PSI FAQ for Students & for Your Clients:

1. What qualifications do I need for your program?

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) licensure 4) population served 5) 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.

2. How long do sessions typically last?

We recommend leaving two hours for drug assisted sessions. How long any individual client takes will depend on their nervous system and how their body interacts with cannabis or ketamine. In the case of ketamine, the active effects of the drug typically last between an hour and thirty minutes all the way up to two hours. Cannabis assisted sessions are more controllable in terms of how long they last. At the low end, they will typically take an hour but clients may want to re-dose themselves if they are in the middle of a process and they feel the level of cannabis support is growing thin. Most clients will appreciate ten to fifteen minutes of discussion and integration after the active processing phase of the session comes to a close. We recommend having a quiet recovery room that clients can move into in case their allotted session time is over and they are not yet ready to leave.

3. Are integration sessions necessary?

Integration can mean different things in different models of psychedelic therapy. Remember that the PSIP model is a bottom up processing approach where the work and therapeutic benefits are accomplished primarily during the psychedelic session in your office. The therapy that takes place while your client is in a non-ordinary state is typically a non-verbal, non-insight based, nervous system based processing of memory

that is consistent with the psychedelic state. This is in contrast to what most integration therapy models provide where clients have their own underground psychedelic experience and come into therapy after the fact to engage in a more traditional form of therapy in which case integration is essential. Because the core work takes place during the psychedelic processing in the PSIP approach, we find that the client's mind naturally and easily engages in its own integration once there has been resolution at the bottom up, primary consciousness levels. We find that top down shifts in thought patterns, understanding, insight and meaning (I.e secondary consciousness processes) come about relatively easily once primary consciousness shifts have been accomplished. With that understanding in place, we find that some clients take the last fifteen or ten minutes of their two hour session for integration, and don't require more. Other clients request a talk therapy oriented integration session the week after they have a deep somatic processing medicine assisted session. The need for integration is based on client need.

It should be noted that integration is different from the support clients need as they are going through the dismantling process that is psychedelic therapy. See the following question for a more detailed discussion on support.

4. What kind of support do client's need?

Psychedelic therapy, if done right, is inherently destabilizing. All of the coping strategies, the compartmentalization, the avoidance that people have developed over years to become functional while still maintaining profound wounds gets challenged. These coping systems are the first to crack before therapeutic processing can actually occur. Different clients become destabilized to different degrees: clients who do not have complex, early childhood, familial trauma become less functional over the short term but will typically move through the process without the need for much support. Those whose symptoms do stem from early childhood, familial, complex trauma can expect to fall apart. We have seen this phenomenon in the MDMA clinical trials and we see it when PSIP is engaged with cannabis or ketamine. This is the opportunity and pitfall that comes with working with the depth and speed allowed by psychedelics substances in therapy. At the Innate Path clinical site, we established a variety of groups that served our community of clients undergoing this work such as art therapy integration, restorative yoga, women's movement, and a talk therapy support group (which we offered at no cost to current clients engaged in individual psychotherapy with us). We found that because of the unique nature of psychedelic therapy and the type of material that arises, clients feel supported by engaging with other clients going through the same process they are. While all of these may not be essential to provide in a private practice setting, these groups are some examples of the type of support your clients will seek as their previous coping mechanisms fall away.

5. Do I need to be working with clients during the training or the supervisory apprenticeship period?

There will not be much difference between a student who is or is not seeing clients during the initial in-person training or the 6 week period following . This is because you will be doing practice trades on other students in your cohort during this time. This is an opportunity to see a variety of nervous systems and a diversity of responses people have but even more importantly, it is an opportunity for you to get a significant amount of your own processing done. Practice trades are an important training element both for the student therapist providing the work and the student client receiving the work. This is why we are not allowing non-local practitioners to attend, you have to be part of an exchange cohort. After the initial 6 week period however, your ability to see clients is important. You will learn a great deal more as you gradually implement the model into your practice and see the arc of a client's process over a period of time. We want to support you through supervision as you are implementing this work into your practice. Is it a requirement to see clients during this phase, no. Is it highly recommended, yes.

6. On your website and presentations, you emphasize cannabis, but does the program provide training for other medicines being used in a therapeutic setting? MDMA, ketamine, or psilocybin, for example. Or is it just for cannabis assisted psychotherapy?

The process of entering primary consciousness, the homeostatic mechanisms that become active, the autonomic nervous system becoming a preferential pathway for psychedelic processing, and ultimately the PSIP modality are not specific to any medicine. It is useful to have a psychotherapy designed for primary consciousness processes regardless of what medicine is used to achieve that state. While cannabis is different from MDMA which are both different from the classic tryptamines, it is always useful to have your body online to process the charge that is part of psychedelic therapy. The primary consciousness state that psychedelic substances induce is very much aligned with the biological processes of the body and is less consistent with insight based, verbal, cognitive capacities (these are secondary consciousness features). From what we have seen in research and clinical use, somatic work is particularly useful for both cannabis and MDMA because they are such embodied experiences, whereas psilocybin has a more metaphorical image quality about it and can more easily be directed towards transpersonal states. However, even with psilocybin, having the nervous system available to process anxiety, fear or even integrate positive learning and corrective experiences is highly useful.

7. What about liability, insurance & state licensing concerns for therapists offering this work in their private practice?

Let us be clear on what we provide during this treatment: psychotherapy. At our clinical facility, we do not sell, administer, advise, recommend or require clients to use substances as part of their therapy. We do, however, provide psycho-education on the effects of cannabis and ketamine in session. The client is fully within their rights to consume or not consume a substance that the state has deemed fully legal. It is no different than the client choosing to smoke a cigarette, or take their prescription medication prior to their session. In fact, many states have deemed PTSD as a qualifying condition for the medicinal prescriptive use of cannabis in which case it is reasonable that cannabis will be used in scenarios where PTSD memories are being evoked.

It is up to the client to procure their own cannabis or meet with a prescribing physician to get a ketamine prescription. Liability for ketamine or for cannabis in a medicinally legal state rests with the prescriber and the individual as it does with any other medication. In the case of cannabis in a recreationally legal state, there is no liability other than the individual's responsibility for personal use since the state has deemed cannabis safe enough to not require medical approval. The service we provide as mental health professionals is psychotherapy that can be considered a form of exposure therapy. We have not had problems getting professional practice insurance, and while we are not on insurance panels, our clients have gotten reimbursed by their insurance companies for the treatment they received. We provide them with a superbill with treatment codes and diagnostic codes as we do with any client irrespective of whether they engage cannabis, ketamine, an SSRI or no substance during therapy.

Lastly, as our legal team informed us before we launched a psychedelic psychotherapy clinic, there are no laws governing the use of these substances in therapy. The law follows, it does not lead. The law is shaped by precedence which is why we purposefully invited an investigator from the Colorado state licensing board to review our program and they noted the treatment model did not violate any statutes.

As a further courtesy, we have a recovery room where clients can stay for as long as they need before leaving the office. Typically physicians will make not driving for 24 hours a requirement after using ketamine.

8. What is a training cohort and how does it affect me?

The training cohort is an important part of your PSI training program. Because you cannot become a skilled psychedelic therapist through understanding theory alone, you will need other student-clients to practice your skills with. The two most important factors that determine whether a student will succeed in the PSI training (and whether

they can work sustainably as a psychedelic therapist) is their willingness to run practice sessions and their willingness to engage their own personal work over time. Both of these are effectively addressed through your training cohort who you will work with exclusively during the 5 day in-person training and for the first 6 weeks post training. Providing as many sessions as possible with different individuals and being a client in the work until your system is cleared of unresolved charge will serve you in the long run. Our ideal scenario is that students live locally to their training site so they have access to conduct cohort exchanges. If you do not live close to a training site, we can help you establish a training near you. In some rare cases, we do allow non-local students who are willing to engage in remote work.

9. How many psychedelic therapy sessions will my clients need?

The answer depends on what your client is bringing to the table. Here is the rule of thumb: if a client has a securely bonded, stable childhood filled with attuned parenting and connection, and if they went through a stressful or traumatic period as an adult; we are typically talking about a shorter course of treatment. This can potentially mean two to four treatment sessions for a significant single event trauma (assuming the client is choosing to work with either cannabis or ketamine in 2 hour blocks). This person's internal system is typically trusting and resource filled (aware of the goodness of their world and relationships) such that the psychedelic therapy can provide a lot of movement and resolution in a short period of time. Alternatively, there is the client who has had stressful, chaotic, traumatic or neglectful experiences particularly in the developmentally sensitive window of childhood. This is a far more complex situation because we are not just working with traumatic charge, we are working with human development that was interrupted and powerful relational transferenance that arises when trauma takes place in a person's family of origin. This is referred to as complex PTSD (C-PTSD), and it typically leads to dissociation, treatment resistance and why people are in therapy for years. Many of the people we see come to us with this background. We see roughly a third of this type of client complete at around twelve sessions, and another third needing to go beyond that and wrap up between eighteen and twenty one sessions.

Unfortunately, stressful and traumatic events are frequently cloaked in dissociation. This is especially true of events that took place in childhood. Because of this, neither the practitioner nor the client can fully know what to expect before actually going in.

10. What frequency of sessions can I expect my clients will typically have with this work?

We recommend that clients maintain a regular weekly frequency of sessions as they move through their treatment. Clients sometimes inquire, 'can I do this

once every other week'? Our recommendation is to hold off and not begin treatment until they can have a regular weekly schedule. The idea here is that weekly sessions are helpful for gaining traction and for continuing the momentum once they have it. Four treatments over two months does not yield the same outcomes as four treatments over one month. On the other hand, clients can increase their frequency as is needed or tolerable. This might be needed if clients are visiting from out of state or if they are in the middle of a particularly difficult piece of work and want to move through it more quickly. Some clients are not able to emotionally tolerate more than one session per week.

11. Do people need to be consciously aware of their trauma to process it using this method?

Absolutely not. We know from researches such as Bessel van der Kolk that explicit, declarative memory systems (the conscious form of memory you can put into language) either shuts down or becomes greatly distorted during highly stressful or traumatic episodes. In contrast, non-declarative forms of memory (non-conscious, non-verbal memory), remains active and records traumatic events accurately. It is the non-declarative forms of memory to which we gain access in primary consciousness. Very frequently, we see that the medicine will go much deeper than people's conscious memory. Even setting an intention to focus on a particular event does not mean the client's system will focus on that event during a session. The process tends to evoke more dissociated, unconscious events for processing.

12. Is it possible to shift nervous system states through insight or verbal means by talking about what is going on?

Simply put, no. Nervous system states are part of a biological defense cascade system we share with other animals. These responses emanate from a very different part of the mind than insight or cognitive understanding.

13. How are the interventions of PSIP different from a simple mindfulness or tracking of body sensation?

During mindfulness or awareness practices, the meditator is observing sensation, emotions, thoughts and other internal experiences and letting them arise and fall. Not all experience comes from the same part of the mind. Some

elements of your experience arise from voluntary, conscious parts of the mind. This is typically the experience that is organized and curated by the default mode network. While other aspects of your experience are involuntary, non-conscious and arise from the networks that make up primary consciousness. Mindfulness does not differentiate between experience, it is all witnessed, and there is typically instruction to allo experience to come and go with equanimity. The *selective inhibition* component of PSIP is much more directive and purposeful. We are seeking to inhibit the voluntary, coping and suppressive aspects of secondary consciousness to allow for the quieter, more nuanced, involuntary signal of primary consciousness to emerge. Selective inhibition leads to autonomic processing whereas mindfulness awareness typically does not.

14. Why not CBT or talk therapy?

We do not use CBT or traditional narrative based talk therapy interventions as part of the PSIP processing model for a number of reasons all stemming from the fact that traditional psychotherapy interventions were primarily designed to operate inside of and support ordinary states of consciousness or 'secondary consciousness'. Insight, cognitive restructuring, meaning making, verbally retelling the story of events are all features of secondary consciousness whereas psychedelic substances work by neurologically taking the brain in the opposite direction towards primary consciousness which is a far more experience, sensory, emotion, and visually dominant form of consciousness.

Essentially, we find that talk therapy approaches do not pair as well with psychedelic medicine as do the more experience focused, body-based approaches. While it is certainly possible to talk one's way through a psychedelic therapy session and gain more insight, we find that many mental health symptoms such as anxiety, panic, depression, bipolar symptoms and addiction do not improve through gaining more awareness of the pattern. Understanding the cause of something or changing a belief in most cases does not change the bottom-up reactivity that clients experience. It is the difference between trying to think your way out of anxiety and depression versus feeling your way out of anxiety and depression. We find that deeper shifts are accomplished when the much more robust pathway of the body is used to help process the difficult revelations, memories, and emotions that typically arise with psychedelic therapy.