Cambridge Quarterly of Healthcare Ethics (2023), 1–10
doi:10.1017/S0963180123000099

CAMBRIDGE UNIVERSITY PRESS

ARTICLE

Is the Requirement for First-Person Experience of Psychedelic Drugs a Justified Component of a Psychedelic Therapist's Training?

Nathan Emmerich* and Bryce Humphries

School of Medicine and Psychology, Australian National University, Florey Building, Acton, Australian Capital Territory, Australia
*Corresponding author. Email: nathan.emmerich@anu.edu.au

Abstract

Recent research offers good reason to think that various psychedelic drugs—including psilocybin, ayahuasca, ketamine, MDMA, and LSD—may have significant therapeutic potential in the treatment of various mental health conditions, including post-traumatic stress disorder, depression, existential distress, and addiction. Although the use of psychoactive drugs, such as Diazepam or Ritalin, is well established, psychedelics arguably represent a therapeutic step change. As *experiential* therapies, their value would seem to lie in the subjective experiences they induce. As it is the only way for trainee psychedelic therapists to fully understand their subjective effects, some have suggested that firsthand experience of psychedelics should form part of training programs. We question this notion. First, we consider whether the epistemic benefits offered by drug-induced psychedelic experience are as unique as is supposed. We then reflect on the value it might have in regard to the training of psychedelic therapists. We conclude that, absent stronger evidence of the contribution drug-induced experiences make to the training of psychedelic therapists, *requiring* trainees to take psychedelic drugs does not seem ethically legitimate. However, given the potential for epistemic benefit cannot be entirely ruled out, permitting trainees who wish to gain first-hand experience of psychedelics may be permissible.

Keywords: psychedelics; psychedelic therapy; psychedelic experience; training

Introduction

Since around the turn of the millennium, research into psychedelics[1] has undergone a renaissance, one that has been primarily orientated around biomedical concerns relating to mental health.[2,3,4] The emerging literature offers good reason to think that various psychedelic drugs—including psilocybin, ayahuasca, mescaline, ibogaine, ketamine, LSD, and MDMA[5]—may have significant therapeutic potential when it comes to treating those who suffer from a variety of conditions, including post-traumatic stress disorder, depression, existential distress, and addiction.[6] Although the use of psychoactive drugs, such as Diazepam, Prozac (Fluoxetine), or Ritalin, is a well-established part of mental healthcare, psychedelics arguably represent a therapeutic step change. As *experiential* therapies, their value does not lie in altering or rebalancing the brain's neurochemistry or in their neurogenic or neuroplastic effects alone.[7] Rather, the therapeutic value of psychedelic drugs seems to be directly related to their subjective and phenomenological effects that are taken to be *mind manifesting* or *mind revealing*. At least in part, it is a matter of the experiences they give rise to,

something that is commonly referred to as a "trip" and may involve hallucinations as well as altered affective or emotional states.[8]

Often referred to as *psychedelic-assisted psychotherapy*,[9] psychedelic therapy generally has two phases orientated around an actual psychedelic experience.[10,11,12] Usually taking place over several sessions, the first or *preparatory* phase generally involves therapists readying patients for a psychedelic experience.[13] In at least some cases, this may include raising the possibility of such novel treatment modalities. This phase is not, however, wholly characterized by a complex but nevertheless common process of securing the patients informed consent via a discussion of the emerging evidence for psychedelic therapy as well as the patient's expectations, concerns, and so forth. The preparatory phase provides an opportunity to establish a therapeutic relationship as well as the broader degree of mutual respect (or, at least, understanding) and trust that relationships are commonly reliant on. Once this process is felt to be complete, the patient undergoes a (or sometimes a small number of) psychedelic experience(s). During such sessions, patients are supervised, monitored, or, perhaps, *guided* by the therapist, and a chaperone or another therapist or healthcare professional will also be in attendance. Subsequently, an integrative phase occurs. This involves further psychotherapeutic sessions where the therapist and patient will seek to examine, process, and *integrate* the psychedelic experience—as well as any affective or emotional realizations and responses that occurred or subsequently emerge—into their psyche, their affective outlook, and/or their worldview.

Given that the clinical evidence is not yet fully established, and the fact that the use of such drugs for any purpose continues to be prohibited in almost all jurisdictions, psychedelic therapy cannot yet be considered a proven treatment modality or specialism. Nevertheless, some pathways for the training of psychedelic therapists have been developed.[14,15,16,17,18,19,20,21,22] Such pathways commonly recommend —or, at least, acknowledge the potential value of—trainees undergoing some kind of personal experience of the subjective effects of (the relevant) psychedelic drug(s). This is somewhat unusual. There has never been any serious suggestion that therapists who prescribe antidepressants or other psychoactive medications ought to have first-hand experience of such drugs, and although the value of first-hand experience is sometimes recognized—not least in the example of psychotherapist's training which requires trainees to engage in and undergo the psychotherapeutic process for themselves—the consumption of any therapeutic medication in the absence of any direct clinical indication for doing so arguably conflicts with "the institutional logic of psychiatry."[23] However, the fact that it seems to be a common recommendation in the context of psychedelic therapy should be seen as relating to the unique epistemic value that is commonly attached to the subjective or phenomenological experience psychedelics induce.[24,25,26] This essay considers if such reasoning can be considered to provide an underlying justification for requiring trainee psychedelic therapists to undergo a drug-induced psychedelic experience and, relatedly, the ethics of any such requirement.

The Epistemic and Therapeutic Significance of the Psychedelic Experience

Consideration of the philosophical thought experiment Mary's Room (sometimes Monochrome Mary) offers *prima facie* reason to suppose that experiencing the subjective effects of psychedelic drugs for oneself offers a unique sort of epistemic insight or benefit. It runs as follows:

> Mary has spent her entire life in a monochrome world; she has never perceived colour from a subjective, first-person or phenomenological perspective. Nevertheless, Mary has been given a comprehensive education in all matters relating to colour. She is scientifically well informed and knows everything there is to know about colour. One day Mary leaves her monochrome world and, in so doing, perceives colour for the first time. Does she acquire new knowledge as a result of her experience?[27]

Generally speaking, most hold that in perceiving color for the first time Mary acquires new knowledge. This is because Mary now *knows* what the phenomenological experience of color is like and, as a result, can better understand the way others subjectively experience the world. The implication of the thought experiment is that phenomenological or subjective experiences can be epistemically significant and that

the only way to acquire such knowledge is to have the relevant experience for oneself. If this is so, then it would seem logical to think that psychedelic experiences—which are generally supposed or imagined to be of a unique sort or kind—might be considered in a similar light. Indeed, as Wolfson says, "it is possible that the experience of psychedelics is so 'non-ordinary' as to be unimaginable without having had the experience."[28] Certainly, some have tried to communicate or otherwise represent psychedelic experiences, either on their own terms by comparing them to other experiences (commonly those of a religious, spiritual, or mystical nature). Nevertheless, it is not a great leap to suppose that those who have personally experienced the effects of psychedelic drugs have a form of knowledge that individuals who have not had such experiences do not possess and cannot otherwise acquire.

On the face of it, Mary thought the experiment would seem to support the inclusion of a drug-induced psychedelic experience in the training of psychedelic therapists; undergoing a psychedelic experience will offer therapists a *sui generis* form of knowledge that would not otherwise be available to them. However, in this context, we might note the importance of set and setting to the psychedelic experience.[29] Although it is a basic truism that individuals will vary in their mindsets and no setting will ever be precisely the same, we should also note that there is a basic distinction between the use of psychedelics in the context of psychedelic therapy and in the context of training as a psychedelic therapist. The set of a patient undergoing a therapeutic psychedelic experience will differ from someone who is undertaking a training exercise. Consequentially, there is no guarantee that the experience of those training as psychedelic therapists will provide them with insight into the experience of patients, a point that calls into question the idea that providing trainees with a psychedelic experience will necessarily have value when it comes to their future work as psychedelic therapists.

Further interrogation of this implication is, however, warranted. The epistemic value of providing trainee therapists with a psychedelic experience is not a question of it being "the same" as the experience of their (future) patients. Rather, it is a matter of there being a sufficient degree of overlap, particularly insofar as the (presumably) exceptional features of the psychedelic experience are present for both patient and trainee therapist. What would seem to be of particular significance is the affective dimension(s) of the psychedelic experience and the relational vulnerabilities that are involved with being in such a state.[30,31] What is of central importance here is not necessarily that psychedelics *reveal* or *manifest* some aspect of (the individuals) mind and nor is it the specific content of the realizations or manifestations they have the potential to provoke.[32] Rather, it is the *profundity* or *sense of meaning* that accompanies or is attached to such experiences and the openness with which one faces the world. Of course, the specific feelings, emotions, and affects that are manifested during a psychedelic experience are generally transient in nature. Nevertheless, although an individual may return to normality or to their phenomenological baseline, there is evidence to suggest that psychedelic experiences can have a lasting impact on the individuals on both their worldview and their affect more generally.[33,34,35,36,37,38] What seems to be unique—and, therefore, of epistemic significance for trainee psychedelic therapists—about the psychedelic experience is the degree to which the affective states they induce seem to be a matter of having an immediate, undeniable, and profound sense of the truth or meaningfulness of whatever one's mind manifests or realizes. It is, perhaps, this phenomenological aspect of the psychedelic experience that we should focus on when considering the value of providing psychedelics to trainee therapists.

Of course, if this is the case—that the phenomenological and epistemic significance of psychedelic experiences lies in the affective state they induce and the way it orientates us toward (the realization of) profound truths or meanings—then it may be that psychedelic experiences are not *entirely* unique. Certainly, it seems that human beings report experiencing a profound sense of truth or meaning in other contexts,[39] and one might also reflect on a range of other experiences that may overlap with psychedelic phenomenology, including non-drug-related forms of religious or mystical experiences, near death experiences, the kinds of states achieved during advanced meditation, holotropic breathwork,[40] and the kinds of (hypnagogic) states that can be induced by sensory deprivation or the (so-called) Dreamachine.[41] Indeed, some have speculated on the possibility of cyberdelics.[42] Although some of these might tend toward the merely hallucinogenic rather than the emotional or affective, it is clear that such experiences represent a form of knowledge (or understanding) that goes beyond what fictional and nonfictional representations of the psychedelic experience can offer

us. Although an epistemic gap might remain—meaning that such experiences are not the same as those induced by psychedelic drugs and that a drug-induced psychedelic experience will continue to hold epistemic significance—they clearly offer some degree of insight. If there are other comparable sources of relevant knowledge, understanding, or insight, and undergoing a psychedelic experience is not the only route trainee psychedelic therapists might take to developing their knowledge and understanding, mandating such experiences as a requirement of training would seem to be overly demanding and, therefore, unethical.

Is Requiring Trainee Therapists to Undergo a Psychedelic Experience Ethically Supportable?

Given the weight attached to autonomy in general and bodily autonomy in particular, one might think that a strong justification is needed if trainee therapists are to be *required* to undergo a drug-induced psychedelic experience. Certainly, given the need to ensure that healthcare professionals meet the required standard, it is legitimate to establish general requirements for their training. Furthermore, given that no one has a perfect right to be a healthcare professional, a therapist, or a psychedelic therapist, it is acceptable for such requirements to challenge to their autonomy in the sense that they oblige trainees to undertake certain tasks or to behave in specific ways. In the final analysis, the autonomy of adult trainees in any field is ultimately preserved as they are always free to discontinue their pursuit of the relevant credential or career. Unsurprisingly, then, the notion that trainees might be required to undergo a drug-induced psychedelic experience is not entirely without precedent. As previously mentioned, therapists are commonly required to undergo therapy as part of their training and, furthermore, healthcare professionals are commonly required to be up to date on their vaccination schedule in order to engage in clinical practice, something that has often included requirements to be immunized against influenza as well as coronavirus disease (COVID-19) more recently.[43]

Given these examples, it is not inconceivable that the requirement for trainee therapists to take a psychoactive substance and undergo a psychedelic experience might be justifiable. However, the suggestion presents and brings together two different kinds of challenges to an individual's autonomy. The first is the requirement to engage with a practice that directly impacts one's psyche and, one might add, does so in a manner that is less controlled than is the case when one engages in therapy. The second is the requirement to ingest (or in the case of vaccination be injected with) some substance. Although such substances are required to demonstrably meet the relevant and stringent safety requirements, this is an unusual demand for almost all kinds of training programs. Nevertheless, one might note that training to be a sommelier requires ingesting (or, at least, tasting) wine. However, if one chooses to train as a Master of Wine, one is choosing to develop an expertise in tasting wine. Whether a similar thing can be said of training to be a psychedelic therapist is far from clear, meaning that requiring trainees to undergo a drug-induced psychedelic experience may not be justifiable.

Certainly, the reason that trainee therapists are required to undergo therapy (the supposition that better therapists will result) remains intact in the context of psychedelic therapy, and the justification for requiring vaccination (the idea that both patients and the individuals themselves will be better protected from some pathogen) is absent. Furthermore, not only is it unclear that a drug-induced psychedelic experience will make a significant contribution to a therapists training, but there are also other ways for individuals to have comparable or, at least, related experiences. As a result, requiring trainees to have a *drug-induced* psychedelic experience would seem overly prescriptive; it may be sufficient to requiring trainees to explore and reflect on the kinds of experiences and altered states of consciousness that can be achieved through meditation, holotropic breathwork, sensory deprivation chambers, or various other means.

Another reason to suppose that requiring trainees to undergo a drug-induced psychedelic experience cannot be unequivocally endorsed is the fact that doing so may be medical contraindicated in some individuals. Of course, the same is true of vaccination, but rather than being taken to undermine the requirement in general, it has resulted in the creation of exemptions, which are granted based on evidence of a previous adverse reaction. In the case of psychedelic drugs, a more cautionary approach is

likely warranted. Although it is unlikely that individuals will be able to provide evidence of a previous adverse reaction, given the psychoactive nature of psychedelic drugs, it is likely that evidence of prior mental illness may amount to a contraindication on the assumption that it increases the risk of a negative psychedelic experience.[44] The same position is likely to be adopted if there is a family history of psychiatric illness. It therefore seems likely that far more individuals will be unable to undergo a drug-induced psychedelic experience for medical reasons than is the case for vaccination. This may mean that the requirement will need to be waived—or an alternative approach will need to be found—for a not insignificant proportion of trainees. It would therefore seem that the most ethical approach is to permit trainee psychedelic therapists a choice as to whether they wish to undergo a drug-induced psychedelic experience or not.

Of course, we imagine that those who are motivated to train as psychedelic therapists in the near future will generally do so precisely because they are already positively disposed toward the therapeutic value of psychedelics and the kinds of experiences they induce. Indeed, such individuals may even be keen to have a drug-induced psychedelic experience of their own. It therefore seems likely that a majority of trainee psychedelic therapists will choose to experience the effects of psychedelic drugs for themselves and may even choose to do so regardless of what some might see as overly cautious contraindications. Equally, if psychedelic therapy lives up to current expectations and becomes an increasingly established part of mental healthcare, it is not hard to imagine that a greater proportion of trainees could adopt a more cautious approach. When it comes to designing, creating, and implementing training in psychedelic therapy, it will be important to ensure that trainees feel able to make their own decision as to whether or not they wish to have a drug-induced psychedelic experience of their own. Furthermore, if it proves to be the case that those who form the initial cohorts of trainees generally elect to have their own psychedelic experience, whereas those in later cohorts are less likely to do so, then care will need to be taken to ensure that they can do so without fear of judgment or (tacit) professional censure.

What Might Patients Prefer?

A final point that might be taken into consideration is whether patients might prefer therapists who have experienced the subjective effects of psychedelics for themselves or if they might prefer those who have not had such experiences. Although there is some evidence to suggest that patients will think it "somewhat important" that psychedelic therapist has had their own drug-induced psychedelic experience,[45] perhaps the first thing to note is that it is unlikely that all those who might be offered psychedelic therapy will have a uniform position on this matter, or on psychedelics more generally. Some might be reassured by the fact that their therapist has experienced the effects of psychedelic for themselves, whereas others might consider it to be a prerequisite for any therapist they might consider working with. Equally, other patients might think that those who would experience psychedelics without clear clinical justification for doing so are entirely unsuited to the role of therapist and may refuse to work with such individuals.[46]

That patients will likely take different perspectives on the matter provides further reason to create training routes that do not require therapists to take psychedelics. This is not, however, to say that therapists should necessarily be clear with patients about their personal experience with psychedelics.[47] Certainly, therapists should seek to establish a trusting relationship with their patients and being truthful contributes to such relationships. Equally, it seems some therapists value being able to draw on their own psychedelic experience as doing so can reassure vulnerable or anxious patients.[48] Nevertheless, knowledge of a therapist's prior experience may present an obstacle to the therapeutic process, particularly if the focus shifts to comparing the patients experience with that of the therapist, or if the patient believes the therapist cannot understand their perspective because they have not undergone the same (or a similar) experience. Such reasoning suggests that it may be preferable for therapists not to be entirely transparent about their prior experiences with psychedelics and for training pathways to facilitate uncertainty in this matter.

Conclusion

In a recent paper, Yaden, Earp, and Griffiths discussed the possibility that nonsubjective psychedelic drugs—meaning psychedelic drugs that do not induce the phenomenological effects associated with psychedelics but nevertheless have the same clinical and therapeutic function—might be discovered and, if so, whether or not such substances should be the preferred approach to treatment,[49] all other things being equal.[50] On the basis of beneficence, and because those that have taken such drugs consistently rate the experience as being among the most meaningful events of their lives, they concluded that clinicians should provide classical psychedelics as the standard of care and do so in preference to nonsubjective psychedelics. Given the significance usually attached to (patient) autonomy, this conclusion seems misguided or, at least, misstated. If the clinical value of two interventions is the same, then clearly the patient should be able to select which option to pursue. Indeed, where two or more clinically comparable treatment modalities are available, clinicians should generally set forth all the options so that patients can make an informed decision as to what is the right course of action to pursue. Thus, although continuing to offer classical psychedelics might be a matter of beneficence and clinicians and therapists might note the extra-clinical contributions such drugs might have and may even elect to recommend them for such reasons, the patient should always be supported in exercising their autonomy to the fullest extent.

This perspective reflects the argument we have made in regard to the training of psychedelic therapists. In the absence of a clear justification for requiring trainees to undergo a drug-induced psychedelic experience, the only ethical option is to permit them to make their own decision. Certainly, if trainees choose to take a psychedelic drug, it seems likely that they will derive some epistemic benefit from their experience, and it may even have positive consequences for both their competence, expertise, and skill as a psychedelic therapist and perhaps more broadly. Nevertheless, in the absence of strong evidence that the former is the case, the ethical principle of autonomy should be given precedence. When deciding the issue for themselves, individual trainees may consider research indicating that the majority of those who have taken psychedelics report having a positive experience and describe it as something which held personal meaning or significance. However, that this is the case does not justify mandating the use of psychedelic in training programs and should not be used to override the autonomy of trainee therapists.

Notes

1. Formed from the Ancient Greek terms *psyche* (meaning mind) and *delos* (meaning to make clear or reveal), the word psychedelic is commonly taken to mean "mind revealing" or "mind manifesting." Hartogsohn I. *American Trip: Set, Setting, and the Psychedelic Experience in the Twentieth Century.* Cambridge, Massachusetts: MIT Press; 2020:77.
2. Langlitz N. *Neuropsychedelia: The Revival of Hallucinogen Research Since the Decade of the Brain.* Berkley and Los Angeles, California: University of California Press; 2013.
3. Sessa B. *The Psychedelic Renaissance: Reassessing the Role of Psychedelic Drugs in 21st Century Psychiatry and Society.* 2012 London, UK: Muswell Hill Press; 2017.
4. Giffort D. *Acid Revival: The Psychedelic Renaissance and the Quest for Medical Legitimacy*. 1st ed. Minnesota: University of Minnesota Press; 2020.
5. While it is not ordinarily labeled a psychedelic, MDMA is generally categorized as such within the contemporary discourse of psychedelic research. Nevertheless, rather than thinking of MDMA as something that reveals or manifests the mind it may be that other terms—such as empathogen (to elicit empathy or social connectedness), entactogen (inner touch, in the sense of engendering a sense of being in touch with oneself), or entheogen (to manifest the divine)—encapsulate its effects more accurately.
6. Grob CS, Grigsby J. *Handbook of Medical Hallucinogens.* New York, NY: Guilford Publications; 2021.
7. This is not to say that the neurophysiological or neuroplastic effects of psychedelic drugs are therapeutically irrelevant. Indeed, it is likely that the phenomenological and neurological effects

work in tandem. Olson DE, Yaden DB, Fejer G. Are the subjective effects of psychedelics necessary for their enduring therapeutic effects? A conversation with David E. Olson and David B. Yaden. *ALIUS Bulletin* 2021;**5**:40–57.

8. Some have recently suggested that the subjective effects of psychedelics might not be therapeutically significant and that analogue drugs which do not induce such experiences might be discovered. Olson DE. The subjective effects of psychedelics may not be necessary for their enduring therapeutic effects. *ACS Pharmacology & Translational Science* 2021;**4**(2):563–7. In this context, Rasmussen and Olson prefer to speak of psychoplastogens rather than psychedelics and distinguish between those that are hallucinogenic and those that are non-hallucinogenic. Rasmussen K, Olson DE. Psychedelics as standard of care? Many questions remain. *Cambridge Quarterly of Healthcare Ethics* 2022;**31**(4):477–81. However, although hallucinations *per se* might be therapeutically extraneous, it is arguable the case that the effects psychedelics commonly have on a patient sense of self—notably ego dissolution and the relation of self to others whether specific, generalized, or to "life" or the universe as a whole; Letheby C. *Philosophy of Psychedelics*. Oxford, UK: Oxford University Press; 2021—do seem to be therapeutically significant. Yaden DB, Griffiths RR. The subjective effects of psychedelics are necessary for their enduring therapeutic effects. *ACS Pharmacology & Translational Science* 2021;**4**(2):568–72. The point here is that we may need to distinguish different aspects of the psychedelic experience (or trip); that there may be a difference between experiencing mere hallucinations and the broader emotional, affective and *reflexive* states that seem to be induced by psychedelic drugs.
9. Obviously, outside of clinical trials, the provision of psychedelic therapy is legally prohibited, at least for the most part. However, not only is it clear that underground provision occurs, but it is also clear that it sometimes involves those who are qualified, licensed, and practicing therapists. Brennan W, Jackson MA, MacLean K, Ponterotto JG. A qualitative exploration of relational ethical challenges and practices in psychedelic healing. *Journal of Humanistic Psychology* 2021. doi:10.1177/00221678211045265; Smith WR, Appelbaum PS. Novel ethical and policy issues in psychiatric uses of psychedelic substances. *Neuropharmacology* 2022;**216**:109165. Wolfson has recently outlined an approach to "psychedelic supportive psychotherapy" that aims to reduce harm and maximize therapeutic benefit while also allowing professionals to insulate themselves from the legal complexities involved with the actual consumption of prohibited substances. Wolfson E. Psychedelic-supportive psychotherapy: A psychotherapeutic model for, before and beyond the medicine experience. *Journal of Psychedelic Studies* 2022;**6**:191–202.
10. Schenberg EE. Psychedelic-assisted psychotherapy: A paradigm shift in psychiatric research and development. *Frontiers in Pharmacology* 2018;**9**:733.
11. Greenway KT, Garel N, Jerome L, Feduccia AA. Integrating psychotherapy and psychopharmacology: Psychedelic-assisted psychotherapy and other combined treatments. *Expert Review of Clinical Pharmacology* 2020;**13**(6):655–70.
12. It is worth pointing out that protocols for *psycholytic* therapy offer an alternative approach to the provision of psychedelic drugs in the therapeutic context. Meaning mind loosening (rather than mind revealing or mind manifesting) psycholytic therapy involves the use of low or "micro" doses of psychoactive substances as part of regular psychotherapeutic sessions. Reiff CM, Richman EE, Nemeroff CB, Carpenter LL, Widge AS, Rodriguez CI, et al. Psychedelics and psychedelic-assisted psychotherapy. *American Journal of Psychiatry* 2020;**177**(5):391–410.
13. Although we have elected to use the terms "therapist" and "patient," one might note various points about such choices. First, it may be that the role of psychedelic therapist might be played by a range of individuals, including psychiatrists, psychologists, counselors, clergy, chaplains, social workers, naturopaths, practitioners of traditional Chinese medicine, and more traditional (or neotraditional) figures such as indigenous elders and shaman. Phelps J. Developing guidelines and competencies for the training of psychedelic therapists. *Journal of Humanistic Psychology* 2017;**57**(5):450–87; Phelps J. Training psychedelic therapists. In: Winkelman M, Sessa B, eds. *Advances in Psychedelic Medicine: State of the Art Therapeutic Applications*. Santa Barbara, California: Praeger Books; 2019:274–94. This raises questions regarding the credentials or experience

required to train as a psychedelic therapist as well as concerns about the biomedical, biocapitalist, or biocolonial implications of emerging discourses regarding the therapeutic potential of psychedelics. Second, despite the fact that their role might be better thought or in terms of following or accompanying rather than guiding, psychedelic therapists might be referred to as "guides," "therapist guides," or "sitters." Given the connotations of terms like guide or sitter in the psychedelic context, it is clear that the term therapist will be culturally preferable in the context of biomedicine and the psychedelic renaissance. Third, some may prefer the term client, consumer, or some other designation, depending on the context in which therapy is being provided. While such matters are interesting and deserve further interrogation, such concerns do not significantly impact on this paper's overall argument and so are left to one side.

14. See note 10, Schenberg 2018.
15. See note 11, Greenway et al. 2020.
16. See note 12, Reiff et al. 2020.
17. See note 13, Phelps 2017.
18. See note 13, Phelps 2019.
19. Phelps J, Henry J. Foundations for training psychedelic therapists. In: Barrett FS, Preller KH, eds. *Disruptive Psychopharmacology*. Cham: Springer International Publishing; 2022:93–109.
20. Tai SJ, Nielson EM, Lennard-Jones M, Johanna Ajantaival R-L, Winzer R, Richards WA, et al. Development and evaluation of a therapist training program for psilocybin therapy for treatment-resistant depression in clinical research. *Frontiers in Psychiatry* 2021;**12**:586682.
21. Brennan W, Belser AB. Models of psychedelic-assisted psychotherapy: A contemporary assessment and an introduction to EMBARK, a transdiagnostic, trans-drug model. *Frontiers in Psychology* 2022;**13**:866018.
22. MAPS, Training Protocol for MDMA-Assisted Therapy Researchers (Open Label Phase 1 Study), 2010; available at https://maps.org/2010/06/29/training-protocol-for-mdma-ptsd-researchers-phase-1/ (last accessed 21 Nov 2022).
23. See note 21, Brennan, Belser 2022, at 17.
24. See note 9, Brennan et al. 2021.
25. See note 9, Wolfson 2022.
26. Nielson EM, Guss J. The influence of therapists' first-hand experience with psychedelics on psychedelic-assisted psychotherapy research and therapist training. *Journal of Psychedelic Studies* 2018;**2**(2):64–73.
27. First proposed by Frank Jackson in 1982, paraphrased versions of the Monochrome Mary thought experiment have been repeatedly presented and much discussed. Jackson F. Epiphenomenal Qualia. *The Philosophical Quarterly* 1982;**32**(127):127–36.
28. See Note 9, Wolfson 2022, at 3.
29. In psychedelic discourse, *setting* is used to referred to the social and cultural context in which psychedelic drugs are being taken, whereas *set* is used to refer to an individual's mindset. Obviously, the context in which such drugs have been used has been highly varied, and ranges from practices embedded in traditional cultural contexts to the mind or consciousness expanding (or recreational) counterculture of the 1960s and beyond. Variations in set are discussed further in the main text. See note 1, Hartogson 2020, at 8.
30. See note 9, Brennan et al. 2021.
31. Hayes C, Wahba M, Watson S. Will psilocybin lose its magic in the clinical setting? *Therapeutic Advances in Psychopharmacology* 2022;**12**:9.
32. The psychedelic experience tends toward the metaphysical and commonly includes realizations of a spiritual or mystical kind. Experiences related to one's sense of self, particularly the unreality of the self or the "oneness" of the self with others and the universe, are also common. Concerned that psychedelic therapy might work by inducing "comforting delusions" (meaning spiritual or mystical beliefs incompatible with the scientific world view of philosophical naturalism), Letheby (see note 8, Letheby 2021) argues that the efficacy of psychedelic drugs should be seen as related to the kinds of experiences that might be characterized as forms of ego dissolution. However, given the prominence

of spiritual or mystical phenomena within the psychedelic experiences, the need to incorporate an appreciation for nondualism into the training of psychedelic therapists seems inarguable. McCarroll V. Mysticizing medicine: Incorporating nondualism into the training of psychedelic guides. *Interdisciplinary Science Reviews* 2022:16. doi:10.1080/03080188.2022.2075199.

33. See note 2, Langlitz 2013.
34. See note 9, Brennan et al. 2021.
35. See note 31, Hayes et al. 2022.
36. Griffiths R, Richards W, Johnson M, McCann U, Jesse R. Mystical-type experiences occasioned by psilocybin mediate the attribution of personal meaning and spiritual significance 14 months later. *Journal of Psychopharmacology* 2008;**22**(6):621–32.
37. Griffiths RR, Johnson MW, Richards WA, Richards BD, McCann U, Jesse R. Psilocybin occasioned mystical-type experiences: Immediate and persisting dose-related effects. *Psychopharmacology* 2011;**218**(4):649–65.
38. James E, Robertshaw TL, Hoskins M, Sessa B. Psilocybin occasioned mystical-type experiences. *Human Psychopharmacology: Clinical and Experimental* 2020;**35**(5):e2742.
39. The experience of falling in love or getting married, or when witnessing a birth or a death, would seem obvious candidates.
40. Initially developed by pioneering psychedelic researchers Stanislav Grof, Holmes SW, Morris R, Clance PR, Putney RT. Holotropic breathwork: An experiential approach to psychotherapy. *Psychotherapy: Theory, Research, Practice, Training* 1996;33:114–20. Holotropic breathwork was conceived of as a therapeutic tool comparable to psychedelics. Indeed, Phelps and Henry present it as an alternative for trainees who are unable to undergo a drug-induced psychedelic experience (see note 19, Phelps, Henry 2022). Furthermore, not only do those training to use holotropic breathwork with patients in therapeutic setting engage in the practice as part of their training, some programs seeking to train psychedelic therapists provide holotropic breathwork so that trainees can experience an altered state of consciousness for themselves. There is, however, an interesting distinction here. Like meditation more generally, holotropic breathwork is a practice one engages in, whereas a drug-induced psychedelic experience is something one undergoes.
41. There have been various iterations of the Dreamachine all of which involve exposure to stroboscopic lights at specific frequencies that are viewed through closed eyes. This stimulates the optic nerve, resulting in a hypnogogic state and induces colorful visual experiences (https://dreamachine.world/). Wong C. Eyes wide shut (Dreamachine preview: A drug-free hallucinogenic trip), *New Scientist* 2022;**253**(3379):35.
42. Hartogsohn I. Cyberdelics in context: On the prospects and challenges of mind-manifesting technologies. *Frontiers in Psychology* 2023;**13**:1073235.
43. One might object that the example of mandatory vaccination is something required of practicing healthcare professionals rather than trainees. However, the first-time individuals will encounter that these requirements will be in the context of their training to enter the relevant profession.
44. The notion of a negative psychedelic experience is not a simple one, particularly in a therapeutic context. First, it is unlikely that any psychedelic experience will be entirely negative. Second, negative experiences may lead to significant therapeutic breakthroughs, something that questions the idea that they are correctly described as negative. After all, surgeons commonly harm patients in the operating room, but do so in order to secure their health overall.
45. Earleywine M, Low F, Altman BR, De Leo J. How important is a guide who has taken psilocybin in psilocybin-assisted therapy for depression? *Journal of Psychoactive Drugs* 2022:1–11.
46. Similar concerns have recently been addressed with regard to psychedelic researchers. However, in this context, it seems clearer that the use of psychedelics is likely to be perceived as a source of epistemic bias rather than insight. Kious B, Schwartz Z, Lewis B. Should we be leery of being Leary? Concerns about psychedelic use by psychedelic researchers. *Journal of Psychopharmacology* (*Oxford, England*) 2022;**37**:45–8; Forstmann M, Sagioglou C. How psychedelic researchers' self-admitted substance use and their association with psychedelic culture affect people's perceptions

of their scientific integrity and the quality of their research. *Public Understanding of Science* 2021;**30**(3):302–18.

47. See note 26, Nielson, Guss 2018.
48. See note 9, Brennan et al. 2021.
49. The idea that nonsubjective psychedelics—or, perhaps better, *psychoplastogens*—could have the same therapeutic effects as classical psychedelics seems deeply questionable at best. Although there is no doubt psychoplastogens will have neurophysiological consequences and that these will likely be therapeutic in some sense, the subjective effects of psychedelics are not therapeutically incidental.
50. Yaden DB, Earp BD, Griffiths RR. Ethical issues regarding nonsubjective psychedelics as standard of care. *Cambridge Quarterly of Healthcare Ethics* 2022;**31**(4):464–71.

Cite this article: Emmerich N and Humphries B (2023). Is the Requirement for First-Person Experience of Psychedelic Drugs a Justified Component of a Psychedelic Therapist's Training? *Cambridge Quarterly of Healthcare Ethics*: 1–10, doi:10.1017/S0963180123000099