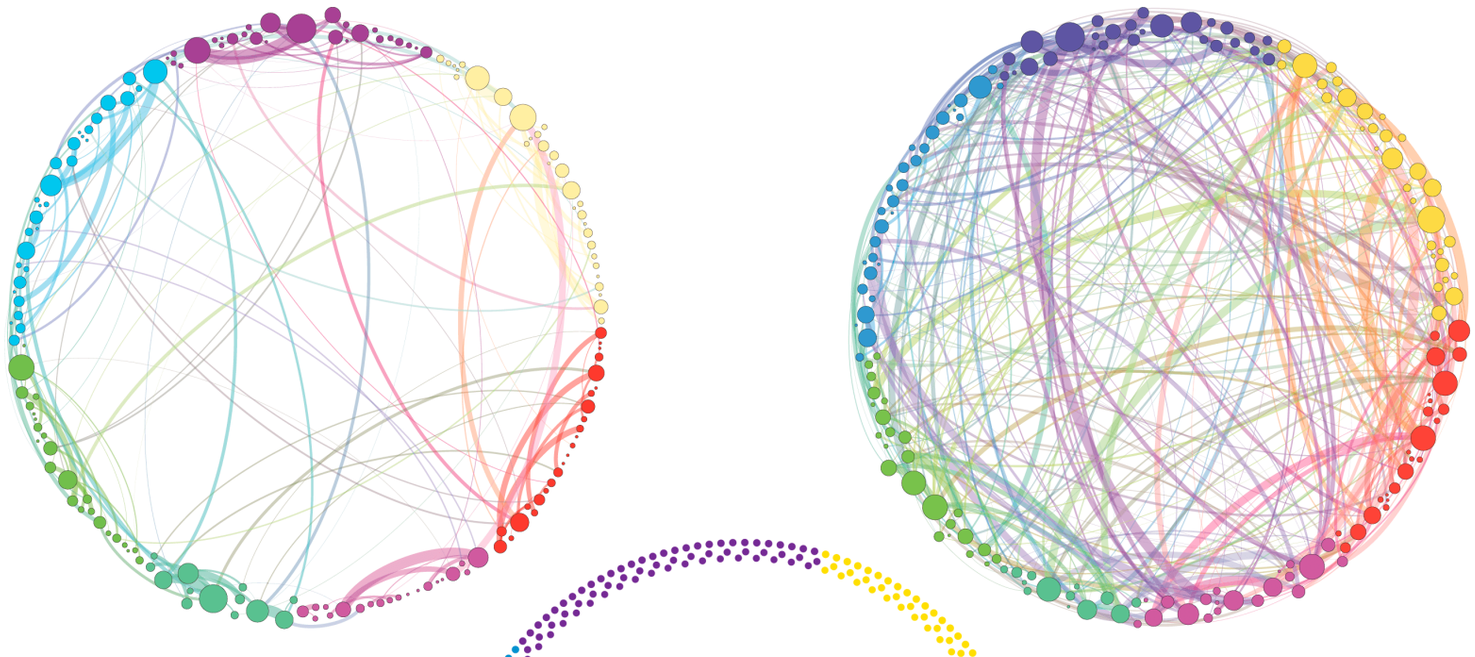

PSI

Psychedelic
Somatic
Institute

# An Introduction to Psychedelic Somatic Interactional Psychotherapy

Saj Razvi, LPC
Steven Elfrink
www.psychedelicsomatic.org

# INTRODUCTIONS



Steve Elfrink is the Director of Community Outreach at PSI

- 30 year corporate refugee in marketing and education
- Co-founder of PSI
- Founder of OmTerra: a non-profit that provided psychedelic therapy symposiums
- Research Assistant: Psychedelic Somatic Interactional Psychotherapy (PSIP) white paper
- Study participant in an FDA Phase I Pharmacokinetics Study of Psilocybin
- Primary interest: Helping people who are suffering and changing the world.

Email Steve:
steve@psychedelicsomatic.org

# INTRODUCTIONS



Saj Razvi, LPC. is a psychotherapist and Director of Education at PSI

- Clinical researcher in the MAPS Phase 2 trial of MDMA-assisted therapy.
- Somatic trauma trainings since 2008
- Primary author: Psychedelic Somatic Interactional Psychotherapy (PSIP) treatment manual
- Taught trauma studies at University of Denver as well as PESI education seminars focusing on complex trauma.
- Primary interest: Developing psychotherapeutic interventions that maximize the healing capacity of psychedelic medicine, and the grass roots adoption of psychedelic therapy through the use of cannabis by private practice clinicians.

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# DISCLAIMER



1) The Portland Psychedelics Society is not liable for any consequences related to attending the PSI in-person training during the COVID-19 pandemic. By choosing to attend this event, you acknowledge there are risks involved (even with social distancing) and you assume all liability for these risks. If you are a part of a vulnerable population, think you have been exposed to COVID-19, or are experiencing possible symptoms, please do not attend this event.

2) The Portland Psychedelics Society does not guarantee or suggest that completion of this training event will meet the requirements for psilocybin therapy licensing under the measure 109 framework as the qualifications for this licensing has yet to be determined by the Oregon Health Authority.

# NOTICING & SETTING ASIDE OUR THERAPY BIAS



We each approach with:

A. Theoretical background / modalities we are invested in

B. Explicit and implicit assumptions about healing

C. Personal or clinical experience with what works and what doesn't

D. Preconceived notions on trauma

E. Preconceived notions on psychedelic medicine / cannabis

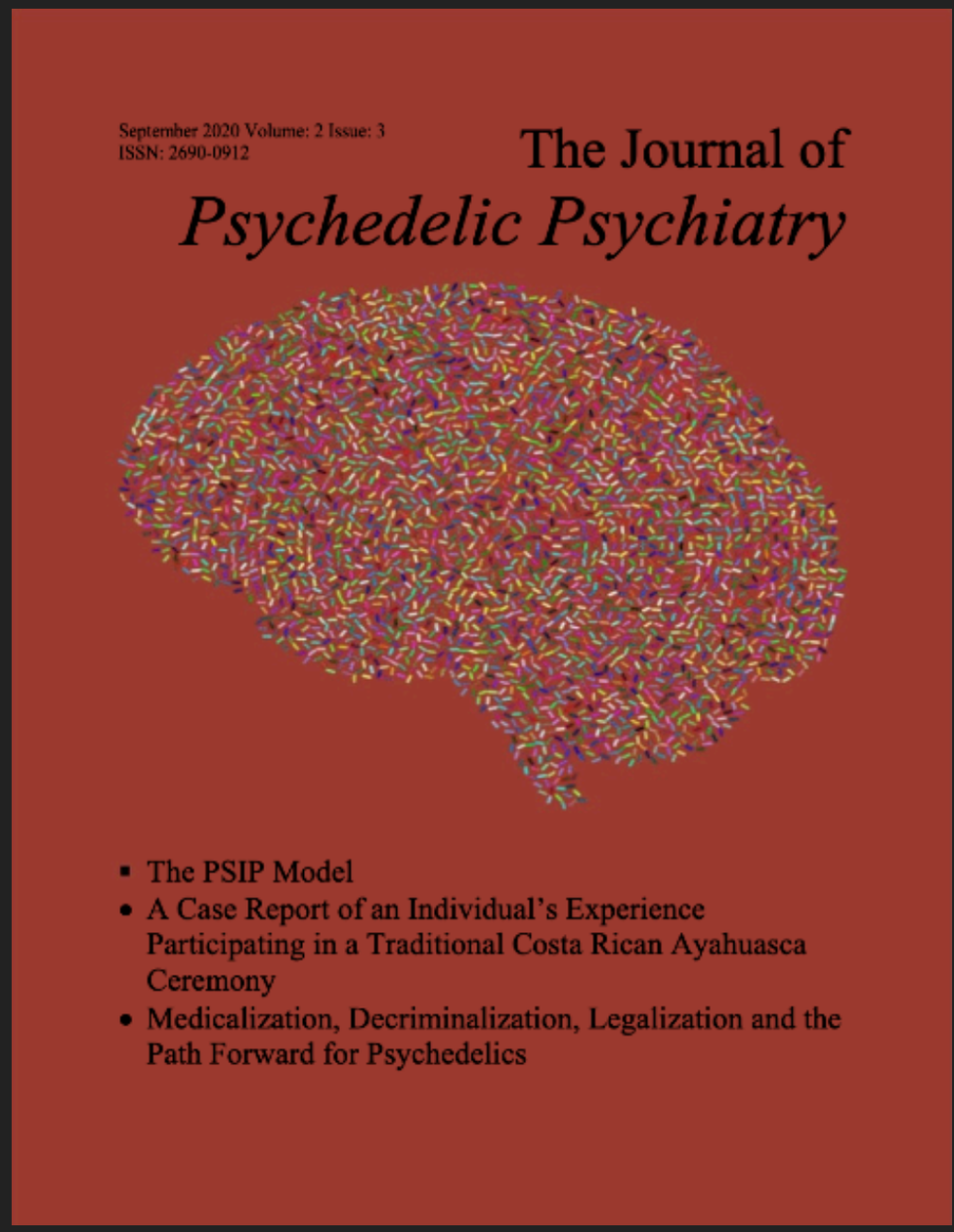
Stance: Healing approaches not mutually exclusive, ultimately how we can better serve…maintain curiosity & let this be surprising.

# THE PSIP MODEL



## Psychedelic Somatic Interactional Psychotherapy

The Journal of Psychedelic Psychiatry



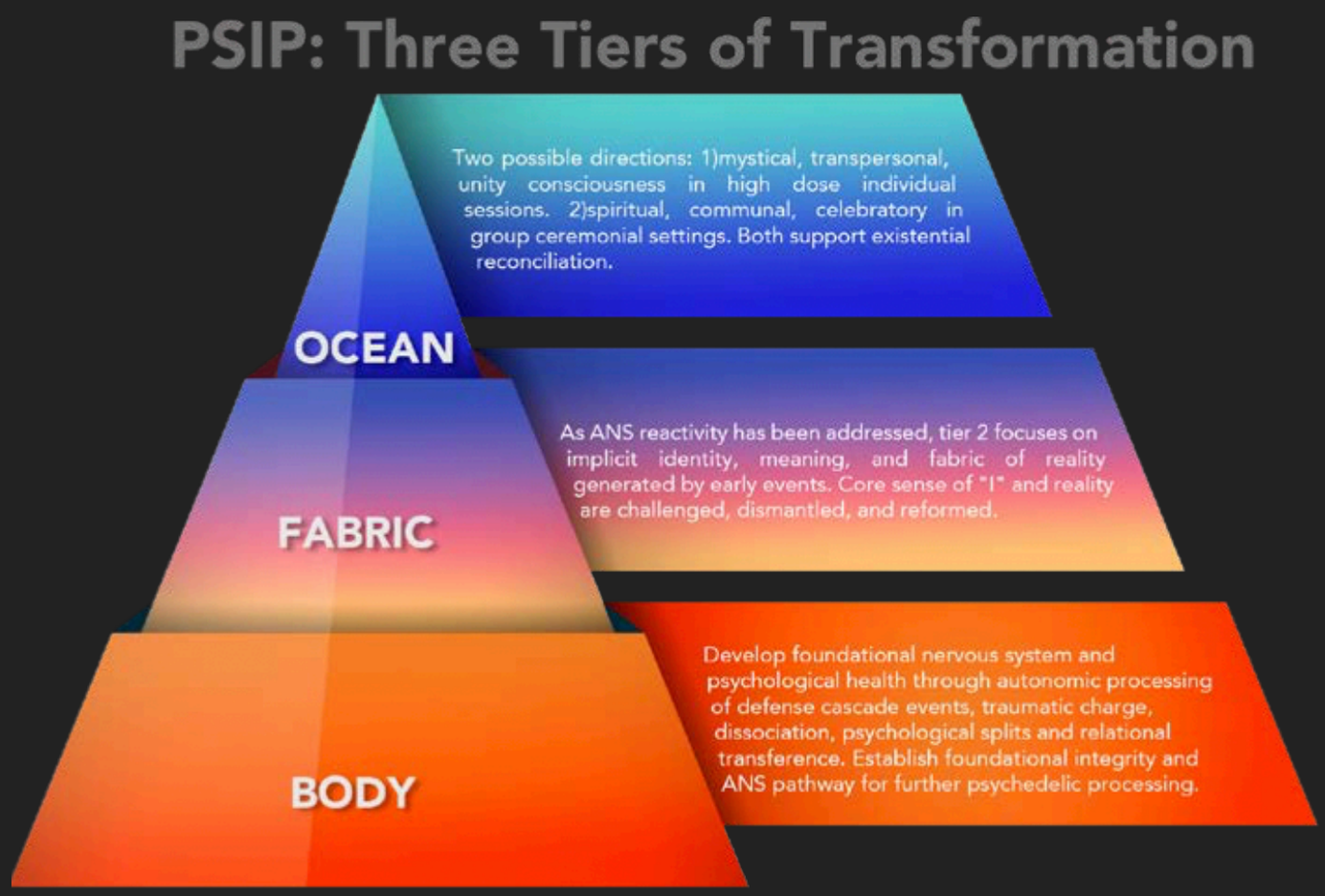

https://www.journalofpsychedelicpsychiatry.org

# THREE TIERS OF PSYCHEDELIC WORK FOR MENTAL HEALTH POPULATION



A. Tier-1 Body: Works with the stressful, overwhelming, traumatic events in a person's life. Not transpersonal focus and very little insight (shifts are bottom-up vs top down)

B. Focus: Develop healthy ego structure through biological nervous system integrity, resolving compromise of the autonomic nervous system (dissociation, depression responses), sub-personalities, and negative relational transference.




C. Premise: healthy ego serves as a necessary foundation for more integratabtle and successful trans-egoic experiences.

D. Cannabis, MDMA, ketamine as Tier-1 substances because of their limited, non-mystical scope. Psilocybin & classic psychedelics as Tier-2 and 3.

E. Requires individual focus (not group work)

# THREE TIERS OF PSYCHEDELIC WORK FOR MENTAL HEALTH POPULATION

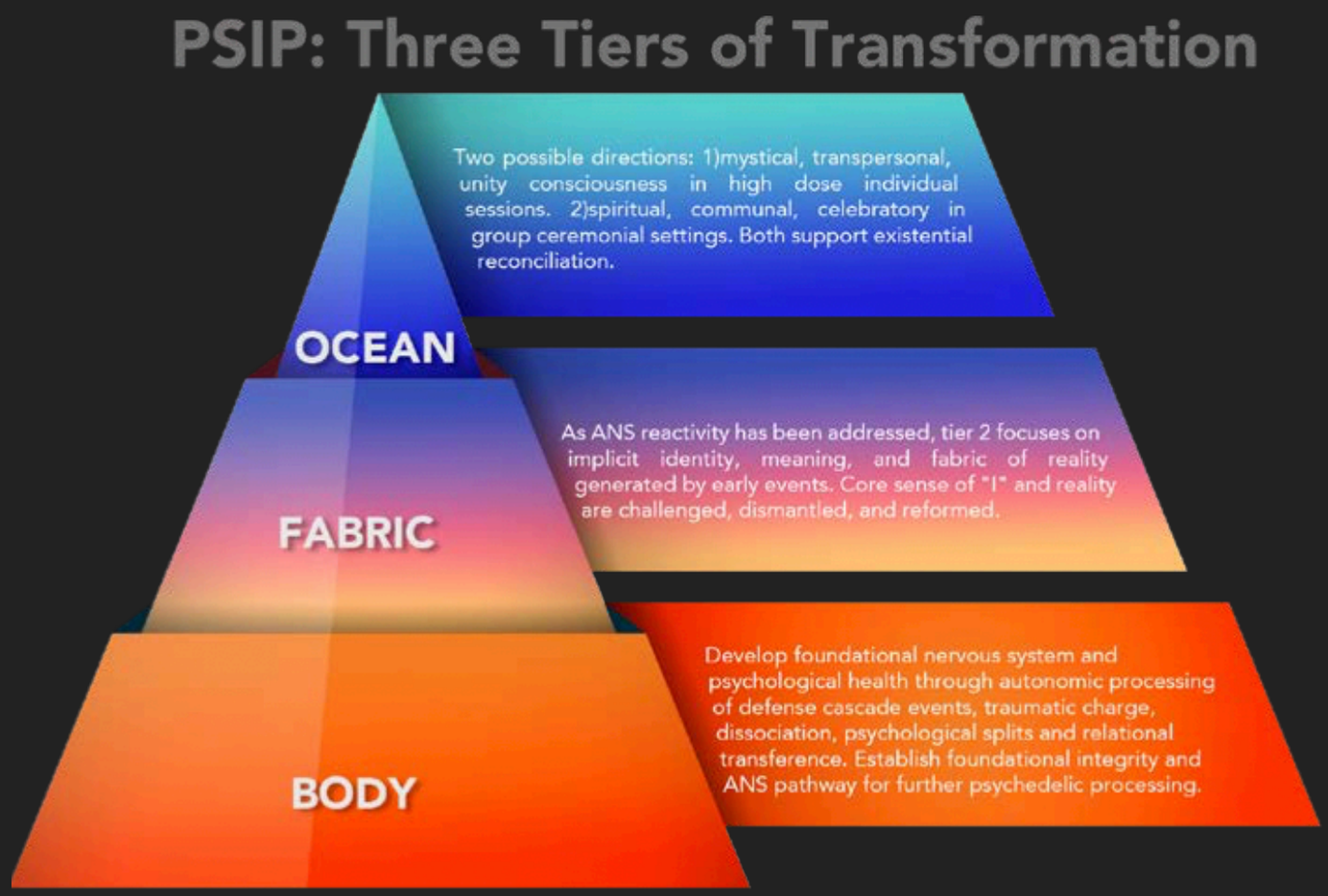


A. Tier-2: Works with the fabric of reality, the identity that was created in response to early developmental programing & events.

B. Psilocybin & classic tryptamine substances ideal for this layer.

C. Highly destabilizing deconstruction and reconstruction requiring support and strong foundational ego integrity.

D. Requires individual focus, not group work



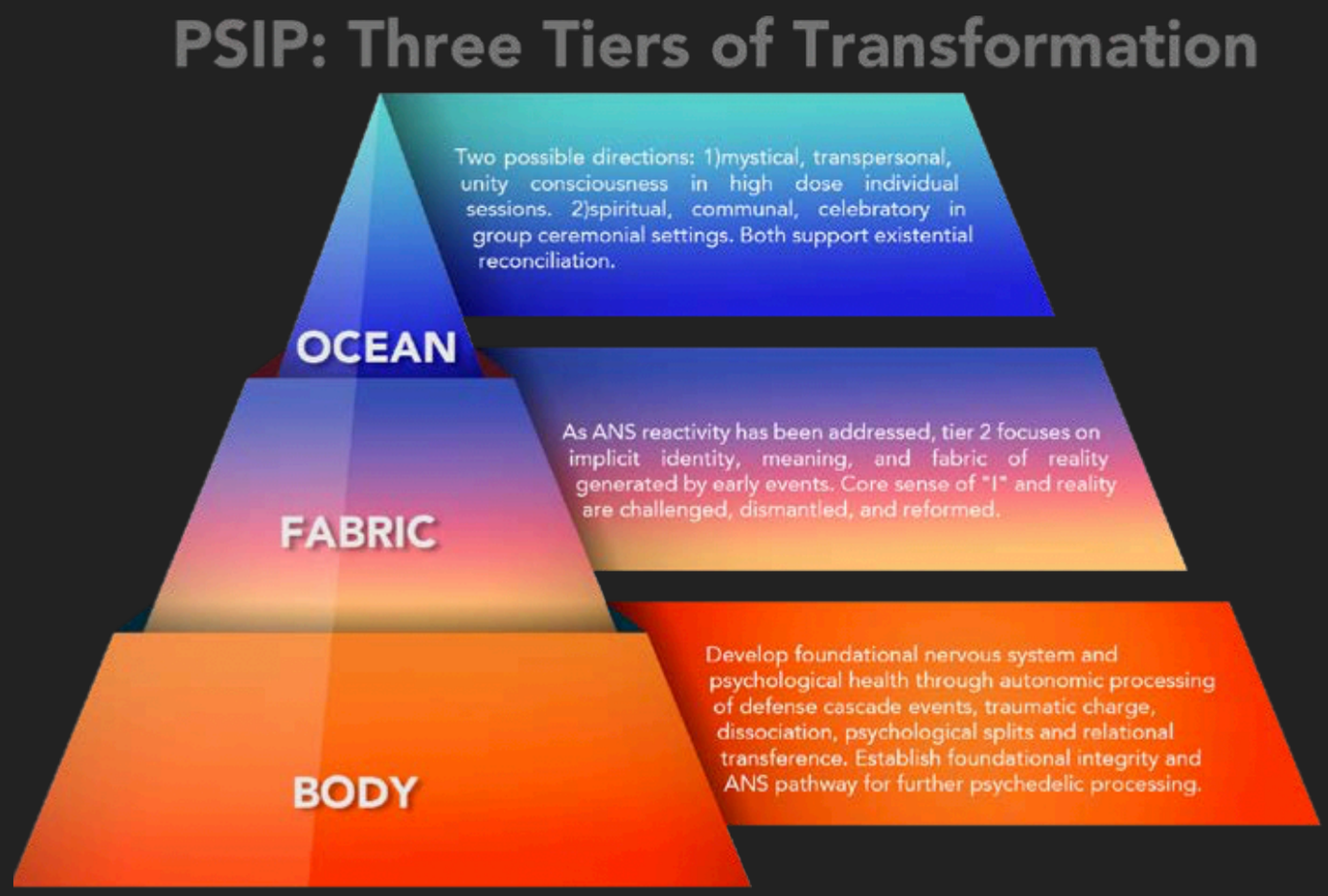
# THREE TIERS OF PSYCHEDELIC WORK FOR MENTAL HEALTH POPULATION



A. Tier-3: Transpersonal, unity consciousness, reconciliation with the existential.

B. Not psychotherapy, not biographically focused, psilocybin & classic tryptamine substances ideal for this layer.

C. Group or sitter work, high dose sessions



# CONSCIOUSNESS & FREUD'S TOPOGRAPHICAL MAP



## Secondary Consciousness

Ordinary waking consciousness, abstract cognitive thought, self awareness, meaning making, goal orientation, rational, temporal (sense of time), linear, narrative / story construction…explicit declarative memory.

Processes involved in traditional therapy, lead to a explicit sense of self (you identify as being you), disrupted by psychedelic substances

## Primary Consciousness

Implicit form of consciousness shared with other animals, consciousness arising from felt sense, sensation, emotion, concrete experience. Not insight based, no abstract cognitive thinking, not conscious, non-linear, non-verbal…non-declarative memory processes (procedural & episodic memory)

Processes involved in psychedelic therapy

# Bessel van der Kolk on Traumatic Memory

Research into the nature of traumatic memories indicates that trauma interferes with declarative memory (i.e., conscious recall of experience) but does not inhibit implicit, non-declarative memory—the memory system that controls conditioned emotional responses, skills, habits, and sensorimotor experience.

van der Kolk, BA: (1994) The Body Keeps the Score: Memory and Evolving Psychobiology of Posttraumatic Stress. *Harvard Rev Psychiatry*. Volume 1, Number 5

Secondary Consciousness

=

Disembodied, foundation-less, disintegrated ego

## Tier 1 Work:

Personal (vs transpersonal) focus

Psychological, biographical (it's about you, your history, your relationships, your nervous system health)

Trans-egoic or Transpersonal

Disintegrated Ego

Problematic Movement

Trans-egoic

Transpersonal

A. Transpersonal processes are not human processes (I.e human wounding requires relational healing)

B. Traumatic dissociation appears unaffected by transpersonal processes.

C. Yields transpersonally experienced individuals with psychological wounds intact

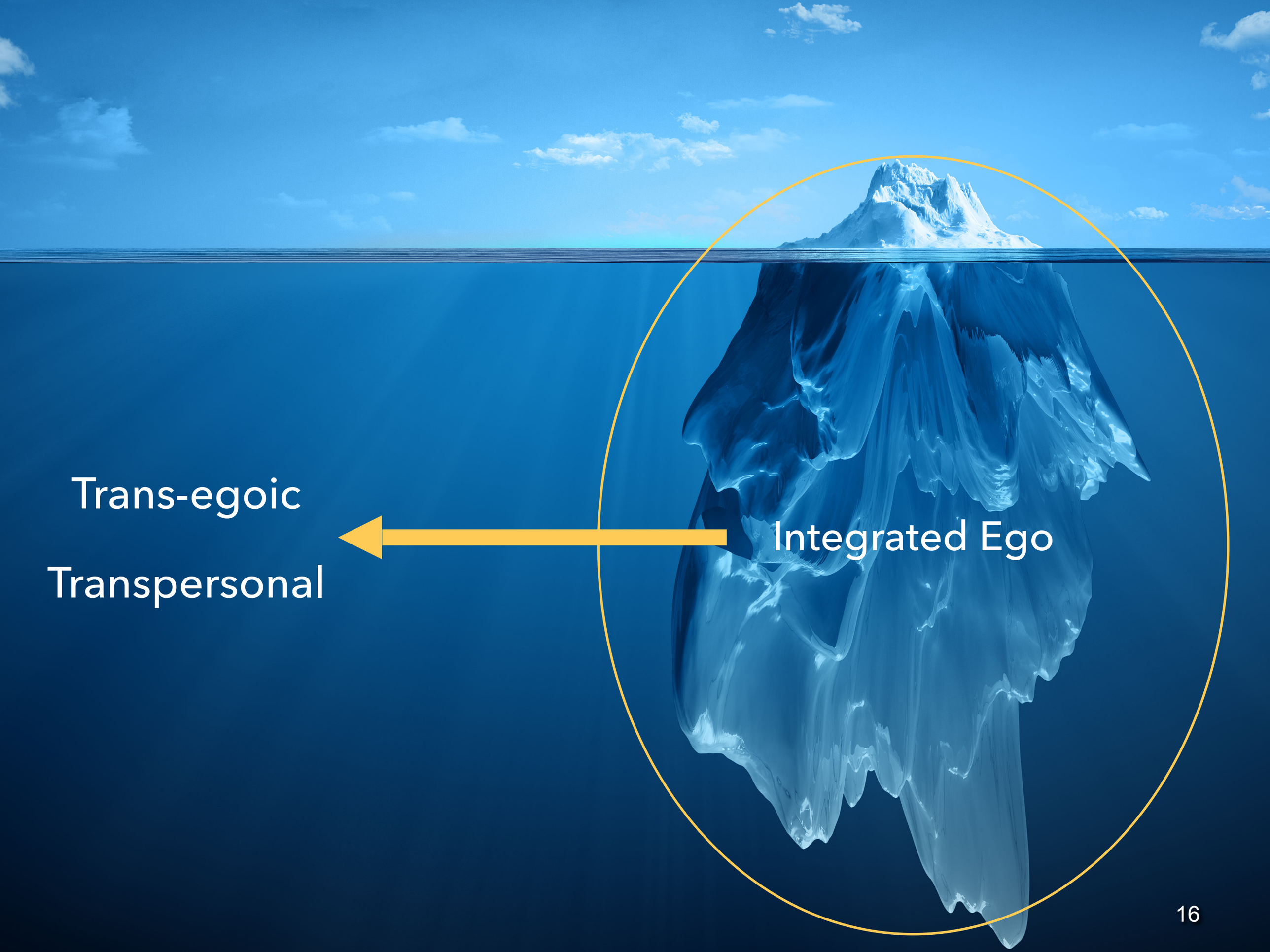
D. Harder to integrate transpersonal reality from DE vs IE. More difficult to integrate into daily life from DE (many visits to the well).

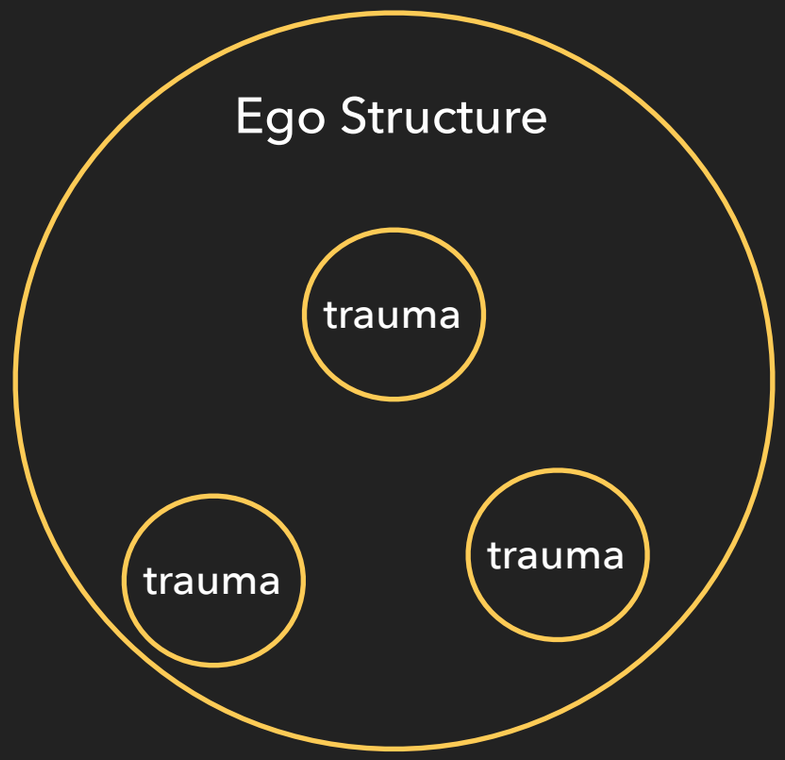
E. Unacknowledged egoic needs hijack/sublimate transpersonal development (I.e psychedelic narcissism)…do lifelong defense mechanisms vanish during psychedelic state?

F. Motivated to bypass and frequently demonize ego/self as the problem

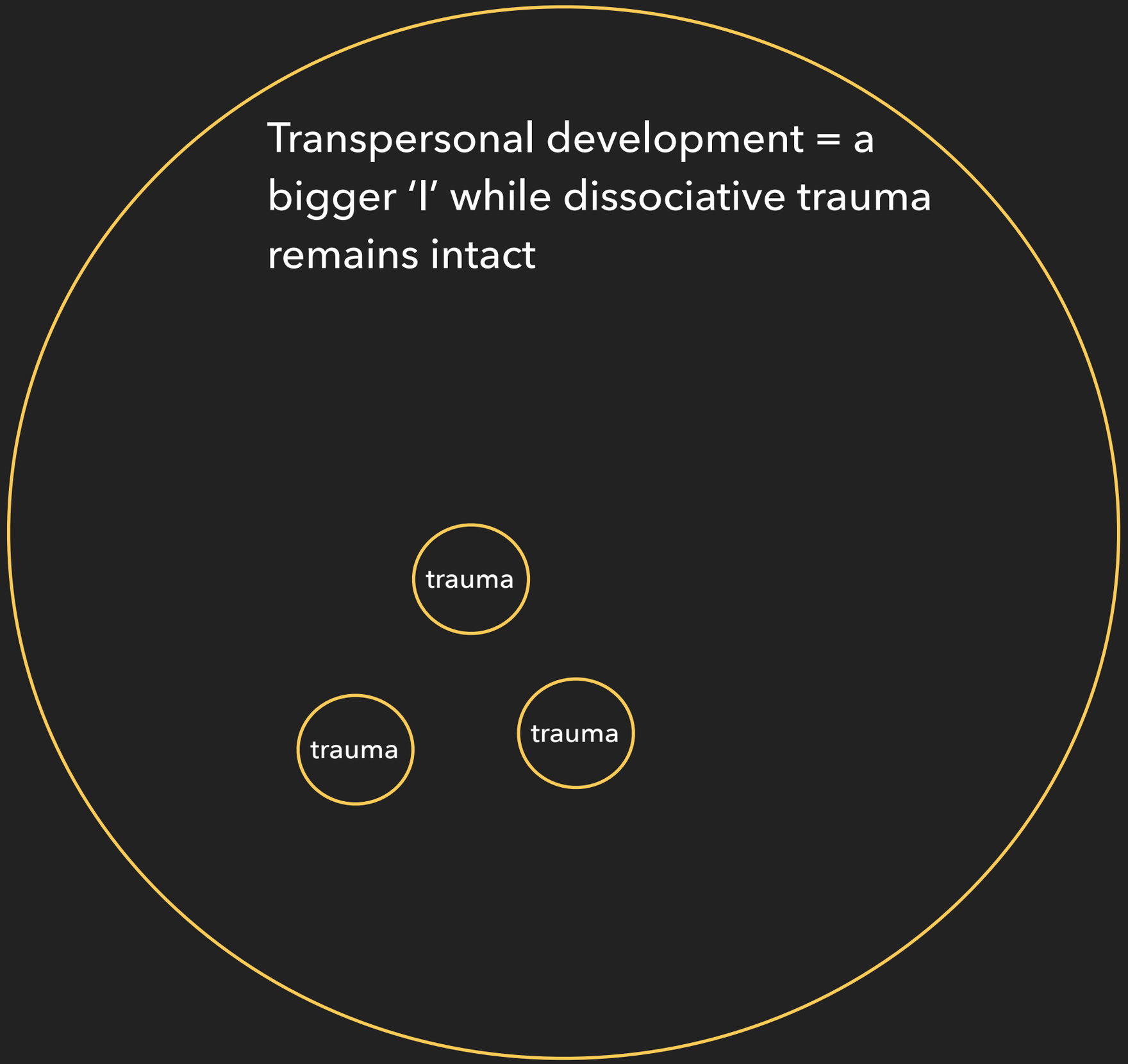
Trans-egoic

Transpersonal




Ego Structure
trauma
trauma
trauma

Transpersonal development = a bigger ‘I’ while dissociative trauma remains intact



# INTEGRATION / SITTER MODEL (NON-DIRECTIVE, NON-INTERACTIONAL)



The drug session itself is given in a room with soft ambient lighting and a comforting soundtrack (which may contribute to the therapeutic value as well). There are generally two therapists present in the room (ideally one male and one female) who are there to provide reassurance, medical cover, and care. They only talk with the patient if the patient wants them to, which they generally do not. It is important to note that there is no expectation of conversation during the "trip" and no direction by either therapist of the patient's speech or thought. It is the next day in the "integration" session that the content of the trip is discussed and interpreted and psychotherapeutic benefits derived.[1] (Nutt, 2019)

# INTEGRATION / SITTER MODEL (NON-DIRECTIVE, NON-INTERACTIONAL)



A. Basic therapy model since 1950's

B. Good news is that it works, participants reliably show significant benefit using this model

C. Is this the best model or can we improve upon it?

D. We speculate that this is the default model because traditional psychotherapy interventions such as reality testing, insight, cognitive restructuring, meaning making, narrative story telling (secondary consciousness processes) don't interface well with psychedelic consciousness. This is why therapy and benefits happen the following day during integration.

E. Design a model whose interventions and processing takes place during the altered state of psychedelic consciousness, and amplifies the healing factors within that state? Realtime processing vs post-session processing.

# A NEW PSYCHO-BIOLOGICAL MODEL OF PSYCHEDELIC THERAPY



Psychedelic Somatic Interactional Therapy:

A. Tier 1 & Tier 2 orientation

B. Focus is primary consciousness processes

C. Autonomic nervous system focus

    1. Strongly implicated in anxiety, panic, depression, dissociative numbing, PTSD symptoms, complex trauma, maladaptive coping, & relationship problems.

    2. ANS is homeostatic (self correcting), becomes far more active / available during the psychedelic state

D. Dissociation (key factor in treatment resistance & in psychedelic therapy)

E. Therapist is relationally interactive in the psychedelic space evoking transference part of FOO wounding

F. Processing is not medicine specific (body & ANS focus is useful regardless of which medicine is used)…we focus on cannabis for legality & ease of access.

# VIDEO



Sample PSIT sessions

# WHAT WAS THAT?



Selective Inhibition:

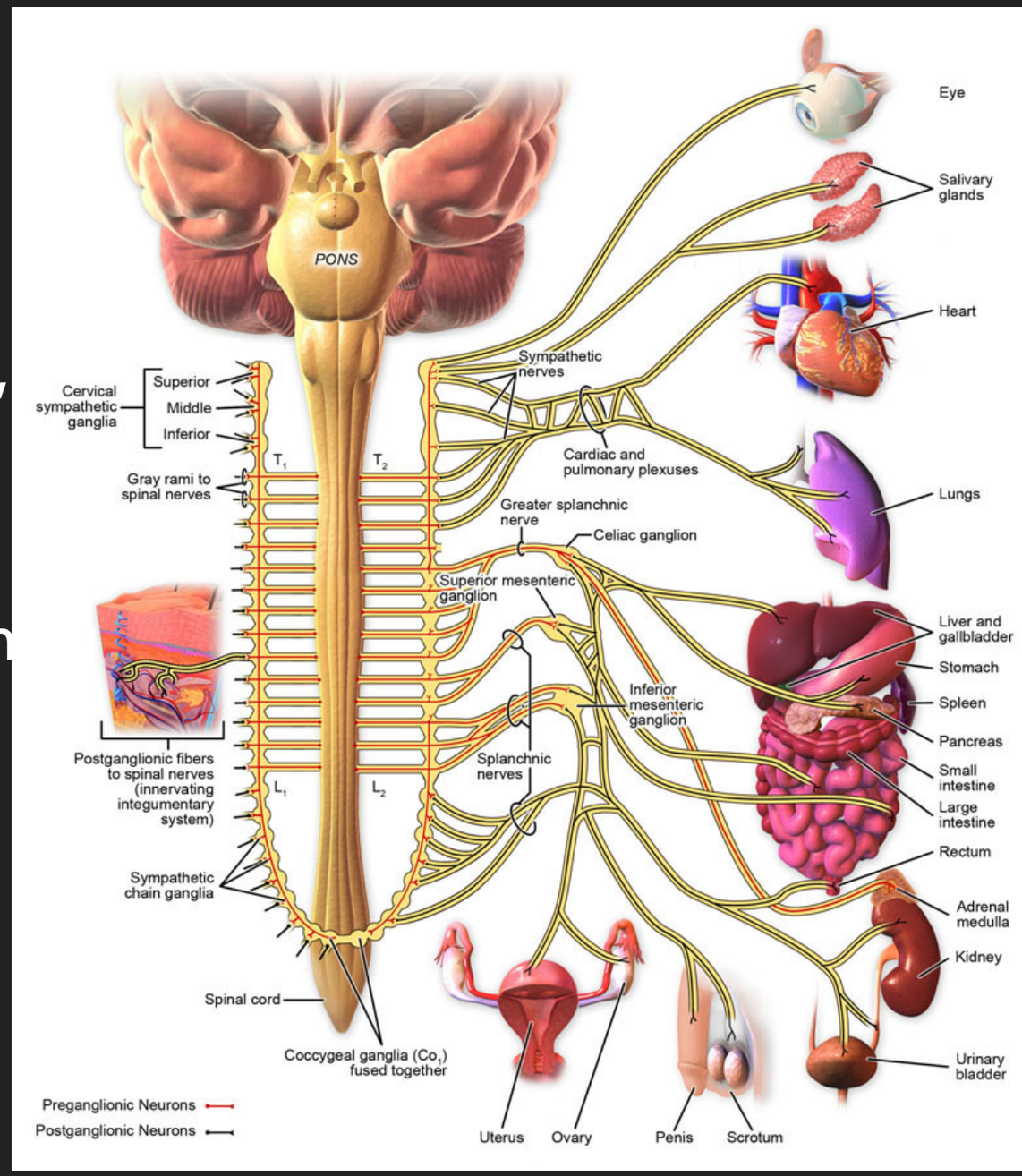
A. The amplification of a client's autonomic nervous system process by inhibiting voluntary coping, avoidance, distraction, and management strategies.
B. Limiting voluntary coping allows for involuntary ANS signal to arise and express
    1. Limit voluntary movement (fidgeting, gesturing, etc.) to allow for emergence of involuntary responses
    2. Not to use their breathing or thoughts to calm down (deep breathing, meditation, 'going to the beach')
C. Directive container that activates homeostatic self correction of the ANS (non-directive process)

# WHAT WAS THAT: AUTONOMIC NERVOUS SYSTEM IN MENTAL HEALTH



Autonomic nervous system is:

A. One of the sub-cortical networks that gives rise to PC; suppressed by SC
B. Biological mech underpinning anxiety, depression, dissociation, PTSD reactions
B. Inhibited by conditioned cultural norm
C. Becomes far more fluid, accessible when clients enter PC (not just with psychedelics)
G. Preferential pathway for psychedelic processing (robust channel).




- What does the ANS do?

All mammals share the same basic autonomic nervous system


Porges, SW: (2001) The Polyvagal Theory: Phylogenetic Substrates of a Social Nervous System. *International Journal of Psychophysiology* 42, 123-146

# DEFENSE CASCADE / MODELING THE ANS

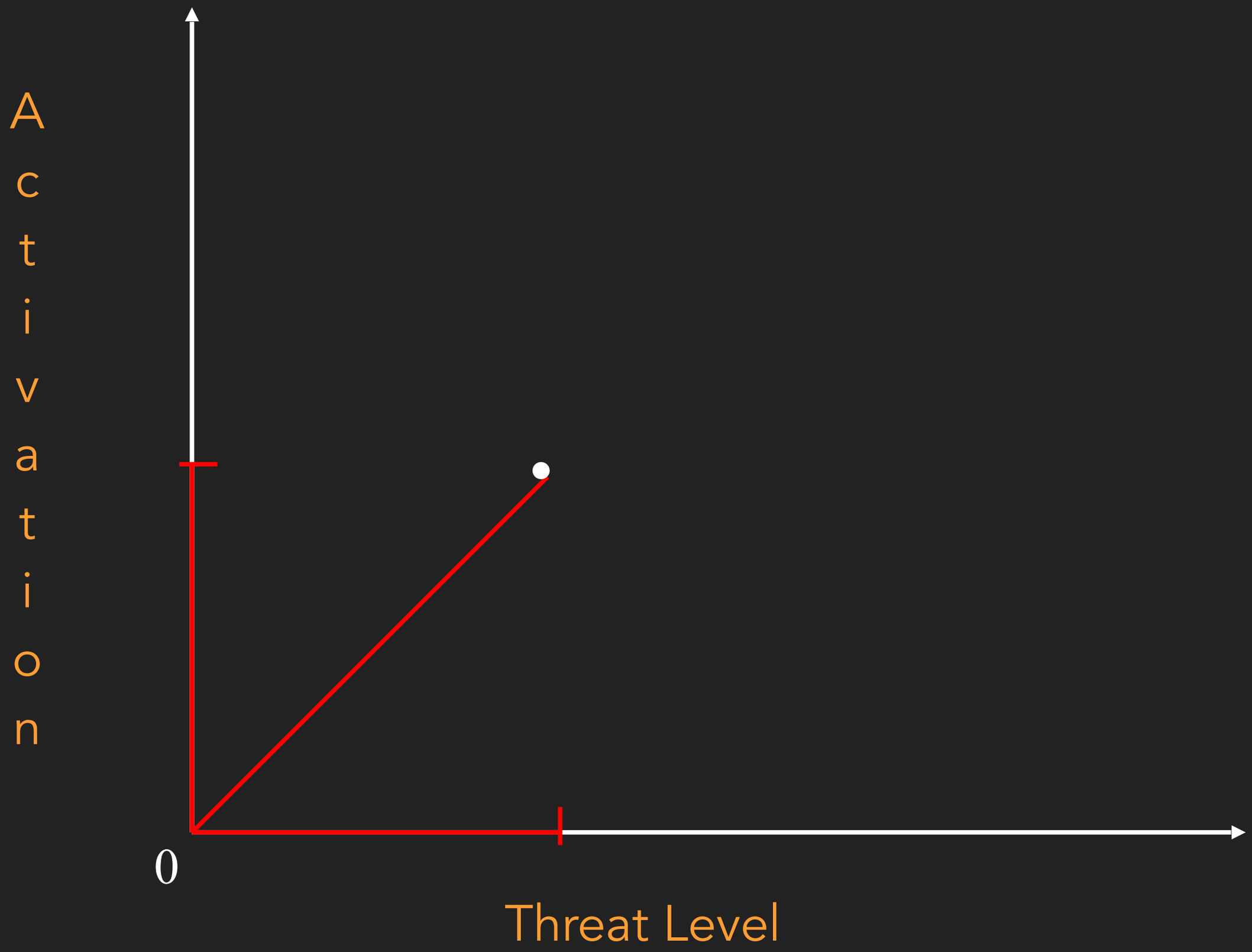


Threat

=

Activation of the ANS

The greater the real or perceived threat, the greater the ANS response


Activation
0
Threat Level

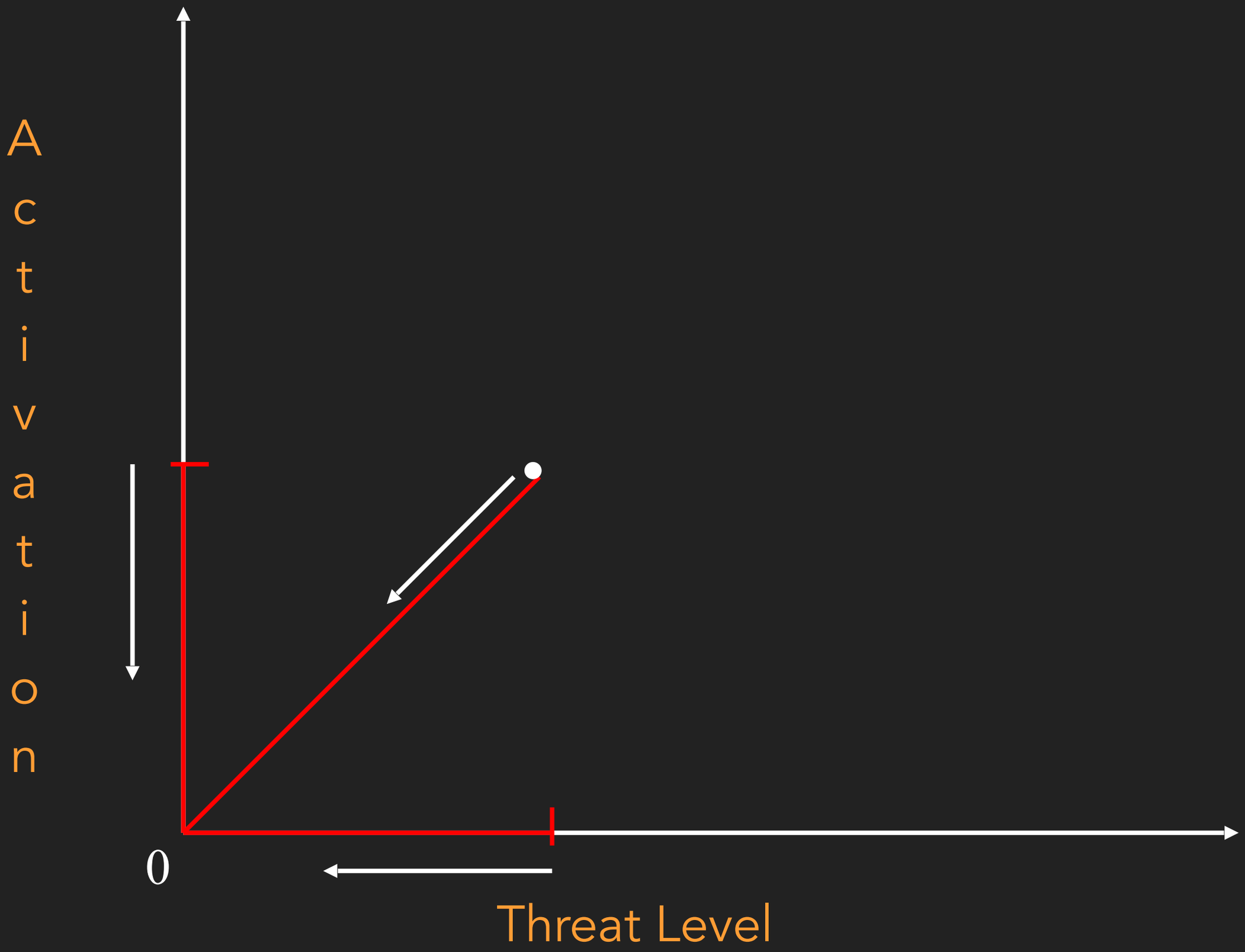
# ANS DYNAMICS



A. For mapping purposes, imagine ANS response as a marble on a track that is being acted on by gravity.

B. The marble seeks the most stable, relaxed, and efficient position possible (because ANS activation is a state of tension and requires biological energy to maintain).

C. Once threat has passed, ANS marble homeostatically seeks calm, neutral state.


Activation
0
Threat Level

# DEFENSE CASCADE / MODELING THE ANS

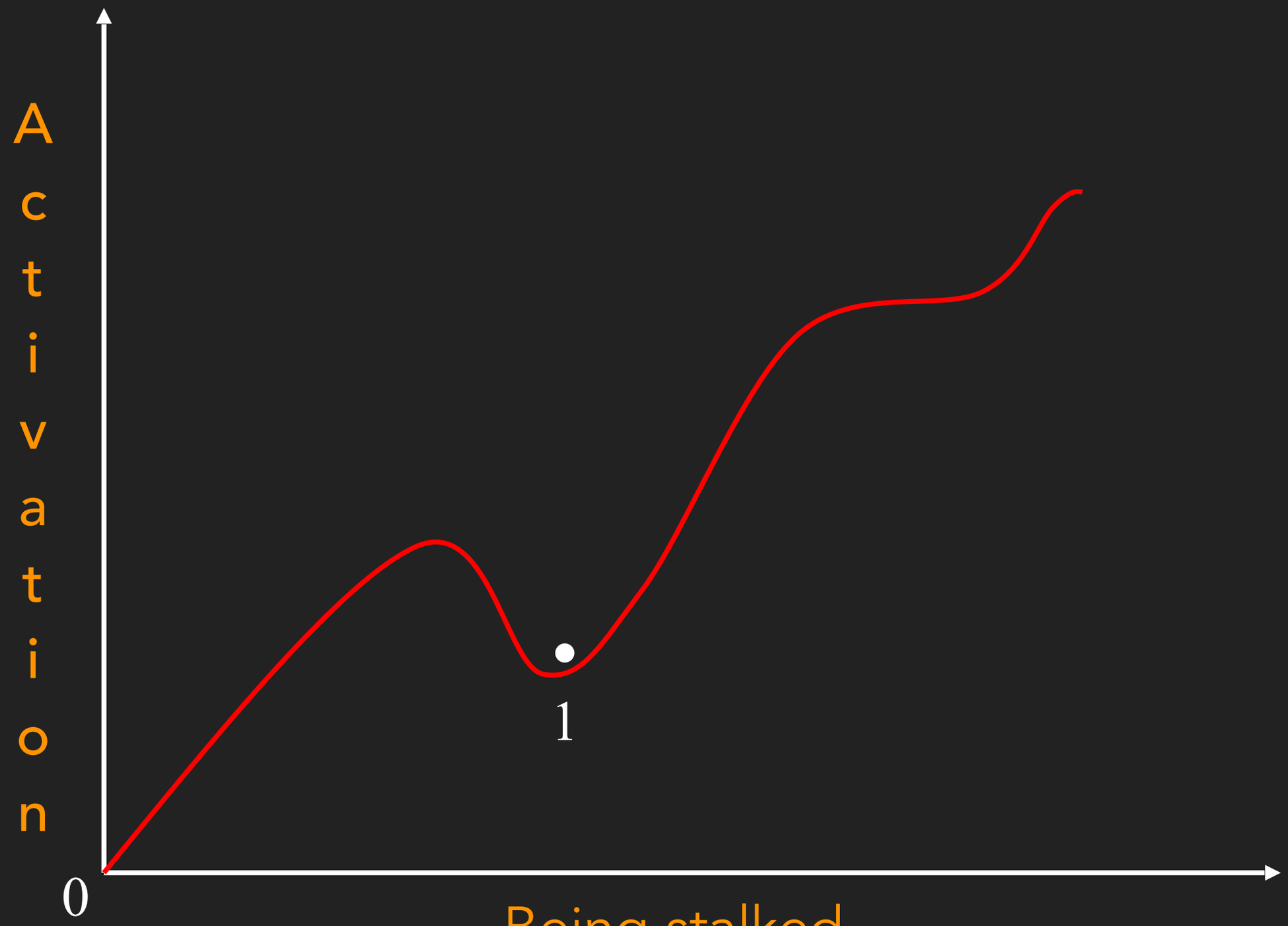


A. Mammalian ANS is more complex with various attractor states built into the system.

B. Attractor states are stable states, can ‘hold’ the marble and ANS activation for long periods of time. They are discontinuous, preferred states for the ANS to pop into.

C. These stable states appear to be adaptive for survival advantage

# State 1 : Mild Stress

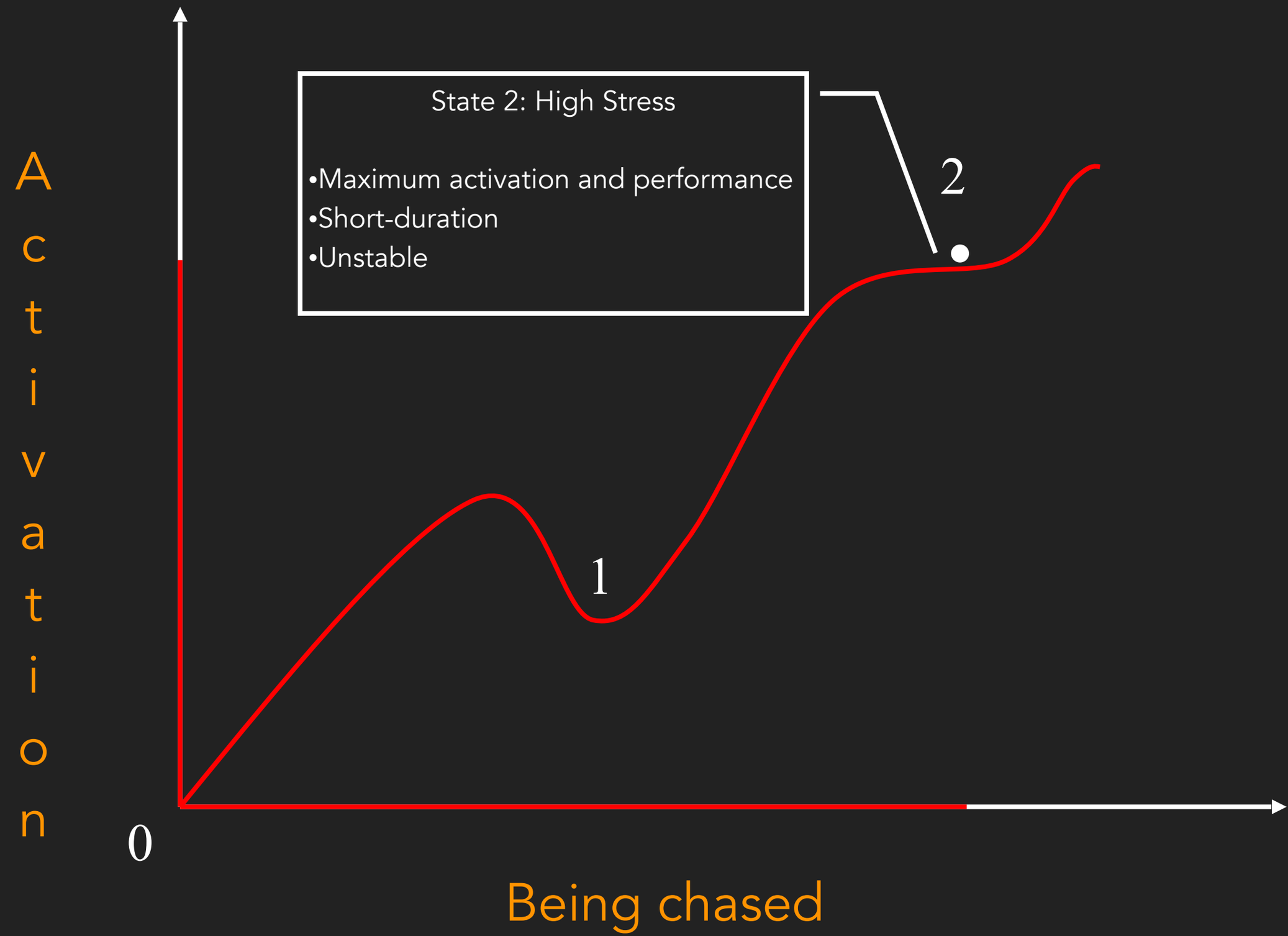


# State 1 - Mild Stress

Adaptive ANS responses & symptoms:

- Increased energy
- Fear
- Anxiety
- Anger
- Hyper-alertness
- Excitement
- Irritability / annoyance
- Increased heart rate and breath speed
- Insomnia
- Somatic Tension: tight muscles, headache or other pain, sensations of heat, contraction
- Restlessness or feeling fidgety
- Speedy thoughts
- Feeling Nervous

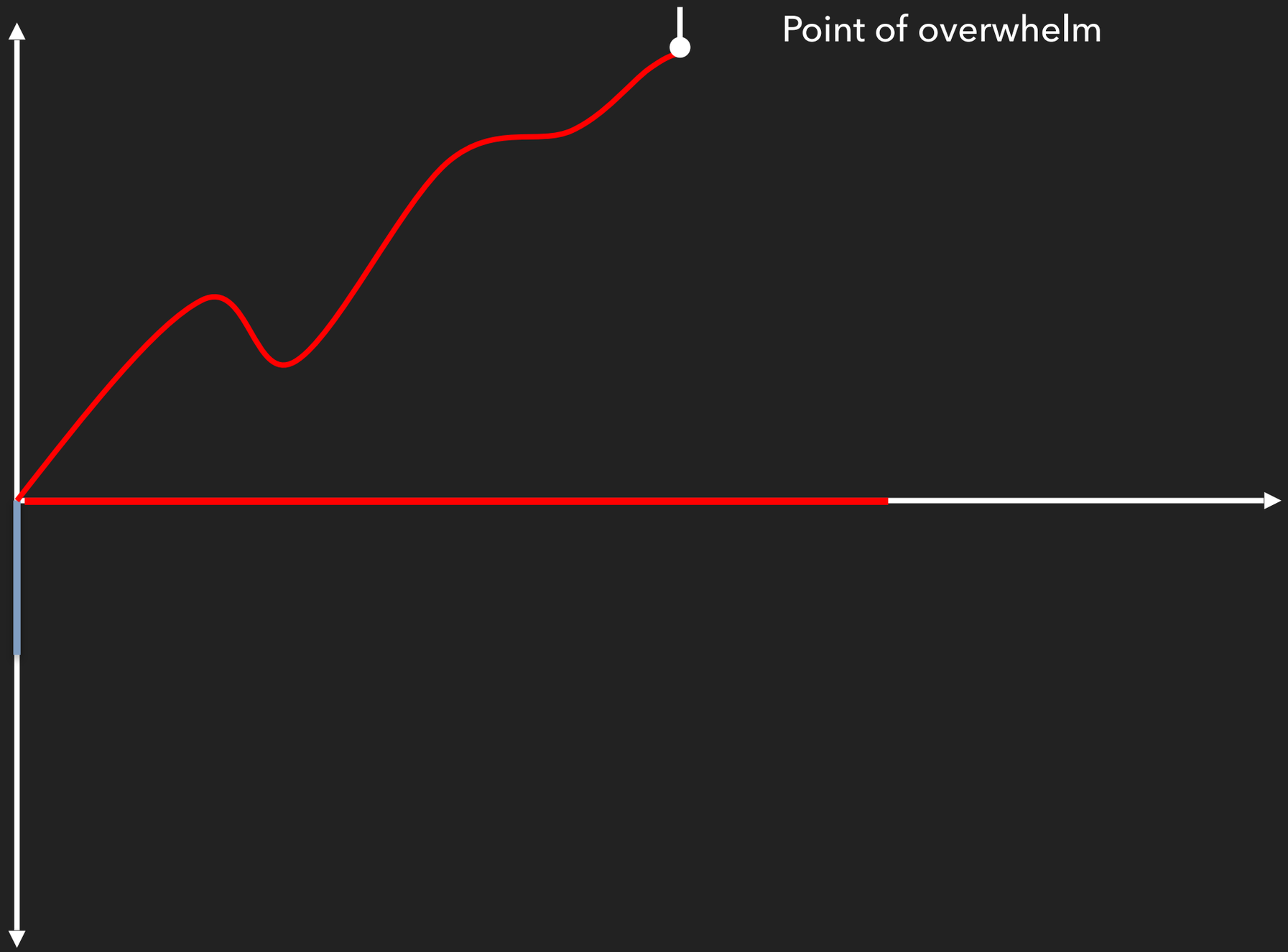
# State 2: High Stress

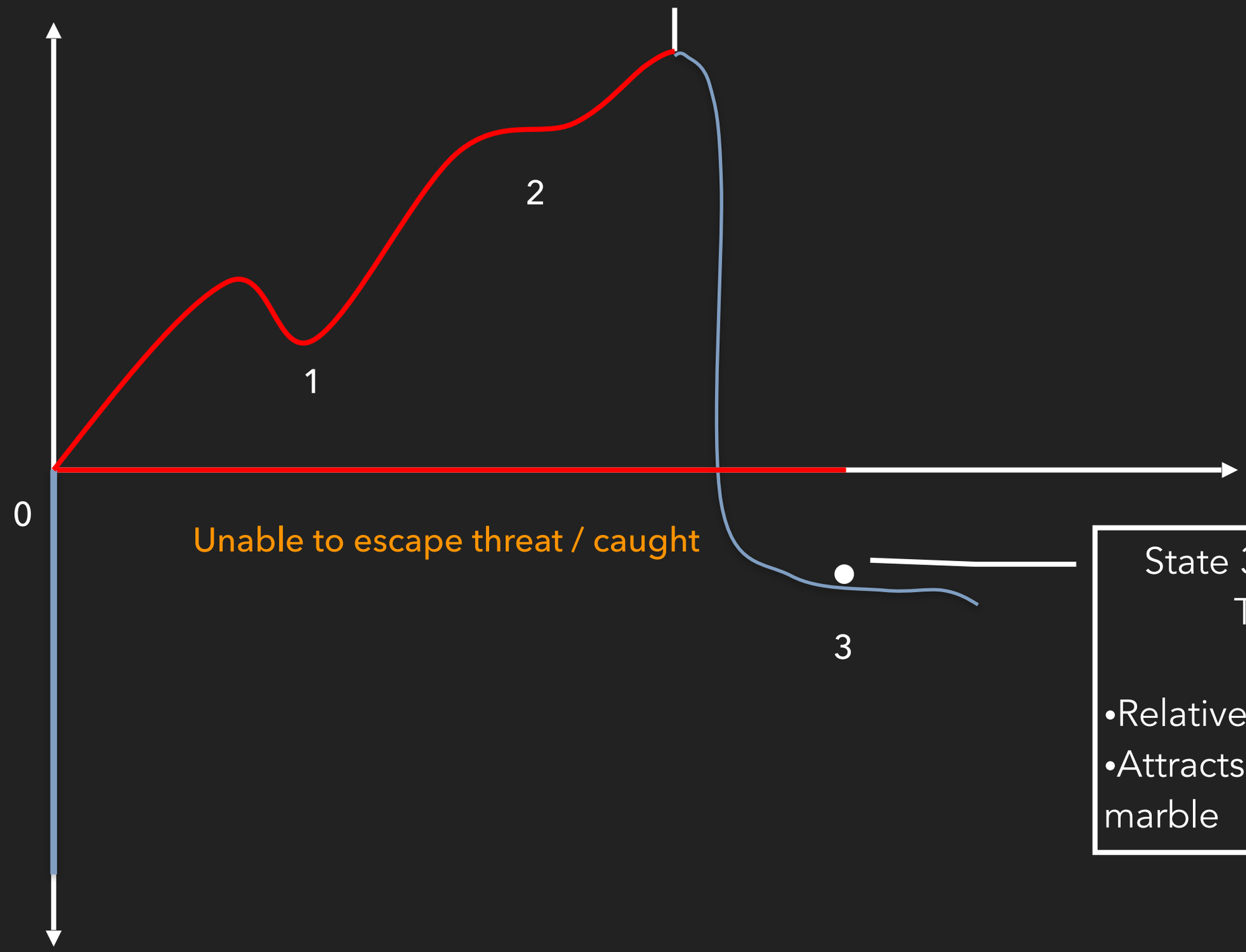


## State 2 Symptoms – High Stress:

## Adaptive ANS responses / symptoms Include:

- Panic
- Hyperventilation
- Heart Racing
- Sweating
- Shaking, trembling
- Overall body tension: muscles contracting
- Rage
- Terror
- Maximum performance
- Very fast thoughts
- Doesn't last very long


Point of overwhelm




State 3: Moderate Trauma

- Relatively stable
- Attracts and holds the marble

# State 3 Moderate Trauma

Adaptive ANS Responses / Symptoms include:

- Moderate opioid dump
- Lethargy
- Sleepiness
- Heaviness
- Collapsed posture
- Lessening muscle tension
- Fogginess / Dissociation
- Sensations of heavy weight
- Feeling cold
- Nausea
- Confusion
- Slow Thoughts
- Suicidality
- Hopelessness

Alternate or occur simultaneously with State 1 & 2 symptoms

# Endogenous Opioids

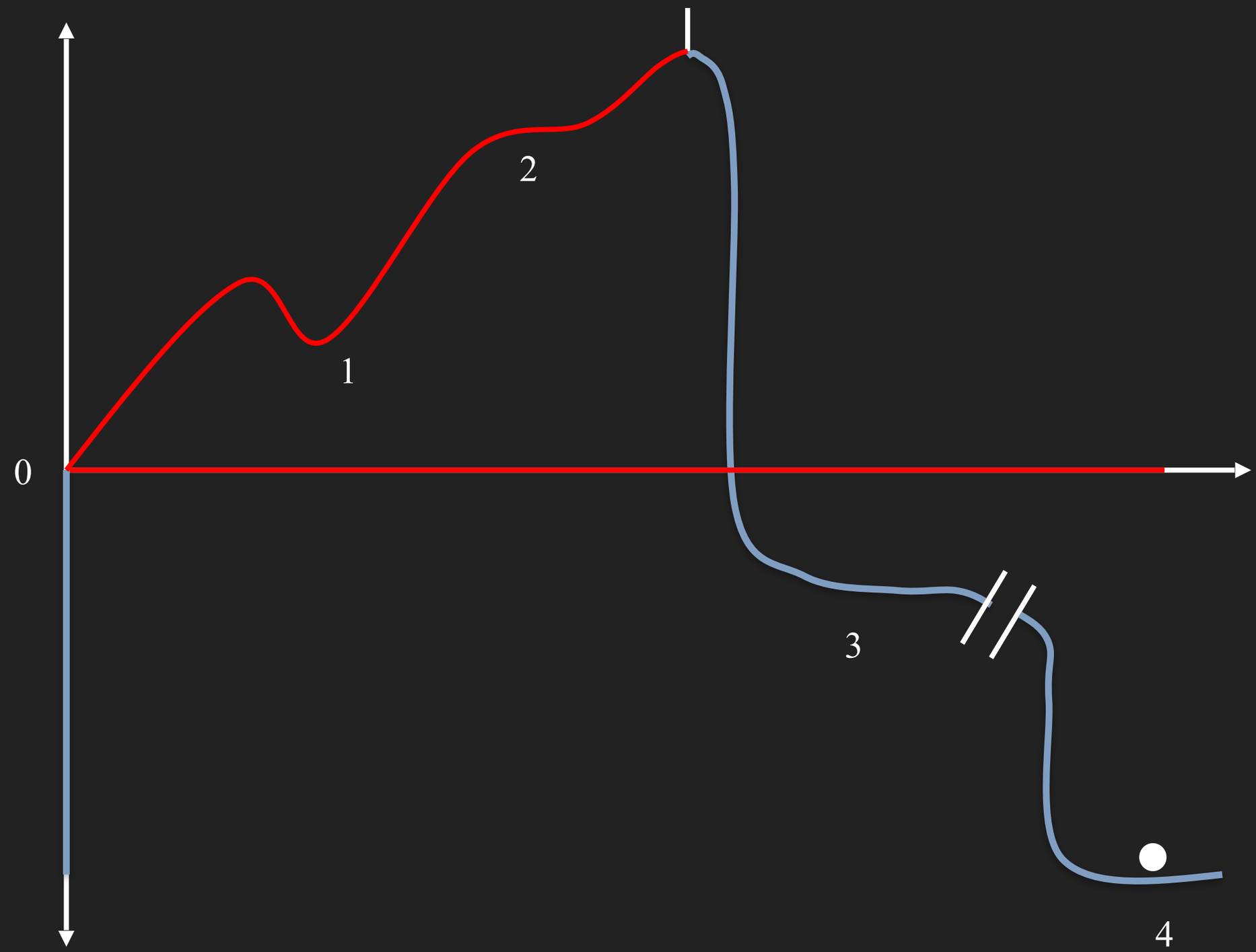
Stress-induced analgesia has been described in experimental animals after a variety of inescapable stressors such as electric shock, fighting, starvation, and cold water swim. In severely stressed animals opiate withdrawal symptoms can be produced either by termination of the stress or by naloxone injections.

…2 decades after the original trauma, opioid-mediated analgesia developed in subjects with PTSD in response to a stimulus resembling the traumatic stressor, which we correlated with a secretion of endogenous opioids equivalent to 8 mg of morphine.

van der Kolk, BA: (1994) The Body Keeps the Score: Memory and Evolving Psychobiology of Posttraumatic Stress. *Harvard Rev Psychiatry*. Volume 1, Number 5

What happens when a psychedelic response meets an opioid response?

Sobriety


0
1
2
3
4

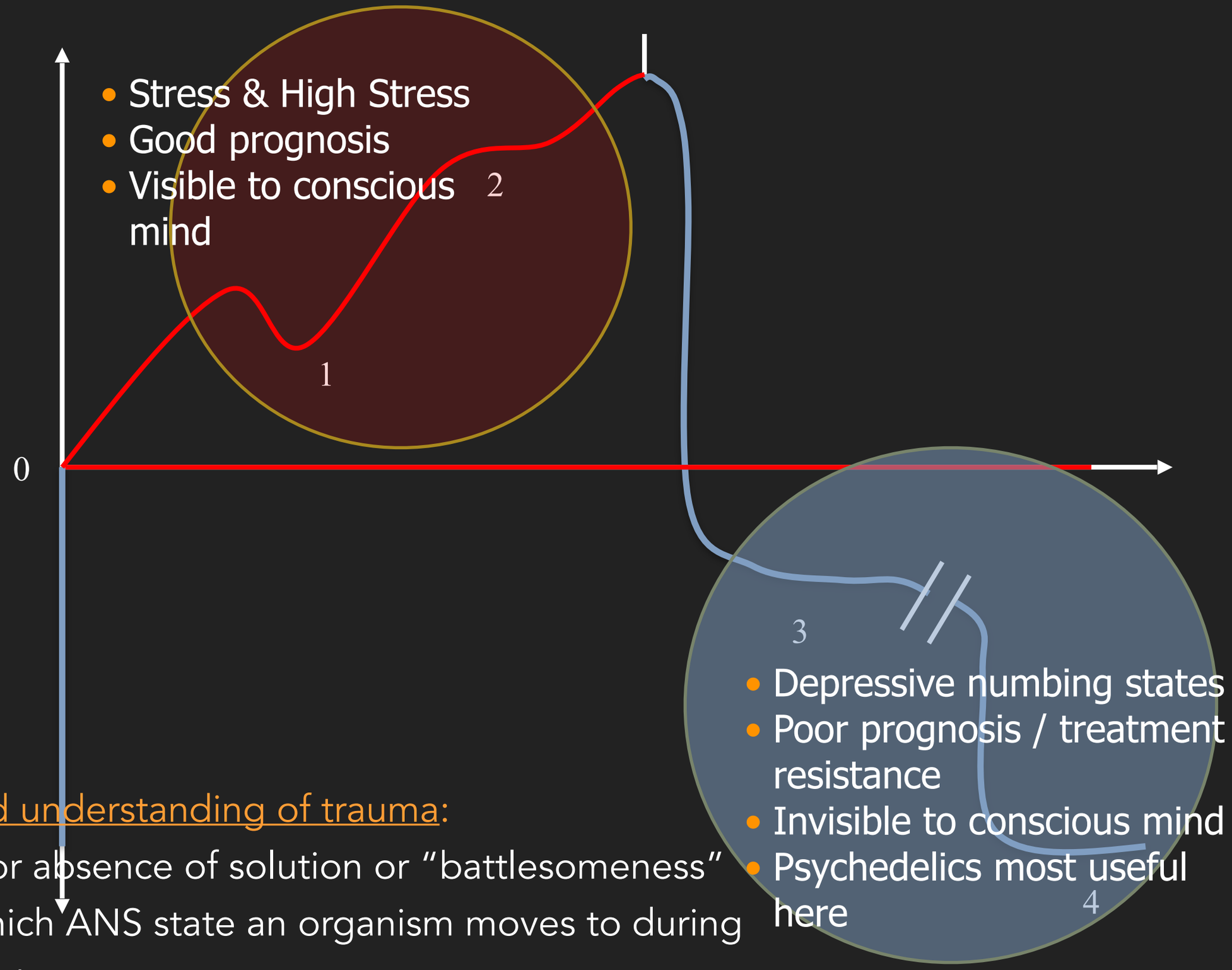
# State 4 Severe Trauma

## Adaptive ANS Responses / Symptoms:

- Large opioid dump
- Blank affect
- Numbness
- Feeling disconnected
- Spaciness
- Vision changes: clouded or tunnel
- Feelings of unreality
- Most dissociated state
- Out of body experiences
- Floaty
- Respite

Absence of State 1 & 2 Symptoms

Selective Inhibition with cannabis




A solution based understanding of trauma:

- the presence or absence of solution or "battlesomeness" determines which ANS state an organism moves to during the actual event
- solution also determines a great deal about how we process trauma now

# PRINCIPLES OF ANS SELF CORRECTION



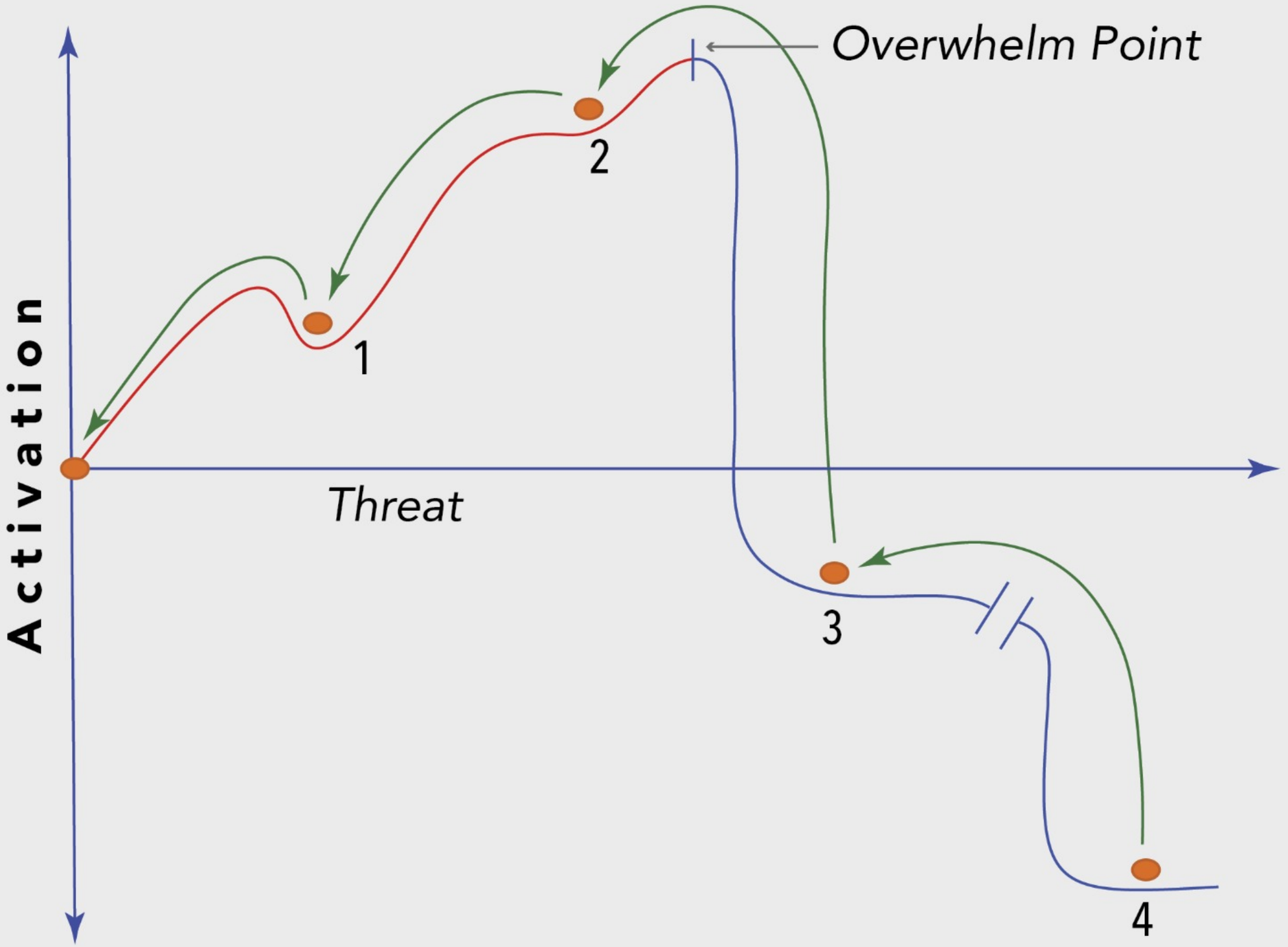
A. Stress & trauma, and many mental health symptoms, are generated by ancient, non-verbal, involuntary features of mammalian biology. Defense Cascade

B. ANS resolution should take the same autonomic pathway to neutrality. ANS generates these states, ANS knows how to return (PC process). Insight does not shift reactivity (SC process).

C. This system is subject to homeostasis (think temperature regulation or insulin release). Surprisingly, homeostasis applies to mental health!

D. Not problematic that these ANS / Defense Cascade states exist, they are adaptive; it's problematic when we cannot return to neutrality.

# Autonomic Nervous System Response Model



# ANS IS ONE ASPECT OF THE PSI TRAIN PROGRAM



You will also learn:

- Somatic tracking: process vs content
- Role of dissociation in traditional therapy
- Role of dissociation in psychedelic therapy
  - Working with dissociation during sessions
- The role of transference in therapy
  - Working with negative transference in psychedelic therapy sessions
- Attachment Styles and how to work with them
- Induction protocol: moving from non-medicine ANS preparatory sessions to to medicine sessions

# WHAT DOES A TYPICAL SESSION LOOK LIKE?



A. Sessions can be done at your office, typically lasting two hours.

B. Two to three non-medicine assisted prep sessions with SI to begin activating the ANS pathway. This can be done by the client bringing up a simple, single event trauma in order to begin feeling the ANS signal.

C. After NMA prep sessions the client will vape / smoke or self administer ketamine. Can titrate the level of medicine as needed with cannabis.

D. Have a "recovery room" to allow the patient to come down from the session

E. Integration at end of or in between sessions (a secondary consciousness process, less essential when majority of processing is conducted during the psychedelic session)

F. Psychedelic therapy will destabilize clients…support is needed between sessions.

# CLIENT BENEFITS: WHY DO THIS WORK?



A. Regain access to implicit, embodied, emotionally fluid, alive self of primary consciousness (wonderment, mystery, awe). Identity drawn from a deeper source.

B. SC is a tool for goal orientation & survival…(surgeon or airline pilot, yes) not so good at meaning. Meaning arises organically, naturally, inevitably from direct contact with world.

C. Direct experience of the mystical, divine vs second hand account

D. Achieve biological / ANS neutrality & responsiveness

E. Regain trust / confidence / access to a more robust somatic pathway to process many mental health symptoms (future resilience)

F. Create a foundation for further psycho-spiritual development.

G. Greater empathy / sensitivity to life

# WHAT ARE THE BENEFITS OF YOUR PROGRAM?



## The PSI Benefits

A. Ability to practice legal, above ground psychedelic therapy for private practice

B. The model targets complex, unresolved, relational trauma always hidden by dissociation: not symptom suppression but symptom resolution.

C. Personal work, personal work, personal work through your cohort (crucial to longterm sustainability as a psychedelic therapist)

D. The model is free of the constraints from the FDA and corporate interests

E. This is psychedelic therapy y'all!

# PSI PSYCHEDELIC THERAPY TRAINING PROGRAM



What can I expect?

A. The PSI psychedelic education program is a full psychotherapy training composed of an in-person component followed by an 8 month online supervisory apprenticeship to fully support you in integrating psychedelic therapy into your practice.

B. The in-person component consists of 5 days of didactic and experiential learning (hands-on fishbowl sessions and supervised trades) in the PSIP model.

C. The apprenticeship component involves remote weekly group supervision for the first 6 weeks and bi-weekly supervision after that. We have training sites around the US. We can also setup trainings in your local area with a minimum of 12 students.

# QUALIFICATIONS FOR TRAINING



As a general rule, we have a number of different criteria that we consider as important in a prospective student:

1) training (traditional graduate school or alternative healing arts)
2) clinical experience working with people
3) population served
4) personal motivation to provide this work

Our primary concern is that students entering the training have a foundation in basic therapy skills and have some level of clinical experience working with people. We would prefer, for example, a student with a Gestalt or Hakomi training background over a licensed individual who might not have clinical experience.

While the PSIP course is a full psychotherapy training, it is not a basic training and the focus is on trauma, somatic and psychedelic processing, and relational transference dynamics. We expect basic therapy skill sets to be in place for students entering the program.

# PSI PSYCHEDELIC THERAPY TRAINING PROGRAM



Costs?

A. 5 day in-person component: $3,200

B. 8-month follow-up apprenticeship: $375 per month

C. This program is not a sitter school for the general public. We train mental and medical health professionals and students as well as those with a qualified background in the healing arts.

D. Here are some of the components of this training that we find greatly support clients in altered states of psychedelic consciousness: body orientation (autonomic nervous system processing), bottom-up experience focus, relational transference work (essential for complex PTSD), physical touch, attachment work, and parts work.

# PSI COVID PROTOCOL



During the 5 day in-person training component, we are adhering to the following rules:

A. Cohort trainings will be limited to no more than 15 students
B. Students are required take a COVID-19 PCR test 3 to 5 days prior to start date
C. Masks to be worn during training
D. Morning temperature checks
E. Self-quarantine at home during the 5 day training period
F. Rapid screening tests (if available)

# TO LEARN MORE ABOUT OUR TRAINING



## PSI PSYCHEDELIC THERAPY TRAINING | UPCOMING DATES:

ASHLAND, OR
DATES: JANUARY 9-13

PORTLAND, OR
DATES: JANUARY 23-27

SAN DIEGO, CA
DATES: FEBRUARY 13-17

SALT LAKE CITY
Dates: February 24-28

BOSTON, MA
Dates: March 6-10

CHICAGO, IL
Dates: March 20-24

CONTACT STEVE ELFRINK AT STEVE@PSYCHEDELICSOMATIC.ORG TO LEARN MORE

The Journal of Psychedelic Psychiatry

“The PSIP Model”

Email us: saj@psychedelicsomatic.org

steve@psychedelicsomatic.org

# THE FUTURE



What is the vision?

A. We can do so much more than putting bandaids on profound wounds (how difficult or impossible healing can be without psychedelic medicine support): from symptom management to symptom resolution.

B. These are our medicines, our right to heal! Grass roots availability of psychedelic therapy.

C. Anyone who wants access to high quality, legal psychedelic therapy can get it.

D. Contact with primary consciousness is both transformative and empowering. Many people without severe conditions requiring light guidance and support can engage their own process.