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ORIGINAL PAPER

Mitigating Ethical Issues in Training for Psychedelic Therapy

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Abstract In the present paper, we analyze the ethical issues in training for psychedelic therapy and discuss mitigation strategies for these issues. Specifically, after describing models of psychedelic training, we describe four problems of psychedelic training: (1) the imperative for comprehensive training due to vulnerability of participants, (2) psychedelic but not psychotherapeutic experience in training, (3) self-disclosure of psychedelic experience, and (4) guruism. In the following, we will delineate mitigation strategies with regard to these ethical issues: we underline the necessity of ethics codes and training, but also argue for the importance of monitoring and control, also through video recording. For accountability, psychedelic practitioners should hold professional licensure. When they offer psychotherapy, they should be trained in psychotherapy. Furthermore, a cooling off period after therapists' personal experience with psychedelics ("honeymoon") is warranted.

Keywords Psychedelic therapy · Training · Psychotherapy · Ethics

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Introduction

Psychedelics have a longstanding tradition of recreational, spiritual, and medical use. In the last two decades, the promise of research in the 1960 s to turn psychedelics into medicine has been renewed. Classic psychedelics and psychedelic-like substances (i.e., entactogens like MDMA) are currently used in clinical trials to assist psychiatric and psychotherapeutic treatment of, among others, treatment-resistant depression [1], post-traumatic stress disorder [2], and anxiety in end-of-life care [3]. Potentially, other indications might emerge with the development of non-hallucinogenic psychoplastogens for Alzheimer's disease or disorders of consciousness [4].

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Psychedelic therapy is a therapeutic approach that utilizes the unique properties of psychedelic substances, such as psilocybin, LSD, or MDMA, to facilitate therapeutic processes. Psychedelically induced altered states of consciousness are assumed to relax rigid beliefs [5] and increase psychological flexibility and openness as dimensions of personality [6]. Contextual factors such as "set (personality, preparation, expectation, and intention of the person having the experience) and setting (the physical, social, and cultural environment in which the experience takes place)" ([7] p.1) shape therapeutic processes. As psychedelic therapy is context-sensitive, it can be considered similar to other psychotherapeutic approaches that take advantage of common factors (e.g., expectations, therapeutic alliance, empathy, and goal setting [8]). Moreover, these common factors may be amplified by psychedelic therapy [6]. However, during these powerful altered states, participants are also particularly susceptible to influence, and Villiger and Trachsel [9] have argued that they are, therefore, particularly vulnerable during psychedelic therapy. In the same vein, Belouin et al. [10] argued that "risks associated with psychedelics come not so much from the physiological effects of the drugs themselves, but from how and with whom they are used" (p. 3), and that psychedelic therapists "anchor the integrity, safety, and ethical use of psychedelics, including during preparation, the dosing session(s), and integration, regardless of the setting" (p. 3). Thus, the role of the psychedelic therapist is demanding from both a clinical and an ethical perspective, and training must address not only clinical but also ethical challenges.

In the present paper, we analyze ethical issues in training for psychedelic therapy and discuss how these issues can be addressed. Specifically, after describing models of psychedelic training, we describe four problems with psychedelic training: (1) the imperative for comprehensive training due to vulnerability of participants, (2) psychedelic but not psychotherapeutic experience in training, (3) self-disclosure of personal psychedelic experiences, and (4) guruism. In the final section, we delineate mitigation strategies with regard to these ethical issues.

Ethical Issues in Training for Psychedelic Therapy

Before pointing out existing problems, it is important to note the structure of current training for psychedelic therapy. Table 1 in the Appendix presents some examples of training programs. In our view, there are currently three different models for training psychedelic therapists: medical, mixed, and non-medical models.

The Medical Model

Predominantly, current training programs pertain to the medical model, which has been favored in clinical trials and compassionate-use programs. Therapists are often required to have medical or psychotherapy training with licensure or board certification (see Table 1). However, the medical model also encompasses training for other medical professions (e.g., nursing, general practice, physiotherapy) to become psychedelic therapists. The training is comprehensive and builds on the experience of treating patients. Therefore, it is only an add-on to preexisting professional qualifications.

The Mixed Model

The most notable model of training psychedelic therapists in clinical trials is likely that of the Multidisciplinary Association for Psychedelic Studies (MAPS) [11]. In its training manual [11], it is stated that "it is required that participating therapists have a proper background, education and experience as therapists" (p. 10). Here, it is important to note that 'therapist' is a vague term and an unprotected title in most states in the US. Thus, the line between the medical, professional, and non-medical models begins to blur. In fact, in MAPS trials, it was usually common to have both a licensed professional therapist and a non-licensed therapist [11].

The Non-Medical Model

In the non-medical realm, several ritualistic and underground providers offer training in different modalities, such as 5-MeO-DMT facilitation through FIVE, "a research-informed development ecosystem" offering a 9-month trauma-informed training program [12]. In this program, they include individuals with "thorough experience in taking 5-MeO-DMT" (approximately 8–10 times with at least one year from the first experience), especially teachers (arguably in a metaphorical sense) who want to "serve a

community". While FIVE states that "5-MeO-DMT should not be used to diagnose, treat, cure or prevent any disease or condition", it also states that a component of integration is "healing trauma" [12]. While the colloquial term of trauma is different from post-traumatic stress disorder, the use of the framing as "healing" does justify viewing the practice as a form of psychedelic therapy.

The Oregon psilocybin facilitation model is another example of a legal, non-medical model. The psilocybin facilitator provides guidance and support before, during, and after the psilocybin experience. The requirements to become a psilocybin facilitator include being at least 21 years old, residing in Oregon, having a high school diploma, and completing training in psilocybin facilitation at an approved institute. Facilitator training takes at least 120 h in the areas of history of psychedelic therapy, cultural equity, safety, ethics and responsibilities, psilocybin pharmacology, neuroscience, clinical research, core facilitation skills, preparation and orientation, administration, integration, and group facilitation [13]. While the Oregon model specifies this core training curriculum, there is a vast list of competencies to be acquired for professional and non-professional psychedelic therapists. Indeed, this list of competencies could be extended ad absurdum to encompass use of music and appropriate touch, spiritual and existential care, personal mindfulness and self-compassionate practice, or philosophical knowledge of metaphysics for integration.

While in Oregon the facilitation process is denounced as non-therapeutic and non-medical, it is nevertheless obvious that therapists also think of the practice as therapeutic or medical.[1] Still, there is an important difference from the medical model: The Oregonian facilitation process of psilocybin denominates the integration part as an optional part of treatment that must be offered by the therapist but is not mandatory for the client.

First Problem: Great Vulnerability of Participants but Less Training of Therapists

The potential harms of the therapeutic interaction have been studied less than the pharmacological safety of psychedelic therapy [14]. There seems to be widespread agreement that interpersonal interaction in psychedelic therapy can be powerful, leading to a strong emotional reaction and response to the psychedelic therapist. On the one hand, qualitative studies on psychedelic practice in extralegal settings provide evidence for this [15]: Brennan and colleagues [15] reported that underground psychedelic therapists "noted that the strength of these [transference] phenomena may elicit equally strong countertransference from unprepared therapists, leaving them susceptible to transgressions" (p. 10). Transference and countertransference refer to psychodynamic concepts which, simply put, refer to the emotional response in therapeutic interaction between therapists and patients. This includes the patient's psychedelically-altered perception of the therapist. On the other, quantitative data from clinical trials show that "higher peak ratings of mystical-type experiences and psychological insight predicted higher bond ratings " [16] of the therapeutic alliance between patient and therapist. This provides some preliminary evidence that the psychedelic experience potentiates relational phenomena present in everyday psychotherapy. It is questionable whether psychedelic therapists are currently sufficiently trained to handle the susceptibility and vulnerability in the interaction with participants. Depending on the therapist's background, knowledge of different psychotherapy traditions could be required, especially for those without prior psychotherapy training. Given the short training time for psychedelic therapists (see Table 1), it seems vital that training prioritizes competencies in handling these interactional phenomena if participants are not trained accordingly in their core professions. Training for psychedelic therapy should thus be adaptive to the gaps in core professional education (i.e. psychologists need to be trained more in pharmacology, non-specialized physicians more in therapeutic interaction).

[1] See for example the interview with two facilitators trained by Fluence (see Table 1): "It's part of the process; you have your intake, you have the medicine session itself, then you have integration. In my opinion integration is the most important part. A lot of facilitators are actually getting their facilitator's license and just doing the integration piece". https://www.bendsource.com/news/qanda-with-oregons-first-psilocybin-facilitators-19097155 (25.09.2023).

Second Problem: Personal Experience with Psychedelics but not with Therapy

It is a common recommendation for psychedelic therapists to have personal experience with psychedelics. This is exceptional among psychiatric and psychotherapeutic approaches and has caused controversy [17, 18]. However, not every psychedelic substance is an option, e.g., in a recent MDMA trial the option for an experience with MDMA-assisted therapy as part of the training was offered. According to Nielson [19] "in the United States, there is presently no research study training programing that offers personal experience with LSD or psilocybin". In the past, the Spring Grove LSD Training Study did provide some evidence for the helpful and positive experience with LSD, as shown in a small secondary analysis of old data [19]. Outside of the US, a few clinical trials offer psychedelic training experience for therapists [20, 21].

However, none of these trials have been published and the statement by Nielson and Guss [22] that "there is no empirical research on personal use of psychedelics by current academic researchers and clinicians; its influence is undocumented, unknown, and undertheorized" (p. 64) is still largely correct.

While there has been some research on psychedelic substance use among psychedelic therapists [23] and researchers [24] in the recent years, there is a lack of research on the importance of these experiences. An argument in favor of personal psychedelic experiences is that openness of personal psychedelic use might also provide the opportunity for reflexivity and positionality within psychedelic research [25]. In a survey study, depressed patients rate the personal psychedelic experience of therapists on average as "somewhat important" [24]. However, personal psychedelic experiences are only one possibility to alter states of consciousness; stroboscope light, breathing exercises, or sensory deprivation have been proposed as alternative training methods.

Emmerich and Humphries [17] argue that the requirement of personal psychedelic experience is unjustified and ethically problematic. They conclude that it should be the autonomous choice of the psychedelic therapist in training and not a necessary component of training. Nonetheless, since most training programs offer some form of experience with altered states of consciousness, it is unclear whether it is possible to opt out.

As this form of experience is viewed as similar to personal therapy in psychodynamic approaches to therapy [26], it might become a quasi-mandatory requirement with the risk of pressuring a trainee toward psychedelic experiences. In their model curriculum reflecting on the importance of psychedelic training experiences, Passie and colleagues [27] write that.

> "It is possible that an SAP [substance-assisted therapy] trainee may strongly prefer not to pursue a self-experience (or may have acute or chronic contraindications), and this choice should be explored respectfully and accepted after sincere discussion. If a rejection of controlled self experience results from personal preferences or anxieties, it should be reflected if a person with such preferences/anxieties is the appropriate candidate to guide patients through severely altered states of consciousness induced by psychedelic drugs" (p. 11).

This is contradictory. On the one hand, the choice should be accepted, but on the other if the choice is due to personal preference it must be questioned whether the therapist is the right candidate for the job. While the latter is reasonable, it obfuscates that personal experiences might be quasi-mandatory, even if it should be, from an ethical standpoint, merely optional.

Interestingly, there is little research to back up the need for these experiences. An ongoing clinical trial assesses the changes in therapeutic competencies through therapists' personal psychedelic experiences [21].

This experiential requirement is different to the common requirement of professional psychotherapists for personal therapy [22], as it is common for instance in psychoanalysis and psychodynamic psychotherapy. Nielson and Guss [22] provide a thorough comparison between the training requirements of psychedelic and non-psychedelic therapists. In summary, the main difference is that psychedelic therapists, as opposed to non-psychedelic therapists, require an unspecified experience with a psychedelic substance rather than a personal therapy, psychedelic or otherwise, with a trained therapist. This is of course only the case if the

psychedelic therapist was not trained in the medical model and has undergone psychotherapy training.

A few codes of ethics of psychedelic therapy stipulate that experience with both psychotherapy and psychedelics should be required for psychedelic therapists [28]. However, there is a lack of knowledge on psychedelic-assisted therapy for training purposes. It is neither clear what kind of psychotherapy should be favored, nor whether the psychedelic experience should be integrated into the psychotherapy.

Third Problem: Self-Disclosure of Psychedelic Experiences

If psychedelic therapists are encouraged to have psychedelic experiences, a further controversial point is the disclosure of these experiences to patients and participants.

In general, self-disclosure is a contested psychotherapeutic intervention**.** While some regard it as "exploitative" by influencing the participant's experience in terms of the therapist's experience, others argue that it is beneficial by mitigating participants' anxiety regarding the psychedelic experience (cf. [11]). In general, self-disclosure in psychotherapy can have positive and negative consequences [29, 30]. Considering this, Peterson [31] has argued that the ethical appropriateness of self-disclosure depends "on the content of the disclosure, the therapist's rationale for the disclosure, the personality traits of the client to whom the disclosure is made, and the specific circumstances surrounding the disclosure" (p. 21), highlighting the complex nature of disclosing personal information, such as personal psychedelic experiences. Effectively, this calls for careful consideration of whether or not to disclose personal psychedelic experiences. Barnett [32] has argued that the process of self-disclosure should be part of "an ethical decision-making model" as part of a "deliberative process" and should always include supervision by an "experienced and trusted colleague" (p. 394).

Additional considerations apply to psychedelic use self-disclosure. If the psychedelic training experience occurs within a legal setting—such as a clinical trial on therapeutic competencies—discussing personal experience may be a reasonable form of self-disclosure if warranted by the therapeutic context. In turn, this could help destigmatize the medical use of psychedelic substances. Further benefits of disclosing personal psychedelic experiences might be the case for researchers [25], e.g. reflexivity and transparency in research. While researchers can weigh the benefits and risks of disclosing personal substance use, psychedelic therapist should be hold to a higher standard. They should be less concerned with their own lives and goals than with the patients'.

Furthermore, in the absence of legal training opportunities which offer psychedelic substances within psychedelic therapy, self-disclosure could be a disclosure of illegal activity in many jurisdictions. Not only can this have repercussions for the professional standing of the therapist, but it can also be detrimental to the relationship between the patient and the therapist. Furthermore, disclosure of recreational use in jurisdictions where some psychedelic substances are legal (e.g. psilocybin in the Netherlands) also has no justified place in psychedelic therapy: it would seem countertherapeutic to discuss recreational activities.

At last, personal psychedelic experiences can also lead to excessive enthusiasm on the part of the therapist, resulting to the urge for unnecessary, uncalled-for, or even ill-advised self-disclosure. This in turn might lead to conscious or unconscious undue influence on the patient, up to a personal transformation of the psychedelic therapist into a guru.

Fourth Problem: Guruism

Johnson [29] has emphasized "guruism" as one of the pitfalls of psychedelic medicine: "It can be challenging to be associated with what might be one of the meaningful experiences in a person's life. The scientist or clinician might, perhaps without explicit awareness, fall into the trap of playing guru or priest, imparting personal philosophies without a solid empirical basis" (p. 580). Thus, witnessing a meaningful experience can lead to feelings of grandiosity on the part of the psychedelic therapist. In the following, we understand a guru to be a psychedelic therapist who imparts spiritual or other beliefs to patients based on confidence in their superiority. This may also include beliefs about the appropriateness of forms of abuse that would otherwise be considered unprofessional and harmful, such as the belief that touching and sexual relations are an essential part of psychotherapy [30]. The complex relationship between psychedelics and guruism is outside the

scope of this paper. For a thorough review of guruism and cultic social dynamics within psychedelic practices see Evans and Adams [31]. In the following, we will focus solely on guruism in psychedelic therapy.

While it is unclear what leads psychedelic therapists to become gurus, some of them do. One example was the transformation of the psychedelic psychotherapist and psychiatrist Samuel Widmer [30]. In 1986, the Swiss psychiatrist Samuel Widmer was granted a special permit by the Swiss Federal Office of Public Health (FOPH) to use psychedelics for research. However, due to allegations of malpractice, the FOPH revoked the permit seven years later. Despite this, Widmer continued to use psychedelics in his therapeutic practice and went on to establish the "Kirschblütengemeinschaft" ("Cherry Blossom Community"). This community, which has been described as "cult-like" [9] offers psychedelic training and therapy forming a network of underground therapists who follow Widmer's approach.

Hence, a key question for research on psychedelic training is what contributes to guruism and the development of feelings and beliefs of grandiosity, as well as the desire to act on them. In general, imparting beliefs on participants (e.g., the role of the incest taboo within the Cherry Blossom community) by psychedelic therapists is a boundary violation [33]. Here, psychedelic research can learn from the psychotherapy research on abuse by psychotherapists. One the one hand, abusing therapists tend to have predisposing narcissistic personalities of both grandiose and covert narcissism [34]. On the other hand, therapists are generally capable of abuse under certain circumstances [35, 36]. Admittedly, most cases of boundary violations are the development of sexual relationships with patients and not the development of cults [35]. Nevertheless, there is the possibility to learn from boundary violations, e.g., their structure of a slippery slope [35]. If this holds for psychedelic therapy, this should warn psychedelic therapists to use any potential boundary violation, such as self-disclosure of personal psychedelic experiences and other biographical narratives, with caution and respect for the precautionary principle.

It might be objected that guruism can occur in any form of psychotherapy and is not exceptional for psychedelic therapy. However, this neglects the impact of a psychedelic substance on the therapeutic relationship. Another objection is that spiritual guidance might not be problematic if it is done for the right reasons and in the right way (i.e., the resulting beliefs are beneficial and freely imposed on the patient). In other words, is there a meaningful difference between spiritual guidance and value change in psychotherapy, which is, to some extent, standard practice? There is however a difference due to the substance-induced vulnerability and susceptibility that challenges the voluntariness of belief change, especially when paired with a dominant psychedelic therapist. Indeed, looking for and finding new ideas and perspectives about meaning in life or relationships as part of the process of psychedelic therapy is one thing; "finding" the ideas that the therapist holds is another.

Apart from personality characteristics and situational factors, Kious and colleagues [32] have hypothesized that "'excess enthusiasm'" after a psychedelically induced "alteration in liking, salience and psychological orientation" (p. 46) could potentially affect motivations of psychedelic therapists and researchers. If a psychedelic experience leads to a change in motivation for psychedelic therapy, its recommendation as part of training requires further justification. However, it is not only psychedelic therapists themselves who can be influenced by the psychedelic experience. In psychedelic therapy, participants might experience "guru projections" [15] onto the therapist. It is currently unclear whether such projections are also evoked by the therapists' behavior and grandiose self-identity or rather due to the susceptibility inherent in psychedelic experiences. Therefore, psychedelic substances might both influence the participant's belief of the therapist's special status as well as the therapist's belief of superior insight due to the "excess enthusiasm" for the psychedelic experience. Both the "guru projection" and the process of becoming a guru as a psychedelic therapist warrant concern and demand more awareness and study. Moreover, it provides an argument in favor of providing personal psychotherapy adjacent to psychedelic experiences within training.

Mitigating the Problems in Training

In light of these four problems of psychedelic training, we propose five mitigating strategies.

Codified Ethics and Ethics Training

In a first step, ethics codes would need to be developed. For professionals in the medical model such codes are in addition to pre-existing professional requirements. For psychedelic therapists outside the medical model, they should be established from scratch, becoming the basis for professional requirements. Indeed, this has been done by the Oregon Health Authority for the Oregon psilocybin facilitation. These ethics codes and codes of conduct should inform training for psychedelic therapy proactively. Examples of ethics codes, e.g. the MAPS ethics code, have only been developed retroactively after unethical behavior within a MAPS trial. By responding to it, these "ethics in hindsight" codices might justifiably focus on specific issues, e.g. in the case of MAPS on touch, sexual abuse, and therapeutic boundaries. In contrast, these ethics codices might neglect other ethical issues that have not come up in professional organizations, such as the aforementioned topics of self-disclosure of personal psychedelic experiences. In our view, ethics codes should thus be synthesized in an interdisciplinary process by different stakeholders (e.g., psychedelic-assisted therapy, ethical and legal association).

Furthermore, while knowledge of ethics codes of conduct is essential, training in ethical competence goes further than requiring mere knowledge of codified ethics. A way to mitigate potential relational harm might be to train psychedelic therapists in ethical competence through case-based training of moral reasoning.

Monitoring and Control

McNamee, Devenot and Buisson [14] have argued that harms in psychedelic therapy should be studied in a systematic way. Furthermore, it is necessary that these studies are free from conflicts of interest. A key question about harm in psychedelic therapy is epistemological: how would we know if harm is occurring?

There are several ways harm could come to light. In close-knit professional societies with small numbers of therapists interpersonal control could suffice; due to close relationships in these societies, therapists would know if a therapist transgressed a boundary because of trusting relationships between therapists. This of course takes for granted that professionals would conscientiously disclose their missteps. This way, professionals would self-regulate potential harms.

However, this model has obvious flaws, e.g., relying on therapist rapport with each other, and it does not account for larger professional organizations. Indeed, as a response to organizational growth, one of these formerly smaller societies, the Swiss Medical Society for Psycholytic Therapy (SÄPT), has established an ombudsperson office. Here, patients can voice their concerns; however, the ombudsperson office cannot sanction therapists. Furthermore, it is not independent of the professional organization, which could result in problems of neutrality. A stronger argument can be made for independent monitoring sites set up by either large-scale professional organizations or governmental institutions such as by the Oregon Health Authority. Independent monitoring sites are necessary for the clinical application of psychedelics [37].

A literal way of monitoring psychedelic therapy is the recording of all psychedelic sessions on video. Indeed, this is common practice in psychedelic trials and non-psychedelic psychotherapy training and it should be an option for psychedelic therapy training. Having independent supervision of video recordings could be another way of safeguarding psychedelic therapy. However, video recording psychedelic therapies brings forth its own ethical issues (for an in-depth discussion see [38]). While potentially beneficial for psychedelic training and research, there is a lack of evidence that video monitoring would reduce harm to patients. Potential concerns are data privacy and confidentiality, and patients should have the opportunity to opt-out of video recording the session [38]. Opting-out of video-recording should not mean that any later complaint by the patient is seen as less credible because they opted-out to begin with.

Accountability Through Licensure

Monitoring sites and ombudsperson offices are only useful if there are consequences to grave misdeeds. However, as illustrated by cases of abuse, accountability for abuse is often tied to licensure. For psychedelic therapists, who were trained in the non-medical model, legally regulation and licensure different to professional, medical regulation is needed.

Personal Psychotherapy for Therapists

Personal psychotherapy for therapists can equip them to handle transference and countertransference in psychedelic therapy. Ideally, it can help them to discover their own narcissistic or other vulnerabilities, so that these are not acted out in the therapeutic process. Generally, these are good reasons for mandating personal psychotherapy for psychedelic therapists who have not had prior experience with psychotherapy. However, as there is lack of evidence for the therapeutic benefit of therapists' personal psychotherapy for patients (18], mandating psychotherapy becomes a contested ethical issue. Ivey [39] has argued that trainees must be able to make an informed choice for personal therapy, which includes disclosure of risks and benefits of personal psychotherapy. Further safeguards should be put in place to uphold the autonomy of trainees. Moreover, dual relationships between trainees and training therapists are a concern, especially in close-knit societies. If personal psychotherapy is mandated, justice demands that financial compensation for trainees is instated.

Indeed, as personal psychotherapy is a costly and time-intensive endeavor, this presents a significant hurdle for the large-scale roll-out of psychedelic therapy.

Cooling-Off Period Before Providing Therapy

The motivation of psychedelic therapists to begin training, e.g. in the Oregon model, is unclear. Due to the novelty of the situation, it is also unclear what background facilitators have. It is possible that like some underground therapists, they come from a place of exaggerated enthusiasm about psychedelics, which might carry uncritical beliefs about psychedelic experiences. This enthusiasm might be fueled by psychedelic experiences, which might then again be a quasi-mandatory part of psychedelic training.

In the psychedelic literature, this phenomenon is often referred to as the "honeymoon" phase as part of the afterglow of a psychedelic experience [40]. For these reasons, a cooling off period after a psychedelic therapist's personal psychedelic experience is advisable. During this time, in combination with personal therapy, the therapist could reflect on the experience and, if applicable, on the enthusiasm caused by it. Indeed, the non-medical training to become a 5-MeO-DMT facilitator offered by FIVE requires one year to process the first experience [12].

Conclusion

There are several ethical problems in training therapists for the roll-out of psychedelic treatments in society. In the present article, we have discussed four pressing concerns for the training of psychedelic therapists and have provided mitigating strategies to ameliorate potential downfalls of psychedelic therapy. Inter alia, these strategies should be discussed by relevant stakeholders (e.g., professional organizations, patient organizations, harm reduction advocacy organizations) in light of efforts to bring psychedelic therapy into society.

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Declarations

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Appendix

Table 1 Examples of training programs for psychedelic therapy

Training program	(Clinical) setting	Prequalifications	Training duration	Method to induce altered states of consciousness	Ethical competence included in the curriculum	Offers psychedelic experience for training therapists	Source (as of November 2023)
Multidisplicinary Association of Psychedelic Studies(MAPS): MDMA for PTSD	Clinical trial	"Education and experience as therapists", especially psychologists or physicians	Five stages of training; online course, a one-week seminar, experiential learning, roleplay, supervision	Pharmacological substance: MDMA	Learning outcome: Describe MAPS Psychedelic Therapy Code of Ethics (from 2019)	Yes, with MDMA as part of a clinical trial with healthy volunteers	1. Mount Sinai in cooperation with MAPS PBC educational opportunity in MDMA-assisted therapy for post-traumatic stress disorder from 2023 (includes reference to the MAPS Code of Ethics for Psychedelic Psychotherapy): https://drive.google.com/file/d/1avtGjn6HZnmX_5pEyjId-Q0vwaFB5Sx5/view 2. MAPS therapist training manual [11]
Fluence: Psilocybin Facilitator under Oregon's Measure 109	Oregon psilocybin services	Prior training and experience practicing psychotherapy or related health care services in the field of mental health or addiction treatment	30 h intensive in-person program plus an Experiential Practice Retreat	Pharmacological substance: Psilocybin	In accordance with OHA-OPS curricular requirements, "Maintain boundaries and confidentiality" as part of therapists' skills	Unclear, option for experiential retreat for contemplative practice	https://www.fluencetraining.com/certificate-programs/psilocybin-assisted-therapy/

Table 1 (continued)

Training program	(Clinical) setting	Prequalifications	Training duration	Method to induce altered states of consciousness	Ethical competence included in the curriculum	Offers psychedelic experience for training therapists	Source (as of November 2023)
MIND Foundation: Augmented Psychotherapy Training (APT)	Outpatient psychotherapy using legal methods	Medical doctors, psychotherapists, and other mental health professionals (for independent therapy)	15 months, three intensive on-site trainings, weekly online training	Learning about pharmacological methods to induce altered states of consciousness: classical psychedelics (psilocybin, LSD, etc.) and atypical psychedelics (ketamine)	Yes, explicitly	Yes, the self-experience curriculum in APT includes the described non-pharmacological methods as well as ketamine	https://mind-foundation.org/apt/
Board of Psychedelic Medicine and Therapies (BPMT)	Various	Experienced healthcare professionals, licensed in the United States with demonstrated proficiency using psychedelic medicines	N.a.: Certification process for board certification	N.a.: Certification process for board certification	Understand, embrace, and adhere to the code of ethics for psychedelic medicine	N.a.: Certification process for Board certification	https://psychedelicsboard.org/
Swiss Medical Association for Psycholytic Therapy (SÄPT)	Outpatient psychotherapy through compassionate use	Psychiatrists, physicians with psychotherapeutic experience, assistants in the field of psychedelic research and non-medical psychotherapists	3 years	Pharmacological substance: Psychedelics and entactogens, unspecified	Yes, explicitly	Yes, psychedelic therapy in group format (within a clinical trial)	https://saept.ch/wp-content/uploads/2023/10/WB-Konzept-01.08.2023-vg.pdf
COMPASS: COMP360 psilocybin treatment	Clinical trials	Mental health professionals with active licenses, in good professional standing	20 hours of theoretical online learning, five days of in-person training, clinical training and independent learning	Pharmacological substance: COMP360 psilocybin	All study therapists are expected to commit to a code of ethics	No information available	[41]

Table 1 (continued)

Training program	(Clinical) setting	Prequalifications	Training duration	Method to induce altered states of consciousness	Ethical competence included in the curriculum	Offers psychedelic experience for training therapists	Source (as of November 2023)
California Institute of Integral Studies (CIIS): Center for Psychedelic Therapies and Research Certificate	Various but the curriculum is certified for Oregon psilocybin facilitation	Historically, licensed mental health clinicians, now no specific requirements.	10 months	Pharmacological substances: MDMA and psilocybin, additional coursework on ketamine-assisted psychotherapy	Information not available	Not available and program does not demand personal experience with psychedelic substances	https://www.ciis.edu/research-centers-and-initiatives/center-for-psychedelic-therapies-and-research/about-the-certificate
InnerTrek	Oregon psilocybin facilitation	No requirement of college degree but states that "Clinicians and healthcare professionals are well positioned	6 months: online coursework and 6 in-person "intensives", 40 h practicum	Pharmacological substance: Psilocybin	In accordance with OHA-OPS curricular requirements, includes "Safety, Ethics, and responsibilities of a Psilocybin Facilitator"	No information available	https://www.innertrek.org/program-details

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