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Relational psychotherapy and psychedelic treatment

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Talking about changing one's relationships is a common feature of therapy sessions. A direct change in one's experience of relationships is a common feature of psychedelic sessions. How can therapy harness this directness? Focus on the relationship at hand—between therapist and patient.

Positive outcomes of both psychedelic experiences and therapeutic treatment frequently depend on changes in one's experience of relationships. In a study on patients' perceptions of the value of psilocybin for those diagnosed with treatment-resistant depression, Watts, et al. found enhanced connectedness to be a primary mechanism of improved well-being: After treatment, many patients reported being able to re-connect with family members, friends, strangers, and even people who had wronged them, identifying "a change from disconnection (from self, others, and world) to connection" as one of the most valuable aspects of treatment.1 At the same time, the quality of connection between therapist and patient (known as the "therapeutic alliance") is thought to be one of the most influential aspects of psychotherapy.2 Despite these links between positive intersubjective experience and well-being, most contemporary therapy methods, and therefore most psychedelic therapy techniques, focus on individual subjective experience, and avoid drawing attention to the "relationship in the room." In this post, we argue for relational psychotherapy, with its focus on the connection between therapist and patient, as a promising adjunct to psychedelic treatment.

An overview of psychedelic therapy

In the 1950s, after a series of studies on LSD and chronic alcohol abuse, British clinicians Humphry Osmond and Ronald Sandison introduced psychedelics to psychiatry, laying the groundwork for what would later become the first two forms of psychedelic therapy. Noting that some of his patients only seemed to be able to stop drinking after intense, hallucinatory episodes of an alcohol-related condition called delirium

tremens, Osmond inferred that a single high dose of LSD might motivate patients to stop drinking as well.3 By the end of the 1960s, Osmond and colleagues had treated over 2,000 patients with LSD, reporting that 40-45% of patients ceased drinking without a relapse over the following year.4 Meanwhile, Sandison had been conducting his own studies using LSD to treat patients with psychosis at Powick Hospital in the UK, leading to the establishment of a purpose-built LSD unit on site.5

Although the political climate and legal restrictions of the late 60s brought Osmond and Sandison's efforts to a halt, their respective forms of "LSD therapy" laid the foundation for the psychedelic therapies we see today. Osmond's method, called psychedelic treatment, involved a single high dose meant to elicit a mystical/peak experience, with little psychotherapy offered; Sandison's method, called psycholytic therapy, involved lower doses and was paired with psychoanalysis, reflecting the Freudian flavor of the time (though Sandison often followed Jung in his own work). Osmond's patients spent most of the session on a couch with eyeshades; Sandison's patients were additionally given colored chalk and encouraged to capture images arising from their unconscious on a blackboard. By the late 90s and early 2000s, when psychedelic research began to re-emerge, a wide range of psychotherapeutic frameworks beyond psychoanalysis had evolved as potential pairings for psychedelics, many of which are now positioned to build upon Osmond and Sandison's methods.

Third-wave cognitive-behavioral therapies including Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), and Mindfulness Based and Cognitive Therapy have now been proposed as frameworks for further study alongside psychedelics.6 The Internal Family Systems (IFS) approach has also been proposed and is currently used in therapist training programs at organizations such as MAPS.7 Other promising models rising out of the third wave include blends of Cognitive Behavioral Therapy (CBT), transpersonal, somatic, mindfulness, and ACT therapies. The ACE (Accept, Connect, Embody) model, a blend of CBT and ACT, was developed by clinical psychologist Dr. Rosalind Watts and adopted by Netherlands-based psychedelic retreat center Synthesis, as well as featured in research articles by Watts and her colleagues.8 The Psychedelic Harm Reduction and Integration (PHRI) model, a transtheoretical approach to psychedelic therapy proposed by Gorman et al., emphasizes patient autonomy and a compassionate rather than stigmatizing view of clients' choices.9 Currently, the approach most frequently used in psychedelic integrative therapy settings is some combination of these techniques, typically more complex than a single traditional approach, and pursues the following goals: helping clients explore what experiences they might avoid, fostering greater experiential acceptance, cultivating meaning, identifying personal and community values, navigating peak experiences, and reflecting on the importance of set and setting.10

What may make these third-wave techniques particularly well-suited to psychedelics, in contrast with earlier cognitive behavioral therapies and psychoanalysis, is their emphasis on acceptance, mindfulness, and detaching from the narrative-weaving nature of mental process rather than "fixing" aberrant thinking or scrutinizing the unconscious.11 Psychedelics themselves seem to encourage such an attitude in the experiencer. What these therapies don't fully harness—and what psychedelics, on the other hand, tend to magnify—is the fundamentally relational nature of human experience. If psychedelic insights frequently arise from a direct change in one's experience of relationships (whether it be with self, other, environment, or deity),12 then why shouldn't this directness be extended to and explored *through* the therapeutic relationship itself? One therapy that mirrors psychedelics in this way, by placing intersubjectivity at the center of the treatment process, is relational psychotherapy.

From individual to relational

Despite their wide variation in focus, third wave cognitive-behavioral approaches are united by a common standpoint — a commitment to what can be called a "one-person psychology." This term describes the

presumption of an individualistic model of mind and development, which results in psychotherapeutic change being understood as an essentially internal, subjective process. From the standpoint of one-person psychologies, the key 'others' of our world —parents and psychotherapists, in this context — are understood to be outside of the transformational processes involved, there to facilitate (or hinder) change that is independent of them. This core model owes much to Piaget and Freud, both of whom maintained that we have primarily asocial, psychologically introverted origins (i.e., a "primary narcissism") and only secondarily — and developmentally much later — "reach out" relationally to others and the world. It is, in other words, an inherently individualistic model.13

While this model perseveres in the majority of the psychological and psychotherapeutic literature, implicitly if not explicitly, it is increasingly being abandoned in favor of a different model — what we can call the *relational model*. Because one-person psychologies are rooted in philosophical and developmental ideas that have largely been refuted, we are seeing this change not just in developmental psychology and psychoanalysis, but in a wide range of disciplines including philosophy, cognitive science, and anthropology. In the simplest terms, the relational model is the inverse of the individualistic model. Instead of starting out as essentially psychologically introverted beings, only later coming to have reciprocal meaningful interpersonal experience with others and the world, the relational model maintains that we are from the very outset attuned to and reciprocally related to others. A 'primary intersubjectivity' replaces a 'primary narcissism,' in other words — not just chronologically, but existentially and psychologically — which, following the inversion, means the focus changes from what is going on in individuals to what is going on *between* people.14

In the context of development, the relational model has been borne out by a considerable amount of empirical evidence.15-19 In the context of psychotherapy, we can see it in the oft-cited, key finding that the 'therapeutic alliance' is the best predictor of therapeutic outcome.2 The relational model also resonates with certain core critiques and assumptions of the phenomenological tradition. We see, for example, a clear connection with Heidegger's foundational replacement of subject-object dualism with the separateness collapsing "being-in-the-world" and "being-with-(others)." Indeed, the phenomenological tradition is uncoincidentally enjoying a renaissance in the disciplines mentioned above, and it is often drawn on by relational theorists to flesh out the picture of the interwovenness of self and other.20-22

In terms of psychotherapy, the most important thing that follows from this is a movement from a 'one-person psychology' to a 'two-person psychology.' There is a shift from the individual subject to the *intersubjective dyad*—which is to say, from what is going on in the client's mental world to the relational interactions and intersubjective experiences with the therapist. The focus shifts from trying to change or fix aberrant or dysfunctional thinking, behavior, or emotions from *outside* the process to repairing relational wounds, absences, or trauma from *inside* of the relationship.

While relational psychotherapists do not, by any means, dispense with thoughts and feelings about events outside the therapeutic relationship, they have a particular interest in drawing attention to what is going on in the moment. They may say things like, "Something very similar to what you describe seems to be happening between us now too. How about we look at that?" or, "It feels like every time I do this, you respond in [such and such] a way…" in order to invite the client to enter into forms of intersubjective dialogue. Relational therapy likewise encourages the therapist to judiciously reveal his or her own thoughts or feelings about the relationship for similar reasons. As a result, the aim shifts from trying to figure out new ways of thinking or behaving to developing new, more secure and rewarding ways of relating.

Psychedelics and relational therapy

What may make relational psychotherapy uniquely suited to psychedelics, then, is its emphasis on connection as therapy. Per the relational model, connection is the ground and impetus of psychic health and development, and the aim of relational therapy is essentially to foster connection unhindered by habitual dynamics. While clients still engage with their 'internal' selves, with a witness present, the main focus becomes the active relationship with that witness.

Positive intersubjective experience not only prompts reorganization at the cognitive level, as evidenced by findings in interpersonal neurobiology,23 but it can also enhance the perceived benefits of psychedelics. In their paper on *psychedelic communitas*, Kettner et al. found intersubjective experience during psychedelic group sessions to predict enduring changes in psychological well-being and social connectedness. Namely, "a positive relationship between participants and facilitators" was especially important in mediating the aspects of perceived togetherness and shared humanity which contributed to these positive changes.24

Recent studies on the neurobiology of psychedelics point toward relational therapy's potential usefulness during integration as well: according to findings from Prof. Gül Dölen's lab at Johns Hopkins University, psychedelics may reopen a social critical period in mice, changing their social learning long beyond the acute dosing. 25 This leads her to speculate that the brain's "therapeutic window" may be open for weeks, if not months, after a high-dose psychedelic session.26 Rather than simply interpreting this window as a longer period for processing subjective experience, it might also be interpreted as a longer period for testing the waters of relationship exploration and/ or repair, here and now, with and through the therapist. Indeed, from a relational perspective, "quick fixes" are hard to come by, and more sustained and consistent psychotherapy in which relational work emerges may be necessary. What's more, Dölen's findings emphasize that this therapeutic window specifically relates to social reward learning, and that this learning can only be modified in a social setting.26 With these points in mind, the quality of the therapeutic alliance, which includes its potential for facilitating cognitive change, may have a significant impact on patient outcomes following psychedelic treatment.

For these reasons, it seems a missed opportunity for psychedelic integration to focus only on experiences outside of the therapeutic relationship. While relational insights from the psychedelic experience would likely only be discussed in most third wave CBT settings, the relational psychotherapist has an opportunity to create space not only for talking about integration but for putting that integration into practice in real time. As the saying goes, "Psychedelics punish avoidance." In that sense, a relational model of psychedelic therapy punishes avoidance too, placing human connection at the front and center of the integrative process.

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