Lessons from the psychedelic community in supporting people through acute psychosis: A grounded theory study

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Professional Doctorate in Clinical Psychology, 2019

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Abstract

Good relationships form a vital part of a person's recovery from psychosis, yet within psychiatric setting there is a lack of quality relational care. A review of the literature indicates that there is limited evidence with which to understand the process of supporting a person in psychotic crises, as well as the knowledges and skills required by a caregiver. To learn more about how support is offered in non-medicalised contexts I investigated how caregivers support people having psychedelic crisis experiences, which can share similarities to supporting a person with psychosis.

Semi-structured interviews were conducted with eight people experienced in supporting people during a psychedelic crisis across a range of contexts including harm-reduction, therapy, recreation, clinical trial, and group retreat. Consistent with my epistemology, constructivist grounded theory methods were used to develop a framework with three core categories; 'nature of the crisis', 'prepared to handle what comes our way', and 'holding people through the experience'. Following analysis of the interviews, the framework was supplemented with secondary data from two psychedelic harm-reduction manuals.

This study described the role of experiential avoidance in the development of a crisis and the approaches and strategies used by caregivers to enable a person to change their relationship to their experiences through acceptance. It highlighted the knowledge, attributes, and support needed by caregivers to provide this support. These findings are discussed in relation to the literature on psychedelic, and on psychosis. Implications and recommendations for research and practice are outlined.

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1. INTRODUCTION

1.1. Overview

I will begin by outlining psychiatric care provision for people with psychosis and some of the issues reported in its provision, particularly within the relational aspects of care. I will outline the importance of relational caring in psychosis and review the literature of the key knowledges and skills required by caregivers. Following this, I will describe attempts that have been made to establish residential care facilities which emphasise these aspects of caring.

I will explore the similarities between experiences in psychosis and from psychedelics, as well as important points of departure. Through this, I will demonstrate how supporting an individual through a psychedelic crisis shares similarities to supporting someone in an acute psychotic state. I will arrive at a research question which explores how people care for a person experiencing a psychedelic crisis in order to consider what useful learning there might be when caring for people with acute psychosis.

1.1.1. Terminology

There is debate about how to describe distressing experiences of perceiving and sensing things others do not, feeling paranoid, holding beliefs and living in realities which others do not share. The prevailing biomedical framework conceptualises such experiences as symptoms of a mental illness which may receive diagnostic labels such as ‘psychosis’ or ‘schizophrenia’ (WHO, 2018). A large accumulation of evidence has failed to support the validity and reliability of these constructs (Read, 2018). Many people understand these experiences differently, such as responses to trauma, social oppression, or as a spiritual process. I will use the language of ‘experiences’, rather than ‘symptoms’ to reflect this. I will use the term ‘psychosis’ as the commonly used word to describe this collection of distressing experiences, with the acknowledgement that many would not use this label for these experiences.

Within the mental health system, a person with psychosis becomes a patient to be treated. When referring to situations operating within this context, I will use the term ‘staff’ to refer to those in the position of giving intervention and the term ‘patient’ to denote those who are in the position of receiving these interventions. More typically, I will use ‘person with psychosis’ or ‘person in psychotic crisis’, and ‘staff’ or ‘caregiver’ for those who are in positions of providing support.

1.2. Psychiatric Treatment of ‘Acute Psychosis’

When a person with psychosis reaches a crisis point of distress, this is deemed to be a psychiatric emergency of ‘acute psychosis’ (Byrne, 2007). This can include “significant impairments in reality testing and alterations in behaviour manifest in positive symptoms such as persistent delusions, persistent hallucinations, disorganised thinking (typically manifest and disorganised speech), grossly disorganised behaviour, and experiences of passivity or control, negative symptoms such as blunted affect and avolition, and psychomotor disturbances” (WHO, 2018).

Not everyone who experiences a psychotic crisis enter the mental health system, but for those that do there are different avenues which may be more or less planned or consensual, depending upon individual circumstances. People experiencing psychosis for the first time are often directed to an early intervention in psychosis team. These teams were established to reduce hospital admissions and improve outcomes for this population. They offer community-based psychological, social, medical, and vocational support. People who have had more than one psychotic crisis would receive support from a home treatment team in community-based secondary care services.

People who have needs that cannot be met in the community are admitted to hospital, either by consensual agreement or through involuntary committal under the Mental Health Act (1983). In 2014-15, 65% of adult acute occupied bed days were used by people experiencing psychosis (NHS Benchmarking Network Review, 2015). There is variation across England in the numbers of people with psychosis admitted to hospital in an emergency; the average was 35.8 per 100,000 in 2013-14 (Public Health England, 2016).

The National Institute for Health and Care Excellence (NICE, 2014) states that first line treatment is oral antipsychotic medication. Medication should be offered in conjunction with individual cognitive behavioural therapy (which aims to reduce the impact of symptoms) and family intervention (which aims to reduce the risk of relapse) either in inpatient or community settings. A national audit indicated that the numbers of people receiving these interventions were low; 39% were offered cognitive behaviour therapy and 18% took up this offer, 12% took up offers of family interventions (Royal College of Psychiatrists, 2014). In addition to antipsychotics, benzodiazepines and rapid tranquilisations may be used to manage behaviour that challenges staff. When deemed appropriate, the person is discharged to their local community mental health team for ongoing treatment.

1.3. Issues with Psychiatric Treatment

1.3.1. Outcomes

There are a range of outcomes following psychiatric treatment. A systematic review of over 4000 people with first-episode psychosis reported that around 40% were thought to have had a ‘good’ outcome and around 30% to have had a ‘poor’ outcome (though there were inconsistencies in how these outcomes were defined across studies) (Menezes, Arenovich, & Zipursky, 2006). It is known that outcomes are more likely to be unfavourable the longer the duration of untreated psychosis (Marshall et al., 2005; Perkins, Gu, Boteva, & Lieberman, 2005); it was this understanding that led to the development of early intervention teams across the United Kingdom. Outcomes are poorer for people who do not respond well to initial treatment; 16% have a good recovery fifteen years later (Harrison et al., 2001).

1.3.2. The Caring Relationship

A number of reports have outlined serious problems with the mental health care system (Care Quality Commission, 2017; Gilburt, 2015). In addition to complaints about the organisational nature of inpatient care, people who have used these services have voiced their concerns about the caring relationship between staff and patients. In their independent inquiry, the charity Mind stated they “were very concerned at the lack of basic humanity and respect that many people described” (Mind, 2011, p. 24). These concerns were echoed in a more recent report that brought together the comments of 2,619 people who had used crisis care in the UK. Two of the main issues brought to their attention were: “People feel like professionals aren’t listening to them”, and “A lack of communication, empathy and respect” (Healthwatch, 2018, pp. 16–17).

Reviews of qualitative studies have also highlighted that patients felt that staff did not understand or empathise with them (Stewart et al., 2015), and that they could experience staff as pessimistic, uncaring, paternalistic and disrespectful (Ljungberg, Denhov, & Topor, 2016). These types of complaints are not new. Concerns about staff not having enough time for patients and being unable to communicate well with them have been present in the literature for some decades now (Ley, 1988; Ricketts, 1996).

Staff working on the wards are very aware of these issues and often complain at the loss of time to spend interacting with patients. Studies have reported low-levels of time spent in nurse-patient interaction, with estimates ranging from 4%-21% of nurse’s time used for this purpose (Altschul, 1972; Hurst, Wistow, & Higgins, 2004; T. Martin, 1992; Sandford, Elzinga, & Iversen, 1990; Whittington & McLaughlin, 2000).

One mother of a patient described her interactions with staff as like ‘relating to a professional façade’. She thought that staff hid their feelings and were unresponsive to the feelings of others. During her time on the ward she felt un-listened to and un-related to, which brought up feelings of frustration and dissatisfaction. She commented on how these experiences led her to lose her faith in mental health services (Clarke, 2006).

Of course, not all patients report poor caring relationships. However, there are enough expressions of dissatisfaction from people using and working in mental health services to warrant investigation as to how care can be improved. The above expressions of dissatisfaction all point towards a deficit in what has been called ‘relational care’. I will now give a more detailed description of what is meant by relational care, and then review the literature on relational caring for people in acute psychotic states.

1.4. Review of the Literature

1.4.1. Aim

The aim of this search was to review the literature on the knowledge and skills required for relationship-centred care for adults in acute psychotic states, specifically in the context of psychiatric inpatient settings.

1.4.2. Design

1.4.2.1. Inclusion criteria

- English language research papers published in peer-reviewed journals
- Studies that focused on relational aspects of care between staff and patients with psychosis in adult acute mental health units
- Primary research employing qualitative methodology

1.4.2.2. Exclusion criteria

- Studies focused on children, adolescents, elderly, or forensic populations
- Studies with mixed or quantitative methodology
- Studies not concerning the aim of this review
- Studies that did not explicitly identify patients as having a diagnosis of a psychotic disorder

1.4.3. Search Methods

Electronic searching was conducted through PsycINFO, CINHAL, Ovid, PubMed. The search phrases (staff, nurs*, psychologist*, psychiatrist*, worker) were combined with (relation*, interaction*, interpersonal), (psychosis, psychotic, schizophreni*), (inpatient, acute, hospital, ward, unit), and (qualitative, ethnographic, phenomenological, interview). Limitations were set for English language and source of publication. Reference lists and citations of relevant papers were further searched using Scopus.

Data were analysed using thematic analysis techniques to develop higher-order themes following established criteria for synthesising qualitative studies

(Thomas & Harden, 2008). This involved coding the study findings and developing descriptive themes, which were compared and developed to generate analytical themes.

1.4.4. Search Outcome

The search strategy identified 595 studies, of which eleven were eligible for inclusion. Studies were excluded which did not meet criteria. A further six studies were identified from the reference lists and citations of those papers (figure 1). In total, seventeen studies were included for review (table 1).

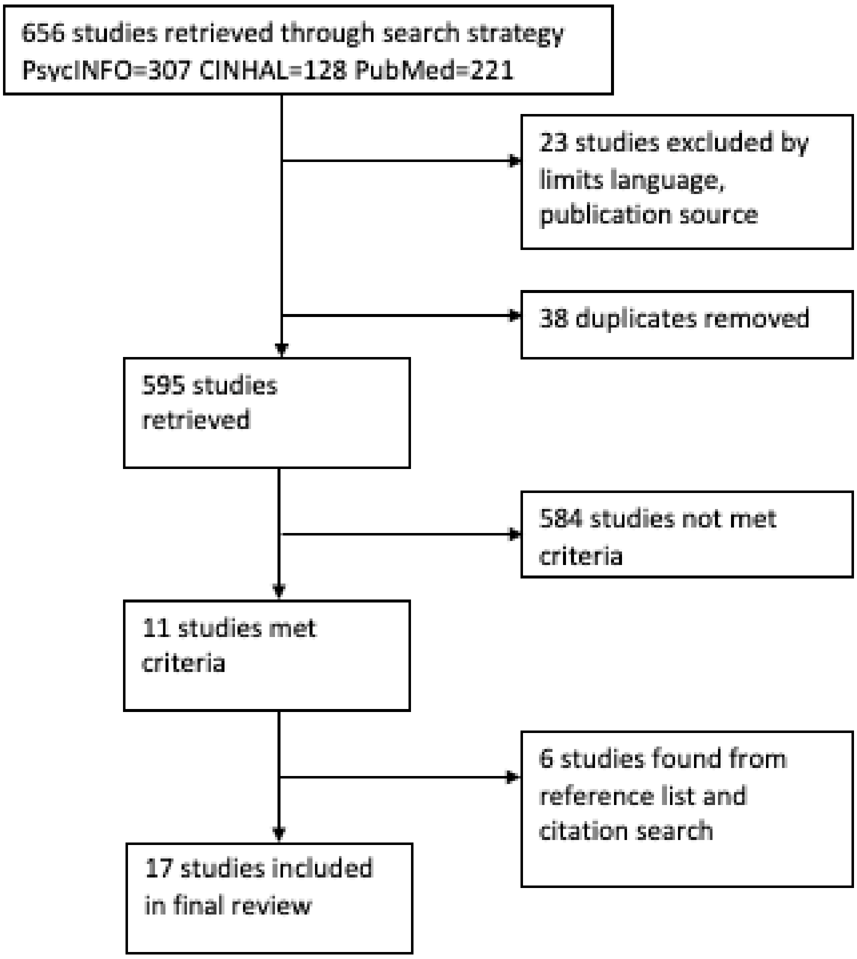

Figure 1. Flowchart of literature review search strategy

Table 1.

Studies identified through literature review

Author(s), year, country	Aim	Design, data collection	Sample	Principal relevant results
Bowers, Brennan, Winship, & Theodoridou, 2010 UK	Discover if there were untaught, traditional or self-developed skills among nurses highly-skilled with psychotic patients	Exploratory, interviews	Twenty-eight nurses	Skills areas: being with the patient, non-verbal communication, emotional regulation, talking about symptoms
Engqvist, Nilsson, Nilsson, & Sjöström, 2007 Sweden	Explore strategies used by nurses in caring for women with postpartum psychosis	Exploratory, interviews	Ten nurses	Presence, continuity, and partnership were used to create relationship. Meeting needs and creating a feeling of security was the foundation of interventions.
Engqvist, Ferszt, & Nilsson, 2010 Sweden	Explore nurse's descriptions of presence and caring for women with postpartum psychosis	Exploratory, interviews	Ten nurses	Nurses described using presence to protect, to facilitate recovery, and for learning

Forchuk et al., 2000 Canada	Describe the nature of the developing nurse-patient relationship and helping and unhelping influences	Descriptive, interview	Ten patients-nurse dyads	Consistency, pacing, listening, attention to comfort and control helped the relationship develop. Inconsistency, unavailability, the patient’s trust, and nurses’ feelings toward the patients could hinder the relationship
Hem & Heggen, 2004 Norway	Examine the role rejection plays in the relationship between patient with psychosis and psychiatric nurse	Ethnographic, observations and interviews	Patients and six nurses	Patients experienced a rejection from nurses. This rejection came from external factors like staffing and internal factors like professional ideals
Hem, Heggen, & Ruyter, 2008 Norway	Explore trust in acute psychiatric wards	Ethnographic, observations and interviews	Five patients and six nurses	Trust and distrust are fragile phenomena that can easily become the other. Nurses must work hard to achieve trust.
Johansson & Eklund, 2003 Sweden	Investigate patients’ opinions on what constitutes good quality care	Phenomenological, interviews	Eight Patients	Most important factor was the quality of the helping relationship and being understood by staff.

Koivisto, Janhonen, & Vaisanen, 2004 Finland	Describe patients' experiences of being helped during hospital care	Descriptive phenomenological, interviews	Nine patients	Being helped involved protection from vulnerability and restructuring/empowering of the self to cope in daily life
Lorem & Hem, 2012 Norway	Examine how experiences with mental illness are perceived by staff	Narrative, interviews	Eleven Nurses, psychiatrists, psychologists	Understanding is an other-oriented process involving sensitivity, human and emotional contact
Moonen, Lemiengre, & Gastmans, 2016 Belgium	Describe how psychiatric nurses deal with patients who have unbearable existential suffering	Inductive, interview	Fifteen nurses	The personal caring relationship was fundamental. Nurses needed to know the patient and acknowledge their suffering to build a relationship based on trust and respect.
Pitkänen, Hätönen, Kuosmanen, & Välimäki, 2008 Finland	Explore patients' perception of nursing interventions in supporting quality of life in acute settings	Explorative descriptive, interviews	Thirty-five patients	Helpful interventions were empowering, social, activating, supported security, and physical health

Salzmann-Erikson & Eriksson, 2005 Sweden	Investigate the meaning of physical contact for patients treated for psychosis	Life-world analysis, interviews	Four patients	Touching means to be in need, to yearn, and to belong. It communicates feelings between bodies and can be a path to feeling acknowledged and belonging
Schroder, Ahlstrom, & Larsson, 2006, Sweden	Describe how patients perceived the concept of quality psychiatric care	Phenomenographic, interviews	Patients (7/20 with psychotic diagnosis)	Good care involves respect of dignity, sense of security, patient participation in care, their recovery, their environment, reducing shame, being looked on like anyone else
Sebergsen, Norberg, & Talseth, 2016 Norway	Explore, describe, and understand how nurses provide help that help to patients with psychosis in acute wards	Explorative and descriptive, interviews	Twelve patients	Nurses openness and sensitivity to changing needs creates moments of confirmation in caring acts
Skorpen, Rehnsfeldt, & Thorsen, 2015, Norway	Explore the experience of patients and relatives regarding respect for dignity following admission	Phenomenological hermeneutic, interviews	Six patients and five relatives	The significance of ‘small things’ was highlighted – being conscious of small things, being conscious of what one says, being met, and being aware of personal chemistry

Small, Pistrang, Huddy, & Williams, 2018 UK	Explore patients' and psychologists' experience of undertaking individual therapy in acute inpatient units	Exploratory, interviews	Patients (2/8 with psychosis) and six psychologists	Forming a human relationship was the basis for therapeutic work. Relationships with psychologists offered hope and understanding
Tidefors & Olin, 2011 Sweden	Investigate how patients describe their wishes and needs in psychiatric care	Inductive, focus groups	Fifteen patients	Relationships seen as key. A need to be seen as an ordinary human and not just a patient. Needed staff to give time, understanding, and hope.

1.4.5. Overview

The majority of the research (15/17 studies) focused on the nurse-patient relationship, though there was also research focused on patient dyads with psychologists and psychiatrists. Most (11/17) were informed solely by, or incorporated, the views of people who had used the services, typically in Scandinavian countries (13/17).

The thematic elements I collated are overlapping, and a clinician is likely to draw from an array of knowledge and skills in any given interaction.

1.4.5.1. Safety, security, and trust: Safety and security can be seen as the building blocks of a caring relationship, evolving into trust if the relationship develops positively (Schroder et al., 2006). A sense of safety was fostered by taking care of the individual's basic needs (such as food and hygiene), minimizing environmental stimulation, and helping them regulate their responses to external stimulation (Engqvist et al., 2007; Tidefors & Olin, 2011b). One patient spoke about how the structural routine that staff organised also fostered a sense of security, "Here there are all those time schedules, times to eat and for silence and waking up. There is a daily routine which in its own way becomes part of you. It creates safety." (Pitkänen et al., 2008, p. 1602).

Staff and patients spoke of different ways in which staff used their selves to calm a distressed patient (Sebergsen et al., 2016). One nurse talked about adopting a maternal-like caring style to soothe, "Sometimes, when a woman has a desperate urge to hurt herself, the [registered psychiatric nurses] sit beside her and soothe her, sometimes even rocking her like a baby." (Engqvist et al., 2010, p.316). Others spoke of how the physical presence of staff could be used to provide security and stability:

> Nurse: what we did there was to be continuously present - just there…//…and I have to be sure where I stand myself, so I have the strength to remain, where I am. And the more experienced I become, the more stability I can give. (Engqvist et al., 2007, p.1337)

Staff also spoke about using their own calmness to be able to soothe others. Highly-skilled nurses recognised that their emotional state influenced their patients' (Bowers et al., 2010). In a review of nurse-patient interactions, authors noted that "it is likely that technical skills will not be interpersonally effective if the nurse does not harbor an inner stillness that patients often perceive" (Cleary, Hunt, Horsfall, & Deacon, 2012, p. 76). One patient described their experience of being soothed:

> When I was psychotic, (…) I sometimes needed limitation. Nurse C, whom I have met several times, limited me in a very good and helpful manner. He used his body to stop me, and he murmured quietly, such as " hum-hum" , and did not argue with me… It made me feel safe. (Sebergsen et al., 2016, p. 7)

People who had received inpatient psychotherapy described how trust was built between them and their psychologist through being given information and a collaborative position in goal-setting. They contrasted this to a sense of coercion they sometimes experienced with other professionals (Small et al., 2018). In an ethnographic study of a Norwegian psychiatric ward, the authors described how:

> "Both trust and distrust are exposed as 'fragile' phenomena that can easily 'tip over' towards their opposites. Trust is not something that nurses possess or are given; it is rather something that they earn and have to work hard to achieve. Regarding themselves as potential causes of distrust and active wielders of power can contribute to nurses developing a more realistic view of their practice." (Hem, Heggen, & Ruyter, 2008, p.777)

1.4.5.2. Whole persons in relation: A recurring theme was the importance of recognising the humanity of the person with psychosis. People with psychosis wished to not be positioned solely as a patient or by 'symptoms' of psychosis (Engqvist et al., 2007; Moonen et al., 2016; Skorpen et al., 2015; Small et al., 2018). When staff members were able to see the individual behind the diagnostic label, this "reduced feelings of stigmatization and perhaps turned mistrust into trust" (Tidefors & Olin, 2011,p.4). This helped the person with psychosis feel valued and respected:

> Nurse: when they get a chance to be a person again, yeah, they can feel that…In fact, our people, our patients, they are very sensitive men and women, in fact I think that's why they develop a disorder, because they are so sensitive. If you can give them that, if they can feel that (…) you're off to a good start, if you ask me (Moonen, Lemiengre, & Gastmans, 2016, p4)

Nurses spoke about how recognising the patient's whole person became possible "from a sense that patient as well as nurse are in the end just human beings" (Moonen et al., 2016, p4).

1.4.5.3. Hope: Patients found it helpful when staff were able to reflect back to them their capacity for hope. This was grounded in understanding where they were in their process of recovery. In some periods, it was necessary for staff to offer their patients "vicarious hope" (Tidefors & Olin, 2011a, p7). Yet during others "the individual could find ways to believe that it was possible to handle what the future would bring; in the context of an ongoing trusting relationship, hope about the future could then emerge" (p6).

In interviews with nurses who cared for women diagnosed with post-partum psychosis, one spoke of how she used her knowledge of the typical course of the crisis to engender hope in the patient and their loved ones:

> my thoughts as a nurse is of course that I know this illness will end, this I have with me the whole time, and then I will try to infuse hope in her, both to the woman, her husband and her relatives. (Engqvist et al., 2007, p1338)

1.4.5.4. Communicating and understanding: Many studies emphasized the importance patients placed on feeling that staff listened to and understood them (Bowers et al., 2010; Forchuk et al., 2000; Hem et al., 2008; Johansson & Eklund, 2003; Koivisto et al., 2004; Skorpen et al., 2015; Tidefors & Olin, 2011a). Patients said that they were often unable to communicate their needs to staff but that they knew their suffering was understood by the staff's actions (Sebergsen et al., 2016).

Norwegian mental health workers highlighted some key attitudes related to understanding their patients well (Lorem & Hem, 2012). The first of these was acknowledging that there was a limited ability to understand the patient and their experience, but that this collapse of understanding could co-exist with the knowledge that their experiences were meaningful. Holding this expectation of meaning acted as a catalyst to open up further dialogue with their patient.

When it was not possible to understand the patient verbally, there remained the possibility for communication on an emotional level. One clinician described how:

> You have to communicate through feelings when words are lacking . . . even though they are blocked from expressing it with words and communicating and discussing, they can still express it through their actions and behaviour, and through feelings. . . Their feelings are there, and it's at the emotional level you have to empathize with the patient, and the emotions are what we communicate with. (Lorem & Hem, 2012, p. 117)

Staff had awareness of how they communicated non-verbally. They could use their attunement to make appropriate adjustments to their body language, tone, and interaction style depending on the patients' needs. Patients described how, in the context of a good relationship, touch could be perceived as "warm, real, and compassionate", whereas if the contact was undesired or the relationship was not securely established it gave rise to feelings of "inferiority, fear, and annihilation" (Salzmann-Erikson & Eriksson, 2005, p. 849). Highly-skilled nurses were thoughtful in their use of touch, recognising times when it was helpful, and when it was not (Bowers et al., 2010).

Staff used a number of strategies to try to improve their understanding of a patient; imagining themselves in the patient's situation, spending time and interacting with them, and trying to connect to the emotion associated with their unusual beliefs:

> Clinician: It’s obvious that a delusion will also be affected by a person’s mood. If you’re afraid, you feel persecuted; if you’re angry, you feel someone has been unfair to you, and there’s almost always some little element of truth behind an emotion which carries that kind of notion with it. (Lorem & Hem, 2012, p. 118)
>
> One nurse says this can involve trying to sympathize with the agony caused for instance by delusions in patients suffering from schizophrenia, even if it is hard for the caregiver to actually ‘feel’ these delusions. (Moonen et al., 2016, p4)

1.4.5.5. Contact with consensus reality and making sense of experiences: Patients spoke about difficulties in understanding their experiences, and that staff were able to help with this by explaining them (Koivisto et al., 2004). One patient found it helpful when staff took a mentoring approach, “it takes time to learn and you need someone teaching you...In the same way as you need a football instructor when learning to play soccer” (Tidefors & Olin, 2011a, p. 6). Staff talked about how they discussed differences between their perception of reality and the patients’:

> Nurse: maybe I say that this is the way you experience it now, but I don’t see it that way…//…I try to neutralize it a bit, not to talk about what is right or wrong, such that the patient is wrong, but to try in another way to explain to her, that this is not the way we see it. (Engqvist, Nilsson, Nilsson, & Sjöström, 2007b, p1338)

Making meaning was a process that both staff and patient undertook. Nurses in one study emphasized that people with psychosis have an active, interpretive relationship with their experiences. As Hanna said: ‘We human beings have an urge within us, which is to make sense of things’ (Lorem & Hem, 2012, p. 118). This process of making meaning became particularly powerful when it was felt to be shared. “If you can make it coherent, together with them, and they think what you say makes sense, the conversation becomes more and more normal, and less and less full of delusions and hallucinations” (Lorem & Hem, 2012, p118).

1.4.6. Summary of Review

The literature about relational care for people in a psychotic crisis is developing; over half of the identified studies were published within the last ten years. However, the evidence base remains limited and is confined predominantly to the Scandinavian nursing literature. This indicates that relational care of adults with acute psychosis in inpatient settings is an under-researched area.

In this section, I have described relational care and demonstrated its importance for people with psychosis. Despite this, a review of the literature has shown there is limited evidence which describes the knowledge and skills needed for clinicians to care for their patients in a relationship-centred manner; *how* to do this. In the chapter to follow, I will explore further this form of care in mental health settings.

2. RELATIONSHIP-CENTRED CARE

2.1. Relationship-centre Care

2.1.1. The Developmental of Relationship-centre Care as a Construct

Harry Stack-Sullivan (1892-1949) is often credited as one of the earliest people to bring an explicitly interpersonally-oriented approach to psychiatry (Perry, 1982). He worked with people experiencing psychosis at the Chestnut Lodge facility in the United States (see page 24). He believed care for people with psychosis took place in “a situation between two persons who meet as persons, attempting social recovery through participant observation rather than medical treatment of an alien body.” (Baklien & Bongaardt, 2014, p. 627).

Later in the twentieth century, ‘patient-centered care’ was introduced as a framework for healthcare provision. This called for understanding the patient as “a unique human being...[whom] makes better sense if understood in terms of the whole.” (Balint, 1969, p. 269). These ideas were built upon through the concept of ‘relationship-centered care’ (Tresolini & Pew-Fetzer Taskforce, 1994) which drew from the humanistic psychology movement of ‘person-centred care’ (Rogers, 1951). It makes relationships the foundation of care; those that link patients, clinicians, teams, organisations, and communities.

2.1.2. Principles of Relational Care

Relational care is composed of four key principles; that healthcare relationships should acknowledge the personhood of participants, that affect and emotion are important parts of these relationship, that they occur in the context of reciprocal influence, and that forming and maintaining these relationships is morally valuable (Beach & Inui, 2006). Similarities can be seen with Carl Roger’s characteristics of a helping relationship, but relationship-centred care extends beyond staff-patient dyads to incorporate teams, organisations, and communities (Rogers, 1958). I will describe further the attitudes towards the staff-patient relationship, from the clinician’s perspective.

2.1.2.1 Personhood: Whilst patient-centered care highlights the importance of recognising the humanity of the patient, relational care also emphasises that clinicians bring their own into the relationship and that this is required in order for authentic relating to take place.

2.1.2.2 Emotion: Moving away from the position of detached and neutral observer, in relational care the clinician is encouraged to empathise with the patient and bring their emotional presence to the interaction. This is believed to facilitate the understanding of patients' needs, to support them in the expression of their emotion, and to improve their experience of care.

2.1.2.3 Reciprocal Influence: There is acknowledgement that whilst the patient's health is a central focus of the relationship, patients also have an impact upon the clinician.

2.1.2.4 Moral Foundation: This approach takes the view that humans are more morally committed to those with whom they have a personal relationship. It is thought that by entering into a genuine relationship with patients, clinicians are more able to develop the investment needed to care for others, and to find this investment rewarding, than by simply performing a professional role.

2.1.3. The Importance of Relational Care for People with Psychosis

The relationship between clinician and patient is known to be important when working with people with psychosis (Gendlin, 1962). One study states "if it was possible to relate to someone, this relationship became a lifeline, even offering a possibility of psychological survival" (Tidefors & Olin, 2011b, p. 7). People who used early-intervention services have emphasized the importance of their relationships with staff in their recovery (Barr, Ormrod, & Dudley, 2015; Watkins, Sanderson, & Richards, 2018). Its importance is also valued by staff; building a solid relationship is recommended as a key component of the psychiatric treatment of people with acute psychosis (Thomas et al., 2009). Many people who experience psychosis have been reported to have insecure attachment patterns and the research suggests that services can find it more difficult to engage with people with greater levels of insecurity (Berry, Wearden, & Barrowclough, 2007; Gumley, Taylor, Schwannauer, & MacBeth, 2014).

A good staff-patient relationship improves the effectiveness of care across a range of contexts. The quality of helping relationship is beneficial to patients in the community in reducing inpatient admission, suicide attempts, self-harm, social functioning, and in returning to employment (Catty et al., 2011; Farrelly et al., 2014; Melau et al., 2015). In group therapy for people with early psychosis, the client’s perception of the relationship was found to predict their levels of psychotic features and self-esteem (Lecomte, Laferrière-Simard, & Leclerc, 2012). This has also been reported in individual psychological therapies. A randomized controlled trial of 308 people with acute psychosis compared the influence of the helping relationship in cognitive-behavioural therapy and supportive counselling. They showed that a better therapist-client relationship increased the number of sessions attended and improved scores on a measure of symptom severity at eighteen months. They also demonstrated that when the relationship between an individual and their therapist was poor, there was a detrimental effect when attending a greater number of sessions (Goldsmith, Lewis, Dunn, & Bentall, 2015). A systematic review reported that a positive relationship also predicts favourable outcomes in psychiatric treatment programmes (Priebe, Richardson, Cooney, Adedeji, & McCabe, 2011).

It is apparent that the staff-patient relationship is important to people with psychosis and that, across a number of different settings, it may act as a mediating factor in an individual’s journey out of psychosis. The characteristics and values of a good helping relationship between clinician and patient have been well-described (Rogers, 1958). In the field of dementia care, there has been detailed work carried out to identify the knowledge and skills a clinician requires to enact such a relationship (Dewar & Nolan, 2013). I was curious to see how developed the research was for the care of people with psychosis and so undertook a review of the literature.

2.2. Case Examples of Alternative Residential Care

2.2.1. Chestnut Lodge

Chestnut Lodge was a psychoanalytically-oriented residential treatment facility in Maryland, United States that operated throughout the twentieth century. It provided around a hundred patients with a variety of treatment options including education, rehabilitation, and family work. Pharmacological treatments were not routinely used as “It was rationalized that most of the patients had been overmedicated...Drugs were viewed as the enemy because they dulled the mind and inhibited feelings that were necessary to access in therapy.” (McGlashan, 2014, p1). The backbone of treatment was individual psychoanalytic psychotherapy four-five times per week. The work broadly fell into the developing interpersonal and relational fields of psychoanalysis; Frieda Fromm-Reichmann, Harold Searles, and Harry Stack Sullivan all worked at Chestnut Lodge (Kafka, 2011).

In the 1980s, Thomas McGlashan undertook a long-term follow-up of people treated at Chestnut Lodge who had been given a ‘schizophrenia’ diagnosis, and compared these outcomes with people who had been given mood or ‘personality disorder’ diagnoses. He reported “two of every three patients treated at Chestnut Lodge were chronically ill or marginally functional at follow-up...the results are clear; by and large treatment as it was constituted failed to alter the momentum of this disease toward lifelong disability” (McGlashan, 1984, p600). However, McGlashan’s methodology has come under criticism, with some arguing that it is only possible to draw conclusions about the courses of these ‘diagnostic conditions’, and not psychotherapy outcomes (Bechgaard, 2003). Additionally, a former Chestnut Lodge therapist emphasised that their patients were a very specific subset of those with psychosis and questioned McGlashan’s interpretation:

> we are dealing with a population of deeply psychotic individuals who had not improved with any other treatment and for whom hospitalization at Chestnut Lodge was the “last resort”, relatively positive outcomes in one-third of this population could be considered remarkable (Kafka, 2010, p37).

2.2.2. Philadelphia Association

In the socio-political context of the Western world in the 1960s, the Philadelphia Association was developed as part of a counter-movement against the psychiatric establishment. It has been providing community households for over fifty years in London and has a psychotherapy training programme. Psychosis was regarded by some as a potential for breakthrough into a more authentic way of being, rather than a ‘breakdown’. Psychosis was thought to be driven by impossible, no-win styles of communication within families known as a ‘double-bind’ (Bateson, Jackson, Haley, & Weakland, 1963). Laing and Cooper, two of the driving forces behind the Philadelphia Association, argued against institutionalisation, forced medication, and diagnostic labelling. They believed that people with psychosis should be provided a non-hierarchical, non-interventional, supportive safe place (Oakley, 2017). They hoped people would be able to work through their difficulties by offering such a space at Kingsley Hall in London. Mary Barnes, a former resident, wrote an account of her stay at Kingsley Hall in which she described aspects of the household which she found to be helpful (Barnes & Berke, 1973).

Houses aim to be as ordinary as possible, with residents paying rent for their own rooms. Residents do the cooking, cleaning, and make decisions in regular household meetings. These meetings are facilitated by house therapists who are also available to residents, when requested. Unlike other therapeutic communities, there is no schedule of activities, treatment plans, or staff (Gordon, n.d.). The houses offer an alternative way of being with people in distress and a focus on the interpersonal aspects of relating to one another. The length of stay varies for each individual, but many stay for between one to four years. Research of outcomes and effectiveness is not a priority for the organisation, though it’s continued survival for many decades in changing socio-political climates points to the usefulness which some people are able to derive.

2.2.3. Soteria

The Soteria project was a study designed to assess the outcomes of people who had recently been given a ‘schizophrenia’ diagnosis and were thought to require hospital treatment. It compared usual psychiatric treatment with twenty-four hour interpersonal phenomenological intervention by non-professional staff (psychology graduates) in a home-like setting in San Francisco’s Bay Area. No neuroleptic medications were used.

There were two cohorts during this project. The initial cohort ran from 1971-1976. At six weeks, despite the vastly different contexts and approaches, they found comparable levels of improvement in between the people staying at Soteria and psychiatric patients (Mosher, Vallone, & Menn, 1995). Two years after admission, the Soteria residents from this cohort had significantly higher occupational levels, rates of independent living, and fewer hospitalisations than the psychiatric patients (Bola & Mosher, 2003). These long-term results were different for a later (1976-1982) cohort, in which no significant differences were found when compared to psychiatric patients. What these studies demonstrated was that interpersonally-focused, non-medical care of people with acute psychosis could be as or more effective as the standard forms of psychiatric care at that time.

Soteria questioned the need for therapy in the traditional sense. Mosher writes

> The core practice of interpersonal phenomenology focuses on the development of a nonintrusive, noncontrolling but actively empathetic relationship with the psychotic person without having *to do* anything explicitly therapeutic or controlling. In shorthand, it can be characterised as “being with,” “standing attentively,” “trying to put your feet into the other person’s shoes,” or “being an LSD trip guide” (Mosher, 1999, p6).

2.2.4. Summary of Case Examples

In each of these three examples, there was an explicit attempt to emphasise the relational aspects of caring for people in psychotic states. We are limited in deepening our understanding from these examples by a number of factors including; the limited research output, and the differences in setting and treatment style, which make it difficult to generalise to mainstream psychiatric services. Next, I will look at what some of the challenges are to providing relationship-centred care in psychiatric hospitals; factors which contribute to the development of a lack of “humanity” (Mind, 2011, p. 24) and of “communication, empathy, and respect” (Healthwatch, 2018, pp. 16–17).

2.3. Effects of Medical-Technical-Legal Discourses

Difficulties in relationally-centred care within psychiatric environments are compounded by the dominance of medical-technical-legal discourse within the mental health system. A Foucauldian discourse analysis of two focus groups, one for staff and one for patients identified the competing tensions and incompatibility of medical-technical-legal discourses and those of ordinary human relating (Cheetham, Holttum, Springham, & Butt, 2018). For example, by increasing rigidity around staff and patient roles, and associated characteristics of sanity, powerfulness, and activeness.

From the staff perspective, they described how the medical-technical-legal discourse constructs ‘relating’ (typically referred to as ‘rapport-building’) as an objective technique employed to gather information that may be useful in treating the ‘illness’. Within the medical context, models of therapy become reconstructed as static tools to be used for a purpose, removing the element of dynamic collaboration. The patients spoke of an expectation that staff would hold expert knowledge that could “cut through” their ‘illness’ (p.6). When this did not happen, they described disappointment with their treatment. Staff were positioned as uncaring, purposely withholding, and unable to understand their experience. When the medical-technical-legal discourse was drawn upon, staff commented on the difficulties of engaging with their own personal experience. Whilst on the one hand it was recognised that doing so facilitated greater authenticity and empathy, it was also viewed as unbearable, exhausting, and in competition with the notion of professional boundaries.

The interactions that patients valued were mundane and ordinary. The participants spoke about finding unqualified staff more humane. For these patients, there was something about the professional training which precluded the development of a satisfying interpersonal relationship. One participant described this by saying “They’ve not been programmed yet” (p.9).

It is apparent that the effects of these discourses could serve to increase the conflicts that act as a barrier to relationship-centred care. The United Nations Special Rapporteur (2017) has called for a move away from these medicalised discourses in mental health, recognising their detrimental impact on care quality.

2.4. Investigating Care Outside of the Mental Health System

There have been calls to change how staff relate to people experiencing acute psychosis for decades. Medical-technical-legal discourses have been identified as contributing to the difficulties in establishing good relational care for people in distress. These discourses are heavily embedded within the UK mental health system and professional training programmes. The United Nations have stated an urgent need to abandon “paternalistic and excessively medicalised concepts” (Puras, 2017).

Given that barriers to relational care are entrenched within the mental health system itself, it is worthwhile looking outside of this system for alternative knowledges and contributions. I believe that the kinds of relationships and strategies used to support those who experience psychedelic crises may be useful in understanding how to support people with psychosis. I am not proposing that psychedelics can be used as a direct model for psychosis, but that the similarity between the types of experiences that can arise presents an opportunity to learn about how people having such experiences are supported outside of a medicalised context.

Historically, there have been attempts to directly equate the psychedelic experience to psychosis which I will now outline.

2.5. Brief History of Psychedelic Research

2.5.1. Historical Psychedelic Research

In 1921, German psychiatrist Kert Beringer proposed ingestion of mescaline, a psychoactive substance derived from the Mexican peyote cactus, could serve as a model of psychosis (Beringer, 1927). He thought that this model would be able to provide insights about the phenomenology of acute ‘schizophrenia’. To this end, his participants were mostly doctors. Beringer hoped that use of mescaline would allow them to gain increased insight into their patients' experiences. Beringer was influenced by Karl Jaspers' psychiatric phenomenology (Jaspers, 1965). He analysed around sixty accounts participants had written about their experiences of "disturbances of perception, illusions, and visual, but sometimes also acoustic, hallucinations and synesthesias; profound alterations in time perception; psychomotor inhibition; and varying alterations in affect and thought" (Langlitz, 2013, p. 139). Beringer produced a phenomenological account of mescaline intoxication which served as a descriptive, second-order model of psychosis.

During the 1950s, there were significant developments in psychopharmacology which coincided with a shift from Beringer's descriptive model toward an explanatory model of psychosis. Lysergic acid diethylamide (LSD) was developed by the pharmaceutical company Sandoz in 1943. Its effects and low active dosage made it an important tool in experiments which employed psychedelics as an explanatory model for psychosis. Specific target mechanisms were postulated. For example, the drug chloropromazine alleviated the 'symptoms' of schizophrenia and also inhibited the effects of LSD. For some, this provided evidence that psychiatrists had developed an experimental system that allowed the explorations of the causes of psychosis, as well as its treatment. Psychedelic intoxication as a model psychosis was now understood from the perspective of biological psychiatry.

There was a great deal of interest in the use of psychedelics for this purpose; by 1961 there were more than a thousand articles published about LSD (Dyck, 2005). Psychiatrists held great hope that this explanatory model of psychosis would be instrumental in the development of new anti-psychotic medication. Yet, by the end of the decade, research using psychedelics as model psychosis had all but ceased.

Throughout the 1960s psychedelic use became more widespread and was associated with the counterculture social movement. After they were made illegal, their use in research was treated with a more critical gaze; regulations were tightened, and Sandoz ceased the production of LSD. Biomedical psychiatry was developing the now discounted dopamine hypothesis of ‘schizophrenia’ and, as no psychedelic substances elicited primarily dopaminergic activity, their use as an explanatory model was no longer tenable (Moncrieff, 2009).

2.5.2. Contemporary Psychedelic Research

In recent decades, changes in the political climate and theories of psychosis has led to some degree of revival in research using psychedelics to understand psychosis (González-Maeso & Sealfon, 2009). For example, neuroimaging studies have reported that psychedelic substances cause changes in functional connectivity between the default-mode and task-positive networks, which can also be found in the early stages of psychosis and in states of non-dual meditation (Carhart-Harris et al., 2013). The authors suggested that this could represent the neural mechanism through which people experience changes in the boundaries of the self. This renewed interest has also led to investigations of ways in which psychedelics may be used as an intervention for a range of different forms of distress, such as ‘treatment-resistant depression’, tobacco addiction, and ‘depression and anxiety’ in people with life-threatening cancer (Carhart-Harris et al., 2017; Griffiths et al., 2016; Johnson, Garcia-Romeu, Cosimano, & Griffiths, 2014).

2.6. Supporting Psychedelic and Psychotic Crises

It is possible, though rare, for long-term psychosis to be brought on by a psychedelic experience. In an early summary of reports that compiled data for almost 5,000 individuals and more than 25,000 LSD administrations, the prevalence of reported psychosis lasting longer than 48 hours was very low (0.8/1000 non-clinical participants and 1.8/1,000 participants undergoing therapy) (Langlitz, 2013). Outside of the controlled research environments this also occurs at low levels. In a survey of 1,993 individuals who self-reported a challenging psychedelic experience with psilocybin, three people reported enduring and impairing psychotic ‘symptoms’ (Carbonaro et al., 2016).

I believe that the two forms of crisis share enough similarities in terms of how the experiences and behaviour they give rise to, that there are likely similarities in the ways in which these individuals can be cared for by others. There are a range of contexts in which people might receive support during a psychedelic crisis, these are outlined in table two.

It is therefore important to consider to what extent the psychedelic crisis shares similar phenomenological properties to psychosis. Its relevance is determined in relation to my purpose of exploring how people are supported with these types of experience, outside of the professional spheres of the mental health industry.

Table 2.

Characteristics of the contexts in which psychedelic crisis support was offered

	Clinical Research Trials	Group Experience Retreat	Harm-reduction Team	Psychedelic-assisted Therapy	Recreational	Spiritual sacrament
Aim	Investigate the use of psychedelics for people with particular psychiatric or physical diagnoses.	Allow people to experience psychedelics in a safe and legal group context.	Provide a safe and supportive environment at music festivals, where individuals can be supported to navigate difficult experiences following substance use.	Support ongoing therapeutic work through the use of psychedelics as a tool, or therapeutic work structured around the in-session psychedelic experience.	Ingestion of psychedelic to induce an altered state of consciousness for pleasure or self-exploration.	Physical, Emotional, Energetic, or Spiritual healing through spiritually-led use of psychedelics (typically called ‘plant medicine’)

Caregivers	Called ‘sitters’. All trained therapists or psychiatrists. Paid.	Called ‘facilitators’. Variety of occupational backgrounds. Trained and commonly with previous harm-reduction experience. Paid.	Variously called ‘sitters’, ‘volunteers’, ‘staff’. Variety of occupational backgrounds. Unpaid and receive specialised training.	Called ‘therapists’. Trained in varying models of therapy. Paid.	When present, friends or acquaintances. Unpaid and untrained.	Varied; healers, shamans, or spiritual leaders from traditional cultural backgrounds or western equivalents. Sometimes facilitators.
Users	‘Participants’ carefully selected according to in/exclusion criteria, including control participants. Some receive reimbursement for participation.	‘Participants’ pay to attend. Set intentions for their experience. They send an application and are subject to an	‘Guests’ experiencing minor through to extreme distress. Guests do not pay.	‘Clients’ with varying emotional issues who chose to work through these using psychedelics.	Varied.	Varied. Increasingly western people seeking above healing experiences who may or may not

		interview before selection.		Clients pay for therapy.		subscribe to spiritual framework used.
Preparation	Considerable preparatory work, including building a good relationship with the sitters.	Suggested reading and meditative practices in weeks beforehand. A schedule of preparatory activities at retreat.	None.	Considerable preparatory work conducted with the therapist in preceding sessions.	None.	Varied.
Setting	Controlled environment within a hospital.	Stay at private dwelling over the four-day retreat. Range of shared, quiet, and outdoor spaces	Tents with shared and private spaces.	Varied; client's home, rented room or dwelling, or therapist's home.	Varied; examples include private dwellings, music festivals.	Shared community spaces or private dwelling.

		used during the session. Incorporates aspects of ceremony.				
Legality & Quality	Legal. Pharmaceutical-grade substance	Legal. Retail-grade substance.	Caregiver’s work is legal, guest’s substance use illegal. Street-grade substances.	Legality depends on local laws. Retail or street-grade substances.	Legality depends on local laws. Retail or street-grade substances.	Legality depends on local laws. Ritually prepared or street-grade substance.
Aftercare	Debriefing and further counselling, if needed.	Integration work with group at retreat. Signposting to further support.	Can be none, discussion later in festival, or signposting.	Ongoing therapy.	None.	Varied.

2.6.1. Similarities between Experiences in Psychotic and Psychedelic Crises

Stanislav Grof is a Czech psychiatrist who has led or supervised over five thousand LSD psychotherapy sessions. He describes the common characteristics of psychedelic crisis states (Grof, 2008, pp. 157–201). These experiences are compared with the psychiatric ‘symptoms’ of psychosis from the eleventh edition of the International Classification of Diseases in table three (WHO, 2018). A more detailed description of psychedelic crisis experiences was developed from a psychedelic research programme in Baltimore, USA (McCabe, 1977). This categorised the types of sensory, somatic, psychological, and metaphysical experiences that can occur.

One review described how a number of papers reported the effects of psychedelic drugs and psychosis to be very similar (Grinspoon & Bakalar, 1983). More recently, a secondary analysis used 1,993 responses to ‘The Bad Trip Survey’ (Carbonaro et al., 2016) to construct a measure of challenging psychedelic experiences (Barrett, Bradstreet, Leoutsakos, Johnson, & Griffiths, 2016). This measure (the Challenging Experience Questionnaire) was validated with a sample of 981 different participants. They developed categories of subjective experiences in psychedelic crisis; fear, grief, physical distress, feelings of isolation, paranoia, feelings of insanity, and the subjective experience of death.

There are clear similarities between some of the types of experience that people with psychosis and people in psychedelic crisis can have. This suggests that there might also be similarities between the ways in which a person can be supported when having such experiences. There are, by definition, differences between the two states which I will now outline.

Table 3.

A comparison of experiences in psychosis (WHO, 2018) and psychedelic crisis (Grof, 2008)

Experiences in Acute Psychosis	Experiences in Psychedelic Crisis
Persistent delusions	Unusual beliefs can develop, commonly beliefs around annihilation of the world or self, such as a belief they are dying
Persistent hallucinations	Visual, auditory, or tactile experiences not shared by others
Disorganised thinking	Thought processes developing a chaotic, fixed, or circular quality
Grossly disorganised behaviour	Repetitive verbal behaviours; Destructive or violent behaviour including self-harm; Inappropriately sexualised behaviour
Experiences of passivity and control	Paranoid thinking; Fear of losing sanity
Blunted or flat affect and avolition	Person becomes unresponsive or uncommunicative; Dissociated states
Psychomotor disturbances	Repetitive movements, unusual posturing, jerking or seizure-like behaviour; Breathing difficulties; Physical pain; Vomiting or incontinence

2.6.2. Differences Between Psychotic and Psychedelic Crises

There are several key differences between psychotic and psychedelic crises. The most notable being that in psychedelic crisis there is one clear precipitating factor to which the state can be attributed (ingestion of a psychoactive substance). Although the majority of people who take a psychedelic substance do not experience a crisis state indicating that multiple factors are involved. There is typically less clarity in identifying a single such factor in the development of psychotic states. Other important distinctions include the duration of crisis, agency and control, content of hallucinations and delusions, and ethnicity.

2.6.3.1 Duration of crisis state: Crises occasioned by the use of psychedelics are predominantly limited to the duration of the substance's effect. Duration of action for psychedelics can vary; approximately twenty - sixty minutes for dimethyltryptamine (DMT), four – six hours for psilocybin-containing mushrooms or truffles, and eight – twelve hours for LSD (Winstock, Kaar, & Borschmann, 2013). The duration of a psychotic crisis is less clearly defined. This is because an individual may be living with psychotic experiences for an unknown period of time before contact with mental health services, and because the transition from a psychotic to a non-psychotic state is not clearly demarcated. Generally speaking, psychotic crises can be expected to last for days-months as opposed to the hours which would be expected for a psychedelic crisis.

The time-limited nature of the psychedelic crisis suggests that caregivers have different strategies available to them than those caring for people experiencing the longer crisis of psychosis. This might be, for example, by providing reminders that the effects of the substance will reduce in a certain number of hours. However, interviews with psychiatric nurses has shown they may employ similar strategies, albeit without such a concrete timeframe (Engqvist et al., 2007). Additionally, an individual in psychedelic crisis can experience alterations in their perception of time and have no understanding that their current state of mind is temporary. Grof calls this a "no-exit state" in which the individual "is unable to see any end to this situation or any way out of it" (p.159).

2.6.2.1. Agency and control: The majority of people who have ingested a psychedelic substance do so knowingly. This is a major point of departure from the experience of a psychosis. The ability to provide individuals with verbal reassurance that their experiences can be attributed to the effects of a substance they have voluntarily ingested is a commonly used strategy in the harm-reduction literature (Zendo, 2015). One manual details this helping procedure by recommending that "the person should be repeatedly reassured that this is a normal feeling in such a state of mind, and that the drug effects will be gradually fading away for sure" (Móró, Stukas, & Tarnai, 2013, p. 19). Whilst less able to specify one clear cause of their distress, psychiatric nurses have been reported to use similar normalisation strategies:

> try to neutralize it a bit...try in another way to explain to her, that this is not the way we see it. But this is the way you see it now when you are not feeling well. Or because you have not slept for three nights, then you can have experiences like this. (Engqvist et al., 2007, p. 1338)

It has been argued that if a person ingested a psychedelic substance unknowingly, this would be indistinguishable from a psychotic state (Gouzoulis-Mayfrank, Hermle, Thelen, & Sass, 1998). Investigating this in a research context would be a gross breach of the ethics and so there is little basis on which to clarify that hypothesis. Such investigations were conducted by the United States' Central Intelligence Agency during the 1950s (Olson vs U.S., 2012). One officer reported the experience of his co-worker who had been given LSD without his knowledge or consent and was found some hours later under a motorway bridge:

> "He reported afterwards that every automobile that came by was a terrible monster with fantastic eyes, out to get him personally. Each time a car passed, he would huddle down against the parapet, terribly frightened. It was a real horror trip for him. I mean, it was hours of agony. ... It was awfully hard to persuade him that his friends were his friends at that point. ... He was alone in the world, and everyone was hostile. He'd become a full-blown paranoid." (Marks, 1979, p. 71)

It is unclear how many cases exist of people unknowingly ingesting a psychedelic substance. However, even for those who have knowingly taken it, an individual in psychedelic crisis may not have access to this knowledge during their crisis. It is likely that the helping strategy of reminding them of this would increase their sense of agency and control which could in turn reduce their feelings of distress.

2.6.3.3 Form of hallucinations: Historically, it was thought that a significant difference between the experiences of psychotic and psychedelic crisis was that psychedelics predominantly induced the experience of seeing things others do not, whereas psychosis typically produced the experience of hearing things others do not (Feinberg, 1962; Maltiz, Wilkens, & Esecover, 1962). These observations were based upon people who had a long-term diagnosis of 'schizophrenia'. Contemporary studies that interviewed only people with a recent diagnosis reported visual hallucinations and disturbances to be more commonplace (Freedman & Chapman, 1973), occurring in 40% of the 40 people interviewed (Chapman, 1966). A more recent review of the literature reported a weighted mean prevalence of visual hallucinations in 27% of 5,873 people with a 'schizophrenia' diagnosis across twenty-nine studies (Waters et al., 2014). This compared to 59% prevalence for auditory hallucinations. When twenty people with a recent diagnosis of 'schizophrenia' were compared with twenty age- and sex- matched users of LSD, there were no significant differences found in five of the seven measures of visual perception that were used (Young, 1974). Participants in this study also reported auditory hallucinations; these were described in 30% of those who had taken LSD and only 5% of those with a recent 'schizophrenia' diagnosis. However, the sensory modalities through which people have experiences that others do not can vary across cultures, and as such, this study can only reflect the time and context in which it was conducted (Bauer et al., 2011).

Visual hallucinations in acute psychosis have been given much less acknowledgement in the literature than auditory hallucinations. This is likely, in part, to be due to researchers' a priori expectations of phenomena that occur in psychosis, combined with the widespread use of standard clinical measures based upon a dichotomous rather than continua conceptualisation of these 'symptoms' (Strauss, 1969; van Os, Hanssen, Bijl, & Ravelli, 2000). A content analysis of twelve Norwegian psychiatric and psychiatric nursing textbooks across a ninety-year period showed that all the texts described people with psychosis using a "'perspective from above' ... [which] emphasises the professional's point of view, guided by already stable and established descriptions, and which sees the patients from a distance" (Fredwall & Larsen, 2018, p. 4).

Describing the experience of psychosis from an outsider and professional standpoint can obscure first-person descriptions of the experience. In their paper summarising a series of phenomenological service user-led interview studies, Jones and Shattell describe how “very few people’s experiences of “psychosis” or “schizophrenia” in fact map onto conventional understandings of either psychopathology or healing” (Jones & Shattell, 2016, p. 1). Nearly all participants had difficulty explaining and communicating their experiences and they “simply did not map onto available terms and constructs”. For example, in their analysis of interviews with eighty voice-hearers who had a ‘schizophrenia-spectrum’ diagnosis, only 17.5% reported experiencing auditory hallucinations as literally auditory (Jones & Luhrmann, 2016). When asked about the earliest onset of symptoms, one woman they interviewed described “perceptual alterations and anomalies – anomalies, she reported, that were not that far afield from the psychedelic states her freshman friends and colleagues sought through LSD” (p.2).

2.6.2.2. Ethnicity: I would also highlight differences in how the two forms of crisis are related to by whiteness and subject to racist power dynamics. Black people are disproportionately labelled with a psychotic disorder (Schwartz & Blankenship, 2014) and for many years have been consistently more likely to be detained under the Mental Health Act (Bhui et al., 2003; Care Quality Commission, 2011; Davies, Thornicroft, Leese, Higgingbotham, & Phelan, 1996; Department of Health and Social Care, 2018; Halvorsrud, Nazroo, Otis, Brown Hajdukova, & Bhui, 2018). The UK mental health care system is regarded by many as institutionally racist (McKenzie & Bhui, 2007); racist discourses may influence how care is provided. Interviews with people who had recent episodes of psychosis and their carers highlighted how, whilst not an issue in community settings, in inpatient environments ethnicity was related to poor care experiences (Weich et al., 2012).

The psychedelic ‘community’ has been criticised for its whiteness. There is little data available on the ethnicities of those using psychedelic substances. However, in the largest international survey of psilocybin use 89% of the 1,993 respondents identified as White and just 0.3% identified as Black. Differences in cultural background may affect the nature of experiences in these states and, at present, descriptions in the literature of psychedelic crisis may be over-reliant on data from people of White American and European backgrounds, limiting current understanding of the experiences of people from other ethnic backgrounds. These figures are unlikely to be representative of the actual backgrounds of people who use psychedelics, in part because, given the legal status of psychedelics and institutional racism within the criminal justice system, the ability to talk openly about drug use is a privilege less accessible to people of colour. The influence of whiteness and racism are beginning to be acknowledged as issues within the psychedelic sphere (Harvey, n.d.; Iyi, 2017; Springer, 2017). There are no data about the dominant ethnic backgrounds of people that care for others in psychedelic crisis; it is likely to vary across the contexts and cultures in which the substances are taken. Differences in the racial and ethnic backgrounds between the carer and cared for may affect the frameworks used to understand experiences, how care is given, as well as the systems in which the care is situated.

2.7. Supporting a Person During a Psychedelic Crisis

There are a number of differences between psychotic and psychedelic crises, including the duration of crisis state, degree of agency and control, the form of hallucinations, and the role of ethnicity. All of these factors may influence the ways in which caregivers support people experiencing these different forms of crisis. However, there are also similarities between some experiences, suggesting similar caregiving approaches may be used to support people. Mosher wrote that staff at the Soteria project aimed to be “like an LSD trip guide” (Mosher, 1999, p. 6). There is very limited academic literature on how to support people having psychedelic crisis experiences. A search of peer-reviewed articles on the PsycINFO database retrieved no relevant results (appendix one). Information tends to be found more widely within the grey literature; books and on websites (Erowid, 2014; Fischer, 2015; MAPS, n.d.; Zendo, 2015).

One study that has been reported was a mixed-methods evaluation of a crisis intervention service at a Portuguese music festival (Carmo Carvalho et al., 2014). Participants included 122 people who had used the service and 36 people who volunteered in caregiving roles. They described key principles of crisis intervention:

- assessment of physical safety
- offering a safe, supportive, and comfortable care space
- facilitation
- ensuring safety
- promoting health and reducing risk.

Facilitation was described as offering the presence of a supportive person with whom a trusting relationship could be developed, and adopting a non-directive, holistic, accepting, and active-listening orientation toward the person in crisis. Interventions were categorised as primarily psychotherapeutic (talking, sitting with quietly, walking with, physical contact, working with significant others), though complementary (music therapy, massaging, homeopathy), medical (nutrition and hydration), and logistical (offering a resting space) strategies were also used.

This study indicates that the approach towards supporting a person having psychedelic crisis experiences at a music festival shares some similarities with approaches described in the literature review of relational care for people with psychosis, and those used by the Phildelphia Association and Soteria House. However, it does not offer detailed information on the knowledges and skills required of a caregiver, or about the process of supporting a person having these experiences. Additionally, this study draws information from just one of many contexts in which people can be supported when having psychedelic crisis experiences. This limited understanding represents a gap in the literature.

2.8 What this Research Seeks to Address

We have seen how there can be problems with caring relationships between staff and people with psychosis in psychiatric inpatient settings, despite an awareness of its importance in good quality care. A review of the literature has shown that there is a paucity of research in this area and, that whilst some studies are beginning to explore relational care, there is limited evidence as to the knowledge and skills caregivers need, and the process of support.

Given the current difficulties of providing relational care to people experiencing psychosis within the mental health system, and limited evidence-base for doing this well, I would argue that there is a case for investigating how people having non-ordinary experiences are cared for outside of this system. Case examples have been given from outside mainstream psychiatry which have more explicitly focused on relational forms of caring, though limited research output curtails our depth of understanding.

In the context of psychedelic use, people are supported through crisis experiences outside of a medicalised setting. I have explored the similarities and differences between these experiences, and the ways in which they may influence how people are supported. This leads me to consider how people are supported when having psychedelic crisis experiences, and what might be learnt about this that could be useful for supporting people through similar experiences when in a psychotic state.

At present, there is limited published research available on how people are supported during psychedelic crises. This leads me to questions which I hope may address that gap: what is the process of supporting a person having psychedelic crisis experiences, and what are the knowledges and skills required of a caregiver in order to do this?

3 METHODOLOGY

I begin this chapter by describing my epistemological position, the rationale for my methodological choices, and the study design. I outline the features of the grounded theory approach employed, with details of the analytic procedure.

3.1. Research Questions

I wish to investigate how caregivers support an individual having psychedelic crisis experiences that might be useful when supporting people having similar experiences or non-ordinary consciousness during acute psychosis. To do this I shall ask:

- What is the process of supporting a person having psychedelic crisis experiences?
- What are the knowledges and skills required of a caregiver in order to do this?

3.2. Epistemology

I sought to explore the meanings created by participants with the recognition that their construction and interpretation was likely to be influenced by an interplay of dynamics between the researcher, participant, and the context. There are, broadly speaking, three types of epistemological framework; realist, phenomenological, and social constructionist (Willig, 2013). My position was best suited to a moderate social constructionist framework of ontological realism and epistemological relativism (also referred to as critical realism). There was the assumption that these data reflect some aspects of the reality of supporting an individual through a psychedelic crisis, whilst retaining an awareness of the historical, social, cultural, and political factors that influence the construction of this process.

Maintaining a realist ontology provided the expectation that, though they may be labelled differently, other grounded theory studies of these types data would develop constructs that could map on to those outlined in this study. In other words, that it could be possible to identify patterns and processes of human activity applicable beyond the individual investigation.

3.3. Research Method

3.3.1. Grounded Theories and Epistemology

Grounded theory methods are a set of inductive strategies that involve "progressive identification and integration of categories of meaning from data" (Willig, 2013, p. 70). They were attractive as they aim to move beyond rich description to produce theory that is grounded in data brought by the participants (Barker, Pistrang, & Elliott, 2002). This data-driven approach to developing theory makes them well-suited for studying phenomena which do not have an established theoretical framework, as is the case here.

There are three main forms of grounded theory; the traditional method, a more structured approach, and a constructivist approach (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1994). The constructivist approach outlined by Kathy Charmaz is most consistent with my moderate social constructionist epistemological position. This countered one of the main criticisms levelled at previously outlined grounded theory approaches. Namely, that despite being positioned as an alternative to hypothetico-deductive approaches, these methods had not fully considered the contribution of the researcher in forming the focus, design, data gathering, and analysis. In constructivist grounded theory approaches, the assumptions, values, and discourses that inform participant's accounts are attended to with acknowledgement of the diverse interpretations which different researchers bring. It invites the researcher to consider and scrutinise her role in construction of data and meanings through reflection upon her position, perspectives, and interactions.

3.3.2. Grounded Theory Practices

Grounded theory does not take a linear form. It consists of a number of tools that can be flexibly applied; coding, categorisation, constant comparison, theoretical sensitivity, memo-writing, theoretical sampling. Data are initially coded descriptively to categorise and explain them. These codes are progressively sorted into higher-level categories to construct more abstract concepts and theory (Charmaz, 2006). Initial codes represent the basic building blocks of analysis and are constructed through the researcher's perspective of what is meaningful and important in the participants' accounts. Data which do not fit with major patterns are scrutinised; this is supported through the continued movement between coding and conceptualising data towards theory construction. Theoretical sensitivity involves considering data afresh in the light of emerging categories and concepts.

Alongside this, Charmaz invites the researcher to engage in memo-writing. Memo-writing provides a forum in which to interact and reflect upon data and developing ideas. It acts as a bridge between data and the final theory through the encouragement of progressively higher levels of abstraction.

Data collection and analysis occur concurrently, and each should inform the development of the other throughout the research process. This study is perhaps best regarded as an abbreviated grounded theory as the ability to engage fully with the cyclical nature of grounded theory was to some degree limited by time constraints and ethical considerations (Willig, 2013). To meet the needs of the ethical review panel it was necessary to specify types of participants in advance, which did not allow scope for expanding recruitment to people outside of the population outlined in my application. Due to the legal implications of working with psychedelic substances in many countries, the population which formed the focus of this research are not easily accessed. This meant that as there was not steady recruitment; there was limited time for simultaneous analysis during the seven-week period in which six of the eight interviews took place. However, time was spent interacting with these data during that period. Interviews were transcribed alongside data gathering. Memos were written of initial coding ideas and these informed subsequent areas of discussion in later interviews. Other key grounded theory approaches were maintained, such as purposive sampling and modifying the interview schedule on the basis of previous interviews.

3.4. Recruitment and Participants

3.4.1. Inclusion Criteria

Participants were required to be over eighteen years old with competent ability to communicate in spoken English. They were required to have experience in supporting people through psychedelic-induced crisis experiences. Participants were given a description of psychedelic crisis taken from a manual of psychedelic harm-reduction to orient them whether their experience of support was relevant (Móró et al., 2013) (appendix two). Participants self-selected as meeting inclusion criteria and I ensured these were met in each instance.

3.4.2. Sampling

Participants were recruited through a combination of purposive and snowball sampling. Purposive sampling refers to the selection of participants based on criteria relevant for research question (Willig, 2013). Snowball sampling involves participants being asked to identify other potential participants to the researcher. It provides a useful means of recruiting participants from ‘hidden’ populations as it contributes to the development of trust through the referral process. There are, however, risks that this sampling procedure can homogenise the participants recruited (Atkinson & Flint, 2001). Three of the eight participants were recruited by snowball sampling allowing for some degree of limitation around this risk.

3.4.3. Recruitment

In keeping with the recognition of the influence of context that is highlighted in social constructionist research, attempts were made to recruit participants that had worked in the primary contexts in which psychedelic crisis support may be offered. It can be seen from the description of contexts in table two that this role was described differently between contexts. Half of the participants spoke about providing support in more than one context; throughout this study I will use the terms ‘participant’ or ‘caregiver’.

The recruitment approach comprised:

- Publicising the study through word-of-mouth at a psychedelics conference
- Publicising the study through a network of therapists who identify as being knowledgeable about non-ordinary states of consciousness
- Referral from the other participants.

3.4.4. Participants

I recruited a sample of eight participants over a five-month period. Profiles of the participants are shown in table four to ensure confidentiality pseudonyms have been used and demographic information given broadly. All participants were white; six European and two North American. Ages ranged between late-twenties and seventies, with six participants falling within the 35-45 age range. Interviews averaged fifty-four minutes duration.

It is common to cite ‘saturation’ as the guiding principle with which to judge when to close recruitment. There are a number of issues with the concept of saturation; it uses a misleading metaphor to invoke a concept of completeness, it can distract researchers from processes, and there are inconsistencies in how saturation is evidenced. I followed a process of ensuring ‘conceptual depth sufficiency’ using criteria outlined by Nelson of range, complexity, subtlety, resonance, and validity (Nelson, 2017). I aimed to recruit eight-ten participants; eight participants were recruited. Additional pragmatic factors that limited sample size were time constraints, access to the study population, and lack of funding.

Table 4

Participant profiles

Context	Clinical research trial	Amanda, Peter
	Group retreat	Eimear
	Harm-reduction team at music festival	Amanda, Eimear, Erik, Peter
	Psychedelic-assisted therapy, legal context	Marija
	Psychedelic assisted therapy, non-legal context	Alexei, Birgitta
	Recreational	Lukas
	Spiritual sacrament	Erik
Occupational background	Massage therapist	Eimear
	Medical doctor	Birgitta, Peter
	Talking therapist	Alexei, Amanda, Erik, Lukas, Marija
Gender	Male	Alexei, Erik, Lukas, Peter
	Female	Amanda, Birgitta, Eimear, Marija

After analysis of interviews, two secondary data sources were analysed as part of a confirmatory process of the framework developed. These were chosen because of the broad range of caregiver contributions they offered from two psychedelic harm-reduction manuals (Móró et al., 2013; Zendo, 2015). One was produced by an American harm-reduction organisation (Zendo Project) in association with the Multidisciplinary Association for Psychedelic Studies (MAPS). The MAPS manual is a 385-page guide to psychedelic support within harm-reduction contexts written by forty-four authors and contains twelve case studies written from the first-hand perspective of people who provide crisis support (appendix three for an excerpt). It covers the history of psychedelic care services and logistical information required to establish one. It contains a discussion of the principles and ethics of support but does not give a model of the process of support. The second manual that was selected was the DÁT2 Psy Help manual. This is a thirty-page harm-reduction manual produced by DÁT2, a Hungarian organization (appendix four for an excerpt). This was selected due to the extensive experience of the organization that produced it; psychedelic crisis support at over 150 Eastern European music festivals between 2013-2018. It contains information required to set-up and run such a service.

3.5. Data Gathering

The primary source of data collection was semi-structured interviews, in-person or via video-call, to allow for in-depth exploration of the topic. Interviews were conducted individually to ensure confidentiality. Secondary data was gathered from two manuals which were coded to aid transferability. In further efforts to optimise transferability, the interview schedule was developed in consultation with forty-three people with lived experience of psychedelic crisis. Consultation was conducted through a survey posted to relevant online forums (appendix five), informed consent was taken for participants contributing to the consultation (appendix six). Contributions were collated and reviewed; significant or frequent themes were included in the schedule (appendix seven). Additionally, participants were recruited who had experience of supporting other across five different contexts.

Prior to interview, potential participants were given the participant information sheet (appendix eight). They had the opportunity to ask any questions and were given at least one day to consider this before arranging an interview. Participants gave written consent (appendix nine). An encrypted electronic recorder was used during the interviews. These files were stored on a password-protected computer. Two interviews took place at the University of East London. All other interviews took place over video call due to location differences. I encouraged participants to give examples to demonstrate what they were describing and prompted them to elaborate points throughout. I used regular brief summaries to check my understanding and asked whether there was anything in the summary they felt had not been captured accurately.

At the end of the interviews, participants were asked to speak about any important areas that had not been addressed. They were also invited to suggest questions to be used in subsequent interviews and asked whether they had other people within their networks who may be interested in participating. Participants were asked whether they would like to receive a summary of the findings. All participants requested this, demonstrating that there was good engagement with the research process. Participants were thanked for their time; no financial incentive was given.

3.6. Process of Analysis

3.6.1. Data Preparation

Interviews were transcribed verbatim and identifying details were removed. As I was interested in the content of interviews, non-linguistic features were not included unless essential to supporting the understanding of what was said (for example, participants using a particular hand gesture to demonstrate a method of touch). Incomplete sentences, repetitions, false starts were included as these provided useful information about how participants spoke about topics. Interviews were transcribed as soon as possible after the interview had taken place and reflections were written on the relational process that occurred between me and the individual. I noted initial codes, which helped to incorporate these ideas within subsequent interviews. As described above, it was not always possible to enter through a full stage of initial coding before the following interview due to time constraints. However, in this instance interview questions were still amended to incorporate significant topics that arose during previous interviews.

3.6.2. Coding

Analysis was conducted using constructivist grounded theory approaches (Charmaz, 2006) and involved a process of iterative coding (figure two). Software was used to facilitate the process (NVivo 12). Initial coding was used on a line-by-line basis for each transcript using gerunds to construct codes which reflected actions and processes. Using the comparative method, I then began to raise significant, similarly oriented, or commonly occurring initial codes to the level of focused codes. Focused codes were refined through further interaction with data and tentative categories were developed. I remained open and attuned to data which did not fit these categories through reflexive and recursive processes. After analysis of the interviews, data from two harm-reduction manuals were included which helped to refine categories further. Selective coding was then used to organise data around the constructed categories.

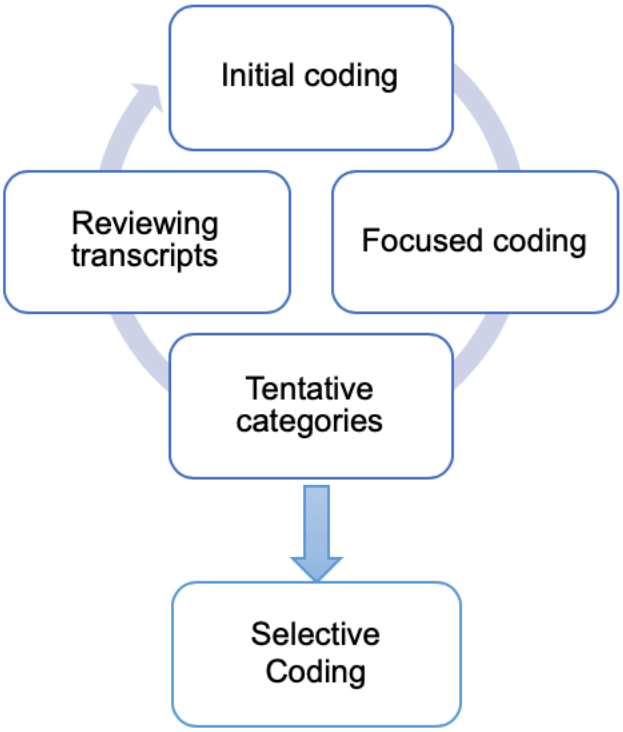

Figure 2. Process of coding used in data analysis

3.6.3. Memos

Memos were used throughout data gathering and analysis to foster analytic engagement (appendix ten for an example). Throughout the research process some memos remained relevant and supported reporting the analysis, others were put aside as ideas and concepts were developed in different directions.

3.7. Ethical Considerations

Ethical approval was granted by the University of East London Ethics Committee (appendix eleven). The research was registered with the University's Research Board. Informed consent was secured from participants and they were informed of their right to withdraw. Given the legal status of psychedelics in many countries, confidentiality was an important area of concern. Time was taken before and after consent was given to discuss confidentiality with participants.

3.8. Trustworthiness and Rigour

To ensure quality, I referred to criteria of credibility, transferability, dependability, and confirmability (Korstjens & Moser, 2018). These criteria will be described more fully in the discussion chapter.

4 FINDINGS

3.1. Introduction

This chapter is an account of my understanding of the accounts of the eight participants constructed using grounded theory methods (table five). It is supplemented by the two manuals that contributed to the study as secondary data sources. Three main categories were developed from data; ‘nature of the crises’, “prepared to handle what comes our way”, and “holding people through the experience”. These categories are outlined and described below.

Table 5.

Number of participants contributing to each category

Core Category	Sub-category	Number of participants
Nature of the crisis		
	“Window of tolerance”	6
	Struggle for control	5
	Feeling overwhelmed	8
	Responses to feeling overwhelmed	8
“Prepared to handle what comes our way”		
	“A decent human being alongside another human being”	8
	“A supportive network on hand”	7
	“Knowing where someone is at”	8
Holding people through the crisis		
	Safety	8
	“Connection to the ground of reality”	8
	Release	7
	After the crisis	8

3.2. Nature of the Crises

This category described the types of experiences which participants considered to be an episode of crisis. Though each situation was individual to the person and their context, there was a common pattern in which a person had unwanted perceptions, experiences, or mind-body states which they felt unable to control. This caused people to feel overwhelmed by what they perceived to be unmanageable and dangerous experiences. People responded to this experience of being overwhelmed through processes of disconnecting from people and their surroundings, and/or through embodied expression. Some people moved between being overwhelmed, disconnected, or embodied expression during a single crisis episode; others would predominantly remain in one of these states. These experiences will be described below and illustrated with examples; the process of support through crisis can be seen below (figure three).

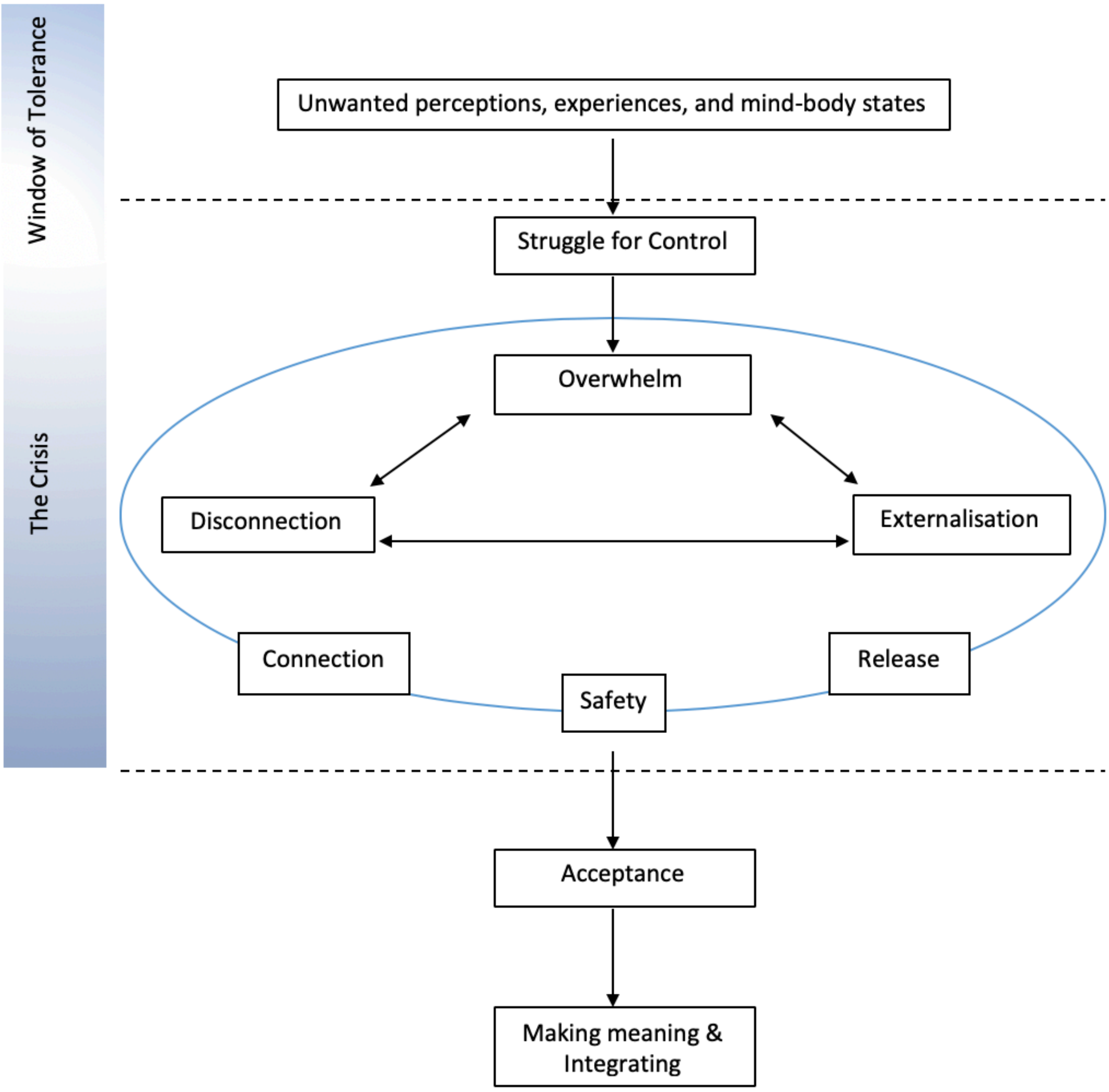

Figure 3. Aspects of the process of supporting a person through a psychedelic crisis

3.2.1. “Window of Tolerance”

Participants did not take the presence of intense distress, by itself, to be an indication that they should offer support. Instead, they described a “window of tolerance” (Marjia) in which caregivers should allow the person to experience distress without becoming involved. This was supported by two principles; “difficult, not bad” (Erik) and least intervention.

The first of these principles was the notion of “difficult, not bad”. This was shared by all participants, regardless of the context in which they worked. It was believed that despite the difficulty of crisis experiences, they also held the potential to be transformative. They “could actually be a really beneficial thing that’s happening” (Eimear) as “in this way people healed ... They really healed” (Birgitta).

The second principle was of least intervention. The principle of least intervention was based upon the belief that potential long-term benefits, unique to that individual’s needs, could arise that were based upon the ability to integrate into one’s everyday life the experiential learning that took place during the crisis. Participants believed that too much intervention could disrupt the process of experiential learning and risked imposing the caregivers meaning on the experiences as they unfolded, and that this impinged on the ability of the person to develop personal meanings later. When a person was in this “window of tolerance” caregivers adopted a non-directive attitude towards the person they were caring for to accommodate this process.

Participants also believed that too much intervention could amplify the person’s struggle for control over their experiences and risked escalating the situation.

> so much work in mental health is really about dampening down, suppressing distress as a therapeutic end whereas here we're encouraging people to go into the most intense pain, distress, with a therapeutic goal. So just how counterintuitive that is. It's quite challenging. And I suppose on a just sort of more fundamental human level we tend to want to try and soothe but I suppose on some level we're kind of edging towards the other way. For therapeutic ends. (Peter)

Peter’s quote highlights the difficult feelings that could be brought up in caregivers who had to bear the other person’s intense distress. In this sense, the “window of tolerance” was shaped not only by the person’s tolerance, but also the caregiver’s. Later in the text, I will describe other factors that contributed to a caregiver’s decision as to whether a person was within a window of tolerance and explore factors which could influence a caregiver’s capacity to tolerate distress. Examples of situations which participants variously judged as being within a window of tolerance and not requiring support included a person feeling afraid of animals only they could see, a person believing they were receiving messages about children needing to be saved, and a person being confused and talking aloud to their repetitive thought patterns.

3.2.2. A Struggle for Control

Nearly all participants attributed the transition into a crisis state as being precipitated by the person unsuccessfully attempting to control unwanted perceptions, thoughts, experiences, or mind-body states. Common examples included people trying to control seeing demons, being reminded of or re-experiencing traumatic memories, and the sensation of being strangled or smothered. Seven participants spoke about this in terms of the person “resisting” their experiences. Resisting referred to a notion that people were responding in ways to try and stop, reduce, or protect themselves from the difficult emotional and physical states with which these experiences were associated. Unwanted and distressing experiences could quickly feel unmanageable for the person having them if they found themselves unable to assert control over them.

> When it goes so fast that the tripper gets scared and tries to put the brakes on and the breaks don't work. That's when the panic happens. So, if you're tumbling through a rabbit hole and you're cool with that, that's not a bad trip. If you're tumbling through a rabbit hole and you want to tumble more slow and you realise that you cannot stop the tumbling, that's bloody scary. (Erik)

> the only reason why people have bad trips is not because of the feeling that they have. It's because they're stuck between wanting to do it and not letting themselves do it. (Alexei)

3.2.3. Feeling Overwhelmed

Those experiences which felt unmanageable led to people feeling overwhelmed by the experience and their emotional responses. Most often, this was associated with panic or confusion, though a wide range of overwhelming emotional states were described by participants. Some people would rapidly shift between different intense emotional states. The intensity (and in some cases changeability) of these emotions indicated that the person was less able to self-regulate their emotional responses.

> he was, yeah, in a complete state of panic. You could tell he couldn't actually focus on anything he was looking at. (Eimear)

> Pretty soon her normal chatting turned into gibberish, and not much later random screaming, crying, and a rollercoaster of emotions. Eve* went from hysterically happy to almost manically sad; laughter and crying followed one another like sides of a coin being flipped. (MAPS Manual, *pseudonym)

For some people, this stuck state of being emotionally overwhelmed by their experiences would constitute the body of their crisis. Others responded to feeling overwhelmed in ways which altered how their crisis was viewed and interacted with by caregivers. Participants conceptualised these responses as a disconnecting response (from other people and surroundings) or embodied expression (of their internal state). A person might move between being overwhelmed, disconnected, and expressive or stay predominantly in one of those states throughout their episode of crisis.

3.2.4. Responses to Feeling Overwhelmed

3.2.4.1. Disconnection: These disconnected states could vary from an intense inward preoccupation where it was more difficult for a caregiver to engage the person in communication, to the person becoming unable to speak, move, or see. Several participants used language such as “cut off”, or “lost” to describe these states. This language highlights how people in these states were less able to engage with consensus reality and the difficulties the caregiver had in interacting with them.

> And in terms of his sort of engagement with me or, I guess the festival setting, that wavered. Sometimes he seemed very much lost in his own process, other times a little bit more in touch with where he was, what was going on. (Peter)

> she was in, er, I think it's too mild to say in a void but something like that, like there was just, there was just nothing. (Lukas)

3.2.4.2. Embodied expression: If states of disconnection could be viewed as an inward retreat from feeling overwhelmed, then states of embodied expression represented the opposite. Participants observed bodily and physiological changes which they felt were responses to the private experiences people were having. These could range from unusual to dangerous; for example, adopting unusual poses, taking off clothes, writhing and flailing limbs, attempting to hurt themselves.

> they were like hitting, their limbs were kind of like up and down, going up and down, and she was kind of hitting her head. (Alexei)

> he was in a demonic state, eyes rolling, blowing his nose with force, covering his face with snot, and spitting all the time. He kept sliding his hands away from the grip of the belts tied up around him, and he tried to pull off his penis three or four times more. (MAPS Manual, p248)

3.3. “Prepared to Handle What Comes Our Way”

“Prepared to handle what comes our way” (Erik) describes the knowledges, qualities, and attitudes that participants drew upon whilst supporting a person in crisis. It outlines how participants approached situations which involved risks of harm as well as the sources of support that caregivers drew upon and how they were used.

3.3.1. “A Decent Human Being Alongside Another Human Being” (Amanda)

Traits described by participants as useful for this work were broadly similar to those that have been outlined in building other types of helping relationships; compassion, patience, authenticity, non-judgement, respect, reflection, flexibility, and openness.

> not imposing their own attitudes and approaches to the client and also allowing clients to have their own experience and have a very beginner[‘s] mind to everyone else and not imposing one model or one approach and accepting that every of us is different, with different needs, with different, erm, coping strategies, with different faults as well. (Marija)

> The main important things for me ... is basically just giving this full presence and unconditional support and acceptance. (Eimear)

> I think warmth, compassion, you know, obviously critical thinking, all that kind of stuff is important but I think what people really respond to is they feel that there's a human being opposite them who really cares about what's happening to them. (Amanda)

Particular emphasis was given to the ability to remain calm under pressure.

> A lot of it was about, you know, not matching how escalated she was but trying to just be very calm. (Amanda)

> [I] just try to be, I suppose as relaxed as possible, um, just sort of patiently quietly available (Lukas)

One way in which participants developed their ability to keep calm was to have a good understanding of their own needs and anxieties and be able to care for and meet these needs. This was because an important aspect of providing support was the ability to bear intense and difficult experiences and to demonstrate to the person that these were manageable. This could not be achieved if a caregiver began to act in a way to alleviate their own anxieties.

> {laughs} I'm not a Zen master but I, you know, there are moments where you kind of notice the child or the young part of you going "oh this is all a bit much!" but you know, right, I need to kind of anchor myself, ground myself, access my adult so I can look after this person who is in a vulnerable and fragile state. (Amanda)

3.3.2. "A Supportive Network on Hand"

Participants described how a caregiver's capacity to tolerate distress and to feel confident and able to manage difficult situations was improved by having "a supportive network on hand" (MAPS Manual, p221). This network included the colleagues within their team and a shared framework (figure four). For those working in harm-reduction, it also included external medical staff and police.

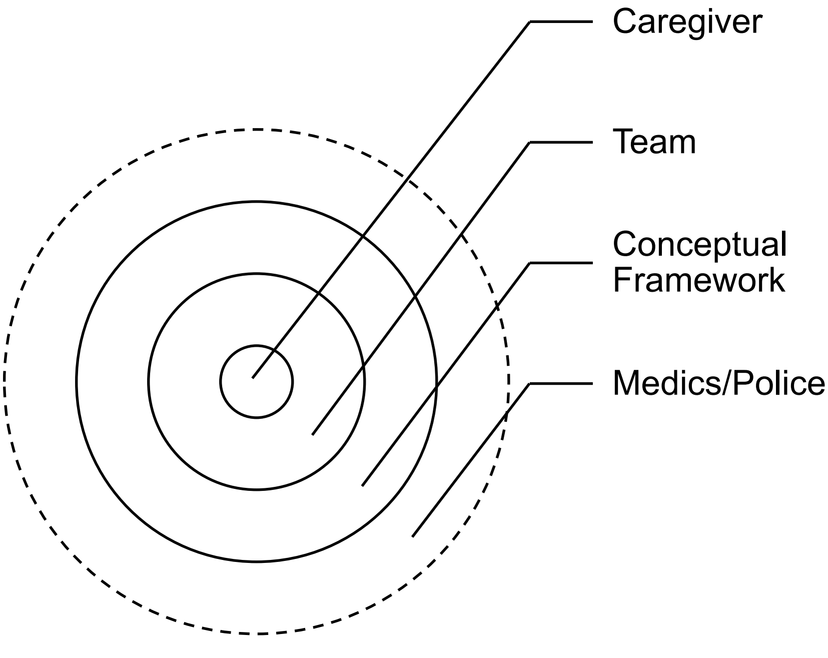

Figure 4. The circles of support around a caregiver. Harm-reduction contexts used additional support from external agencies.

3.3.2.1. Team: All but one of the participants worked as part of a team. In therapeutic settings, this typically comprised of one other person acting as a co-therapist. On the retreats and at music festivals, teams of caregivers worked with people predominantly on an individual basis unless there were particularly challenging situations. Participants spoke about how working with others helped to reduce anxiety, increased opportunities for sharing knowledge, and allowed caregivers to make sense of difficult situations together.

> you know there are other people there so if this feels like overwhelming or over my head I can always pull someone else in or I can get someone else alongside me. (Amanda)

> We got quite a strong sense before this trial starts that there's a need to look after one another, checking in. (Peter)

It also allowed for increased flexibility in caregiving approaches. Four of the participants spoke about how it was helpful to be able to swap caregivers if there seemed to be difficulty establishing a good relationship with the person (as will be later described, the interpersonal context was highly influential in crisis support). Erik tells how this was particularly helpful approach when the person in crisis was experiencing strong feelings of suspicion or fear towards the person supporting them.

> I'm working with someone, it's fine and then all of a sudden they realise that I'm Satan and then you go "Look, I'm just going to go for a cup of tea". Because you don't want to do the official switch of I'm just switching for one of my friends who is also Satan. "Yeah, don't worry about it. I'll just go for a cup of tea" and then all of a sudden [Erik's partner] rocks up and she kind of is a new face. So, switching is good. (Erik)

3.3.2.2. Framework: Participants often referred to a framework that supported them during this work. The majority of the interviewees were trained therapists and so typically drew from different psychological understandings (e.g. existentialist, psychoanalytic) however, there was a recognition and respect for the fact that other people held different beliefs and understandings (e.g. shamanic perspectives). It may be that the content of the framework was less important than the confidence and anchoring that it could offer for the caregiver as they went about their work. Many participants talked about recognising spiritual aspects and influences on the experience and both harm-reduction manuals encouraged their readers to develop this understanding further.

> it's very about honest approach ... what a person's preference [is], and fine if someone has a shamanic approach, but there's many other approaches. (Marija)

> Spiritual emergencies (or spiritual crises) should be recognized and distinguished from other types of emergencies. (DÁT2 Manual, p19)

An important component of this was a caregiver’s ethical position and how this informed boundaries. Participants recognised the vulnerability of people in crisis states and the power imbalance that was inherent in the work. Most of the participants were used to working to professional ethical standards and held themselves to similar principles during this work (for example, confidentiality, limited self-disclosure). Participants would define and maintain boundaries they adopted to protect people in these vulnerable states.

> we obviously make it very clear that sex, death, violence may well come up with what they are experiencing but that we are there to ensure that it will just be their experiencing, that those boundaries will always be maintained. ...boundary transgressions would be an obvious terrible thing to do. (Peter)

Touch was seen as an invaluable means of establishing connection, signalling presence, grounding, and comforting a person in crisis. Participants emphasised how careful consideration was given as to whether and how touch would be appropriate to use for any particular individual at that given instance within that context. There was some variation across contexts as to the extent to which touch was seen as permissible. For example, participants from the clinical trials spoke about how touch would be used sparingly, if at all. Amanda told me how they practised non-romantic hand-holding as part of their preparations for the trial. She contrasted this with her experience volunteering at a music festival in which the use of hugs could at times be appropriate and beneficial. Peter ascribed some of this variation around the use of touch to the desire of the trial group to be seen to be conforming to the norms of discourses around touch within the mental health profession.

3.3.2.3. Medics and Police Participants working in harm-reduction spoke about an additional source of support from medical and security staff, or the police. Participants did not speak about their involvement in any other contexts. Involvement of the police or hospitalisation was regarded as an undesirable, but occasionally necessary, last resort to ensure physical safety.

> he was becoming actually physically unsafe. So, unfortunately eventually we couldn't do anything. It wasn't a case of us holding space for him and talking through his experience. He was so far gone that he needed to be sedated and taken to hospital. (Amanda)

This was likely informed by the historical context of harm-reduction organisations, which were established with the explicit aim of reducing the need for hospitalisation. They believed there to be a risk that the person in crisis could suffer long-term harm from using these services, particularly if they did not consent to do so. One idea about this was that use of tranquilisation arrested the process of working ‘through’ a crisis, such that the person would be left with issues that were unresolved and potentially unsettling or destabilising.

> taking you out of the experience forcefully is very, very bad. (Erik)

> Precipitously halting the unfolding of such an experience through the administration of a tranquilliser, ... can do more harm than good. ... for it

> often results in the individual waking up with memories of a horrific experience that haunts them for a long time to come (MAPS Manual)

This perspective was shared by Erik, who also added that taking a person to hospital or calling in the police invoked a process of removing agency from the person and submitting them to an authoritative control that risked further escalating a situation. Harm-reduction participants believed that involvement of the medics or police could then serve to confirm to the individual that their experiences were as dangerous and unmanageable as they perceived them to be and thus aimed to avoid this situation whenever possible.

In the majority of cases, participants were able to contain a situation with the potential for harm to the person or another amongst their team. The awareness that other teams were available reduced anxiety and supported them in feeling more able to tolerate difficult situations. The caregiving teams might further support the development of this relationship between teams by offering formal or informal training and advice about psychedelic crises to security or medical staff they worked with.

3.3.3. “Knowing Where Someone Is At”

This referred to the caregiver’s ability to gauge a person’s state. Participants regarded the ability to discern the point at which a person was transitioning from the window of tolerance into a crisis state as a particular challenge.

The context in which the crisis occurred played an important role in “knowing where someone is at” (Eimear). Several of the participants initially found it difficult to verbalise how they gauged a person’s state. When this was explored further, it became apparent that the intuition which participants spoke of drew from their immediate observations of the person, any contextual information they held or gained, their knowledge of the substance, and their own lived experience of such challenging psychedelic states.

Outside of harm-reduction, participants were able to be with the person before they entered crisis and would take an approaching of monitoring the person. At music festivals, people were typically brought to the harm-reduction facilities by friends or the security team in an already escalated state. Participants working here might be more likely to engage in a supportive intervention more quickly, whilst at the same time as monitoring for medical risk, mental state, and where possible identifying which substance(s) had been taken.

3.3.3.1. Observation Participants made careful observations of the person's orientation, responsiveness, non-verbal cues (such as posture, gesture, movement, facial expression, tension), verbal communication, and behaviour. The body was seen as an invaluable source of information as it could provide clues to a person's mental state even when a person could not communicate verbally.

> There's a lot about body. If you're hyperventilating and you're pale, it's very different from if you're just kind of resting and kind of with it. (Erik)

> The body movement is the indication ... obviously if they're clenched ... then maybe you know they need to feel more anchored or more relaxed or to go into whatever is happening for them. (Amanda)

They spoke about monitoring the duration and intensity of emotional state, their safety, their ability to connect with some aspect of consensus reality or to take an observing perspective on their experience. These factors would combine with the context, the caregiver's knowledge of the substance and knowledge through lived experience to guide the caregiver in deciding whether a person was outside the window of tolerance, what state of crisis they were in, and what caregiving approaches to implement.

3.3.3.2. Information Participants varied in how much prior information they had about the people they supported; those working in clinical trials had full medical and psychiatric history, whereas those working in harm-reduction might not have any information at all. What this indicated is that information could be a helpful, but not necessary, component of "knowing where someone is at".

Learning about the person's state through observation could be preferable to questioning them about their experience. In part, this was because the person could fluctuate in their ability to respond verbally. More important was the recognition that the act of questioning could be perceived as intrusive upon what participants essentially viewed as a private experience, and that it ran the risk of escalating a person's feelings of anxiety about the dangerousness of their experiences.

> To not enquire too much. To the point where they really have to over-think what they are trying to say because that might send them a bit more into an anxiety of being like I actually really don't know what's going on. (Eimear)

Participants spoke about a need to have a basic understanding of the situation, there was also a risk that seeking information could be used as a means to allay their own anxieties.

> being more comfortable with the uncertainty as to where they are at. The not knowing. (Peter)

3.3.3.3. Knowledge of the Substance: It was important for caregivers to have information about the substances that were being used such as duration of effects, drug interactions and common adverse effects. Knowing the specific effects and interactions gave participants confidence in being able to make appropriate decisions around the involvement of medics and the ability to offer reassurance to the person about the substance's safety profile and duration of action. Where possible, caregivers shared some of this knowledge before the substance was taken. Knowledge of the substance could be gained from peers, elders, and published literature.

3.3.3.4. Lived Experience: All participants thought that it was very important, if not essential, for a caregiver to have lived experience of challenging psychedelic states. They felt this gave them an understanding of the breadth and nature of experiences that could occur. This could be used to support the caregiver in being able to "accompany the client" (Birgitta) in a number of different ways, such as through building empathy and trust, being nonjudgemental, identifying experiences, and guiding decisions around how to support.

> the nature of psychedelic experience in terms of ineffability, language and usual modes of making-meaning or sense do kind of break down. ... having not done it. I mean, it's just, there's no kind of map to even start to gauge where they'd be at (Peter)

> I'm not that familiar with, from first-hand experience what those things are like for her, at the same time, because, you know, I got, er, I've had psychedelic experiences. I know that wavelength. (Lukas)

> I think my work changed through my own experiences... because I knew how it feels to be dissociated ... [I’ve had my] own experience where sometimes I would need, er, a hand that holds me. (Birgitta)

Two of the caregivers thought it was possible to gain some of this experience through other forms of non-ordinary states of consciousness, for example through long-term meditation practice or holotrophic breathwork. All participants agreed however, that it was preferable to have direct psychedelic experience.

3.3.3.5. Knowing the Limits of Support: Despite determined efforts to avoid involving the police or medical teams, this was sometimes necessary in harm-reduction contexts. Participants said that part of their duty of working safely was to be able to recognise when they had reached the limits of their ability to support an individual. In some instances, such as when one person tried to run on to the motorway, it was clear that this external support was necessary. These clear decisions came when the team were unable to keep the person physically safe, or if there were risks to health (typically from polysubstance use).

> when we can't, we cannot contain. When it's outside of our ability to deal with it, I'm talking purely {harm-reduction organisation} here. I've never called the police in other situations. It's like when there is physical danger involved. (Erik)

More difficult were incidents that the team felt were on the threshold of their ability to contain. One example of this was an incident reported by Eimear in which a man had accidentally consumed an entire bottle of liquid LSD and entered a crisis state in which he risked seriously hurting himself. Using their knowledge of the substance's duration of effect and from their position of wanting to avoid hospitalisation, the team chose to adopt the approach of ensuring the man's physical safety by restraining him until the intensity of the LSD began to abate. They asked the medical team to attend so that both teams could think together about whether and when a threshold for hospitalisation was reached. The harm-reduction team were with him for many hours. Eventually, a decision was made together that the man was at risk of hypothermia and exhaustion; that hospitalisation was required. Eimear reflected that having the medical team on hand allowed them to feel more confident in how long it was safe to remain with their caregiving approaches.

Outside of the harm-reduction settings in which poly-substance use and sleep deprivation were common, participants spoke much less about issues surrounding risks of harm and none spoke about requiring external support. They attributed this to several factors including having a pre-existing relationship with the person, having prepared the person for the types of experience that can arise, and having a calm and controlled environment. Typical risks that occurred here were due to the person being less aware of their surroundings or moving in a way which could cause injury.

> I called over to the other people that were working with me at the time and we went over to try and intervene with this guy who was hurting himself climbing over a fence. (Eimear)

> we also had a girl ... who kind of looked like she'd be falling in the fire, so we were kind of physically looking after her. (Amanda)

3.4. “Holding People Through the Experience”

“Holding people through the experience” (Eimear) outlines how participants worked with people in crisis, what they were hoping to achieve by their interventions, and what support might be offered after the crisis episode. Participants’ overarching approach was to create the conditions (using least intervention) which would allow a person to move to a state of acceptance in which they would no longer seek to stop, reduce, or control their experiences. Participants often used directional metaphor such as “moving through”, “going towards”, or “on their journey” to describe this transition. The conditions that allowed the transition were safety, connection, and release of tension. The extent to which caregivers needed to focus on supporting one or all of these conditions varied for each individual, depending on the context they were in.

When a participant had identified that a person was in a psychedelic crisis, there were several different approaches that they might use depending on whether the person was feeling overwhelmed, disconnected, or was being expressive. There was variation between participants in their use of specific strategies, but the function of these strategies shared a common purpose. This provided a team with more flexibility and opportunity for a good-fitting dyad to be formed between a caregiver and a person in crisis. It allowed caregivers to develop a personal style which could be adapted to each person they supported, facilitating authentic engagement.

3.4.1. Safety

Participants recognised the importance of prioritising a person’s physical safety when necessary, this has been described in greater detail in ‘knowing the limits of support’. Other forms of safety came from interpersonal, environmental, natural, and spiritual realms.

3.4.1.1. Interpersonal: Participants said that creating a sense of interpersonal safety between themselves and the person in crisis was essential to effective support. A key aspect of this was about avoiding actions, verbal and non-verbal communication which could trigger or escalate an overwhelmed feeling. They said they aimed to convey to the person that they were with a benign other, who was able to stay with them despite the difficulty and distress of the crisis experiences.

Participants believed that people in crisis were in a state of amplified sensitivity and thus could be greatly influenced by small and sometimes almost imperceptible verbal and non-verbal social cues that were being communicated by the caregiver and other people in the vicinity. They discussed how it was important for them to increase their awareness of how they might influence the person in crisis, as they could be a source of positive or of negative influence.

> they're obviously in such suggestible state, arguably vulnerable, erm, it's good to be very alive to the influence of everything you bring into it yourself. Because you hope it's going to be healing or helpful but yeah. (Peter)

> there was probably an element of panic or “oh my god, what should we do now?” ... and that maybe compounded him, he was thinking like “oh they don't know what to do, maybe I'll move back further into myself”. (Amanda)

Participants spoke about how they tried to convey the sense of being non-threatening through their choice of language, tone of voice, laughter, eye contact, facial expression, posture, gestures, and movement.

> So it's very much getting on the level, staying with, being quite soft and not rush in. Often, often if you're really in distress I will kind of approach almost in a sideways way. I would avoid going straight at you. I would be more kind of like standing next to you. ... [as] opposed to having this challenging thing. So, it's more like we're looking at that thing over there. Which is quite wise. It's not as scary. (Erik)

> When noticing being observed, confused and anxious clients can easily create delusions about what other people think of them. Therefore, eye contact should be always accompanied with clear words or easily interpretable mimics and gestures. (MAPS Manual)

Another way in which participants fostered a sense of interpersonal safety was through the use of touch. Touch, typically holding a hand or putting a hand on the shoulder, was used to physically indicate to the person in crisis that they were not alone and that another person was with them during their experience.

> it would be quite a firm hand hold. It's not one of them {gesture a floppy hand}, it's I'm here {gestures firm grip}. I really got you. (Erik)

> So I just held her, like I kind of cradled her in my arms for a really long time and just like really held her. (Eimear)

3.4.1.2. Environmental: All of the participants spoke about the physical environment in which they supported someone as highly influential. They gave detailed consideration to how it might be used to support a sense of safety. Many of the participants spoke about trying to give people a sense of ownership over the space that was inhabited. Two of the three participants who worked as therapists conducted the psychedelic sessions in a venue of their client's choosing, partly for this reason. On the retreats, people were invited to bring objects of personal significance into the space. In harm-reduction, there were typically a number of different spaces which could be used flexibly (such as a central communal space with a fire, a quiet tent, and a tent for people being more expressive). They also tried to offer a degree of privacy to those who wanted it through the use of curtains.

All the participants shared a belief that mind and body were inextricably linked and so it was important to ensure the space was comfortable, for example by giving spaces to lie down and using cushions rather than chairs. This was also done through gentle sensory stimulation; the use of soft furnishings, aesthetic decoration, diffused lighting.

> on the retreats we really basically try to make it so comfortable for people. ... a place that you would like to be born into [laughs] like the most comfortable place for a baby to be in is the place that a psychedelic space is really great. (Eimear)

Three participants spoke about times when they gave a person a soft object such as a blanket or cushion to provided continued comfort and to act as a reminder of interpersonal safety.

> And then I put a blanket over him and kept my hand on his shoulder. So the feeling of him like holding on to something really soft and really being held back by that. ... saying nothing but kind of giving him this energy of like, yeah it's okay. (Eimear)

3.4.1.3. Spiritual: The spiritual realm could be drawn upon to support feelings of safety if it was meaningful to that individual. Caregivers spoke of needing awareness and understanding of this.

> I've been a meditator for many years. I am like exuding presence so like when they look at me they see like this guru or something. They, whatever it is that they see. I'm sat upright, sitting in full lotus. I'm giving them, like it's an image that they can see that they can really ground with. (Alexei)

> guests may call on a protector (such as the spirit of an animal with which the guest feels an affinity; guardian angels, if the guest’s religious beliefs support such beings; the spirits of a guest’s ancestors; or God, if the guest feels this is appropriate) to assist them in bravely facing what is troubling them. (MAPS Manual)

Erik told me about his experiences in ayahuasca and peyote circles. He described how in these contexts people are there to perform a sacrament within a specific spiritual framework by taking the substance. He commented that in these settings there was much less interpersonal support for people in crisis. He suggested that this was because the belief system surrounding these rituals provided structure and safety as well as there being different expectations and rules surrounding behaviour.

> it does seem like people are moving through their stuff in a useful way in ayahuasca and peyote circles even though they don't actually have anyone with them. They just have their compatriots sitting next to them and they have the shaman doing their stuff with a fire in front of them. But they are, I guess the belief that they are held is enough for them to feel held while, er, it has to be more manifest in the [harm-reduction organisation] tent because there is no big story around the mushroom or around acid or whatever they're taking. So instead [in harm-reduction] ... I have to kind of create this holding that the whole ayahuasca lore creates. (Erik)

3.4.2. Connection to the “Ground of Reality”

Participants described a range of strategies that were used which had the aim of reconnecting the person in crisis with some aspect of consensus reality; the “ground of reality” (Erik). These shared similarities with grounding techniques that are used in trauma work. The aim of reconnecting approaches was initially to encourage the development of an awareness that there were objects, people or experiences that existed independently of that person’s crisis experience. Participants spoke about reconnecting people to their body, the caregiver, the physical space, and the natural world. This would then be built upon to try and support the development of the ability to take an observer perspective on their experience.

> they can just like step out of themselves and be an observer and watch the situation from the outside (Alexei)

> "Okay. Go there but keep the normal, the reality contact with me". So, with one part the client could look where he was, [yet] was sure he was in the here and now, and go into it. (Birgitta)

Participants named this observer perspective differently depending on their framework (for example, “witness consciousness” or “awareness of the parts”). Others did not name it directly but used metaphorical language to describe it as the goal of reconnecting approaches.

> there's something beyond this moment, there's something beyond this space. ... I'm going to cross this line. I'm going to go stand over here and you're going to get over here. Okay? I know where you are. I'm looking across the divide. I know where you are right now. I understand it. I'm not going to be in there right now because I think you need me to be over here helping you to find you way over here. ... we were sort of navigating space together ... but she knew that I knew what it was like on her side and she knew that there was something [that] it was like to be on my side. (Lukas)

3.4.2.1. "Re-anchoring" the body: Participants spoke about helping a person to become more aware of their body as another way of grounding them in consensus reality. They used this to try and draw people out of a disconnected state of unresponsiveness, and also to support people in managing their feeling overwhelmed.

> Oh, connection. Connection. We are our bodies, and our minds can create fantastic worlds, as anyone on LSD will tell you, but getting you back to body. It's kind of the ground of reality (Erik)

> we could just make the stimulation from the body stronger, so walking barefoot in the garden on the grass makes [him] more connected to the body because [he will] feel something on his body. (Marija)

For people in a state of disconnection, who could be unable to move, communicate, or engage with anything in their surroundings, participants described firmly holding a shoulder, massaging a hand, pinching an arm, walking, using cold water, giving sweet tea, and getting bare feet in contact with the ground. This increased stimulation was thought to provide an "anchor" (Amanda) or "focus" (Eimear) which would provide the person with new sensation to attend to and bring awareness to the present. It also provided an alternative to verbal communication.

Peter thought that it could provide awareness of a boundary between themselves and other people or objects. This technique could be helpful for people having ‘ego-death’ or ‘ego-dissolution’ experiences in which the sense of a subjective self is lost and the person is unable to differentiate themselves from other people, objects, or the universe.

Increasing the person’s awareness of their bodily state was also used as a supportive approach for people who were experiencing overwhelming emotion. All participants spoke about working in this body-oriented way but for Alexei this was his primary way of working with this state. He would encourage people to identify, name, and follow sensations within their body. This was driven by the idea that by making the body state observed and known, the mind-body state would feel more manageable. Birgitta described feelings as “the language of the body”. These techniques enabled the person to develop more congruence between the emotional state and feeling states in the body.

> if they are grieving, I might say “Okay. Let's notice what's happening in your chest”. It's not that I'm talking them out of their grieving, it's that they can come to a more accurate sense of their grief through the body. (Alexei)

3.4.2.2. Interpersonal connection: Participants attempted to make an interpersonal connection with people through communication. When participants gave examples in which they spoke to people, they used short, clear sentences. They might use questions to try and increase the person’s awareness of their presence. Two participants spoke about using gentle humour with some people (for example, Erik would ask people “How’s my hair?”), though other participants cautioned against using humour as they felt this was open to misinterpretation which could develop into feelings of mistrust and attack. Caregivers also attempted to establish connection through use of facial expressions, eye-contact, breathing with the person, and gesture.

> through the eye contact, you immediately get someone more into reality. (Birgitta)

> Just sitting beside him ... and breathing myself. To know that he can hear me breathing and stuff. He can follow my breath. Giving people really subtle focuses. (Eimear)

> he was grimacing in a spectacular way, moving all his facial muscles at an incredible pace. As he was reluctant to respond to my questions, I decided to imitate his grimacing. It seemed to work and, little by little, a minimal communication began to be established. (MAPS Manual, p240)

3.4.2.3. Other-than-human connection: Sometimes participants described using objects, images or features of nature to provide a focus point. These non-human sources of connection were useful for people who were finding human interaction too threatening or demanding.

> we would probably allow people to be in a very distressed state for around fifteen [minutes], ... but after that we would then show them a rose ... so they're not stuck in there too long (Amanda)

> tree grounding allows the person to dissipate some of the powerful energy, which can be “safely absorbed” by the tree. For people experiencing paranoia or mistrust of others, a tree can be a neutral friend they can turn to. (MAPS Manual, p179)

3.4.3. Release

All but one of the participants spoke about the idea of supporting a person to release physical tension (posture, muscular tension, feelings of excess energy). From their observations, they interpreted these as supporting the person in expressing some emotional tension. There were a few different beliefs that contributed to this approach. One was that physical tension could have a negative effect on mental state and so changes in mental state might be seen as a consequence of releasing such tension. Participants found it helpful to invite and support people to realign their posture so that it was symmetrical and open (for example, laid supine with palms facing up).

> It's like if people are physically uncomfortable or if they're sitting there with their palms, if they're just clenched or their jaw tensed and they are physically saying “no way now am I going into this”. That's when the mind can start to have a really challenging time. (Eimear)

> no matter how hard you try to be mentally positive, if your body is contorted, you're not going to be able to come out of it. (Alexei)

The other belief was that if emotions could be physically expressed through action, the person would move away from the struggle for control which they hypothesised generated the crisis experience.

> he said "I, I have murderous anger". So, um, I asked him "What do you want to do? What would you like to do?", "Choke him". ... He really allowed his hands to do the {makes choking gesture with hands} to finish the movement of wanting to choke the other (Birgitta)

Caregivers reported that the release of physical tension often brought up a surge of emotional expression from the person. Sometimes connection to another through the caregiver’s touch also prompted a sudden shift into emotional expression. Often this was regarded as an indication of a shift in the person’s state and caregivers took it as an opportunity to re-assess the person’s needs and their approach to supporting them.

> To take her really out of her mind and feel into the earth, feel like the breeze and just bring her a bit more into the body. Um, and yeah that seemed to really help like she then afterwards started crying a lot, um, and that was potentially like a sign of her coming back a bit from what was happening. (Eimear)

Generally, these types of emotional and physical releases were viewed as positive by the participants. They were seen as something to be supported and encouraged.

> If someone is shaking like hell, er, I just er, er, again [use] a tiny little body contact. [So] that he knows [that I am there]. But I would not hinder it. I'd even say "Oh yeah, let it out. It's wonderful" you know. It's the energy, it's the stored thing. (Birgitta)

As in Birgitta’s quote, language used by some of the participants (such as “purging” and “overflowing”) suggested that some caregivers drew on a hydraulic metaphor of the mind and that there was a need to release some tension. There were exceptions to this. Erik and Birgitta both noted that “sometimes letting something out just makes it worse” (Erik). They spoke about this in relation to instances where release of bodily tension did not result in a quick shift of emotional release; “the tears spread out and then it’s over” (Birgitta). In these instances, the person was still attempting to stop, reduce, or control their experiences but this was now being expressed in a more bodily manner (as described in section 3.2.4.2.)

3.4.4. After the Crisis

3.4.4.1. Accepting: Participants described a shared goal of supporting people to change their relationship to their experiences. Through their supportive approaches of creating safety, connection, and releasing physical tension or emotion they hoped that the person could shift to an accepting state in which they would not seek to stop, reduce, or control their experiences.

> allowance brings relief, no matter what the content is. So any time the person is having a hard time, I invite them to allow that. ... I get them to give in to it. I support them to say okay, there's room in here for that. Like let's just allow that. (Alexei)

> being there with somebody, letting them know that you are there in whatever is happening. That ... whatever is happening is okay and to accept it. ... just being present in whatever that is happening and yeah giving permission for people to allow whatever's coming to come and not repressing it. I think that's also a really important thing. (Eimear)

Acceptance did not necessarily mean people were no longer distressed. Sometimes there were reductions in distress associated with no longer engaging in a struggle for control. Other times, the person may be more connected with distressing emotions or experiences once they had moved into a state of acceptance. As with identifying a crisis state, participants found it difficult to describe how they gauged when a person first transitioned into acceptance. They spoke of observing changes in the person's verbal and non-verbal communications and interactions, and of drawing on their lived experience of psychedelic crisis and past experience of supporting others to judge this.

After the person was out of crisis but still under the influence of the psychedelic, there were some variations between participants in terms of whether to take a non-directive approach, or a more active therapeutic approach. Participants who worked in a therapeutic context often then used this time to invite the person to go “deeper” (Birgitta), “towards” (Peter), and “into” (Marija) the experience as part of the therapeutic work. This might be achieved through asking questions about their experience, role-playing scenarios, chair work, or by engaging directly with the experience. An example; if a person was feeling afraid of demons they were seeing the therapist might encourage them to adopt a curious stance towards them, to ask them questions, to try to see from their perspective, or to take care of them. When participants took this approach, they carried an awareness that by doing this they were engaging with material that could again shift the person into a state of crisis. They needed to have the skills and experience to manage this.

> It sort of becomes more advanced skills, clinical skills because basically you're confronted with, do I allow this experience for like it's therapeutic value ... or is it damaging to them? Are they re-traumatising themselves in this moment? (Alexei)

3.4.4.2. Integrating All participants agreed for the crisis to become a lasting “transformative” (Amanda) or “healing” (Eimear) experience it was important for people to take part in an additional process of making meaning from their experiences and to integrate this learning in their everyday life. This took place after the crisis was over and the effects of the substance had abated. This was to ensure that the person was no longer in a heightened state of suggestibility and that they had their usual cognitive capacity when considering their experiences.

It was outside the focus of this study to explore these processes in great detail however, it was viewed by the participants as an essential factor in establishing long-term benefits from a crisis. All participants spoke about this, typically calling it “integration”. Integration did not need to take place with the same person who had been supporting them at the time of crisis though in most contexts it was incorporated into the process. In harm-reduction, the participants had no control over whether people chose to return to make sense of what had happened. Some people did not seek any support from others when integrating their experiences or were not interested in doing so. Some of the participants offered support with integration separately to their direct work with psychedelics; in individual or group contexts.

A flavour of some of the work that takes places during a process of integration can be found in the quotes below.

> in the integration group because people have all these archetypal transpersonal experiences they can, maybe there's something about normalising them and seeing, maybe collectively, these are symbolic experiences. Do I need to take these literally? Of course they're relevant and meaningful to me but, I think having that space we've created for people to talk about these experiences and normalise them and to sort of say, yes I've touched the void, I know what meaninglessness is but to have other people hear that, witness that, and not to feel mad, I think is very holding because you can probably think, “Oh my god, I've broken my brain” (Amanda)

> So, you went, you saw a dragon. Then I go, "What did the dragon see?". And all of a sudden the dragon sees a little girl and it's like, "Oh wow, that's how you see yourself". Or he sees this wizened old woman or whatever the hell you see yourself as. ... Then also to integrate, put it into

> real life. "Well, okay. What are you going to do now? How are you going to see yourself?". ... I have some clients who do a trip every six months. So that means then that's regular psychotherapeutic work and then integration work and preparation work kind of all rolled into one. This is your job, this is how it is, this is your partner, this is your kids, this is your sense of self-worth, this is your history. And in two months this thing is coming up. “Oh you want to work on that? Okay. How can we make sure you stay on that journey when you do your twice annual mushroom trip?” Okay. Then they come back from it. “Okay. How was that? Oh it went that way? Oh interesting.” And you weave it in. It becomes quite seamless. (Erik)

5 DISCUSSION

4.1. Introduction

In this chapter, I will relate the findings of this study with the aims of research and the literature then critically review the research and provide a reflexive account of the work. This will be followed by a discussion of implications for practice and further research.

This study sought to explore the process of supporting people who have taken psychedelic through episodes of acute and intense distress. In the introduction, a case was made that supporting people through a psychedelic crisis could have shared similarities to supporting people through an acute episode of psychosis. This research asked, “How do caregivers support an individual through a psychedelic-induced crisis experience that might be useful when supporting people experiencing acute psychosis?”. I will firstly discuss the findings in relation to the psychedelic literature and secondly in relation to work on psychosis.

4.2. Interpretation of Findings in Relation to Literature on Psychedelics

It is recognised that people can have very challenging experiences when taking psychedelics and that the availability of somebody to support the person during these can be beneficial. Despite this, there is little published research that describes how to support a person having psychedelic crisis experiences. Here, I will discuss the framework in relation to the psychedelic literature.

4.2.1. The Role of Experiential Avoidance

A key principle of the way in which participants supported people in crisis was that they did not attempt to stop or reduce the experiences that were tormenting the person. They conceptualised a crisis as caused by an individual struggling to control their experiences, rather than experiences themselves causing crisis. They believed that acting to stop or reduce the experiences could run the risk of escalating the crisis further as this might confirm a person’s fears that their situation was unmanageable, unstoppable, or dangerous. This is consistent with a survey of 1,993 people who had a psychedelic crisis in which 91% described ways in which they tried to stop their experience. The framework describes how support involves creating conditions of safety, connection, and release to enable a person to change their relationship toward their experiences from a position of avoidance to acceptance.

Early psychedelic research was dominated by psychoanalytic frameworks; here, avoidance was described as ‘resistance’ to the experience (Abramson, 1956; Blewett & Chwelos, 1959; Frederking, 1955; Martin, 1957; Rhead, 1978). Psychoanalytic theory holds that anxiety arises in parallel with psychological struggle and that overcoming resistance is required for emotional breakthrough and insight (Freud, 1920). This process could equally be understood in relation to the process of experiential avoidance; a concept which describes the attempt to escape or avoid private psychological experiences by attempting to modify their form, frequency, or intensity (Boulanger, Hayes, & Pistorello, 2012). It has been described as a transdiagnostic process in distress, found in psychodynamic, gestalt, humanistic, existential, behavioural, and ‘third-wave’ therapies. For these participants, experiential avoidance was the driving process in the development of a crisis state. This conceptualisation of the mechanism of crisis informed the approaches taken by caregivers.

4.2.2. Supportive Processes

Participants did not use approaches which attempted to stop or reduce the person’s experiences as this was viewed as a continuation of experiential avoidance. Instead, participants used three mutual processes; developing a sense of safety, establishing a connection, and releasing tension. The strategies that were used to support this were informed by their view of an individual as an embodied self, embedded within their context.

A sense of safety could be achieved through interpersonal, environmental, and spiritual realms. Participants used strategies in these areas to try and reduce the person’s threat arousal. In interviews with twenty-two mental health professionals who took LSD during the 1952-1974 era of legal psychedelic research in Czechoslovakia, 82% emphasised that the presence of a supportive other was necessary for them to feel secure in the experience and develop feelings of safety and trust (Winkler & Csémy, 2014). Trust is recognised to be an important factor when supporting a person having psychedelic experiences. A study of 78 people with heroin dependency staying in a residential facility who underwent LSD psychotherapy highlighted the failure to develop an adequately trusting therapist-participant relationship as a contributing factor to ‘unsuccessful’ cases. The authors suggested the wide sociocultural gulf that existed at that time (1970s USA) between the white therapists and the predominantly black participants as one factor contributing to difficulties establishing trust (Savage & McCabe, 1973). More recently, guidelines developed for psychedelic research recommend that participants have several hours of preparatory meetings with the explicit purpose of developing trust. A trusting relationship is felt to be so important that if, after further meetings, it cannot be developed then participation should be withdrawn (Johnson, Richards, & Griffiths, 2008). The development of trust can open up a broader range of strategies for caregivers to use, allowing for more adaptable responses to people’s needs (Carmo Carvalho et al., 2014). Participants used strategies that promoted reductions in physiological arousal through the release of tension. These body-oriented strategies have been reported as helpful elsewhere and were able to be used if trust is established (Carmo Carvalho et al., 2014; Meckel Fischer, 2015).

The environment is believed to be an influential factor that mediates psychedelic experiences (Carhart-Harris et al., 2018). Participants spoke about using the environment to reduce arousal through offering privacy, comfort, ownership of the space, quiet, and soft lighting. Few controlled studies have directly investigated the influence of these factors (Harden, 2018; Hartogsohn, 2016). Negative long-term outcomes following psychedelic experiences have been more commonly reported in contexts in which environmental influences were not considered (Larsen, 2016). One area which has been investigated is the influence of carefully selected music; this was shown to promote calm and a sense of safety during trials of psilocybin for ‘depression’ (Kaelen et al., 2018). This provides some support to the notion that reductions in threat arousal is the mechanism by which environmental factors can have a beneficial influence on psychedelic crisis experiences.

People can experience profound alterations to their sense of self, including feelings of merging with the surroundings, universe, or complete loss of subjective self-identity (Grof & Halifax, 1977; Leary & Weil, 1968; Schultes, Hofmann, & Rätsch, 2001). Supportive strategies used by participants to establish connection may help to counter the over-whelming nature of these perceptions without using reality-defining techniques that seek to distract the person from their experience and have been reported to escalate difficult experiences (McCabe, 1977). Many of the techniques were recognisable as grounding techniques which brought attention to the person's body and its boundaries.

4.2.3. Supporting Acceptance

The transition to acceptance is captured through phrases commonly used in the literature such as 'surrender', 'let go', and 'trust the process' (Johnson et al., 2008; Lucas, 2005; McCabe, 1977; Richards, Rhead, Dileo, Yensen, & Kurland, 1977; Zendo, 2015). A retrospective study of 143 people who had taken psilocybin indicated that positive psychedelic experiences were most often predicted by entering a state of surrender (Russ, Carhart-Harris, Maruyama, & Elliott, 2019). This also relates to participants' beliefs that attempts to stop or reduce experiences (through caregiving strategies or hospitalisation) could be harmful as they prevented the development of an accepting relationship.

In follow-up interviews with people who had improvements in 'treatment-resistant depression' following psilocybin, participants identified this same transition as one of the change processes which contributed to their improvements (Watts, Day, Krzanowski, Nutt, & Carhart-Harris, 2017). It has been argued that this mechanism is shared with third-wave behaviour therapies (Walsh & Thiessen, 2018). A study of twenty-five people found that they had increased capacities for mindfulness after taking ayahuasca (Soler et al., 2016).

Participants' beliefs that crisis experiences should be considered 'difficult, not bad' relates to this opportunity for experiential learning about changing relationships to crisis experiences. The adoption of a non-directive, active-listening approach could be seen to be enabling this experiential learning to occur.

4.2.4. Integration

All participants emphasised the importance of integrating this learning in everyday life to make lasting positive changes. The focus of the present study was on support during crisis experiences and so this integration phase (which happened afterwards) was not explored in great detail.

The extent to which integration support was offered varied depending on the contexts in which participants worked; those working in therapy, on clinical trials, or on retreats considered this work to be a part of their role as a caregiver. In relation to ayahuasca use, it has been argued that there is not a framework with which to understand these experiences in Western cultures and that psychotherapy may present a culturally-sanction medium through which to engage in a meaning-making process (Lewis, 2008). Meaning-making is a central process within psychedelic psychotherapy (Belser et al., 2017; Harden, 2018; Meckel Fischer, 2015; Phelps, 2017) and therapists who do not work with psychedelics also offer support integrating these experiences after they have occurred (MAPS, 2019). Transpersonal frameworks may be well-suited to accommodating the range of unusual experiences which can occur (Friedman, 2014; Roberts & Winkelman, 2013).

4.2.5 Caregiver Knowledges and Skills

Participants described the qualities, knowledge and skills they required for this work. Much of this has resonance with descriptions of qualities needed to establish therapeutic relationships (Rogers, 1958). Guidelines of competencies for psychedelic therapists also identified the importance of knowledge about the substance and particularly for lived psychedelic experience (Phelps, 2017).

4.3. Relating the Framework to Psychosis

4.2.1. The Role of Experiential Avoidance

There is evidence that this process is used by people having psychotic experiences and that it can contribute to levels of distress (Freeman, Garety, & Kuipers, 2001; Daniel Freeman et al., 2007; Goldstone, Farhall, & Ong, 2011; Hacker, Birchwood, Tudway, Meaden, & Amphlett, 2008; Morrison, 2001; Tully, Wells, & Morrison, 2017). Studies that have compared clinical and non-clinical voice-hearers describe how clinical voice-hearers report using more techniques to control, suppress or distance themselves from the experience of hearing voices (Hill, Varese, Jackson, & Linden, 2012; Sorrell, Hayward, & Meddings, 2010). Anxious responses to psychotic experiences have been reported as having a greater relationship to emotional distress than the intensity of the experiences themselves (Morrison & Wells, 2007).

4.2.2. Supportive Processes

Some psychotherapeutic approaches to psychosis conceptualise the core difficulty as a person being unable to bear their emotions and that recovery involves acknowledging, bearing, and putting into perspective these intolerable emotions (Garfield, 2009). In the present study, one the of processes by which participants enabled people to move from experiential avoidance to acceptance was through developing a sense of safety. This was reached by reducing levels of mind-body arousal on an interpersonal level, by facilitating release of bodily tension, and by reducing sensory stimulation from the environment.

A Swedish study found significant reductions in use of injections and restraint to manage aggression when they compared a psychiatric ward which had moved to a hospital incorporating new stress-reducing design features to the old hospital in which it was based (Ulrich, Bogren, Gardiner, & Lundin, 2018). These new design features included elements that would reduce interpersonal threat such as single patient rooms, spacious and moveable communal areas, and low social density. It also incorporated elements to reduce sensory overload such as noise reduction and daylight lighting. Similarly to the present study, they also drew upon the natural world through incorporating an accessible garden, views of nature from windows, and installing art of nature. Interaction with and viewing of the natural world has effects on stress physiology and emotion regulation (Brown, Barton, & Gladwell, 2013; Johnsen, 2011; Park, Tsunetsugu, Kasetani, Kagawa, & Miyazaki, 2010; Ulrich et al., 2018), possibly due to the potential for nature to be experienced as an attachment object, providing containment and a secure base (Schweitzer, Glab, & Brymer, 2018).

Participants adopted a number of strategies to facilitate the release of bodily tension including alterations to posture, breathing, and support of movement. There is a limited evidence base for the use of body-oriented approaches for people with psychosis. There have been systematic reviews on the effects of yoga, tai-chi, and aerobic exercise which indicate promising potential for these interventions. However, all three reviews highlighted the poor methodological quality of studies and did not distinguish between people in acute psychosis or those living with its long-term effects (Lin, Lee, Tong, Lee, & Chen, 2014; Vogel et al., 2019; Zheng et al., 2016).

This notion of developing a sense of safety can be found within compassion-focused approaches to psychosis, which aims to help individuals develop a compassionate self-reflective stance towards their experiences (Gumley, Braehler, Laithwaite, MacBeth, & Gilbert, 2010). Within this approach, creating conditions of safeness by reducing threat arousal alongside developing compassion allows for improvements in emotional regulation and therapeutic change (Heriot-Maitland, McCarthy-Jones, Longden, & Gilbert, 2019).

Participants also worked to support people to establish a connection to some aspect of reality; their body, the caregiver, or a physical object. Many of the techniques they employed were recognisable as grounding techniques that are described more widely when working with trauma (Boon, Steele, & Van Der Hart, 2011). A systematic review of twenty-five studies indicated that there were some promising effects of trauma-focused treatment for psychosis (Brand, McEnery, Rossell, Bendall, & Thomas, 2018). Both in the present study and in a grounded theory study of sixteen people with psychosis, this process was referred to with the word ‘anchoring’. This was described as “providing a base to return to, limiting how far they can drift or be carried away by unpleasant experience” (Abba, Chadwick, & Stevenson, 2008, p. 81). Elsewhere, it is described as acting as a counter-point to experiences of fragmentation and facilitating a shift towards an observer perspective (Mills, 2010). It is possible that the use of touch to establish connection was particularly useful in this regard as it involves a bodily recognition of the boundaries of the self and the existence of another.

Participants used a variety of techniques to support the person to develop an observer perspective on their experiences. This perspective allows for private experiences to be recognised as distinct from the self and reduces their power. This might be of particular relevance in psychosis for people who have feelings of powerlessness in relation to their experiences (Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000; Vaughan & Fowler, 2004).

4.2.3. Goal of Support

The ability to adopt an observer perspective was one part of moving away from a process of experiential avoidance and into a process of acceptance. This represented the person undergoing a change in relationship to their experiences, rather than continuing to attempt to directly change the experience and was the primary goal of caregivers.

The goal of changing relationships to experiences in psychosis is a concept which has been used in several therapy approaches, most centrally in acceptance and commitment therapy (ACT) and person-based cognitive therapy (Chadwick, 2006; Wakefield, Roebuck, & Boyden, 2018). The usefulness of these processes was reported by people with psychosis who had taken part in qualitative study after a trial of ACT (Bacon, Farhall, & Fossey, 2014). A grounded theory study of sixteen people with psychosis who took part in a mindfulness group programme described the experience of relating differently to psychosis through three stages, ‘centring in awareness of voices, thoughts, and images in the moment’, ‘allowing voices, thoughts and images to come and go without reacting or struggle’, and ‘reclaiming power through acceptance’ (Abba et al., 2008). This relates closely to some of the processes in the present study of moving away from a struggle for control towards a position of acceptance. It also points to acceptance as an empowering position for the individual to adopt and is an approach used by people who have positive experiences of voices and not accessed mental health services (Jackson, Hayward, & Cooke, 2011). An interpretative phenomenological analysis of interviews with ten people with psychosis identified that the development of compassionate self-acceptance resulted in empowered action and promoted recovery and growth (Waite, Knight, & Lee, 2015).

4.2.4. Integrating the Crisis

The negative impacts of psychosis have been extensively reported in the literature. Comparatively less is known about the experience of people who described beneficial changes after psychosis (Jordan, Pope, Lambrou, Malla, & Iyer, 2017). A systematic review of 715 participants across forty studies of positive change outlined a range of individual, interpersonal, social, and spiritual changes. One of the factors that was reported to be instrumental in facilitating these changes was making sense and reflecting on the impact of psychotic experiences in everyday life (Jordan et al., 2018). A comparison of religious voice-hearers with and without psychosis found that those without psychosis still experienced powerful voices but that they assimilated these experiences with their religious beliefs, resulting in their positive interpretation (Cottam et al., 2011). This suggests that supporting integration to facilitate lasting positive changes is shared across both contexts of psychosis and psychedelic crisis, and so may represent a worthwhile avenue of further investigation.

A paper from the early period of psychedelic research noted the similarity between ‘sealing over’ or ‘integration’ as recovery styles in both psychosis and following difficult psychedelic experience (Rhead, 1978). It recommended that people with psychosis were able to access ongoing group support to help integrate their experiences, similar to groups that had been established for people who had been treated for alcohol dependency with psychedelics (Rhead et al., 1977). The author noted at the time that the only groups that were available held a biomedical perspective on ‘schizophrenia’ which promoted a sealing over, rather than integrative response style. Since this time, a range of peer-led groups have developed, notably the hearing voices movement. They argues that voice-hearing is a meaningful experience and they offer spaces in which people are able to explore these according to their preferred systems of belief (Corstens, Longden, McCarthy-Jones, Waddingham, & Thomas, 2014). A survey of 101 group members reported that they found the groups helpful in facilitating their recovery processes (Longden, Read, & Dillon, 2018). Also important to note was that whilst 95% of participants used mental health services, one of the most strongly endorsed survey items was that the groups allowed them to access support they could not get elsewhere.

If changing the relationship to experiences and then integrating them are components that support a person towards a positive recovery after their psychosis, then it is important that forums which provide spaces for this are promoted and accessible. In the NHS, there is limited access to therapy for people with psychosis, despite NICE recommendations that cognitive behavioural therapy and family intervention should be offered, and art therapies considered (Kuipers, 2011; National Institute for Health and Care Excellence, 2014). One report estimated that only one in ten people who could benefit from cognitive behavioural therapy for psychosis are able to access it (The Schizophrenia Commission, 2014).

4.2.5. Support Around Caregivers

Participants recognised this work could be emotionally and physically demanding, and disorienting. They emphasised the importance of individual caregivers being surrounded by layers of support which included their knowledge, team, a conceptual framework, and in harm-reduction contexts the support of medical or police colleagues. These sources of support increased the caregiver’s confidence in their approach and helped them to manage their feelings of anxiety.

They emphasised the importance of having lived experience of non-ordinary states of consciousness to support them in their work. Nurses and psychologists have found their feelings of empathy and confidence in talking to people with psychosis were increased by experiencing simulated voices (Orr, 2017; Riches, Khan, Kwieder, & Fisher, 2019).

The importance of staff support in mental health contexts is widely acknowledged and the dynamics involved in negotiating the differing experiences of reality between staff and patients with psychosis brings particular challenges (Hinshelwood, 2004; Shattock, Berry, Degnan, & Edge, 2018). It has been suggested that incorporating literary accounts of psychosis in supervision could present an opportunity to deepen understanding and develop empathy (Leonhardt et al., 2015).

Whilst most of the participants drew from a psychological framework to support their work, there was a shared recognition and respect for different conceptualisations of a psychedelic crisis. Participants spoke about being able to work flexibly with people holding different beliefs about their experience and the importance of not imposing their own meanings onto another's experience through holding an attitude of engaged curiosity. This holds relevance for those working within mental health settings which predominantly hold biomedical perspectives of psychosis, as this may differ from the views of people with psychosis. The ability to work flexibly and respectfully across frameworks is particularly important when we consider how developing personal meanings was a key factor in positive changes following psychosis. One participant who worked as a psychiatrist, Peter, said that he hoped spiritual understandings could be brought into psychiatric training and that this dimension could form a routine part of assessment.

Participants working in harm-reduction spoke about how hospitalisation was an absolute last resort. They believed it limited possibilities for positive learning that could arise from the person being supported to change their relationship to their experience, and that at worst it held the potential to be a harmful and traumatising experience with lasting negative consequences. Many people with acute psychosis are hospitalised when their personal and professional support network are no longer able to manage them safely in the community. One of the key differences between psychedelic and psychotic crises is their duration, which has important implications for the extent of demands placed on the support network. Yet it is also true that many people with psychosis who are hospitalised find this process traumatic and disturbing (Berry, Ford, Jellicoe-Jones, & Haddock, 2015; Frueh et al., 2005; Meyer, Taiminen, Vuori, Äijala, & Helenius, 1999).

Participants believed that the harm caused by hospitalisation came from the symbolic meaning of the process (particularly the removal of agency and control), and the caregiving approach of attempting to stop or reduce 'symptoms' with medication. These factors are built in to the dominant biomedical psychiatric management of psychosis though less heavily implicated in other approaches, such as crisis houses and host family schemes (Beckett, D’Angelo, Pattison, & Walker, 2012; Chevalier, Ntala, Fung, Priebe, & Bird, 2018; Kamera, 2013; Mackler, 2010; Sweeney et al., 2014; Woodward, Berry, & Bucci, 2017). Careful consideration of alternatives to hospitalisation is warranted given the high proportion of people who experience traumatic reactions to episode of psychosis (Chisholm, Freeman, & Cooke, 2006).

It is not just the support around staff teams that needs to be considered. Family and friends are a vital source of support for many people with psychosis and are known to play an important role in recovery (Bjornestad et al., 2017; Georgaca & Zissi, 2019; Harrop, Ellett, Brand, & Lobban, 2015; White, 1987). Guidelines recommend that people with psychosis are offered family work (National Institute for Health and Care Excellence, 2014) however. in practice this is not adequately provided or made accessible (Day & Petrakis, 2017; Martindale, 2017; The Schizophrenia Commission, 2014).

The framework outlined how layers of support were used to increase confidence and decrease anxiety for people caring for others in psychedelic crisis. Applying this approach to friends and families would argue for increased knowledge, the support of others within their network, developing a shared framework or the ability to work flexibly across different frameworks, and clear support from services, especially structures for situations which felt unmanageable. Interviews with families of people that have used early-intervention for psychosis services have highlighted a useful role for these services in developing family members knowledge, yet it was also found that these services could leave family member’s feelings unacknowledged (Lavis et al., 2015). Friends and family that support people with psychosis have their own needs and services may be required to work more holistically with them in order to for these to be addressed and for good working relationships with services to be developed (Cairns, Reid, & Murray, 2015; Poon, Joubert, & Harvey, 2018; Taylor, Mellotte, Griffiths, Compton, & Valsraj, 2016; Yesufu-Udechuku et al., 2015). This is particularly important as relationships with services may be a key factor in mediating some of the emotional impact of supporting a loved one who is experiencing psychosis (Kuipers, Onwumere, & Bebbington, 2010).

People can develop complex systems of understanding around what they experience during psychosis (Carter, Read, Pyle, & Morrison, 2017). Traditional family work interventions for psychosis are uncritical of psychiatric constructs and focus on behavioural work and communication rather than developing multiple understandings. It may be that approaches which promote the ability of family and friends to work flexibly across different frameworks, such as Open Dialogue, would help develop the types of support that holding a framework offered in the present study (Bergström et al., 2018; Seikkula & Olson, 2003; Seikkula, Arnkil, & Erikson, 2003).

4.3. Critical Review

4.3.1. Limitations

This study may be constrained by a small sample size. However, this allowed for in-depth analysis of conversations with people drawn from a range of contexts and from a population that might be classed as ‘hard to reach’ by researchers due to legal contexts. The analysis was supported by secondary data sources. Further limitations were that the majority of the sample worked as mental health professionals, this may have influenced the frameworks used to understanding caregiving and the methods implemented. The only study of a psychedelic harm-reduction service reported that 65% of the caregivers had a mental health occupation so the high proportion in the present study may partially reflect actual demographics (Carmo Carvalho et al., 2014). In addition, all participants came from white ethnic backgrounds, though differing nationalities. This may have implications for the transferability of findings. A further limitation was that, due to time constraints, the framework was not shared with participants for their feedback. All participants requested a summary of the findings, indicating their engagement with the topic, though two explicitly said they did not wish to give feedback.

This study offered a creative and original way of learning more about caregiving approaches for people experiencing non-ordinary states of consciousness outside of dominant psychiatric contexts. It is hoped that useful clinical implications can be derived from the study, as well as sparking avenues for investigation in future research. To ensure quality, I referred to criteria of credibility, transferability, dependability, and confirmability (Korstjens & Moser, 2018).

4.3.2. Credibility

In qualitative research credibility refers to the equivalent concept of internal validity that is used in quantitative approaches. In this study, credibility was ensured through processes of data triangulation (as outlined in method chapter), prolonged engagement, and persistent observation:

- Prolonged Engagement: Interviews took place over the course of approximately one hour, which allowed sufficient time for detailed engagement. Participants were invited to support their accounts with examples and asked follow-up questions to develop the richness of data.

- Persistent Observation: I transcribed all interviews myself. These transcripts were continuously re-read throughout the coding process. Codes were compared and revised throughout the analysis which facilitated repeated, detailed engagement with data.

4.3.3. Transferability

Transferability refers to the applicability of the research. It is hoped that through providing thick descriptions of the research process, participants, and contexts the reader will be able to form a transferability judgement as to the resonance of this study to other contexts. This was supported through a discussion of how the findings relate to psychosis earlier in this chapter.

4.3.4. Dependability and Confirmability

To meet criteria of dependability and confirmability, the research process has been transparently described within the methods chapter. An audit trail was maintained through records of supervisory meetings, as were reflective thoughts and the development of findings through the memo-writing process (see appendix twelve for an anonymised transcript excerpt, appendix thirteen for an example of initial codes, and appendix ten for an example of a memo).

4.3.5. Reflexivity

There is some tension within using constructivist approaches for grounded theory as whilst there are rigorous and systematic techniques to ensure that conclusions drawn are grounded in the data, the researcher's involvement in framing and constructing the analysis is both acknowledged and legitimised. To write a research proposal, I was required to review the literature before embarking on the research, a practice which is not recommended in grounded theory. I limited the influence of pre-existing literature by not engaging with it until writing up the study, after analysis. Yet, without having some pre-existing knowledge of psychotic and psychedelic crises I would not have arrived at the research question. This was sparked by reflections on observations from my professional role as a psychologist and from experiences in my personal life about ways in which people are supported through episodes of acute psychosis in the public mental health system within the UK. Before and alongside my training, I had the opportunity to observe people being supported through psychedelic crises. I recall being struck by the similarities between the behaviour of highly distressed people in these different contexts and how care was offered outside of a medicalised or psychological setting.

I was aware that I held an assumption that there could be beneficial learning across these contexts, and that this could introduce bias, though I felt unclear at the outset what that might be. To moderate this, I maintained a curious attitude during interviews and asked open and neutral questions. I engaged reflexively with the analytic process through memo-writing and supervision. This belief has not changed over the course of the research, yet I was surprised at the direction in which the research took particularly at the ways in which participants emphasised the importance of caregiving approaches other than interpersonal ones, such as body-oriented approaches and environmental modifications.

Another assumption underlying my interest in this area was my belief that the dominance of psy-professional narratives of distress subjugates other forms of caring such as at community, or peer-to-peer levels. I had not anticipated that the majority of the participants would hold professional roles in mental health, but I recognised how people skilled in caregiving roles are likely to be drawn to them in multiple contexts. I considered how our similar occupational positions may have influenced who felt willing to participate and what was discussed. There were also risks that this status could impede the research process if participants made assumptions of shared similarities which limited their explanations of concepts. It was helpful to include the secondary data sources to aid triangulation. It was also possible that our positions could emphasise shared factors between myself and participants. This was considered during supervision and in my reflection on the research process. For example, I tried to avoid using jargon in the interviews and to ask for clarification when participants did so. I also made notes when this type of language arose in the transcripts and considered the function of that, and whether further clarification was needed.

It was helpful for me to consider other ways in which I held ‘insider’ or ‘outsider’ status and to reflect upon the tensions that exist when working within the “space between” (Acker, 2000). I had a network of contacts which allowed more ready access to some participants than may have otherwise been secured. Four of the participants were recruited through a network of contacts, though no-one was invited to take part if we held a pre-existing personal relationship. An advantage of this partial insider status is acceptance. It may have bestowed a level of trust and openness from the four participants who had been recruited in this manner which may have contributed to the richness and depth of interviews (Dwyer & Buckle, 2009).

There were also ways in which I held an ‘outsider’ position in relation to participants. One shared difference across all participants was that I had not worked providing psychedelic crisis support. My position as a young, middle-class woman of mixed ethnic heritage and Hindu faith at times held me in positions of difference between the varying demographics of the participants. Through processes of memo-writing I was able to reflect upon the influences of these interactions between myself and individual participants, particularly during discussions of gender, age, ethnicity, and spirituality which arose during the interviews. For example, I noticed that male participants tended to spend longer describing the role of boundaries in the use of touch and referred more explicitly to issues around the perception of sexualised touch, whereas female participants tended to spend less time describing this or referred to the problems of uncomfortable touch rather than sexualised touch. I recognised the influence my gender may have played in these conversations and considered the role of gender in regard to touch more broadly.

4.4. Implications and Recommendations

4.4.1. Implications for Research

- Further research is warranted to investigate how environmental factors influence people having crisis experiences and what particular features may be beneficial (Gross, Sasson, Zarhy, & Zohar, 1998).
- Experiential avoidance (Boulanger et al., 2012) was found to be a key mechanism through experiences developed into crisis states in the context of psychedelics. Future studies could investigate the relationship between experiential avoidance and the content of psychotic experiences within clinical populations.
- The study highlights enabling a person to adopt an accepting position towards their experiences as the aim of supportive psychedelic crisis intervention. Additional research is required to support this claim and to verify the usefulness of interventions which work towards acceptance in different contexts (Pankey & Hayes, 2001).
- Participants highlighted the role of body-oriented techniques in establishing connection and reducing physiological arousal. Further investigations could explore what forms of body-oriented approaches are helpful and in relation to which particular experiences (Röhricht, 2009).
- Participants described using strategies similar to grounding techniques (Williams & Poijula, 2016). It would be helpful to gain greater understanding of the use of such strategies when working with people with psychosis.
- Participants felt that integration work was a vital part of incorporating experiential learning from a crisis experience and translating it into lasting positive changes. It is unclear to what extent integration requires another person’s support and by which processes it is most effective.

4.4.2. Clinical Implications

- In order for people to be able to adopt an accepting position, caregivers supported people to feel safe and to establish some connection with consensus reality. This has implications for the design of ward environments that support this process, including providing privacy and ownership of space, and design elements that reduce physiological arousal from sensory overload and through incorporating the natural world (Brown et al., 2013; Ulrich et al., 2018). It also indicates a role for ways of working which acknowledge the mind-body relation to stress regulation.
- Participants held a range of specialist knowledges which informed their work, including lived experience. This points to the importance of those without experience of psychosis working closely with those who do throughout all stages of planning, treatment, and evaluation (Faulkner, 2017; Newman, Boxall, Jury, & Dickinson, 2019). It suggests there could be value in mental health professionals exploring safe, legal methods of experiencing non-ordinary states of consciousness. There may also be a role for psychedelic practitioners to develop training for staff. Additionally, psychologists with lived experience should be appropriately supported to bring this knowledge to their professional work (Weerman & Abma, 2019); forums for this could include during training, supervision, and professional networks such as in2gr8mentalhealth (Kemp, n.d.).
- An important element of caregiver support was holding a framework, but one that could be used flexibly with others who drew from different belief systems. This would encourage a move away from rigidly held systems of understanding towards ones which can be held more flexibly and discussed openly. It would suggest the usefulness of staff working with psychosis to be trained in using such a framework, such as the one developed in the present study.
- Participants regarded it as important for caregivers to have layers of support which they could draw from. This holds implications for staff teams, but also for friends and family supporting people with psychosis. Services should be able to offer a layer of support to friends and family that extends beyond information-giving, given their influential role in recovery (Bjornestad et al., 2017; Georgaca & Zissi, 2019).

- Participants believed that the process of hospitalisation could hold risks of traumatisation and reduce the possibility for positive changes following crisis (Berry et al., 2015; Frueh et al., 2005). People in psychotic crisis should have access to alternatives to ward admission, such as crisis houses.
- Participants believed that integration work was an important component of developing lasting positive changes following a crisis experience. In the context of psychosis, this would imply that all people should have access to forums which provide space for integrating their experiences. This would require the adequate provision of psychological therapy, as well as access to non-professional alternatives such as the hearing voices network (Longden et al., 2018).

4.4.3. Policy Implications

- Current legislation in the UK permits the use of psychedelic substances only within research contexts. This status places limitations upon the extent to which these substances can be used as a source of learning for clinical contexts. It would be useful for policymakers to take into consideration the potential for applied knowledge available from such substances (The Psychedelic Society, n.d.).

4.5. Conclusion

Human experience can manifest itself in many bizarre, uncertain, and sometimes terrifying ways. This can happen in similar ways in psychedelic crisis and psychosis. The psychosis literature has focused on ways in which to stop, reduce, or control psychotic experiences. A growing body of work now emphasises the importance of a person’s relationship to these experiences and the meanings they have; principles are shared with the findings of the present study.

We are beginning to understand how to support people having these experiences in ways that align with these principles. It is hoped that by keeping dialogues open with people who have such experiences, and communities which hold skill in supporting them, that those working with people with psychosis may better understand the ways of being that best support them.

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Appendix 1. Search strategy for literature on psychedelic crisis support

(psychedelic or hallucinogen) AND (crisis or challenging or difficult) AND (support or care or sitting or guiding or ‘harm reduction’)
Filters: English language, peer-reviewed, 1950-2019

Appendix 2. Description of psychedelic crises given to participants

Psychedelic emergencies (“PsyEm”) are hallucinogen-induced situations in which a person goes through a difficult mental process due to a significant alteration in his/her consciousness. In PsyEm situations, perceptions of world, body, and mind may radically change, which may lead to anxiety and fear. Thought processes may become "looping" or incoherent, short- and long-term memory may be grossly impaired, hallucinations and delusions may appear as real, and attention may turn inwards or toward unreal things. In some cases, repressed emotional contents or traumatic memories may come to the surface. Paranoia, catatonia, disorientation, or stupor might appear as well, and in general, the person may be difficult to access by the default rational and verbal levels of interaction. Ethical norms and social roles are usually also diminished, which may result in unpredictable behavior. (Móró et al., 2013, p. 18)

Appendix 3. Example of a Case Study in MAPS Guide to Psychedelic Support

Pretty soon her normal chatting turned into gibberish, and not much later random screaming, crying, and a rollercoaster of emotions. Eve went from hysterically happy to almost manically sad; laughter and crying followed one another like sides of a coin being flipped. I quickly realised that she needed help. She started calling out to somebody whose name did sound like mine, and started blabbering a bit about calling her mum. Pretty soon she started to mix up English and her native language. It seemed like she was slipping in and out of strange patterns of thought, and that these were loops of desperation from which there was no apparent escape.

Eve was in a totally disorientated state of mind, and one of the ways that you could notice this was the manner in which she used her voice. She would go from whispering to screaming without any discernible trigger, or at least nothing visible to us. I could clearly see in her eyes that she was viewing something completely different than most of the people there. You could tell that she was focusing on places where there was nothing to be seen. Even when talking to me sometimes, I could see how she seemed to focus a little bit above my eyes instead of looking at them. This to me was a clear sign that “Eve had left the building…”. It was as if someone had a finger on a button, and when this button was pressed Eve would disappear, to be replaced by what appeared to be only automated thought patterns.

A few people who were also hanging around at the entrance then did something I will never forget, and this should be prevented at all times. Because we had other guests inside the service also attempting to get a grip on their experiences, I tried to get Eve to keep her voice down. She would only partially react and sometimes still go off into bursts of screaming. As a result, some people who were sitting close to us started to make remarks about this directly towards Eve. It goes without saying that she did not understand, and as a result got even more confused. Apparently these people, who were not from our team, weren’t aware of what was happening, even after I and several others told them that this girl was having a hard time. This should have been avoided by all means. The truth is that those remarks made at Eve contributed to her growing state of confusion, and she picked up on all remarks hinted at her.

In her state it was impractical to let Eve go inside the care space where some of the other guests were sleeping, as she would have greatly disturbed the peace inside. At the same time, walking away alone with her didn't seem like a solution, as I would be by myself if the situation developed into an even harder experience. It was only afterwards that I realized how this decision turned out to be a really wise one. It became increasingly difficult reasoning with Eve. She was wondering what she did wrong, why people were reacting as they were to her. For me, it was clear that she was heading towards a total psychological collapse, so I asked some other care givers to come help me and sit near by just in case. By now, an hour had passed. After all this time, she still was going in and out of sanity, being a happy little creature one second and the saddest person alive the next.

I will try to give a description of one example of how this translated into behaviours in Eve, recounting her words, describing the expressions on her face and the intonations that went hand-in-hand with them. Eve was talking in two different languages, jumping from one to another, speaking in English and in her mother tongue, a language of which I couldn't understand a word. I can only say I was happy at the time to have someone in the vicinity who could translate part of what she was saying. It would go slightly like this,

“I have to call my mum. I have to tell her that everything is okay. Can I call my mum, Jay?” (Question directed at me, although she was confusing me with her boyfriend the whole time.) “Jay, where are you? You are so far away. Jay, please call me. I really have to call my mum right? I really have to. Jay, don't leave me, Jay… But it is late, maybe my mum is asleep. What if she is asleep? Should I call my mum, Jay?”

The intonation of her voice made it all seem even weirder. She would whisper, then scream, then whisper, and so on. She would talk with a high-pitched voice followed by a low one, sometimes switching in the same sentence. She would take her mobile phone out of her pocket, and then put it back, only to get it out again a second later. She kept on repeating the same things, but in different order and with different intonations. This was all accompanied by an array of facial expressions that seemed to be out of this world. Her face would literally change with every episode that exploded into existence.

I decided the best thing to do, as always, was to remain contained in my own energy and calmness, and try to be a pillar of steadiness for Eve by just being present, breathing calmly, and not being alarmed by anything. In the meantime Eve wanted to go to the toilet, so I asked some female co-workers to escort her there. I explained to them the situation, what Eve had taken and when she took it, and her current condition. I also told them how long I had been sitting with her. This felt really important to me, because you do start to feel responsible for someone as soon as they take shelter under your wings.

Once they left, I felt temporary relief. I finally had some time to reflect on what had just happened. From the start until this point, over two hours had passed. It was supposed to be a quiet night for me—enjoying the sunset and the stars and then off to bed—but it turned out to be something completely different.

In those two hours I witnessed and partly felt the emotions and the energy that was raging inside Eve’s body. Although the aim is not to get involved emotionally or energetically, it is not possible to completely detach from these things, as a little will always trespass through any defences you might have. The thing that helped me the most during this time was knowing that I had people backing me up, as I realised at that point that Eve’s journey would take her long into the night… But I told myself, “She is safe now, she is being taken care of”, and I felt as though I had just walked out of a huge amusement park ride, totally shaken and trying to rearrange myself. During this moment of reflection I noticed something really interesting: my tiredness had disappeared during this whole period. It is fascinating to see how easily our consciousness influences our physical condition. As soon as I slowed down again, the tiredness hit me very hard and I planned on going to sleep.

I was grounding myself a bit again when I heard someone scream from the direction of the toilets, and I quickly realized it was Eve; the female care givers were now in need of some aid. Eve had become completely deranged, and was getting pretty aggressive towards the people who were trying to help her. I quickly got up from my place, cleared my head, and ran over to the other volunteers. Again I was amazed at how rapidly I adjusted to the situation, revived once more from my tiredness, putting on my so-called psychological battle helmet again.

By the time I arrived there, Eve was foaming from her mouth, and was frantically trying to get out of the grip of the volunteers. I stepped in and tried to subdue Eve physically, by holding one of her arms, and we managed to get a little bit of control over her largely uncontrollable physical movements. It was amazing to see how strong a person really can be physically in these sorts of situations.

To be clear, restraining Eve was only done because, at this point, she had started to physically harm herself and the people around her. Two more male volunteers came to help, and together with three female volunteers we carried Eve towards the care space. We decided as a team that it would be best to put her in the restricted space that was set up especially for cases that might disturb the others present in the main care space. This turned out to be a very good choice, and we finally got Eve to lie down in this place.

It took four people to hold her down, one on each leg and each arm. The power that came from her was unimaginable, it seemed as if the energy of a complete galaxy was rushing through her and driving her body to do physical things that were simply not possible. Eve lingered in this strange outbreak—screaming, kicking, laughing, and crying—as if all these emotions could combine into one at the same time.

It is also hard to describe how much a person changes during these experiences, concerning the appearance of their face and their body language, as I had the chance to witness with Eve. The young girl who is sitting quietly next to you in one moment, is kicking and spitting at you an hour later, eyes popping out and facial expressions totally blown out of proportion. Remaining calm was the only thing we could do, especially for Eve's sake.

After following her for another hour, I asked someone to take over because I was getting too tired. Soon I was relieved from my duty and I could finally go to sleep. I had a very good rest because I was really exhausted. After I woke up, the first thing I did was walk out to the care space, because I was wondering about Eve's follow-up. It turned out she came to her senses, only four hours after I left. I got to hear a wonderful story from my fellow volunteers about how, in the end, she started to say she was Shiva and all was love, falling asleep afterwards. In the morning she was totally fine, apart from being shaken up from the psychological ride, which is to be expected after an experience of this magnitude. (p222-225)

Appendix 4. Excerpt from DAT2 Manual

It can be clearly seen from the above mentioned emergency situations that the “psy help” interaction is a sensitive process between helper and client. However, most situations can be handled properly with a genuine sense of compassion that fundamentally guides the helper’s talk and behavior. This positively self-confident and friendly “vibration” will be surely felt by the client, even nonverbally and intuitively. Next, we enlist some aspects that can be consciously affected (and sometimes manipulated for the sake of the client) to enhance the client–helper interaction:

Attention – A proper amount of attention resides obviously somewhere between the extremities of leaving the client unattended for a long time, and of paying so much attention that it becomes overwhelming for him/her. Because of their sometimes utterly confused states, clients can truly do unexpected things when left alone. Alternatively, they may feel that they are not getting proper care, and may simply leave the helping area if they feel insecure. On the contrary, too much attention may become strongly negative: Continuous attention from several helpers may give the client an impression about the situation being very severe or life-threatening (which would indeed logically explain the need for so many helping persons involved).

Eye contact – Eye contact and conscious gaze control can be good methods of building trust in the client, especially when verbal assurance is limited due to the client’s mental condition. Needless to say that staring – with or without talking – should be always avoided. When noticing being observed, confused and anxious clients can easily create delusions about what other people think of them. Therefore, eye contact should be always accompanied with clear words or easily interpretable mimics and gestures. Conscious gaze control and other bodily “tricks” may be used to direct the client’s attention away from his/her inner problems toward other, safe stimuli outside.

Proximity – At the helping location, the client needs to feel maximally safe, which can be achieved only gradually. Firstly, a good spot should be assigned, and the client should be guided there, and then he/she should be convinced to stay there. During these, it needs to be properly judged whether or not the client is ready to accept proximity and body contact, such as friendly hands around his/her shoulder. For some clients, a touch can be too much – irritating, provocative, or exploitation-like – and it may trigger unexpected reactions. On the other hand, proximity of a positive person can be also “addictive”, and clients may unintentionally build up a gradual attachment toward the helper, which should be recognized and kept under control by the helper.

Body talk – Body talk is also a great way to build trust with the client, and to establish a role of a “normal” partner for him/her. Postures and gestures should carry a message that the helper is not avoiding, not despising, and not afraid of the company of the client. Even though the helping process may include a significant amount of waiting, signs of boredom (like flicking a lighter) should be avoided. However, other body talk methods to manipulate the client’s state may be cautiously used, e.g., repeated yawning may induce a “contagious” sleepiness and relax the client.

Talking – The job of a helper – and in particular, in the role of a sitter – should involve an appropriate balance between listening and talking. When listening to the client, the helper should show genuine compassion and a soothing presence. Avoid questions about complex and sensitive issues, because these may confuse the client and/or raise baseless suspicion. Making jokes for a relaxing atmosphere is generally not recommended in the company of confused persons, as they may not be able to separate laughing with them from laughing at them. Similarly, nothing should be said half-aloud or from a distance so that a client would not hear it clearly; he/she must not get an impression of being the subject of an ongoing talking “behind his/her back”

Items around – People in stupor have diminished control functions, hence in their automatized and semi-conscious states they may attempt to utilize items that they find around. Therefore, helpers should not leave any sharp, heavy, hot, flammable, corrosive, fragile, falling, pourable, etc. objects around, and should be constantly alert to prevent the clients from interacting with such items.

Wording – The importance of choosing words appropriately needs to be emphasized in particular. It is essential that the helper should omit all references to negative emotions and fictive threats, as these might get selectively picked up by the client, and escalate to excessive levels. If the client needs to be instructed, commands should be brief and direct, telling what to do (instead of telling what not to do). Even simple tasks, such as to drink water, are best to be instructed.

Telecommunication – The use of mobile phones for private conversations at work is not recommended if the helping situation needs continuous monitoring of the client. It may also give false impressions and create delusions to the confused client about the conversations concerning particularly him/her. Similarly, the use of walkie-talkie phones (as sometimes provided by the festival security to the helper staff) is also not recommended – their loud and distorted sound may remind clients of a “police radio”, thus giving space to further delusional thoughts.
(p20-21)

Appendix 5. List of websites where consultation was listed

www.reddit.com/r/LSD
www.reddit.com/r/RationalPsychonaut
www.reddit.com/r/shrooms
www.bluelight.org

Appendix 6. Information sheet for participants in consultation for interview schedule

You are being invited to develop the interview process of a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?
I am a professional doctoral student in the School of Psychology at the University of East London and am studying for a doctorate in Clinical Psychology. As part of my studies, I am conducting the research which you are being invited to provide consultation on.

What is the research?
I am conducting research into how members of the psychedelic community care for and support people through psychedelic crises (sometimes called “bad” or “challenging” trips). I would like to know what people do to provide care or support, how they do this and what it is like to provide this care or support.

Although a psychedelic crisis is not exactly the same as a mental health crisis, there are lots of overlaps in the types of experiences people can have in both forms of crises. These include fear, paranoia, unusual thinking or speaking, “death”-like experiences, unusual physical behaviour or feelings and hallucinations. Some of the types of care or support that are helpful for psychedelic crises could be helpful for other crises.

Most of the research within the mental health world looks at causes or treatment of crises. There is not a lot of information about how to be with, care for and support the person through their crisis. I think that the psychedelic community holds a lot of knowledge about this. This could be useful for people working in mental health to learn from.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?
You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve people who have experience of being cared for or supported through a psychedelic crises.

I emphasise that I am not looking for ‘experts’ on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect. You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?
This online survey will ask you some questions that will help me to develop the interviews that I will be conducting with people who provide care or support for psychedelic crises.

Your taking part will be safe and confidential
Your privacy and safety will be respected at all times. You do not have to answer all of my questions and can stop at any time, without consequence. I won’t ask you for any

personally identifiable details, unless you would like to receive a summary of the findings. If you would like me to send you this, there is the option to leave an email address.

What will happen to the information that you provide?
The information will be held in encrypted files on a password protected computer. It will be erased after five years to allow time for publication and dissemination. If you have requested a summary of the findings, your email address will be stored separately from the data in encrypted files on a password protected computer and will be erased once the summary has been sent to you.

What if you want to withdraw?
You are free to withdraw from the research study at any time without explanation, disadvantage or consequence by choosing to not submit your responses to this survey. If you have completed and submitted the survey, I would reserve the right to use material that you provide.

Contact Details
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me; [researcher name], u1622899@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr David Harper. School of Psychology,
University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller,
School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: m.j.spiller@uel.ac.uk)

Appendix 7. Consultation contributions to the interview schedule

Calming strategies

Caregiver’s lived experience of psychedelics

Knowing when not to provide support

Meeting person’s physical needs

Caregiver self-care and emotional responses

Caregiver’s beliefs about the purpose of a psychedelic experience

Appendix 8. Information sheet for participants

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a professional doctoral student in the School of Psychology at the University of East London and am studying for a doctorate in Clinical Psychology. As part of my studies, I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into how members of the psychedelic community care for and support people through psychedelic crises (sometimes called “bad” or “challenging” trips). I would like to know what people do to provide care or support, how they do this and what it is like to provide this care or support.

Although a psychedelic crisis is not exactly the same as a mental health crisis, there are lots of overlaps in the types of experiences people can have in both forms of crises. These include fear, paranoia, unusual thinking or speaking, “death”-like experiences, unusual physical behaviour or feelings and hallucinations. Some of the types of care or support that are helpful for psychedelic crises could be helpful for other crises.

Most of the research within the mental health world looks at causes or treatment of crises. There is not a lot of information about how to be with, care for and support the person through their crisis. I think that the psychedelic community holds a lot of knowledge about this. This could be useful for people working in mental health to learn from.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve people who have experience in caring for and supporting others through psychedelic crises.

I emphasise that I am not looking for ‘experts’ on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to have a conversation with me about caring for and supporting others through psychedelic crises. I might ask you to tell me about what you do (or do not do) when people are in crisis, how and why you do this and what it is like for you. I would also be interested in how you understand what is happening during a crisis and how this influences your approach to providing support.

I would value your input on this study so, after we have spoken, I will ask for your feedback to help develop conversations with future participants. I will send you a summary analysis of the accounts collated from participants and ask for your thoughts and feedback about it. I will incorporate these comments into the final analyses (a summary copy of which will be available upon request).

We will meet for about an hour and this can take place in a public place of your choosing within or near London, or at the University of East London. If these options are not feasible then we may decide to have this conversation over Skype or the telephone.

There is no funding for this study. I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic. There may be a small amount of money available for travel expenses for people who would otherwise face financial barriers that would prevent them from participating in the study.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. We consider this together when choosing the location where we meet to speak. Given the current legal status of some psychedelic substances, maintaining your confidentiality will be of paramount importance to me. You do not have to answer all of my questions and can stop at any time, without consequence.

What will happen to the information that you provide?

I will audio-record all conversation and type them up myself. I will remove any information which could overtly identify you and will change all names. These files will be encrypted and stored on a password-protected computer for five years. Only myself, supervisors, examiners and you can have access to these anonymised transcripts.

Extracts from these transcripts will be published in an academic journal and may be used in other settings when the results are shared. Efforts will be made to select quotes carefully to protect anonymity but it is possible that members of the psychedelic community who know details of how you care and support people through crisis could identify your contributions.

Your contact details and consent form will be stored separately in encrypted folders on a password protected computer. This will ensure that your overtly identifiable details are not linked to the material from the conversation. These will be deleted five years after the study is completed.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw I would reserve the right to use material that you provide if data analysis has already begun.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me; [researcher name], u1622899@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr David Harper. School of Psychology,
University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller,
School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: m.j.spiller@uel.ac.uk)

Appendix 9. Participant consent form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Lessons from the psychedelic community in supporting people through acute psychosis: A grounded theory study

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

………………………………………………………………………………………

Participant's Signature

………………………………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)

………………………………………………………………………………………..

Researcher's Signature

…………………………………………………………………………………………

Date: ……………………..……..

Appendix 10. Example of a Memo

Participants described using intuition quite a bit. This seemed in part due to the 'ineffable' nature of psychedelic experiences meaning that it becomes difficult to put words to what particular aspects of their experiential knowledge they may be drawing from in order to guide their actions.

It was also recognised as something that was important to listen to and that it was a useful source of information to notice, evaluate and potentially respond to. Some people who were more psychoanalytically-inclined spoke of counter-transference and projections. Be aware that is very technical language containing many underlying assumptions and not exploring this further may limit understanding of what is going on.

Keep looking for what lies behind their feeling that they are using intuition. It may be useful to go back through codes relating to using lived experience to support this. Also look closer at codes relating to non-verbal communication. Perhaps participants are simply finding it difficult to put words to ways of communicating which haven’t taken a verbal form before.

Appendix 11. Ethical Approval Application

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

If you need to apply to have ethical clearance from another Research Ethics Committee (e.g. NRES, HRA through IRIS) you DO NOT need to apply to the School of Psychology for ethical clearance also. Please see details on https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/NHS-Research-Ethics-Committees.aspx

Among other things this site will tell you about UEL sponsorship
Note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised. You do need NHS approval is collecting data on NHS premises.

Before completing this application please familiarise yourself with:

The *Code of Ethics and Conduct (2009)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website http://www.bps.org.uk/system/files/Public%20files/aa%20Standard%20Docs/inf94_code_web_ethics_conduct.pdf

And please also see the UEL Code of Practice for Research Ethics (2015-16) https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Documents/Ethics%20forms/UEL-Code-of-Practice-for-Research-Ethics-2015-16.pdf

HOW TO COMPLETE & SUBMIT THIS APPLICATION

Complete this application form electronically, fully and accurately.

Type your name in the ‘student’s signature’ section (5.1).

Include copies of all necessary attachments in the ONE DOCUMENT SAVED AS .doc

Email your supervisor the completed application and all attachments as ONE DOCUMENT. Your supervisor will then look over your application.

When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' (section 5) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

Your supervisor should let you know the outcome of your application. Recruitment and data collection are NOT to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See section 4)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

A copy of the participant invitation letter that you intend giving to potential participants.
A copy of the consent form that you intend giving to participants.
A copy of the debrief letter you intend to give participants.

OTHER ATTACHMENTS (AS APPROPRIATE)

A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

Example of the kinds of interview questions you intend to ask participants.

Copies of the visual material(s) you intend showing participants.

A copy of ethical clearance or permission from an external institution or organisation if you need it (e.g. a charity, school, local authority, workplace etc.). Permissions must be attached to this application. If you require ethical clearance from an external organisation your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation (see Section 5).

Disclosure and Barring Service (DBS) certificates:

FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS: A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. This is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Mary Spiller (Chair of the School Research Ethics Committee) at m.j.spiller@uel.ac.uk

FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS: DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see Section 4 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another in order to conduct research with vulnerable populations.

SECTION 1. Your details

Your name: Emily Shah

Your supervisor's name: Dr David Harper

Title of your programme: Professional Doctorate in Clinical Psychology

Submission date for your BSc/MSc/MA research:

☐

Please tick if your application includes a copy of a DBS certificate

☐

Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mary Spiller for confidentiality reasons
(Chair f the School Research Ethics Committee) (m.j.spiller@uel.ac.uk)

Please tick to confirm that you have read and understood the British Psychological Society's Code of Ethics and Conduct (2009) and the UEL Code of Practice for Research Ethics (See links on page 1)

☒

SECTION 2. About your research

What your proposed research is about:

Numerous studies, reports, and inquiries have highlighted inadequacies in the care of people experiencing acute psychosis. There is a dearth of research about how to be with, support, and communicate with people in this extreme state of distress, both within traditional psychiatric and alternative non-psychiatric literatures. This study will use crises occasioned by the use of psychedelics as a phenomenological model for acute psychosis. It will aim to develop a model of the process of supporting an acute crisis. It will do this by seeking to address the following questions:

How do people in the psychedelic community care for and support an individual through a psychedelic crisis which could be useful in supporting people experiencing acute psychosis?
What types of psychedelic crisis have they provided support for?
How do they respond to these crises?
How do they experience providing this support?
What approaches or models do they draw from when providing this support?

Design of the research:

This study will employ a constructivist grounded theory approach to data collection and analysis. It aims to develop a model of support processes drawing from several sources of data. The main source of information will be participants interviews. Online surveys will also be used and, in the case of recruitment problems, written texts.

If I am unable to recruit participants for interview, the research question could be addressed through analysis of a combination of online surveys and written texts. If recruitment problems make it difficult to reach saturation through interviews alone, then the online survey can help with model development.

10. Recruitment and participants (Your sample):

I will be approaching people who have experience in providing support through a variety of avenues:

I will be approaching a range of university-based research projects which involve the supervised administration of psychedelic substances. These projects employ staff (typically clinical psychologists or psychiatrists) to support participants during the session.

I will also approach people from a range of informal networks such as The Psychedelic Society. The Psychedelic Society is a UK not-for-profit organization that advocates for the careful use of psychedelics as a tool for personal and spiritual development. They hold monthly “experience weekends” in the Netherlands where a small group of people are able to take psilocybin truffles in a safe and legal environment. These weekends each have around three facilitators who do not take any psychoactive substances and have the role of supporting those who have throughout the experience.

Another potential source of recruitment would be amongst those involved in harm-reduction. Kosmicaid are a UK organization that offer free support for people having difficult drug-related experiences at music festivals. They have trained volunteers who provide this support that come from a range of backgrounds including youth/community workers, psychiatric nurses, psychologists, drug workers, nurses, Reiki masters, healers, art and dance therapists and practitioners of many other alternative care services.

If there are difficulties in recruitment then I will open participation to people that are able to attend an interview via videocall. This will allow me to expand a search for participants to include sources such as; university projects outside of the UK, the students and alumni of the California Institute of Integral Studies (a graduate certificate course that trains advanced professionals working in related therapeutic areas as therapist-researchers for future FDA-approved psychedelic-assisted psychotherapy research), facilitators at ayahausca retreats, non-UK harm-reduction organizations such as the Zendo Project.

With the grounded theory method, it is difficult state beforehand the exact numbers of participants and their characteristics. Recruitment will continue until data saturation has been met; as a rough estimate from previous trainees' experiences of grounded theory research, this will likely be after interviews with around ten participants. Following initial interviews, I will use purposive sampling to ensure that the gaps in the developing model are best addressed.

11. Measures, materials or equipment:

Initial Consultation

This online survey will be conducted with people who have had a psychedelic crisis. I will describe the aims of the study and ask them to write some questions that they will be useful to ask to best address these aims. I will then show them the initial interview schedule and ask for their feedback about this and for recruitment avenues they think would make a useful contribution.

Interview

A semi-structured interview style will be used. In order to facilitate more organic questioning that is attuned to the individual participants, exact questions will not be pre-determined. A schedule of the topics that will be covered during the interview is attached (appendix 3). This schedule will be developed in consultation with people who have experience of being supported through psychedelic crisis and updated throughout the research process following feedback from participants.

Feedback on the model

An online survey with people who have experience of supporting others in crisis will be used to verify and amend the putative model. This will describe the model and ask for general feedback and for comments on more specific areas. It will ask about areas that they think might be missing or under-developed and for their thoughts about recruitment sources to address this.

12. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?
NA

13. Outline the data collection procedure involved in your research:

Stage 1: Consultation with people who have had a psychedelic crisis

The interview schedule will be developed in consultation with people who have experience of *being supported* through a psychedelic crisis (for information sheet and consent form see appendix 1 and 2, respectively). This will be done using an online and anonymous survey that will be posted to relevant websites (such as www.reddit.com; www.shroomery.org; www.bluelight.org; www.drugs-forum.com). The survey will be hosted by www.qualtrics.com.

Here, I will describe the aims of the study and ask responders what questions they think would be useful to ask the participants in the interviews. Following this, I will list the questions in the initial interview schedule (appendix 3) and ask for feedback

At the end of the consultation survey I will ask whether they would like to receive a summary of the findings. They will be asked to give an email address and informed that this will be kept securely (as outlined in section three). I will also ask whether they have experience of supporting others through a crisis and an interest in contributing to this study further:

If an individual indicates yes, they will be able to leave an email address so that I may contact them again in stage three of the study. It will be made clear that providing their email does not represent an obligation to participate further.
Their email address will be stored securely (as outlined in section three).
They will be able to indicate their interest in the following options:
Taking part in an online survey asking about their experience of supporting people in psychedelic crisis and asking for feedback on the provisional themes/model.
Taking part in a face-to-face interview and able to travel to London, UK.
Taking part in a Skype interview.

All responders will be given debrief information (see appendix 4).

Stage 2: Interviews with people who have provided support to a person in crisis

Interviews of approximately one-hour will be conducted with people who are experienced in supporting others during psychedelic crises (for information letter and consent form see appendix 5 and 2, respectively). People may provide this support in a variety of contexts. Some examples of these settings include: as part of a research study, as part of an organized event in the Netherlands with the Psychedelic Society, at festivals, or in A&E. People involved in supporting others are not under the influence of substances at these times.

Preference will be given to participants able to attend a face-to-face interview in London, either at the University of East London or in a quiet but public place of their choosing (such as a café). If there are difficulties in recruitment, this will be expanded to include participants able to attend an interview over Skype. The provisional interview schedule is found in appendix 2, though this will be updated to incorporate feedback from the consultation in stage one of the study and feedback given from other interview participants as the study progresses.

After the interview, participants will be given debrief information (see appendix 6). Those who have expressed an interest in reviewing the provisional model will be sent part two of the survey in stage three.

Stage three: Survey of people who have provided support to a person in crisis

An online survey will be conducted with people who are experienced in supporting others during psychedelic crises (for information sheet and consent form see appendix 7 and 2, respectively). This will be posted to relevant websites (such as www.reddit.com; www.shroomery.org; www.bluelight.org; www.drugs-forum.com). It will also be sent to any responders from the consultation that expressed an interest, and the second part of the survey will be sent to interview participants that expressed an interest. The survey will be hosted by www.qualtrics.com.

Part one of the survey will ask similar questions to those in the interview schedule (see appendix 3). This will allow for some degree of comparison of the interviewees responses with a wider pool of respondents.
Part two of the survey will present the provisional themes and model generated from the interview data and will ask questions to evaluate this. For example, 'To what extent does this capture...', 'Are there any important elements missing? If so, which?'.

All respondents will be given debrief information (see appendix 8). If response rate to this survey is poor, then the model will be compared against a selection of written texts about supporting people through these crises.

SECTION 3. Ethical considerations

14. Fully informing participants about the research (and parents/guardians if necessary):

Potential interview participants will be asked to email me to receive more information about the study. Upon their request, they will be given a participant information sheet to read (appendix 5). This will be done before informed consent is obtained, in order to allow people to consider and reflect upon their desire to participate in the research. I will make my contact details available should they have any questions that arise. They will be made aware that requesting information about the study puts them under no obligation to participate.

For people involved in consultation for the interview schedule or reviewing the initial model development, an adapted participant information sheet will be made available before the survey can be completed (appendix 3 and 7, respectively).

15. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

Once potential participants have read the information sheet, had chance to ask further questions and then confirmed they wish to participate, they will be given the informed consent sheet to read, initial and sign (appendix 2). This will be done before the interview takes place. I will explain the consent process, with particular attention to confidentiality and their rights to withdraw.

For people involved in consultation for the interview schedule or reviewing the initial model development, the consent form will be made available before the survey can be completed that will allow for completion online using the Qualtrics formatting.

16. Engaging in deception, if relevant:

There is no deception involved in this study.

17. Right of withdrawal:

I will explain that they are able to withdraw without explanation, consequence, or disadvantage at any point up until data analysis has begun. This will be clearly stated in the participant information sheet and consent forms.

18. Will the data be gathered anonymously?

No

19. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

It is recognised that confidentiality may be of particular concern to participants given the legal status of most psychedelic substances in the UK. All data and information will be stored in encrypted files on a password-protected computer. Participant contact details and consent forms will be kept separately from anonymised data.

I will transcribe all interviews myself and remove overtly identifying information. I will change all names of people and place and give people pseudonyms. Only me, my supervisors and examiners will have access to these anonymised transcripts (participants may have access to the transcript of their own interview).

It will be made clear to participants before the interviews that extracts from the transcripts will be included in the thesis and may be included in any resulting journal publications. Efforts will be made to select quotes carefully to protect anonymity though it is possible that other members of the psychedelic community may identify their contributions. To allow for publication, data will be kept in encrypted files on a password-protected computer for five years before being erased.

Data from online surveys will be collected anonymously unless the participant chooses to leave a contact email to receive a summary of the findings. These contact details will be handled and stored with the same protections as those of the interview participants.

20. Will participants be paid or reimbursed?

YES

If YES, why is payment/reimbursement necessary and how much will the vouchers be worth?

Participants will not be paid but there may be a small budget to allow travel expenses to be reimbursed.

SECTION 4. Other permissions and ethical clearances

21. Research involving the NHS in England

Is HRA approval for research involving the NHS required? NO
If YES, please go to the above link for important information

Will the research involve NHS employees who will not be directly recruited through the NHS and where data from NHS employees will not be collected on NHS premises?
NO

If you work for an NHS Trust and plan to recruit colleagues from the Trust will permission from an appropriate member of staff at the Trust be sought?
NO

22. Is permission required from an external institution/organisation (e.g. a school, charity, workplace, local authority, care home etc.)?

NHS ethical approval is NOT required for research involving staff. However, approval IS required if recruitment and/or data collection takes place on NHS premises.

Is permission from an external institution/organisation/workplace required? NO

If YES please give the name and address of the institution/organisation/workplace:

In some cases you may be required to have formal ethical clearance from the external institution or organisation or workplace too.

23. Is ethical clearance required from any other ethics committee?

NO

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet?
YES / NO

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation confirming its ethical clearance is acceptable.

SECTION 5. Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible.

If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

24. Protection of participants:

The online survey asking for consultation in interview development from people who have experience psychedelic crises could evoke some distress or memories of distressing events. Questions will be focused on developing the interview schedule. There will be no questions asking them to discuss their personal experiences. Participants are able to pause or terminate the survey at any point.

The interview and online survey to check the putative model are less likely to be distressing for the participants because, by virtue of their participation, these people will be experienced in having witnessed a variety of crises. By offering to participate in this study, they have signalled an openness to discussing how they support people experience psychedelic crises. There will not be any questions that do not fall under the remit of this topic.

In all my participant debriefs, I will provide links to the free online support service offered by the International Centre for Enthobotanical Education, Research and Service (http://www.iceers.org/support-service.php) and to the international list of therapists that offer integration for psychedelic crises hosted by the Multidisciplinary Association for Psychedelic Studies (http://www.maps.org/resources/psychedelic-integration-list).

As a trainee clinical psychologist, I have skills in attunement to and de-escalation of distress which can be utilised during the interview process. The interviews will take place at the University of East London or in a public place that has been suggested by the participant and agreed with by myself.

25. Protection of the researcher:

All interviews will take place at the University of East London or in an off-campus venue that has been suggested by the participant and agreed with by myself. An off-campus venue would be a quiet but public place, such as a café.

I will inform my director of studies as to the location and time of all interviews, along with my contact details and emergency contact details. I will agree to contact him before and after any off-campus interviews have taken place. We will establish a procedure to follow in case of my not contacting him after the end of an interview.

There are no known additional health and safety risks.

26. Debriefing participants:

There is no deception involved in this project and the interviews are unlikely to cause distress. Interview participants will be given a verbal debrief after the interview has been completed and this will be followed up with a debrief email. People who contribute through the online surveys will be given a debrief message after completing the survey. My personal contact details will not be shared with participants.

There are no organisations that provide support for the particular topics addressed during this interview, from the perspective of the caregiver. If, however, any participant does experience a response to the interview which they find difficult to manage, this will be discussed on a case-by-case basis with my supervisor to ensure we can provide the most appropriate support necessary.

27. Other:

28. Will your research involve working with children or vulnerable adults?*

NO

If YES have you obtained and attached a DBS certificate? YES / NO

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

YES / NO

If NO please give reasons. (<u>Note that parental consent is always required for participants who are 16 years of age and younger</u>)

* <u>You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2)</u> 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see:

https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/Research-involving-children.aspx

29 Will you be collecting data overseas?

NO

If YES in what country or countries (and province if appropriate) will you be collecting data?

Please click on this link **https://www.gov.uk/foreign-travel-advice** and note in the space below what the UK Government is recommending about travel to that country/province

SECTION 6. Declarations

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: *Emily Shah*

Student's number: U1622899 Date: 05/04/2018

Supervisor's declaration of support is given upon their electronic submission of the application

I confirm that, in my opinion, the proposed study constitutes an ethical investigation of the research question. Declaration of supervisory support of an application is confirmed once an application is submitted via the supervisor's UEL email account.

YOU MUST ATTACH THESE ATTACHMENTS:

1. CONSULTATION INVITATION LETTER FOR INTERVIEW SCHEDULE DEVELOPMENT

You are being invited to develop the interview process of a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a professional doctoral student in the School of Psychology at the University of East London and am studying for a doctorate in Clinical Psychology. As part of my studies, I am conducting the research which you are being invited to provide consultation on.

What is the research?

I am conducting research into how members of the psychedelic community care for and support people through psychedelic crises (sometimes called "bad" or "challenging" trips). I would like to know what people do to provide care or support, how they do this and what it is like to provide this care or support.

Although a psychedelic crisis is not exactly the same as a mental health crisis, there are lots of overlaps in the types of experiences people can have in both forms of crises. Most of the research within the mental health world looks at causes or treatment of crises. There is not a lot of information about how to be with, care for and support the person through their crisis. I think that the psychedelic community holds a lot of knowledge about this. This could be useful for people working in mental health to learn from.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve people who have experience of being cared for or supported through a psychedelic crisis.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect. You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

This online survey will ask you some questions that will help me to develop the interviews that I will be conducting with people who provide care or support for psychedelic crises.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. You do not have to answer all of my questions and can stop at any time, without consequence. I won't ask you for any personally identifiable details, unless you would like to receive a summary of the findings. If you would like me to send you this, there is the option to leave an email address.

What will happen to the information that you provide?

The information will be held in encrypted files on a password protected computer. It will be erased after five years to allow time for publication and dissemination. If you have requested a summary of the findings, your email address will be stored separately from the data in encrypted files on a password protected computer and will be erased once the summary has been sent to you.

What if you want to withdraw?

You are free to withdraw from the research study without explanation, disadvantage or consequence by choosing to not submit your responses to this survey. If you have completed and submitted the survey then withdrawal would not be possible because the surveys are anonymous.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me; Emily Shah, u1622899@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor; Dr David Harper. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: m.j.spiller@uel.ac.uk)

5. CONSENT FORM(S)

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Lessons from the psychedelic community in supporting people through acute psychosis: A grounded theory study

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study before data analysis begins or an online survey is submitted without disadvantage to myself and without being obliged to give any reason. After this time, the researcher reserves the right to use anonymised data.

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant's Signature

………………………………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)

………………………………………………………………………………………..

Researcher's Signature

…………………………………………………………………………………………

Date: ……………………..……..

3. INITIAL INTERVIEW SCHEDULE

Types of experience
- Number of people supported
- Range of substances taken during those incidents
- Setting and duration of crisis support
- Examples of crisis

Support given
- When to and not to provide support
- Purpose of support
- Types of verbal support
- Types of non-verbal support

Personal experience of providing support
- Effect of providing support on oneself
- Effect of own state on the person in crisis
- Methods of managing these effects

Personal approach to providing support
- Perspective of own role during crisis
- Models or approaches used
- Relevant background or life experiences
- Motivations for involvement

4. ONLINE SURVEY: CONSULTATION DEBRIEF SHEET

Thank you for sharing your thoughts. Your contribution to the development of this study is valuable and much appreciated.

If taking part in this survey has brought up any thoughts or emotions that feel difficult for you to manage and you would like some support, the following may be helpful:
International Centre for Enthobotanical Education, Research and Service (http://www.iceers.org/support-service.php) offer a free, online support service over Skype
Multidisciplinary Association for Psychedelic Studies (http://www.maps.org/resources/psychedelic-integration-list) host a list of therapists, available internationally, that offer integration for psychedelic crises.

If you have requested a summary of the findings, this will be sent to the email address you have provided.

5.PARTICIPANT INVITATION LETTER FOR INTERVIEW

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am studying for a professional in Clinical Psychology in the School of Psychology at the University of East London. This research forms part of my studies.

What is the research?

I am conducting research into how members of the psychedelic community care for and support people through psychedelic crises (sometimes called “bad” or “challenging” trips). I would like to know what people do to provide care or support, how they do this and what it is like to provide this care or support.

Although a psychedelic crisis is not exactly the same as a mental health crisis, there are lots of overlaps in the types of experiences people can have in both forms of crises. Most of the research within the mental health world looks at causes or treatment of crises. There is not a lot of information about how to be with, care for and support the person through their crisis. I think that the psychedelic community holds a lot of knowledge about this. This could be useful for people working in mental health to learn from.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve people who have experience in caring for and supporting others through psychedelic crises.

I emphasise that I am not looking for ‘experts’ on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect. You are free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

We will meet for about an hour and this can take place in a public place of your choosing within or near London, or at the University of East London. If these options are not feasible then we may decide to have this conversation over Skype or the telephone. I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic. There may be a small amount of money available for travel expenses.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. We consider this together when choosing the location where we meet to speak. Given the current legal status of some psychedelic substances, maintaining your confidentiality will be of paramount importance to me. You do not have to answer all of my questions and can stop at any time, without consequence.

What will happen to the information that you provide?

I will audio-record all conversations and type them up myself. I will remove any information which could overtly identify you and will change all names to pseudonyms. These files will be encrypted and stored on a password-protected computer for five years. Only myself, supervisors, examiners and you can have access to these anonymised transcripts.

Extracts from these transcripts will be used in the thesis and may be used in journal publications or other academic settings where research is shared. Careful efforts will be made to select quotes that protect anonymity but it is possible that members of the psychedelic community who know details of how you care and support people through crisis could identify your contributions.

Your contact details and consent form will be stored separately in encrypted folders on a password protected computer. This will ensure that your personal details are not linked to the material from the conversation. These will be deleted five years after the study is completed.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw I would reserve the right to use material that you provide once data analysis has begun (approximately late 2018/2019).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me; Emily Shah on u1622899@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr David Harper. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: m.j.spiller@uel.ac.uk)

6. **INTERVIEW PARTICIPANT DEBRIEF SHEET**

Dear,

It was great to meet with you and thanks for taking part in this study. Your contribution has been really valuable.

If there has been anything that came up during the interview that you are struggling with or in want of support for, please get in touch and we can think together about how best to help you with this. The following organisations may be helpful:
International Centre for Enthobotanical Education, Research and Service (http://www.iceers.org/support-service.php) offer a free, online support service over Skype
Multidisciplinary Association for Psychedelic Studies (http://www.maps.org/resources/psychedelic-integration-list) host a list of therapists, available internationally, that offer integration for psychedelic crises.

As I mentioned when we met, if you want to withdraw your participation for any reason then you are able to do so up until data analysis has begun (approximately late 2018). You can contact me on this email address.

It was very useful to get your feedback on the interview process. This will be helpful in thinking about how best to improve future interviews. I will be in touch again once the initial findings are put together to send you a summary of these. It would be great if you were able to share your thoughts about this so that I can consider and adjust to incorporate them. You're not under any obligation to do this, so if you don't want me to send you over a summary then just let me know.

Thank you once again,

7. PARTICIPANT INVITATION LETTER FOR ONLINE SURVEY/MODEL EVALUATION

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a professional doctoral student in the School of Psychology at the University of East London and am studying for a doctorate in Clinical Psychology. As part of my studies, I am conducting the research which you are being invited to provide consultation on.

What is the research?

I am conducting research into how members of the psychedelic community care for and support people through psychedelic crises (sometimes called “bad” or “challenging” trips). I would like to know what people do to provide care or support, how they do this and what it is like to provide this care or support.

Although a psychedelic crisis is not exactly the same as a mental health crisis, there are lots of overlaps in the types of experiences people can have in both forms of crises. Most of the research within the mental health world looks at causes or treatment of crises. There is not a lot of information about how to be with, care for and support the person through their crisis. I think that the psychedelic community holds a lot of knowledge about this. This could be useful for people working in mental health to learn from.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve people who have experience of caring for or supporting others through a psychedelic crises. I have already conducted interviews with people who have this experience. I am looking for feedback on my analysis of these interviews

I emphasise that I am not looking for ‘experts’ on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect. You are free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

This online survey will ask you some questions that will help me to corroborate my analysis of the interviews I have conducted. Any new insights from this survey will be incorporated into the final study results.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. You do not have to answer all of my questions and can stop at any time, without consequence. I won't ask you for any personally identifiable details, unless you would like to receive a summary of the findings. If you would like me to send you this, there is the option to leave an email address.

What will happen to the information that you provide?

The information will be held in encrypted files on a password protected computer. It will be destroyed after five years to allow time for publication and dissemination. If you have requested a summary of the findings, your email address will be stored separately from the data in encrypted files on a password protected computer and will be erased once the summary has been sent to you.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence by choosing to not submit your responses to this survey. If you have completed and submitted the survey, I would reserve the right to use material that you provide.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me; Emily Shah, u1622899@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr David Harper. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk

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Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: m.j.spiller@uel.ac.uk)

8. ONLINE SURVEY: ONLINE SURVEY/MODEL EVALUATION DEBRIEF SHEET

Thank you for sharing your thoughts. Your contribution to the development of this study is valuable and much appreciated.

If taking part in this survey has brought up any thoughts or emotions that feel difficult for you to manage and you would like some support, the following may be helpful:
International Centre for Enthobotanical Education, Research and Service (http://www.iceers.org/support-service.php) offer a free, online support service over Skype
Multidisciplinary Association for Psychedelic Studies (http://www.maps.org/resources/psychedelic-integration-list) host a list of therapists, available internationally, that offer integration for psychedelic crises.

If you have requested a summary of the findings, this will be sent to the email you have provided.

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Claire Marshall

SUPERVISOR: David Harper

STUDENT: Emily Shah

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: TBC

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments required *(for reviewer)*:

1. P.7 “Stage 2: Interviews with people who have provided support to a person in crisis. Preference will be given to participants able to attend a face-to-face interview in London, either at the University of East London or in a quiet but public place of their choosing (such as a café).” This is also referred to on P. 11 and P.12
P.9. “It is recognised that confidentiality may be of particular concern to participants given the legal status of most psychedelic substances in the UK”

It seems that, given the participants potential concern about confidentiality, as well as the potential distress of recounting experiences where they have supported people in crisis, it would not be appropriate to have this kind of a conversation in public. It is therefore suggested that the research interviews only take place in confidential and private settings, such as a private room within UEL or another such appropriate venue to be agreed with supervisor.

2. P. 11 “The interview and online survey to check the putative model are less likely to be distressing for the participants because, by virtue of their participation, these people will be experienced in having witnessed a variety of crises. By offering to participate in this study, they have signalled an openness to discussing how they support people experience psychedelic crises.” p.12 “**Debriefing participants:**There is no deception involved in this project and the interviews are unlikely to cause distress.” P.18 **. INITIAL INTERVIEW SCHEDULE** “Effect of own state on the person in crisis”

There seems to be a claim on the researcher’s part that witnessing crisis and being open to discuss this is unlikely to cause distress. However, there is some research that does not support this assumption (compassion fatigue, vicarious trauma, vicarious distress, neuroscientific research e.g. mirror neurons etc.). The researcher should be more tentative about making such assumptions so that if the participants do experience distress, there is room for this to be expressed. Furthermore, as outlined in the interview schedule, the researcher is asking for his/her/zir own experience of the impact this had on them. The researcher should be open to this as a possibility when conducting the research and proceed tentatively.

3. P.15 **CONSULTATION INVITATION LETTER “**Although a psychedelic crisis is not exactly the same as a mental health crisis, there are lots of overlaps in the types of experiences people can have in both forms of crises. Most of the research within the mental health world looks at causes or treatment of crises. … I think that the psychedelic community holds a lot of knowledge about this. This could be useful for people working in mental health to learn from.” Repeated in **PARTICIPANT INVITATION LETTER FOR ONLINE SURVEY/MODEL EVALUATION** p.23

There are many, varying opinions in the field of the psychology of exceptional human experience on ‘crisis’ experienced under the influence of psychedelics. Many of these perspectives do not align with the comparison the researcher makes with mental health crisis. It may feel stigmatising or pathologizing to be presented with this assumption/ imposition at the outset. Therefore, the researcher, in consultation with her director of studies, should consider removing this comparison.

4. P.21 “**What if you want to withdraw?** You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw I would reserve the right to use material that you provide once data analysis has begun (approximately late 2018/2019).” Repeated in **INTERVIEW PARTICIPANT DEBRIEF SHEET p.22**

These sentences need to be clarified and specific dates should be given. It might read: ‘you are free to withdraw from the research study at any time without disadvantage or

consequence. If you withdraw before (insert specific date e.g. month and year) the material (insert item e.g. voice recording) will be destroyed. If you withdraw after (insert specific date e.g. month and year) the material (insert item) will be used in the study as the data analysis process would have began.'
This is to ensure the participant is absolutely clear on the nature of the data being used and the timeline of this.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES ~~/ NO~~

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Dr Claire Marshall

Date: 24.05.18

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix 12. Anonymised excerpt of transcript

00:05:39.8	00:05:44.6	Okay. And when you say you get extremely calm, that's a sort of conscious thing? What are you doing there?	ES
00:05:44.6	00:05:56.3	No. It's an interesting one, er, please tell me if I'm going off something that might be useful but guide me yeah. So my previous background was with the UN and I have some military background.	Erik
00:05:56.3	00:05:57.3	Okay.	ES
00:05:57.3	00:06:28.0	So, my, my normal reaction in [country in conflict] when under attack would be okay. boom, boom, boom how do we do? And I actually do the same thing and it's not a conscious thing. It's not like, oh I gotta do this. But if you, if you actually right now started having a panic attack...ok look at me. How's my hair today? Okay. Stay with me. Stay with me. {gestures with hands close to camera] And I'll often use my hand in this way. Trying to get. you. to. stay. with. me.	Erik
00:06:28.0	00:06:28.1	Okay. And what do you think the hands are doing?	ES
00:06:30.9	00:06:31.9	They're kind of holding you {laughs}.	Erik
00:06:31.9	00:06:34.1	Holding, yep. Okay.	ES
00:06:34.1	00:07:47.0	They're like {gestures held close}. And I notice I do that when people are...losing it, on psychedelics or other drugs. Erm, so it's quite a calming, restful: okay, this is going on for you right now. Can you connect with me? Okay. And sometimes they can and they come out and they go okay. Then the use of light humour, like "How's my hair?" kind of forces you to connect with reality. Er, and just like stay with me, calm down. Sometimes, they can't. Sometimes, you can't. So, then it's a case of: okay, so let's stay in your head. What's going on for you? Communicate with me. And, it's quite an interesting one because you're kind of vacillating between getting someone out of the trip, if it's not beneficial for them, you get them out into consensus reality. If that's not possible then you stay with it and you actively stay with it. "There's a dragon here." "Okay. Tell me about the dragon".	Erik

00:07:47.0	00:07:47.1	And what's your thinking behind doing that?	ES
00:07:47.0	00:07:51.6	God, what is my thinking..?	Erik
00:07:51.6	00:07:52.5	{laughs}	ES
00:07:52.5	00:08:27.9	I, I think...that resistance to the mind, resistance to what's going on in your head will cause panic. Try not to think of a pink elephant. It's, it's, I think if you are scared and I can get you out of that fear then hallelujah, that's great, yeah? But, if I can't get you of that fear, that could be even more scary so you're stuck with it. Then it's wiser for us to go with it. And familiarise ourselves with it.	Erik

Appendix 13. Examples of some Initial Codes

describing physical environment
describing qualities of a good leader
describing role to tripper
describing uncontrolled contexts
Describing using intuition
Developing understanding of what led to crisis
Differentiating between carer and cared for
distracting tripper from panic
doing things with tripper, not to them
Drawing on nature
Drawing on own personal experience as helpful in doing the work
Emotion affecting time perception
emotions causing physical tension
Encouraging energy to be release through shaking
Encouraging feelings to be expressed through action
Encouraging multiple perspectives on experience afterwards
encouraging release of energy
encouraging rest
encouraging self awareness
encouraging tripper to go further into emotions
encouraging tripper to lie down
encouraging tripper to move through process
encouraging tripper to stay in safe place
encouraging tripper to stay with experience
encouraging witness consciousness
engaging the sense in physical environment
ensuring acceptability of touch
ensuring carer's self is cared for
ensuring physical environment feels caring
ensuring physical environment feels safe
ensuring physical environment is comfortable
ensuring physical environment is peaceful
ensuring physical safety
Ensuring physical safety as priority
ensuring physical space available
ensuring tripper reaches safety
ensuring tripper remains in place of safety
entering into the experience
environment affecting tripper's experience
establishing contact