks may be less attuned to the phenomenology of psychedelic experiences. Rather than contradicting the GPS finding, the present study may illuminate the experiences of a subpopulation for whom general support-seeking is insufficient.

While a growing body of research suggests that psychedelics can provide psychological benefits in naturalistic settings [38, 39, 6], and large-scale studies indicate that many individuals navigate difficult psychedelic experiences without formal clinical support [40, 41], participants who did engage in psychotherapy frequently described encounters where their meaning-making was restricted rather than expanded.

When therapeutic encounters prioritized definitive conclusions over exploratory inquiry — what might be termed epistemic closure — participants experienced these interactions as foreclosing rather than supporting their processes.

Throughout the analysis that follows, we use "integration" to refer to participants' ongoing process of making sense of and incorporating psychedelic experiences into their lives, recognizing that this process is non-linear, differently understood across clinical and cultural frameworks, and socially situated rather

than a discrete clinical endpoint. We map the difficulties described by participants across three interdependent dimensions: ontological, characterized by a clash between participants' existential meaning-making and therapists' belief systems regarding psychedelics; temporal, involving misalignment between participants' non-linear transformative processes and clinical expectations of linear symptom reduction; and relational, marked by breakdowns in therapeutic safety that produced concealment. Together, these dynamics illuminate the care gap described by participants, which this discussion analyzes through frameworks from Contextual Behavioral Science (CBS), critical medicalization studies, and bioethics.

Helpful Therapeutic Elements: Contextualizing the Mismatch Findings

Before examining the dimensions of therapeutic mismatch in detail, it is worth noting the relational and interpretive conditions that participants associated with constructive therapeutic engagement. While accounts of helpful therapy were generally less elaborated than descriptions of difficulty – a pattern consistent with well-documented tendencies to narrate negative experiences in greater detail than confirmatory ones [42] – they nonetheless identify elements that participants experienced as genuinely supportive, and that serve as an implicit counterpoint to the frictions described below.

A central element described as helpful was the presence of a non-judgmental relational space in which participants felt able to disclose and explore their experiences without fear of dismissal or pathologization. P18 described the importance of "having a safe place where there wasn't any judgment," emphasizing the relief of being able to speak openly within a supportive therapeutic relationship. P19 described feeling "hugely supported" by a practitioner who could "hold everything I was saying" without imposing interpretation, instead offering what she described as simple "witnessing." For P20, the non-judgmental atmosphere of an integration group was experienced as "invaluable," particularly in allowing difficult or confusing material to be spoken and reflected upon in the presence of others.

Participants also described therapy as helpful when it supported efforts to understand or contextualize their experience in new ways. P21 described therapy as helping him "understand what the meaning of what I saw [sic]," allowing previously confusing or distressing material to become more coherent over time. P22 described therapy as supporting his ability to distinguish between elements of his personal history and the effects of the substance, situating the experience within a broader psychological context rather than leaving it inexplicable or destabilizing. Where distress manifested somatically, body-oriented approaches were described as facilitating regulation and reconnection: P23 found somatic therapy helpful in "managing whatever the heck was happening," while P19 valued body-focused work for helping her "come back into my body." P24 found analytic therapy helpful in understanding the experience as "unconscious material... made visible," and P25 described exposure-based work as allowing gradual re-engagement with previously triggering material.

Across these accounts, therapy was experienced as helpful when it offered relational safety, openness, and interpretive flexibility. Notably, the qualities participants described as helpful often mirrored, in their presence, the very qualities whose absence defined the mismatch themes examined below — suggesting that the two sets of findings are best understood as complementary rather than as separate phenomena. That accounts of therapeutic mismatch were generally more elaborated likely reflects both the study's sampling frame — participants were recruited from a cohort reporting extended difficulties [11] — and a well-documented tendency to narrate negative experiences in greater detail than confirmatory ones [42]. This asymmetry should be borne in mind when interpreting the findings that follow.

1. Ontological Incompatibility

A central source of mismatch in the therapeutic process following a psychedelic experience stems from the divergence in how distress is conceptualized. Certain dominant models within mental healthcare, particularly those grounded in biomedical psychiatry or structured cognitive approaches, tend to prioritize correcting cognitive distortions or regulating biological symptoms — an orientation that did not fit the needs of participants who described crises of meaning experienced as defying biological reduction. This tension aligns with what Argyri and Evans [43] term Ontologically Challenging Psychedelic Experiences (OCPEs). These phenomena do not merely alter mood but profoundly disrupt fundamental assumptions about reality, existence, and the self.

As P2's and P3's accounts illustrate, clinicians at times interpreted psycho-spiritual crises primarily through diagnostic frameworks that did not align with participants' own understanding of their experiences — a pattern consistent with what medical sociologists term biomedical reductionism [44]. OCPEs blur the boundary between clinical disturbance and valid existential questioning. Philosophical perspectives on illness phenomenology suggest that diagnostic interpretation may differ substantially from patients' lived experience [45]. At the same time, resisting pathologization should not imply that the chaotic mental and emotional states sometimes precipitated by psychedelics require no professional support. Chwyl et al. [46] caution against reflexively reframing such chaos as a learning opportunity, emphasizing that psychedelic experiences can precipitate fundamental identity crises requiring therapeutic support focused on validating phenomenological distress rather than cognitive correction.

This tension is intensified by the directional nature of psychedelic belief changes. Psychedelic experiences may precipitate shifts away from physicalist worldviews toward panpsychism or dualism [47, 48], and such shifts have been associated with improvements in psychological well-being. However, clinical trials demonstrating therapeutic efficacy in conditions such as depression [49] have not directly examined whether these belief changes contribute to observed outcomes. For participants in this study, these were not abstract philosophical questions but lived dilemmas with direct implications for therapeutic care. Participants who reported such shifts described clinicians treating their interpretations as cognitive errors requiring correction rather than as meaningful attempts to make sense of anomalous experiences, whereas psychotherapeutic models developed specifically around such experiences encourage phenomenological exploration, containment, and depathologization of the experience [50].

As P1's account illustrates, when a clinician framed his post-psychedelic beliefs as cognitive errors to be corrected, the therapeutic relationship became a site of contestation rather than exploration. This pattern points to the need for what Stein et al. [51] describe as a "soft naturalism" attentive to the interdependence of facts and values. At the institutional level, it reflects what Muyskens et al. [52] characterize as the breakdown of epistemic humility — when clinicians presume sole authority over what counts as valid knowledge rather than recognizing the patient as a co-participant in the interpretive process. Letheby's [53] concept of epistemic innocence deepens this point: even if psychedelic-related beliefs do not correspond to objective reality from a scientific standpoint, they may still offer significant psychological and meaning-making benefits — a possibility foreclosed when clinicians treat such beliefs exclusively as symptoms.

These accounts point toward what Aixalà [54] and Argyri et al. [55] describe as "ontological integration" — therapeutic engagement with shifts in one's fundamental understanding of reality that can hold multiple interpretive possibilities without rushing toward resolution. Interview research with qualified therapists specifically managing extended difficulties following psychedelic experiences also reported that a more nuanced approach was needed for differing symptoms [56]. Integration therapists indicated the need to first stabilize ontological shock through somatic grounding, avoiding 'philosophical spiraling' and using psychoeducation to normalize the experience, followed by processing and integrating the experience by anchoring abstract insights in personal context [56]. The distress reported in this study may reflect limitations in existing therapeutic frameworks' capacity to sit with such existential uncertainty, particularly when psychedelic insights contradict cultural values or a client's pre-existing life circumstances [57].

2. Temporal and Definitional Incompatibility

The results highlight epistemological dissonance between clinical metrics and participant phenomenology, specifically a timeline mismatch where clinicians interpreted post-psychedelic destabilization as clinical deterioration.

Recent bioethical scholarship on Transformative Experience [58] offers an interpretive frame for this misalignment. Jacobs argues that experiences that induce fundamental shifts in worldview may render the post-experience self difficult for both the person and their clinician to anticipate using pre-experience frameworks. This resonates with participants' descriptions of temporary destabilization that they initially could not interpret as meaningful.

Standard psychiatric models prioritizing linear symptom reduction (restitution) are ill-equipped to map this trajectory of becoming. P13's description of "blocks being shaken about" captures this phenomenology: a process experienced as necessary reorganization that could easily be read as deterioration through a symptom-focused lens at a single point in time.

However, the issue may be less about *when* progress occurs and more about how progress is defined altogether. Therapeutic frameworks oriented toward psychological flexibility and values-aligned living —

such as those grounded in Contextual Behavioral Science (CBS) — would not necessarily interpret initial destabilization as a delay in improvement, but may recognize it as progress itself, if it reflects the loosening of rigid patterns and the emergence of new values-based engagement [59, 60]. In this view, the incompatibility participants described is not only temporal but definitional: it concerns which changes count as therapeutic movement at all.

Watts and Luoma's [60] ACE (Accept, Connect, Embody) model offers a particularly useful framework for understanding these dynamics. Rather than interpreting destabilization as a waypoint on a developmental trajectory, the ACE model emphasizes how psychedelic experiences may temporarily loosen rigid patterns of thinking, feeling, and behaving, creating conditions for acceptance, connection, and embodied meaning-making. The therapeutic emphasis is on relating differently to experience through acceptance and connection, rather than on distress or disruption per se. Dąbrowski's [61] theory of Positive Disintegration offers a complementary vocabulary, conceptualizing certain forms of destabilization as potentially developmental rather than regressive — though it is important to note that not all post-psychedelic destabilization is developmental, and some individuals experience clinically significant deterioration warranting standard intervention. When clinicians lack frameworks that can accommodate non-linear change, they may interpret periods of increased distress as treatment failure, potentially shifting focus away from the meaning-making processes that participants in this study identified as valuable.

Participants' retrospective accounts raise questions about how clinicians might respond to destabilization without presuming either that distress indicates pathology or that difficulty is inherently developmental. Among participants who described the eventual resolution of difficult periods, many emphasized emotional acceptance rather than symptomatic suppression — suggesting that the clinician's capacity to remain present with uncertainty, without rushing toward resolution, may itself be a therapeutic resource. This points to the value of an embodied, whole-person attunement in which the therapist's relational stance — rather than their interpretive framework alone — creates the conditions for integration [60].

Several participants described shame as a significant affective component during periods of disintegration, consistent with research linking shame and psychological inflexibility to non-disclosure in therapy [62]. The dynamics of shame and non-disclosure are explored further in the following section on relational failure; here, we note the implications for therapist stance during periods of destabilization specifically. What emerges from these accounts is the centrality of the therapist's orientation toward compassion — not primarily as a technique taught to clients, but as a relational posture that signals safety. When therapists approach distress with warmth and non-judgment rather than corrective intent, they may create conditions more conducive to self-compassion and present-moment engagement [63, 64, 65]. The implications of this relational stance are developed further in section 6.

3. Relational Failure and the Concealment of Distress

Participants described withholding parts of their experiences from therapists, viewing these omissions as protective responses to anticipated judgment. These patterns can be examined through frameworks addressing knowledge production and silencing within institutional contexts. Fricker's [66] concept of epistemic injustice — in which a speaker's testimony is systematically devalued due to identity-based prejudice or structural features of knowledge systems — offers a useful lens for understanding how clinical frameworks may constrain which experiences are recognized as credible or meaningful. Participants who perceived therapists as dismissive described a dynamic consistent with what Fricker terms testimonial injustice: their accounts of psychedelic experience were received not as valid reports of lived phenomena but as symptoms or cognitive errors, effectively reducing their epistemic standing within the therapeutic relationship.

P6's and P8's accounts illustrate how concealment may result in clinical decision-making based on what participants believe therapists want to hear, arising from both fear of judgment and — as in P8's case — a perceived reversal of the therapeutic container.

These accounts suggest that integration processes are inherently social and cultural rather than exclusively individual clinical achievements. When integration is framed as an individual achievement measured by the resolution of ambiguity, participants may experience pressure to 'perform' wellness rather than disclose ongoing uncertainty. Kiverstein et al.'s [67] causal pluralist account of psychedelic experience supports this interpretation by emphasizing that outcomes are co-shaped by substance effects, set, and socio-cultural setting [68, 69]. From this perspective, concealment can be understood as a patterned response to the therapy's socio-cultural setting, in which patients learn which experiences are legible and which threaten belonging or continued care [67].

The consequence of these dynamics is that concealment, while protective, limits clinicians' ability to assess participants' actual states. When clinicians cannot hold the possibility that a worldview disruption may be both distressing and meaningful, patients learn that authenticity threatens the relationship.

4. Informal Support as a Response to Unmet Post-Psychedelic Needs

Some participants developed self-directed strategies they found helpful, particularly informal support networks that offered acceptance, flexibility around timeframes, and a lack of judgment.

Participants' descriptions of sharing experiences in informal networks reflect a relatively universal human need: to have one's experience witnessed and made sense of in the presence of others who have traveled similar ground. Where professional frameworks sometimes foreclosed meaning-making, peer contexts offered what several participants described as shared experiential knowledge — an understanding that required no translation.

The vocational turn observed in some accounts — where participants like P12 described aspiring to become the kind of practitioner they had needed — suggests that the ordeal clarified what mattered to

them, orienting their lives toward supporting others.

The picture that emerges is not one of informal care triumphing over professional frameworks — indeed, some participants turned to therapy precisely after peer support had reached its limits. Rather, these accounts point to a particular quality of support, characterized by shared experiential knowledge and freedom from evaluative expectations, that participants described as difficult to find within standard clinical settings [70]. This suggests not a failure of professional care per se, but a gap between what clinical models currently offer and the fuller range of needs that post-psychedelic distress may present.

5. Cascading Dynamics Across Dimensions

While participants did not typically frame the ontological, temporal, and relational dimensions as interconnected failures of a single system, our analysis suggests they often co-occurred and mutually shaped the therapeutic encounter: when existential concerns were interpreted through biomedical or corrective frameworks, periods of increased distress were more readily interpreted as treatment failure, which in turn shaped participants' reluctance to disclose the full scope of their experiences. We propose this cascading pattern as a hypothesis warranting investigation through longitudinal or process-oriented research designs. If supported, it would suggest that interventions targeting any single dimension in isolation may be insufficient, and that effective psychedelic-informed therapy would need to address all three concurrently.

6. Implications for Mental Health Services and Practice: Toward Psychedelic-Informed Therapy

The findings highlight what we call psychedelic-informed therapy — a clinical approach that does not involve giving psychedelics but prepares mental health professionals to work effectively with clients who have experienced psychedelics in other settings. As explained in the introduction, this approach is based on trauma-informed care, harm reduction, and integration frameworks [27, 28]. Based on these findings, we suggest that psychedelic-informed therapy involves competencies that span two categories: those that represent domain-specific knowledge and skills, and those that represent general therapeutic qualities given particular salience by the phenomenology of post-psychedelic distress. In the first category, we identify: (1) ontological competency — the ability to engage with non-materialist or existentially challenging interpretations without viewing them as pathological; (2) temporal flexibility — understanding that recovery may not be linear and that instability does not always mean worsening; and (3) a patient-centered and exploratory approach to integration that resists premature interpretive closure. In the second category — general therapeutic capacities that participants described as especially critical in the post-psychedelic context — we identify: (4) compassion as a fundamental relational stance, particularly salient given the shame and self-criticism participants associated with challenging experiences; (5) somatic literacy — attunement to the bodily aspects of experience, made especially important by the unusual and sometimes alarming somatic phenomena that psychedelic states can produce; and (6) prioritizing relational safety, including awareness of how power dynamics and anticipated judgment influence disclosure. This distinction matters: the domain-specific competencies — ontological competency, temporal flexibility, and exploratory integration — require specialized training in

psychedelic phenomenology that falls outside standard clinical preparation. The general competencies — compassion, somatic literacy, and relational safety — are not unique to psychedelic contexts, but the vulnerabilities of post-psychedelic distress, including shame, somatic dysregulation, and fear of judgment, give them heightened salience and require clinicians to apply them with greater intentionality than standard training may emphasize. In this sense, psychedelic-informed therapy occupies a middle position in the debate outlined in the introduction: it does not call for an entirely new therapeutic modality, nor does it suggest that existing frameworks require only minimal adjustment. Rather, it identifies specific domains of competency that may need to be cultivated beyond what standard training currently provides — a need likely to grow as naturalistic use continues to expand. Each dimension is explained in more detail below.

Patient-Centered and Exploratory Integration. The friction described in Theme 1 suggests that effective integration support may require clinicians who can hold uncertainty and adopt a cocreative, exploratory stance rather than one led by predetermined frameworks. This aligns with findings from Tadmor et al. [71], whose phenomenological study of mental health professionals with personal psychedelic experience identified a shift toward non-directive, patient-centered approaches characterized by increased openness to unconventional experiences, greater tolerance for not knowing, and recognition that therapeutic progress may unfold through processes the clinician does not fully control. Their participants described learning to "trust the process" and to accompany clients "wherever they want to go" rather than steering toward predefined outcomes—qualities that constitute core elements of psychedelic-informed therapy and that may be particularly relevant when supporting individuals navigating the epistemic and ontological uncertainties that follow psychedelic experiences.

Ontological Competency. Approaches capable of engaging with non-materialist interpretations without dismissing them as pathology might address gaps described by participants. As P10 noted, in the absence of traditional spiritual leaders, mental health professionals may need to expand their scope to hold non-ordinary states without judgment, potentially requiring preparation in altered states phenomenology and cross-cultural healing traditions [52, 57].

Reframing Progress. Mental health professionals may benefit from greater exposure to frameworks that challenge not only the expected timeline of recovery but the definition of therapeutic progress itself. Transformative experience theory [58] offers one such lens, suggesting that fundamental shifts in worldview may require entirely new evaluative categories. Participants' accounts raise questions about whether outcome metrics might be expanded to include meaning-making, identity coherence, and the quality of one's relationship to uncertainty — measures better suited to the forms of change described than symptom scales alone. Psychedelic-informed therapists would resist pressure to evaluate outcomes through frameworks that may misread early destabilization as deterioration.

Compassion as Foundational Stance. As discussed in relation to shame and non-disclosure, compassion as a relational posture — the therapist's capacity to approach distress with warmth, non-judgment, and genuine openness to suffering — is especially salient for clients navigating post-psychedelic states,

where disorganization and vulnerability may intensify self-critical processes. Compassion-focused approaches were developed precisely for individuals with high shame and self-criticism who find self-compassion difficult [72] and may be well suited to this population. When the therapeutic relationship itself offers a direct experience of warmth and acceptance, clients with histories of difficult attachment may find in it a model for extending similar kindness toward themselves [63]. Supporting clients' self-compassion, in this sense, begins with the therapist's own relational stance rather than with technique.

Somatic Literacy. Accounts of somatic distress suggest that therapeutic approaches attending to somatic awareness and affect tolerance may offer resources beyond cognitive processing. P23 described needing tools to work with intense bodily sensations that had persisted beyond the acute psychedelic experience, while P19 valued body-focused approaches for helping her "come back into my body," supporting a sense of grounding and safety. These accounts suggest that psychedelic-informed therapists would benefit from training in somatic and mindfulness-based modalities that can help clients develop a curious and non-reactive relationship with unusual somatic experiences, recognizing these as potential expressions of psychological material rather than symptoms requiring suppression or immediate resolution.

Relational Safety as Clinical Priority. Given the concealment patterns observed, mental health professionals may need to attend to how power dynamics and diagnostic categories influence disclosure. Creating space for disclosure also requires institutional openness to outcomes that fall short of transformation — allowing patients to voice disappointment, ambivalence, or a sense that the experience did not deliver what was anticipated, without feeling they have failed or been failed. Psychedelic-informed therapy thus requires not only technical knowledge but also a relational posture that signals safety around the full range of psychedelic outcomes.

Community Integration Models. These findings suggest potential value in collaborative models where clinical services work alongside community-based integration circles or peer support, though maintaining clinical boundaries within such collaborations remains an open question. Recovery-oriented frameworks such as CHIME [73] and Intentional Peer Support [74] highlight the importance of integrating peer and professional roles within mental health systems, and peer support workers are increasingly incorporated into formal services to complement professional expertise with experiential knowledge [75]. Psychedelic-informed therapy may likewise be strengthened by positioning clinicians not as sole authorities but as one resource within a broader ecology of care.

Limitations and Future Research

Several limitations need to be considered. As noted above, participants were recruited from a cohort that had self-identified as experiencing ongoing difficulties after psychedelic use [11], which pre-selects for challenging outcomes. The findings should therefore be interpreted as highlighting the experiences of a specific subgroup rather than representing psychotherapy after psychedelic use overall. The study also relied on retrospective self-reports, capturing participants' current interpretations of past events rather than real-time experiences. Whether destabilization was seen as productive at the time or only later

gained that meaning cannot be determined from these interviews. This is a common issue in qualitative research on transformative experiences, but it is especially relevant here because participants tend to reinterpret difficult periods as meaningful in hindsight. Additionally, the study captures only participants' experiences of therapeutic encounters, not therapists' perspectives, intentions, or clinical reasoning. Participants' accounts of being pathologized, judged, or dismissed represent their subjective experience of the interaction — which is the legitimate object of phenomenological inquiry — but should not be read as objective descriptions of therapist behavior. Therapists may have had clinical rationales for their approaches that participants did not perceive or that were not communicated effectively. Future research incorporating dyadic or therapist-side perspectives would help distinguish between failures of clinical competency and failures of clinical communication.

To address these gaps, future research should prioritize: (1) longitudinal studies tracking real-time integration processes to capture temporal dynamics; (2) systematic evaluations of community-based support models to identify active ingredients of informal support; (3) assessments of clinician knowledge and attitudes about psychedelics and non-linear recovery; and (4) exploration of how clinicians might approach periods of destabilization without presuming pathology or developmental inevitability, attending instead to participants' evolving understanding of their process.

Conclusions

Participants in this study described seeking support for experiences that disrupted their understanding of reality, self, and meaning — only to encounter clinical frameworks oriented toward restoring a prior equilibrium rather than accompanying them through transformation. The ontological, temporal, and relational dimensions of this mismatch reflect deeper assumptions embedded in mainstream psychiatric epistemology — that distress signals pathology, that recovery follows predictable timelines, and that the clinician holds interpretive authority — sometimes resulting in misattunement, concealment, and disengagement from care.

As naturalistic psychedelic use continues to expand, mental health systems will increasingly encounter individuals whose experiences do not map neatly onto existing diagnostic categories or treatment protocols. The care gaps described here may represent an early signal of a larger challenge: the need for frameworks capable of holding existential complexity, tolerating ambiguity, and engaging with the possibility — as participants in this study described — that some forms of distress may be inseparable from processes of psychological change. The participants in this study, in describing what they needed and did not receive, offer an empirical outline of what psychedelic-informed therapy might look like in practice — exploratory rather than directive, relationally safe, and capable of accompanying transformation without prematurely foreclosing its meaning.

Abbreviations

PAT: Psychedelic-assisted therapy
CBS: Contextual Behavioral Science
OCPEs: Ontologically Challenging Psychedelic Experiences
ACE: Accept, Connect, Embody
CHIME: Connectedness, Hope, Identity, Meaning, Empowerment
GPS: Global Psychedelic Survey
CBT: Cognitive Behavioral Therapy
PTSD: Post-traumatic stress disorder
IFS: Internal Family Systems

Declarations

Ethics approval and consent to participate: The study protocol was approved by the Bar-Ilan University Institutional Review Board. All participants provided informed consent for both the interview and the publication of anonymized data.

Consent for publication: All participants provided informed consent for the publication of anonymized data. No individual person's identifying data is included in this manuscript.

Availability of data and materials: The datasets generated and analyzed during the current study are not publicly available due to confidentiality, but are available from the corresponding author on reasonable request and upon approval of the IRB committee.

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Authors' contributions:

GS conceptualized the study, designed the methodology, conducted and supervised the interviews, led the data analysis, and drafted the manuscript. NT conducted the interviews, contributed to writing, reviewing, and editing the manuscript. JE contributed to the study design, provided access to the original survey cohort, and reviewed and edited the manuscript. DL reviewed and edited the manuscript. JL contributed to the analytical framework, provided critical intellectual input throughout the analysis and interpretation of findings, and reviewed and edited the manuscript.

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References

1. Phelps J. Developing guidelines and competencies for the training of psychedelic therapists. *J Humanist Psychol*. 2017;57(5):450–87.
2. Reiff CM, Richman EE, Nemeroff CB, Carpenter LL, Widge AS, Rodriguez CI, Kalin NH, McDonald WM. Psychedelics and psychedelic-assisted psychotherapy. *Am J Psychiatry*. 2020;177(5):391–410.
3. Yaden DB, Potash JB, Griffiths RR. Psychedelics in psychiatry – keeping the renaissance from going off the rails. *JAMA Psychiatry*. 2021;78(5):469–70.
4. Schenberg EE. Psychedelic-assisted psychotherapy: a paradigm shift in psychiatric research and development. *Front Pharmacol*. 2018;9:733.
5. Simon G, Tadmor N, Halperin D. Psychedelics in the age of reproducibility: reflections on aura, set and setting and the medicalization of mystical-type experiences. *Int J Drug Policy*. 2026;147:105074.
6. Nayak SM, Jackson H, Sepeda ND, Mathai DS, So S, Yaffe A, Garcia-Romeu A. Naturalistic psilocybin use is associated with persisting improvements in mental health and wellbeing: results from a prospective, longitudinal survey. *Front Psychiatry*. 2023;14:1199642.
7. Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: results from the 2024 National Survey on Drug Use and Health. HHS Publication No. PEP25-07-007, NSDUH Series H-60. Rockville: Center for Behavioral Health Statistics and Quality. 2025. <https://www.samhsa.gov/data/report/2024-nsduh-annual-national-report>. Accessed 17 Apr 2026.
8. Australian Institute of Health and Welfare. Illicit drug use in Australia: National Drug Strategy Household Survey 2022–23. Canberra: AIHW. 2024. <https://www.aihw.gov.au/reports/illicit-use-of-drugs/hallucinogens-ndshs>. Accessed 17 Apr 2026.
9. Lake S, Lucas P. The Global Psychedelic Survey: consumer characteristics, patterns of use, and access in primarily anglophone regions around the world. *Int J Drug Policy*. 2024;130:104507.
10. Rockhill KM, Black JC, Ladka MS, Sumbundu KB, Olsen HA, Jewell JS, Hunt J, Wolf RC, Nerurkar K, Dart RC, Monte AA. The rise of psilocybin use in the United States: a multisource observational study. *Ann Intern Med*. 2025;178(7):1052–4.
11. Evans J, Robinson OC, Argyri FK, Suseelan S, Murphy-Beiner A, McAlpine R, Prideaux E. Extended difficulties following the use of psychedelic drugs: a mixed methods study. *PLoS ONE*. 2023;18(10):e0293349.
12. Simon G, Tadmor N, Skragge M, Evans J, Robinson O. Recalled childhood trauma and post-psychedelic trajectories of change in a mixed-methods study. *Sci Rep*. 2025;15:42852.

13. Robinson OC, Luke D, Evans J, Aday JS, Johnson M, Lake S, Kruger D, Boehnke KF, Lucas P. Extended difficulties after psychedelic experiences: prevalence and associations in a global, multilingual sample. *Res Square*. 2026. <https://doi.org/10.21203/rs.3.rs-9304959/v1>.
14. Robinson OC, Evans J, Luke D, McAlpine R, Sahely A, Fisher A, Sundeman S, Ketzitidou Argyri E, Murphy-Beiner A, Michelle K, Prideaux E. Coming back together: a qualitative survey study of coping and support strategies used by people to cope with extended difficulties after the use of psychedelic drugs. *Front Psychol*. 2024;15:1369715.
15. Robinson OC, Evans J, McAlpine RG, Argyri EK, Luke D. An investigation into the varieties of extended difficulties following psychedelic drug use: duration, severity and helpful coping strategies. *J Psychedel Stud*. 2025;9(2):117–25.
16. Aday JS, Heifets BD, Pratscher SD, Bradley E, Rosen R, Woolley JD. Great expectations: recommendations for improving the methodological rigor of psychedelic clinical trials. *Psychopharmacology*. 2022;239(6):1989–2010.
17. Mitchell JM, Bogenschutz M, Lilienstein A, Harrison C, Kleiman S, Parker-Guilbert K, Ot'alora GM, Garas W, Paleos C, Gorman I, Nicholas C, Mithoefer M, Carlin S, Poulter B, Mithoefer A, Quevedo S, Wells G, Klaire SS, van der Kolk B, Doblin R. MDMA-assisted therapy for severe PTSD: a randomized, double-blind, placebo-controlled phase 3 study. *Nat Med*. 2021;27(6):1025–33.
18. Williams ML, Korevaar D, Harvey R, Fitzgerald PB, Liknaitzky P, O'Carroll S, Puspanathan P, Ross M, Strauss N, Bennett-Levy J. Translating psychedelic therapies from clinical trials to community clinics: building bridges and addressing potential challenges ahead. *Front Psychiatry*. 2021;12:737738.
19. Yaden DB, Griffiths RR. The subjective effects of psychedelics are necessary for their enduring therapeutic effects. *ACS Pharmacol Transl Sci*. 2020;4(2):568–72.
20. Canadian Public Health Association. Discussion document: public health perspectives on the future of psychedelics. Ottawa: CPHA. 2024. <https://www.cpha.ca/discussion-document-public-health-perspectives-future-psychedelics>. Accessed 17 Apr 2026.
21. Harrison TR, Faber SC, Zare M, Fontaine M, Williams MT. Wolves among sheep: sexual violations in psychedelic-assisted therapy. *Am J Bioeth*. 2025;25(1):40–55.
22. Michaels TI, Purdon J, Collins A, Williams MT. Inclusion of people of color in psychedelic-assisted psychotherapy: a review of the literature. *BMC Psychiatry*. 2018;18(1):1–14.
23. Noorani T. Making psychedelics into medicines: the politics and paradoxes of medicalization. *J Psychedel Stud*. 2020;4(1):34–9.
24. Grof S, Grof C. The stormy search for the self: a guide to personal growth through transformational crisis. Penguin; 1992.
25. Noorani T. Policing the boundaries of spiritual emergency. Breaking Convention lecture [Video]. YouTube; 2019. <https://youtu.be/GtkuFwNCYe8>. Accessed 17 Apr 2026.
26. Holmøy B, Andersen KAA. Persistent altered states: psychological treatment of psychedelic adverse effects. *Tidsskr Nor Psykologforen*. 2025. <https://doi.org/10.52734/HGSN7664>.

27. Gorman I, Nielson EM, Molinar A, Cassidy K, Sabbagh J. Psychedelic harm reduction and integration: a transtheoretical model for clinical practice. *Front Psychol*. 2021;12:645246.
28. Pilecki B, Luoma JB, Bathje GJ, Rhea J, Narloch VF. Ethical and legal issues in psychedelic harm reduction and integration therapy. *Harm Reduct J*. 2021;18:16.
29. Argyri EK, Krecké J, Robinson OC, Evans J, Skragge M, Morgan CJA. Practitioner perspectives on extended difficulties and optimal support strategies following psychedelic experiences: a qualitative analysis. *Harm Reduct J*. 2025. <https://doi.org/10.1186/s12954-025-01347-0>.
30. Bathje GJ, Majeski E, Kudowor M. Psychedelic integration: an analysis of the concept and its practice. *Front Psychol*. 2022;13:824077.
31. Giorgi A. The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *J Phenomenol Psychol*. 1997;28(2):235–60.
32. Englander M. The phenomenological method in qualitative psychology and psychiatry. *Int J Qual Stud Health Well-being*. 2016;11(1):30682.
33. Neubauer BE, Witkop CT, Varpio L. How phenomenology can help us learn from the experiences of others. *Perspect Med Educ*. 2019;8(2):90–7.
34. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101.
35. Braun V, Clarke V. Reflecting on reflexive thematic analysis. *Qual Res Sport Exerc Health*. 2019;11(4):589–97.
36. Braun V, Clarke V. One size fits all? What counts as quality practice in (reflexive) thematic analysis. *Qual Res Psychol*. 2021;18(3):328–52.
37. Lincoln YS, Guba EG. *Naturalistic inquiry*. Thousand Oaks: SAGE; 1985.
38. Garcia-Romeu A, Davis AK, Erowid F, Erowid E, Griffiths RR, Johnson MW. Cessation and reduction in alcohol consumption and misuse after psychedelic use. *J Psychopharmacol*. 2019;33(9):1088–101.
39. Garcia-Romeu A, Davis AK, Erowid E, Erowid F, Griffiths RR, Johnson MW. Persisting reductions in cannabis, opioid, and stimulant misuse after naturalistic psychedelic use: an online survey. *Front Psychiatry*. 2020;10:955.
40. Krebs TS, Johansen PØ. Psychedelics and mental health: a population study. *PLoS ONE*. 2013;8(8):e63972.
41. Carbonaro TM, Johnson MW, Hurwitz E, Griffiths RR. Survey study of challenging experiences after ingesting psilocybin mushrooms: acute and enduring positive and negative consequences. *J Psychopharmacol*. 2016;30(12):1268–78.
42. Baumeister RF, Bratslavsky E, Finkenauer C, Vohs KD. Bad is stronger than good. *Rev Gen Psychol*. 2001;5(2):323–70.
43. Argyri EK, Evans J. Ontologically challenging psychedelic experiences: considerations for managing associated distress. *Curr Top Behav Neurosci*. 2025. https://doi.org/10.1007/7854_2025_609.
44. Rocca E, Anjum RL. Complexity, reductionism and the biomedical model. In: Anjum RL, Copeland S, Rocca E, editors. *Rethinking causality, complexity and evidence for the unique patient*. Cham:

- Springer International Publishing; 2020. pp. 75–94.
45. Carel H. Phenomenology as a resource for patients. *J Med Philos.* 2012;37(2):96–113.
 46. Chwyl C, Elvenes OS, Kleven ASR, Kongshaug EW, Luoma JB, Pilecki B, Naess ET. Beyond the journey: a qualitative analysis of therapists' perspectives on psychedelic integration challenges. *Res Square.* 2025. <https://doi.org/10.21203/rs.3.rs-6874539/v1>.
 47. Timmermann C, Kettner H, Letheby C, Roseman L, Rosas FE, Carhart-Harris RL. Psychedelics alter metaphysical beliefs. *Sci Rep.* 2021;11(1):22166.
 48. Griffiths RR, Richards WA, Johnson MW, McCann UD, Jesse R. Mystical-type experiences occasioned by psilocybin mediate the attribution of personal meaning and spiritual significance 14 months later. *J Psychopharmacol.* 2008;22(6):621–32.
 49. Davis AK, Barrett FS, May DG, Cosimano MP, Sepeda ND, Johnson MW, Griffiths RR. Effects of psilocybin-assisted therapy on major depressive disorder: a randomized clinical trial. *JAMA Psychiatry.* 2021;78(5):481–9.
 50. Rabeyron T. When the truth is out there: counseling people who report anomalous experiences. *Front Psychol.* 2022;12:693707.
 51. Stein DJ, Nielsen K, Hartford A, Gagné-Julien AM, Glackin S, Friston K, Maj M, Zachar P, Aftab A. Philosophy of psychiatry: theoretical advances and clinical implications. *World Psychiatry.* 2024;23(2):215–32.
 52. Muyskens K, Ang C, Kerr ET. Relational epistemic humility in the clinical encounter. *J Med Ethics.* 2025. <https://doi.org/10.1136/jme-2024-110241>.
 53. Letheby C. The epistemic innocence of psychedelic states. *Conscious Cogn.* 2016;39:28–37.
 54. Aixalà M. Psychedelic integration: psychotherapy for non-ordinary states of consciousness. *Synergetic*; 2022.
 55. Argyri EK, Evans J, Luke D, Michael P, Michelle K, Rohani-Shukla C, Robinson OC. Navigating groundlessness: an interview study on dealing with ontological shock and existential distress following psychedelic experiences. *PLoS ONE.* 2025;20(5):e0322501.
 56. Wright A, Luke D, Robinson OC, Evans J. Symptom-specific nuances in psychedelic integration: a qualitative study of insights from therapists supporting extended difficulties in naturalistic settings. *Harm Reduct J.* Forthcoming. 2026.
 57. George JR, Michaels TI, Sevelius J, Williams MT. The psychedelic renaissance and the limitations of a White-dominant medical framework: a call for indigenous and ethnic minority inclusion. *J Psychedel Stud.* 2020;4(1):4–15.
 58. Jacobs EJE. Transformative experience and informed consent to psychedelic-assisted psychotherapy. *Front Psychol.* 2023;14:1108333.
 59. Luoma JB, Sabucedo P, Eriksson J, Gates N, Pilecki B. Toward a contextual psychedelic-assisted therapy: perspectives from acceptance and commitment therapy and contextual behavioral science. *J Context Behav Sci.* 2019;14:136–45.

60. Watts R, Luoma JB. The use of the psychological flexibility model to support psychedelic assisted therapy. *J Context Behav Sci.* 2020;15:92–102.
61. Dabrowski K. Positive disintegration. Boston: Little, Brown and Company; 1964.
62. Lear MK, Luoma JB, Chwyl C. Psychological inflexibility prospectively predicts client non-disclosure in outpatient psychotherapy. *J Context Behav Sci.* 2021;19:36–41.
63. Luoma JB, Platt MG. Shame, self-criticism, self-stigma, and compassion in acceptance and commitment therapy. *Curr Opin Psychol.* 2015;2:97–101.
64. Fauvel B, Strika-Bruneau L, Piolino P. Changes in self-rumination and self-compassion mediate the effect of psychedelic experiences on decreases in depression, anxiety, and stress. *Psychol Conscious Theory Res Pract.* 2023;10(1):88–102.
65. Zeifman R, Danias G, Agin-Liebes G, Pagni B, Kettner H, Bhat V, Carhart-Harris R. Psychedelic therapy, positive emotional experiences, and the central role of self-compassion. *Res Square.* 2025. <https://doi.org/10.21203/rs.3.rs-7420529/v1>.
66. Fricker M. Epistemic injustice: power and the ethics of knowing. Oxford: Oxford University Press; 2007.
67. Kiverstein J, Beyköylü H, van Elk M. A causal pluralist theory of the interaction of substance, set and setting in psychedelic experience. *Philos Psychol.* 2025;1–30.
68. Hartogsohn I. American trip: set, setting, and the psychedelic experience in the twentieth century. Cambridge: MIT Press; 2020.
69. Hartogsohn I. Modalities of the psychedelic experience: microclimates of set and setting in hallucinogen research and culture. *Transcult Psychiatry.* 2022;59(5):579–91.
70. Simon G, Gal-Birman M, Tadmor N, Halperin D, Ben-Zion Z. Psychedelics and collective trauma: multisystemic resilience and recovery pathways among Nova festival survivors – a qualitative study. *Eur J Psychotraumatol.* 2025;16(1):2582303.
71. Tadmor N, Halperin D, Simon G. Integration of personal psychedelic experiences into clinical practice: a phenomenological study in mental health professionals. *J Psychedel Stud.* 2025;9(2):136–48.
72. Gilbert P, Procter S. Compassionate mind training for people with high shame and self-criticism: overview and pilot study of a group therapy approach. *Clin Psychol Psychother.* 2006;13(6):353–79.
73. Leamy M, Bird V, Le Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry.* 2011;199(6):445–52.
74. Mead S. Intentional peer support: an alternative approach. Portland: Shery Mead Consulting; 2005.
75. Davidson L, Bellamy C, Guy K, Miller R. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry.* 2012;11(2):123–8.