Therapy Chat Episode 261

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[00:00:00] **Laura Reagan:** Therapy chat Podcast Episode 261.

[00:00:04] **Announcer:** This is the Therapy Chat podcast with Laura Reagan LCSW-C. The information shared in this podcast is not a substitute for seeking help from a licensed mental health professional. And now here's your host, Laura Reagan, LCSW-C.

[00:00:34] **Laura Reagan:** Hi, welcome back to Therapy Chat. I'm your host, Laura Reagan. And I hope you caught episode two 60 last week. My interview with Saj Razvi, on psychedelic assisted psychotherapies using medical cannabis and ketamine. I thought it was so interesting when he explained what makes up the default mode network.

[00:00:57] I was like mind blown [00:01:00] because I get it, but I didn't get it at that level. So part two goes more in depth into how the psychedelic assisted psychotherapy happens and their training process. So I hope you will enjoy this one just as much as last week. I know there's been a lot of interest in what they're doing.

[00:01:23] I am very excited about it. So, as I mentioned in last week's episode, you can sign up for one of their webinars on their website, which is psychedelicsomatic.org. And when you sign up for the webinar, if you are doing it, because you heard about it on Therapy Chat, please let them know that we have partnered, so that I could help them spread the word.

[00:01:45] And I'm hoping to attend their training in DC, July 2021. So, if you're in the DC area and you're a therapist, you might be interested in doing that too. All right. As always, I'd love to hear your [00:02:00] feedback. If you go to therapychat podcast.com, you can leave me a message using your voice with SpeakPipe. I love when that happens, and you can also email me at therapychatdotpodcastatgmail.com. If you have something you'd like to let me know. As always, thanks for listening.

[00:02:20] Hi, welcome back to therapy chat today, we are going to continue the fascinating discussion that was started last week when I spoke with Saj Razvi of the Psychedelic Sematic Institute about his work training therapists in a therapy model that is specifically for using psychedelic assisted therapies.

[00:02:45] So Saj, thank you so much for coming back to Therapy Chat today.

[00:02:48] **Saj Razvi:** Laura, thank you for having me again.

[00:02:50] **Laura Reagan:** So let's just pick up right where we left off. We were talking about how you have developed a model for [00:03:00] psychotherapy using psychedelics specifically, you're working with cannabis and ketamine. Am I right?

[00:03:07] **Saj Razvi:** That's correct.

[00:03:08] **Laura Reagan:** So why don't you just give our audience a little overview of how you're doing all that and then we'll get right into talking more about that model.

[00:03:18] **Saj Razvi:** Oh, sure. Yeah. So we were a training organization that was started in the early two thousands, and we've really focused on somatic trauma work again, we thought. It was sort of addressing the cause of why most people end up in therapy and why most people end up in therapy for years because there's a lot of treatment resistance. And so that's our background. And then more recently we got involved with the psychedelic research with maps and then basically paused our, our trainings, uh, simply to revamp them to include psychedelic processing because it was again, [00:04:00] the psychedelic moved out medicines boosted while we saw clinically significantly enough that we didn't want to run trainings without it.

[00:04:08] And so, uh that's so we have a training model. That really focuses on the, the therapy techniques that optimize psychedelic medicine and, you know, it can be used with MDMA. It can be used with psilocybin. I've had experience working with both in clinical trials as well as in Amsterdam, but, uh, what we're very excited about is that it can be used with something that is readily accessible, easily accessible and inexpensive, and not under an FDA framework. Something like cannabis that has legalization through the States as opposed to, uh, you know, uh, medical, uh, framework. So that, that is our great excitement about this. We were surprised when we saw the responses, uh, that we could get from something like cannabis.

[00:04:56] Uh, as compared to what we saw with other medicines, because it [00:05:00] speaks to a grassroots quality here. Right? So we, the mission that I personally hold is that psychedelic therapy should be accessible to anybody who it's appropriate for whom and who seeks it. And I think the way that it's going to be rolling out in our society is going to be through, you know, through a for-profit model of, of healthcare and things like that. And, uh, the excitement for us is that we can use medicines that create that psychedelic response that can be used in, uh, in a private practice setting, as opposed to a larger Institute setting that has a psychiatrist on board that has, you know, two clinicians that can do this work, things like that.

[00:05:42] **Laura Reagan:** So it sounds so promising and I'm really excited about it. Can you tell us, I want you to tell our audience about your model, but you were mentioning to me how there are kind of two different paths to working with psychedelic assisted therapies, and I'm [00:06:00] wondering if you can kind of tell our audience about that before we go into talking about that.

[00:06:05] **Saj Razvi:** Sure. And are you referring to the two different paths? Oh yeah. Okay, great. Yeah. So. There are there's something known as the sitter model or sitter schools that, that train people in it. And it's basically the model that's been used since the 1950s in psychedelic research. And it's still being used today.

[00:06:24] Like when Johns Hopkins runs psilocybin trials or Imperial college runs, these trials, they're using the Sitter Model. So the basics of it are that the heavy lifting, the

therapeutic interaction is between the participant and the psychedelic that they take. Right? So it's a very internal experience that their having.

[00:06:46] There are two therapists sitting with that person, but there's not much if any interaction between them. Uh, there's no expectation that the client, the participant should be talking to the therapist or, or the therapist talking to them [00:07:00] frequently. People are sitting very. The therapists are sitting in a meditative stance, just kind of holding space for, for the participant.

[00:07:07] And sometimes they may come out and just ask them to hold their hand or be taken to the bathroom or something like that. They're there for just in case something happens. Um, so I would refer to their model is the non-directive non interactional model. Right. And so, and the good news with it is that it works.

[00:07:26] We know that it works. Uh, we can tell that, you know, the results from. Basically, uh, what I would call unguided, you know, loosely guided psychedelic use is that the results are typically better than what we see with current psychiatric treatments. So that's one, the other option is the integration model that's kind of in trending at this point. In the integration model is saying that you know, there's enough awareness by people in the world around like Michael Pollan's book or what's happening with the research that people are taking it upon [00:08:00] themselves to do their own psychedelic work by themselves or with an underground shaman or a practitioner. And then, after they'd done that, then they go to a therapist and then derive therapeutic benefit from it.

[00:08:11] So that's the integration model. It's an after- the- fact- model. And so currently, training programs are either one of the one or the other, the CIS program in, uh, California is a much more of that Suiter model where they, you know, you, you learn, okay, this is the effect of. Um, you know, music on, on the client and this is how you, you choose a playlist, things like that.

[00:08:33] And then, and then the other model of course, is the integration one. And so how, what we're doing is different from that is that we think that if you develop a psychotherapy that's designed to work with non-ordinary States of consciousness that the heavy lifting can and should be done during the actual psychedelic session.

[00:08:53] Right? So. And, and we find that if the therapist is a player in the, in the [00:09:00] participant's psyche, during that experience, then it changes the direction of the session because left left, left to themselves, typically clients will often have trans personal experiences or a cosmic consciousness experiences or unity consciousness experiences, which are very sort of powerful they're based on taking higher doses.

[00:09:22] And, you know, there's a re there's an existential reconciliation. There's a lot that can happen at that level, but it's moving beyond a person's own ego in their autobiographical, uh, material, basically moving beyond themselves to go to a much larger sense of identity, much larger sense of self, which again, it's powerful.

[00:09:44] That's how the sitter model works. Our suggestion is if you have a, a human relationship that's active in the session, then it directs the session from transpersonal or

cosmic consciousness to [00:10:00] autobiographical to the person's family of origin, to their childhood, to the stresses and traumas in their life.

[00:10:07] Um, it makes it a human session. It makes it a human relational session. And the idea that we, we articulated a tier system here suggesting that, you know, it's a good idea for people to process the things that caused him to have a, a wounded developmentally fragmented ego before they go-to Transpersonal States.

[00:10:31] So, the basic premise of all this is, you know, before you transcend your ego, it's a good idea to have a healthy ego.

[00:10:38] **Laura Reagan:** Yeah. I mean, that makes sense. And what comes up for me is that not to knock the other ways, but you know, I hear, I tend to hear anecdotally the things, when things go wrong for people, how they'll have this big experience um, not necessarily with psychedelics, but let's say they'll do some kind of big trauma releasing [00:11:00] experience of some kind on their own. And then there's like a backlash in some way where they're, they're not, they don't, it kind of takes them away from what feels like healing to them. And it's like, they have a great experience, but then they have a negative experience afterwards that makes them afraid to do more healing work. So it's in that just like instinctively based on what I know I'm hearing, that could be an outcome of not, you know, the wounded places still wounded. And then you go and have this big thing, but then when you come back, the woundedness is like very painful. I could be wrong.

[00:11:36] **Saj Razvi:** No, no. I would completely agree with that assessment of it. You know, when you're, you're just working in a different realm. When you're doing transpersonal work than you are then working within the realm of your nervous system, your biology and your relationships. I would agree that it's much harder to integrate much harder to, um, assimilate what you get in a, in a cosmic [00:12:00] consciousness state into your ordinary waking, uh, wounded ego reality. If so, yeah. It's I think what we've see is that people tend to want to return to that big picture experience more frequently, and they need to return there because it's not something that they can take home with them. They're their small self is not healthy enough to integrate the, um, the experience.

[00:12:24] **Laura Reagan:** Yeah. That feels so true. And, and it also brings to mind the whole idea of, um, that what was wounded in relationship as you know, childhood relational trauma, family of origin trauma is. It has to be healed in relationship. That's what I've learned.

[00:12:41] **Saj Razvi:** I would fully agree. Yeah. Um, relational wounding re requires relational healing.

[00:12:46] I don't see any way around it. And there is a profound therapeutic opportunities that I, again, not knocking the other pathways. They, they do accomplish things. They're there, they're there for a reason. And I think we can [00:13:00] build upon what we've learned there. You know, there is a therapeutic, therapeutic opportunity that's lost when sessions psychedelic sessions are don't involve relationships.

[00:13:12] Uh, there's there's so much, we, we find that on the one side, you know, people can have powerful corrective emotional experiences, uh, touch in a psychedelic session is incredibly powerful because all the parts of somebody that needed a touch that are now defended against touch against the nurturing touch are up at the surface because they're not they can protect it anymore. They're not being censored anymore. And so if people receive corrective nurturing touch, they internalize that it goes to a very deep place and people when they get that. And then the flip side of that is that, you know, people have a lot of internalized, um, negative transference around that that comes from the traumatic relationships that they've had in their life. So [00:14:00] just, I think a quick definition here. So we're all on the same page. You know, transference is when a person takes the experiences, the feelings, the sensations, the memories, the thoughts that were, uh, that came from a prior relationship in their life, and then project them onto a current relationship in their life and that could be the therapist, but it could also be a spouse. Right? And so when you're dealing with a complex early childhood trauma, that is so that is laid in with heavy amounts of negative transference. In fact, one of the things that we saw in the MDMA trial was that because there were, we had the luxury of having two therapists per participant. The participant would quickly, their, their psyche would quickly pick one therapist who would become their idealized parent. It would be the parent that they wished they have the parent that was attuned to them. And then their psyche picks the other therapists that could be the parent they got. [00:15:00] So, basically that that therapist holds the negative transference and frequently for, you know, for people who let's say had, you know, a male perpetrator parent or something like that. Uh, as a child, they would tell their, their male therapist just, you know, sit in a corner of the room, they don't want to interact with them, they don't want to hear from them, they don't want them to get up. And, you know, they and yeah, it was such powerful transference that got opened up because we're taking a deep dive into the uncensored primary conscious of, of people during a psychedelic state.

[00:15:37] During regular therapy, people censor this all the time. They're feeling this from a bottom-up place, but their conscious rational mind is suppressing that. That's not what's going on in a psychedelic session. And so there's an incredible opportunity, when that transference comes out to, to allow it to welcome it by the therapist. And [00:16:00] unfortunately, one of the things that's happening in the world of therapy training is that, you know, with a focus on something like CBT, most clinicians are not trained to work with powerful negative transference.

[00:16:11] So it's very easy to be blown out of the water as a therapist. And, you know, you're, participant, your client is sitting there looking at you like you don't care about them like, you you hate them or you're going to perpetrate against them or something like that. They're basically handing the therapist a script of who they need them to be, and the script is an ugly, ugly script. And so it takes training to be able to sit with that kind of, uh, a thing. Yeah.

[00:16:42] **Laura Reagan:** Yeah. And then you have, you know, a relational rupture in the therapeutic relationship, you can either be able to repair it, if, you know, if you know what's

happening and you know how, or you can have a client has a negative experience, the therapy ends and you know, that's a new wounding.[00:17:00]

[00:17:00] **Saj Razvi:** Yeah. And I would say just like all of those pieces can happen to a much deeper extent than they happen in traditional therapy, simply because the you know, the, the regulators, the, the, the bumpers that hold the bowling ball on in the alleyway are no longer there. So, uh, yeah.

[00:17:17] **Laura Reagan:** So can you tell us about the model that you have developed?

[00:17:23] **Saj Razvi:** Yeah. Yeah, I will. You know, we are starting from the basics, meaning that, you know, we look at, uh, the basic biological reactivity that people hold in their system. So here, here's the way of thinking about it, it's just an example that we use in them in the paper: which is, let's say somebody has depression, but that depression is coming from the fact that they only eat sugar.

[00:17:47] Right? And their brain is not making neurotransmitters because they have a horrible diet. Is that, how do you treat that depression? Do you treat it because as you know, this is like [00:18:00] they're trans personally they're disconnected from their world or relationally there, they have things going on?

[00:18:06] Our suggestion is no. Like you have to address where things are coming from. And so you have to get this person to make neuro-transmitters and have a better diet. You have to handle their biology. And so similarly to that, we find that people that have a lot of stress and trauma in their system. And by that, I mean, you know, they have a lot of anxiety responses. They have panic responses on the, um, sympathetic anxiety side of the spectrum. Uh, the flip side of that is that they have a lot of numbing depressive responses, uh, like a dissociation, right? People feel disconnected from themselves and other, uh, and, and their world. And that is very frequently. We find a, a response to, um, traumatic events.

[00:18:53] And, and so our suggestion is, you know, let's work at the level of body. Let's work at the level of [00:19:00] the nervous system that comes online because primary consciousness comes online and, you know, these, these homeostatic mechanisms are far more available to us. And so once we resolve, uh, somebody's core nervous service system reactivity, or their core dissociation that's going on, then they can sort of move up the ladder and then start working with more complex things like, you know, like the definition of intimacy, the definition of father, different definition of a mother, things like that, how, how they hold at a very core programming level, how they hold intimacy.

[00:19:36] It means to them. Is it a positive thing? Do you get to relax with intimacy or do you have to be on guard? Because it comes with strings that are, that are attached. So basically we're working from the biological, to the relational, and then the, the transpersonal, right? So there really is a place for, for transpersonal work here.

[00:19:55] We're just suggesting, you know, taking the developmental pathway to [00:20:00] get there. Is that, is that answering the question or?

[00:20:03] **Laura Reagan:** I that makes sense. I am really curious. One of the things that we ended with in our part, one was the, you were saying that you found that cannabis can, I think you said unlock dissociation and I I'm wondering if you can sort of talk about that. Cause my, the way I see it, my perspective is that the reason why talk therapy even semantically oriented talk therapy can, can be such a slow process, is that, you know, it's, it's the trust building process.

It takes so long because the person is so defended against it, because of previous negative experiences from childhood where it wasn't safe to trust and to be cared for and to receive help, you know, and what really inspires me when I hear about these psychedelic therapies is that it seems as if those dissociative processes can be more safely, I guess I [00:21:00] don't want to say overcome or remove because they're there for a reason, but they can, the person can safely let their guard down enough to receive the information they need to be able to trust. It's within the relationship. I don't know if I'm oversimplifying it, but it seems like it's like, it's not a magic bullet, it's it's a quicker path to developing emotional safety. Am I off base?

[00:21:23] **Saj Razvi:** No, no, I think that's a, definitely a good, clear player in, in the dynamic. And I love what you said there, there, as impressive and deep as psychedelic medicine can allow us to work, it is not a magic bullet. There's no, uh, Deus ex Mokena.

[00:21:43] There's no magical thing that happens that all of a sudden people take, uh, take this or take a high dose of anything. And all of a sudden, their trauma is gone. That's not what we see happen. People have to work. Clinician's work. Um, it takes it, it [00:22:00] takes a lot of focus, and moving with things, feeling within feeling things that are very difficult.

[00:22:06] So, um, and I actually even think that, you know, this idea that people have of, 'Oh, it's a one and done, or a three and done model,' is not accurate. I don't think that's what the data is telling us. So I just wanted to sort of. Uh, touch on that before moving on to the rest of your thought there. Yeah.

[00:22:23] I, I would say that reestablishing relationship, re-establishing trust, re-establishing attachment is a big part of what happens in psychedelic work. Definitely with MDMA it just softens everything. It makes people more open to themselves, to their clinician, to the world. Right? And so all of a sudden, you're introducing the resource of relationship into a space that was, you know, armored against it and didn't have it when it needed it.

[00:22:54] And so it, I would say that that's a resource that allows opening [00:23:00] and the processing of trauma, but I think the process still has to be there. There's a lot of just raw nervous system charged that comes up for people when they open these doors. Right? So that's how I would see that the one caveat to that I would say is with something like cannabis, which is that I don't think cannabis works in the same way that MDMA works.

[00:23:22] I mean, we know like neurologically and biochemically, it doesn't work the same ways at all. One's an amphetamine molecule, the other one is a works on the endocannabinoid system. But one of the things that I think cannabis does so excellently that

that is therapeutically helpful is that it basically interrupts all of the interrupters that we have, and it interrupts all of the coping mechanisms, it interrupts all of the ways that we censor what our nervous system is actually trying to do. And so, so I guess what I'm saying is that there are a couple of different pathways to get to the really wonderful processing that we [00:24:00] see in psychedelic medicine.

[00:24:01] One is what you were describing the relationship, right? That you, you feel connected with yourself and other people in the world and you're, you know, your backpack is full. You're ready to climb that mountain. Now, the other way is. Well, all the mechanisms that you have that prevented you from, from prevented your body from doing what it wanted to do, uh, we're interrupting those mechanisms, you know, and consequently, that's the reason I think why cannabis is hated by many in, in mental health people don't trust it. I think they see it like, like they see vodka, right? Like it doesn't allow people to do insight work, it doesn't allow people to talk very much, it basically interrupts all of this higher order, meaning making functions that that CBT relies on. But,if your modality is valuing very different things, like if you value the value of very deep contact with your emotions and your body, then I think cannabis is something that is pretty perfect for that.[00:25:00]

[00:25:00] **Laura Reagan:** That's really interesting what you just said. And I do see that some clinicians have an extreme, negative reaction, even a fearfullness about cannabis. And, you know, it's, it's interesting. There's just so many mixed messages going around because there's one group of people who say it's dangerous and it can cause psychosis, and then there's another group of people who think, you know, that it's natural and it's better than pharmaceuticals. And, but then there's the whole, you know, it's more than just natural, it's like, what is the scientific process that's happening inside? What's the biologic biological process that's happening with the endocannabinoids, which I don't pretend to know or understand, but, um, you know, it seems like there's a lot going on. And when I saw your, one of the videos you sent me, which people can access on your website, the, uh, woman in part of the video, this struck me, I've mentioned it to you a few times already, but it struck me so deeply how this woman was first experiencing a [00:26:00] freeze response, and then, you know, moved through to like a discharging of fear and, I've never seen someone have a somatic experience like that well at all, but also with cannabis and I've never dreamed that that would be possible. So I was extremely curious about that.

[00:26:22] **Saj Razvi:** Yeah. I know that we see that pretty regularly, um, with cannabis again. I don't know the biology behind this, but for some reason, cannabis interrupts defensive responses, interrupts avoided responses and it interrupts dissociative responses.

[00:26:39] So let's say you're working with somebody who, let's take a very simple single event trauma like a car accident or something like that. And normally they would be when they bring it up, they move into a numbed out flattened dissociative state. When you bring cannabis on board with that, that that same person [00:27:00] relatively quickly starts having high anxiety responses, uh, fight or flight responses, other types of nervous system responses. It basically breaks up the frozenness that is dissociation and then they begin to have sort of the responses that we would want them to have. That, you know, might take, you know, many sessions to get somebody to that we've seen that turn on relatively quickly

with cannabis and there's a pitfall to that. There is absolutely a pitfall to, you know. It's the therapeutic opportunity and a pitfall in terms of how deep and how quickly psychedelics go to work in a person's system. Right? So, you know, I think the clinician, the, the participant, the client has to be aware that, you know, doors are going to be, doors are going to open up in your psyche that have been shut for a very long time. And you're going to feel things that you don't know about, you're not expecting. At our clinical site in Colorado in the past, uh, [00:28:00] we would just let people know about that, uh, ahead of time that, you know, for anybody engaging in psychedelic therapy, their functioning is going to decrease over the short term, right?

[00:28:11] So, they're going to need extra resourcing, they're going to need extra integration, they're going to need extra support as the medicine and the psychotherapy is going to work in their system. So, we did a pilot study, for example, with combat veterans, and we gave them the option of using either cannabis or Ketamine, and most of them use cannabis. And the arc of treatment looks, something like this, where, you know, these people were absolutely treatment resistant. Uh, they had gone through the, the hoops that the, uh, that the VA puts them through in terms of psychiatric options. And so, they were all pretty much using high doses of cannabis to manage their PTSD symptoms um, before coming into this pilot study. And so, they took this intro the same plant, the same thing that they use to [00:29:00] manage symptoms. And, but they put it in a different context, right, in psychotherapy. They had no faith that, that this was going to work and basically around session two, three, four, that's when they really fell apart.

[00:29:12] Right? That's when you know, all the coping strategies that they were trying to use to calm hobble things together, that's when those things fell apart. And that's when, you know, we, we set up different groups and things like that integration groups, art therapy groups, uh, yoga groups, uh, things like that to kind of support them.

[00:29:32] And then it was around session nine, ten, eleven, twelve where their systems really started to come back together in a much more stable, much more organic way. So they were, they were spending that time processing a great deal, which is what you saw in that video, Laura. So the, the arc of it is about fall apart early, stay falling apart, and then, and then come back together, um, you know, around session nine, ten, eleven [00:30:00] and you know, that's with a group of people that had enormous amounts of adult war trauma, as well as a significant childhood trauma. If somebody is approaching the table with, you know, much, um, a much lighter load than that than we would expect a very different arc of therapy.

[00:30:16] **Laura Reagan:** That's really interesting. And in the example you just gave of the you said it was a pilot study with the combat veterans, were they, did they stay in your location? Like, was it a residential treatment or was it just week by week or how was the timing structured?

[00:30:35] **Saj Razvi:** Yeah. Yeah, it was not a residential treatment. It was done in the same way that we would do outpatient psychotherapy. And some of them were from out of state, uh, and we knew that they were living in Colorado just so that they could do this, do this

program. It was a, it was a 12 session, uh, protocol, which we extended at the end to being 18 sessions altogether.

[00:30:56] So yeah, it was. It was outpatient, and one of the [00:31:00] things we offered to these guys was, uh, the possibility of doubling up on their sessions. So if they wanted to double up and get their 12 done sooner than they could, they wouldn't have to stay in Colorado. Uh, some of them tried it and then moved back to the single session a week because it is destabilizing. It is, uh, um, you know, the things that come up, they were, they were like, we're, we're fine with one a week, basically. Yeah, exactly. And I will also say that we saw the same exact thing in the MDMA clinical trials. Right? So for anybody out there that thinks that, you know, psychedelic therapy is a light, easy walk in the park kind of thing, it is not at all. And I think that's also one of the reasons why we don't see addiction with any of this, because when people are working with on psychedelics, they are going to hell realms they're going to very difficult places inside of themselves. They have the support of the medicine. They have the support and the therapy to get them to the other [00:32:00] side of it. But it's by no means an easy process. People will at the end of an MDMA session, take off their eye shades and just say like, why, why do they, we call that ecstasy?

[00:32:13] So we don't see addiction, because it's not something that you take, you get high, everything gets better. And then you come back down and then your life is still very painful and difficult in which case. That, I think it's the pattern to set up for a, that's a setup for rejection. This is very different people don't treat this lightly at all. Right? And the one other big, I think significant piece I would add is the veteran group that we worked with, they ended up using less cannabis after the pilot study to, you know, uh, on a, on a daily basis, they use less cannabis to numb the pain in their lives then they did before the study. So for anybody who's concerned about, you know, we're supporting drug use or something like that, again, therapeutic use of these medicines [00:33:00] I think is very different than recreational or even, you know, repeated long-term use of these medicines.

[00:33:05] Uh, you know, we saw again a decrease afterwards.

[00:33:09] **Laura Reagan:** Yeah. I, you know, you use this expression when we were talking offline. Bandaid, but I can see how, you know, it's like the way we tend to see the function of cannabis and supporting PTSD is for the symptoms. So that's the band-aid, you know, to calm or numb the symptoms, you know, feel less and then this is like, steeper it's feel more, but, you know, move through it instead of just putting a bandaid on it.

[00:33:38] **Saj Razvi:** Yeah. Yeah, absolutely. I think that the two different ways, I think those are good ways of describing it. You know, I think one option is the symptom management option, which is, you know, to a large extent, I think the entire world of psychiatry is a symptom management approach and I think a lot of what we do in psychotherapy is symptom management. Which if that's what [00:34:00] you need to do to, you know, if that works for the time being then great, it's sometimes it's necessary. But I think these tools are giving us a very different world. I think we're in a symptom resolution world with, uh, with these types of medicines at this point.

[00:34:14] What we're seeing in the clinical trials. I'm sorry, go ahead.

[00:34:16] **Laura Reagan:** Yeah. I mean, I'm with you. I agree. I sounds like it. I mean, I know that, you know, we can heal from trauma, but you processing it is the way to heal and, and to process it, you know, people can not feel ready and that's what prolongs the process, you know, and everybody's at their own place.

[00:34:34] Right. Totally get that, but it sounds very, Oh my gosh, the potential is just so exciting.

[00:34:40] **Saj Razvi:** I think so I think we're looking at a revolution in mental health, I think we were looking at it with, um, you know, even though again, I think. You know, if, when MDMA comes out in the, sort of the limitations on how it can be used in the context in which it can be used and the cost and the [00:35:00] medicalization of it and everything, even with that, it is a revolution in mental health.

[00:35:03] I think we're going to start looking at mental health as not just a highly functional secondary consciousness process. I think we're going to start saying that, "look, know, um, non-rational, uh, non-verbal processes that, you know, dream processes, uh, things that don't look nice and tidy or make sense in a lot of ways. I think the, the primary consciousness mind is going to achieve a new status in terms of you know, where we derive our mental health from, you know, so one of the things that we talk about in that, in that paper is, you know, there are, this is not bad mouthing, um, or putting down a secondary consciousness, you know, do you want your surgeon to be steeped in secondary consciousness? Do you want the airline pilot that's flying the plane that you're on to be in secondary consciousness? Absolutely. [00:36:00] But does that mean that you want to derive all of your meaning of the world? Do you want to derive your direct contact with nature? Do you want to derive your, uh, experience of the divine from secondary consciousness?

[00:36:15] I think not. Right? I think, you know, even, even most of hope I don't get in trouble for saying this, but most of the religion that we have is you know, a secondhand account of somebody else's primary account, a primary encounter with God with, with the divine. And I think one of the things that really changes with psychedelics is people have their own primary experience of the divine. They have their own primary experience of the world. It's I think it's the difference between being a chess player that, you know, you're removed from the game you're, you're analyzing the game, you're seeing the game from a meta-position versus being in the game. Right? Uh, being in the flow of life where you feel things in a very different way [00:37:00] than you do, when you think about life through the lens of secondary consciousness.

[00:37:06] **Laura Reagan:** Hm. So interesting. Oh my gosh. So as we finish up for our part two. What would you want clinicians who are listening to know? I'll give you a two parter. What would you want clinicians who are listening to know and what would you want people who are listening, who aren't clinicians, but might be curious about these therapies? What would you want each group to know?

[00:37:31] **Saj Razvi:** Okay. Great. Great, great, great. Let me see for clinicians, or I would even say anybody in the healing arts world, right? So I would expand it beyond just

clinicians. I would say that we did not get into this field to put band-aids on profound wounds. And I think a lot of times, you know, we're doing it because, you know, we're an empathic bunch and this is our life mission, but I think the tools that we have that [00:38:00] are coming online now are allow us to do so much more than that. But that means that we have to really think about therapy in a radically different way. We have to sort of, you know, let go of the idea that the, of, you know, Um, that, you know, people can't have very intense experiences and come out on the other side and be in a very different place and people that absolutely need support people absolutely need, you know, integration and support between sessions. But the sessions. Yeah. Trust people to take that deep dive. Right. They're built for it. We are built for it. We have a nervous system that's taken millions and millions of years to evolve that is designed to homeostatically process these experiences. Um, it it's, I would say it's the difference between feeling your way through anxiety and panic and depression versus thinking your way through those things.

[00:38:59] Right. I think it's [00:39:00] far more effective to feel your way through it. And I think that's the access that psychedelics give us. The other piece that I'd like people to really know is this is not something that has to be in the hands of, you know, a corporation, a for-profit model. This is not something that has to roll out in our society through those means or through the, you know, the heavy medicalized regulation that is going to be imposed by the FDA. This is something that is available to us now. We've been doing it for years and we had the state of Colorado specifically look at our program. We invited them to look at it because we were a fairly large clinic and, you know, we didn't want to invest all of that and, uh, and then have the state say, no, we're not appreciative of what you're doing.

[00:39:48] So we had them look at it and they were fine with, uh, with how we've constructed our model, which, you know, using cannabis and ketamine along with psychotherapy. And again, because especially [00:40:00] cannabis is a, is already approved for the condition of PTSD in most States. So I guess I just want to say it's possible to do psychedelic psychotherapy in your private practice today, not something we have to wait for. Uh, you do need training for it. You absolutely have to have your own experience. You have to sort of take your own deep dive and know the processes of primary consciousness are very different than the processes that that rule secondary consciousness. So I want to, uh, give hope and inspiration to people like, yeah, we are, you know, we're on the cusp of something really amazing here.

[00:40:41] And the other group was to, or was it to consumers of therapy, Laura, or who are you thinking?

[00:40:45] **Laura Reagan:** People who are curious about different ways to heal from their traumatic experiences.

[00:40:51] **Saj Razvi:** Yeah, but there's really good news here. Um, I think people really can heal from their traumatic experiences. It's don't but [00:41:00] don't get me, don't confuse what I'm saying there with saying that, like there there's a magic bullet or super easy way to do it. It's still takes a lot of focus and attention and commitment on your time. And it takes working with somebody who knows what they're doing. This is, again, this is not magical

stuff. You don't just take a high dose of something and have a powerful experience. And then everything's better.

[00:41:21] I mean, potentially I'm sure there's some group of people that, that.can happen for, I don't want to rule that out, but there's also equally, uh, somebody on the other side who can have powerfully traumatic experiences. I will say that one of my, um, one of the people on our team, uh, Steve Alford was, uh, one of the, uh, University of Wisconsin, Madison, uh, psilocybin participants.

[00:41:47] And, you know, he had an escalating higher dose and they were doing the sitter model with him. And he describes that as profoundly traumatic, or I hope I'm not putting words in his mouth, but, um, you know, he, [00:42:00] he, he, this is a person that had a lot of trauma and there was just a lot of space for him to sort of go into it and loop and loop and loop around in it.

[00:42:09] And it was just, he describes it as pure suffering. You know, I think these medicines are incredible, but they do need direction. They do need contact and engagement therapeutically. Um, I don't think that's true if you're, you don't have that a lot of trauma or mental health concerns. I think if you're sort of the average neurotic walking around, you know, you can do an Iowasca session in Peru where you can do the ceremonial sessions that are designed for you know, uh, a sense of spirituality in worship, and I'm not saying anything about those. I think those are incredible, but if you have a significant mental health concern, then I think your focus needs to be mental health with the use of these medicines at this point.

[00:42:54] **Laura Reagan:** Well, that’s very helpful. And I appreciate you saying that the someone, we all need to know what [00:43:00] we're doing, if we're doing this work, whether it's You know, for a consumer who may seek out this type of therapy, you need to be working with someone who knows what they're doing. And if you're a practitioner, some kind of healing helping professional, you need to know what you're doing to be doing this kind of work.

[00:43:17] So where can people find out more about your training?

[00:43:21] **Saj Razvi:** I know we'd love to have you. Um, uh, we do, you can go to psychedelicssematic.org, and I'll just say the way that we've structured this training is there's a five day in person component. And then there's an eight-month remote supervision component.

[00:43:39] And in the reason for that is that people don't magically learn skills overnight. They really have to practice and practice and practice and implement and things like that. So we designed it to be. Sort of longer term like that. I think relevant piece here is that we don't want people to travel for this and what, [00:44:00] because a person's cohort that they train with is important. Right? Uh, and what I mean by that is you doing this work by providing sessions to people in your training and receiving sessions for people in their training is critically important, right? To just getting time in the seat, getting time in that psychedelic space is very important.

[00:44:20] And then, and then you bring everything that happened to supervision. And because of that, if we're running a training in Dayton, Ohio, we don't want people flying in from Chicago or something to take that training simply because they're not going to have a cohort there in Chicago yet. To do that, that, that, that practice trade with, so our goal is to have smaller trainings, like 12 to 15 people trainings and all, not just the major cities, but at smaller places.

[00:44:47] So if you guys go to psychedelicsomatic.org, you can see a list of the places that we have right now. And if you want to have a training in your local area and you have some people that you think might be interested, then [00:45:00] shoot us an email and we'll, we'll help you organize.

[00:45:03] **Laura Reagan:** That's great because I didn't see DC or Baltimore on that.

[00:45:06] I'm going to have to, uh, talk with some people and see if people want to bring that. Um, because you know, I was like, I'll go to Boston, but, um,

[00:45:15] **Saj Razvi:** no, no, we'll, we'll come to you. Yeah, I think you probably have some pull, Laura.

[00:45:25] **Laura Reagan:** I do know a lot of pull.

[00:45:28] Saj, thank you again for being my guests on therapy chat and talking with us about this fascinating area of study and practice.

[00:45:39] **Saj Razvi:** This has been great, Laura. I really appreciate it. Thank you so much.

[00:45:46] Hey, everyone just wanted to take a and to tell you about my trauma therapist, consultation groups. These are small online groups for trauma therapists or therapists who are working with clients who [00:46:00] have trauma and want to become more trauma informed in the way they practice. The groups are limited to six people per group, and we meet one hour or one hour and a half.

[00:46:12] Per month, depending on which option you choose. And the group is for learning, improving your skills, connecting with additional resources, for helping trauma survivors. And it's also for support and community because being a therapist can be very isolating and trauma work can be very isolating. So we come together and share our common experiences to help each other.

[00:46:39] Remember that we're all human. And give and receive support. So if you're interested in learning more, you can sign up for the email list to find out when registration opens. It will be opening on February 1st. And if you want to be one of the first to find out about that, when it's [00:47:00] goes live, join the email list.

[00:47:02] There is a link in the show notes for this episode to sign up for that. I'll also announce it here on the podcast. When registration opens. Hope to see you there.

[00:47:11] **Announcer:** Thank you for listening to Therapy Chat with your host, Laura Reagan LCSW-C. For more information, please visit therapychatpodcast.com.