A Future for Psychiatry:

Psychedelic Therapy as a Synthesis of Evidence-based Psychiatry and Existential Psychotherapy

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Abstract

The fields of psychiatry and psychotherapy currently find themselves dominated by schools of thought that show an admirable scientific purity, but fail to acknowledge fundamental aspects of the human experience. Conversely, an examination of the history of these disciplines reveals alternative approaches that provide a philosophically deeper and more authentic analysis of human being, but lack the scientific rigor of the mainstream practices. The current thesis proposes a potential synthesis of these two directions in the form of psychedelic-assisted psychotherapy. It is argued that the nature of the psychedelic experience is such that the philosophical depth of the alternative approaches is unavoidably preserved while simultaneously allowing for a degree of scientific precision akin to that of the mainstream approaches. Ultimately, in order to construct truly effective mental health care, it is argued that the current exclusive domination of the fields of psychiatry and psychotherapy should be outgrown, and that professionals should receive training in a wide array of different conceptual and therapeutic approaches.

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Introduction

This thesis represents an amalgamation and a culmination of both my academic thinking and, equally, my personal experiences over the past number of years. It is therefore no mere academic exercise, but an expressly personal pursuit, as well. Specifically, the views and opinions expressed on the following pages were first given shape through my own encounters with depression, psychotherapy, and psychedelic substances, and only further substantiated and crystallized through my academic training. On all fronts – personal, clinical, and academic – a few things seem to me immediately necessary. First among these is a thorough articulation and explication of the problem. Chapters one and two will therefore be dedicated to an exploration of the diversity of lines of thinking in the fields of psychiatry and psychotherapy – including the dialectical forces that I perceive within each of them – which will hopefully alleviate some of the confusion that I know existed in my own mind, and that I suspect to exist in many other minds, as well. Secondly, it seems pertinent to me to draw attention to some of the nascent developments in the field that, in my mind, show a potential to unify many of the current lines of thinking, and thereby try to encourage their continued and further elaboration. Chapter three will therefore offer a synthesis of some of the opposing forces sketched in the previous two chapters and thus complete the admittedly clichéd but in this case unavoidable Hegelian picture.

In a (more specific) nutshell, the following three chapters will argue that the current iterations of mainstream psychiatry and psychotherapy labor under a specific conception of what it means to be a healthy human being that is not necessarily wrong, but certainly incomplete (Chapter 1). On the other hand, alternative conceptions of psychiatry and psychotherapy – with a special focus on existential and humanistic psychotherapy – have attempted to complete the picture, but are contending with their own predicaments that have left them largely marginalized in the current scientific discourse (Chapter 2). To unify these schools of thought and provide a more complete conception of the human being while also giving the advantages of the mainstream approaches their due room and respect, I will finally introduce the nascent field of psychedelic psychotherapy as a candidate with inspiring potential (Chapter 3).

Chapter 1

An Introduction to Mainstream Psychiatry and Psychotherapy

The fields of psychiatry and psychotherapy as practiced today are not always easy to distinguish from one another. In fact, in common contemporary parlance and even in some health professions, it is not altogether uncommon to hear the two terms used interchangeably. Although – as will become apparent – there is much overlap, I want to avoid this imprecision at the outset by highlighting what I see as the most critical difference between the two. According to the American Psychiatric Association, psychiatry is "a branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders" (American Psychiatric Association, n.d.). Thus far, it might sound almost indistinguishable from psychotherapy. However, as is apparent from the phrase "branch of medicine," psychiatry has an explicit medical bend that psychotherapy does not. This means that psychiatrists, in contrast to psychotherapists, are medical doctors – a fact that shapes the discipline in significant ways. Psychotherapy, on the other hand, is situated much closer to the (historically) softer discipline of psychology. In order to properly acknowledge the individuality of these two fields, I will begin by introducing them separately and only subsequently offer an analysis of what I perceive to be the underlying commonalities that call for a unified solution.

1.1 Psychiatry

The history of psychiatry is complex, multifaceted, and contested, and thus, in its entirety, beyond the scope of this thesis (Gask, 2004). Insofar as it is germane to my argument, however, I will offer a brief overview of important elements.

As a field, psychiatry officially developed as a sub-discipline of medicine around the beginning of the 19th century. It has been noted that this – at the time – new discipline by no means invented the famous asylums that were used to house individuals who were deemed "insane" by society for centuries prior, but rather developed as a reaction to those asylums in an attempt to treat their inmates (Porter, 2002). From its inception through to the present day, psychiatry has had a tumultuous and contentious history. As Gask (2004) suggested, the history of psychiatry over the last two centuries can be likened to a pendulum swinging back and forth between two main camps (albeit passing a handful of factions on its way): those that believe that mental illness is primarily or exclusively a result of biological factors (e.g., brain degeneration, genetics), and those that believe that psychiatry should pursue a more subtle, sometimes more holistic, approach to the complex etiology of mental illness. The

latter coalition, including such movements as community psychiatry, anti-psychiatry, and psychoanalysis, will be more fully discussed in Chapter 2. For now, it is sufficient to note that the last 30 years of psychiatry have been marked by a substantial swing of the pendulum in favor of the biological side of the divide (Gask, 2004). In other words, the last few decades of psychiatric development have been more or less emphatically focused on the development of new drugs, neuroimaging, and similar biology-based methods. Common to these approaches is the underlying belief that mental illness is essentially explainable as a malfunction of the brain, analogous to other physical organs (e.g., the liver), and therefore receptive to similar treatment approaches. The reason for this development, as far as it is discernable, seems to have been a justified frustration with the lack of progress other approaches exhibited in the fight against some of the seemingly intractable mental illnesses faced by many people (Gask, 2004). In such an environment, the tangibility of the biomedical approach infused the field with a new feeling of hope. Owing to its contemporary dominance in the field, I will refer to this approach as "mainstream psychiatry" throughout this thesis.

The biological focus of this current mainstream psychiatry comes with some clear advantages. Firstly, throughout human history, mental illness has come with decidedly uncomfortable stigmata. As previously mentioned, individuals who were classified as "insane" were, for hundreds of years, siphoned out of society into specially designed asylums (Porter, 2002). To put it mildly, such asylums usually tended to be rather harsh environments to live in (Beveridge, 1998). In "milder" cases of mental disturbance such as "shell shock" or depression, the individual was not ostracized from society, but was instead frequently maligned for possessing a "weak" character (Li et al., 2018). In short, whatever the extent of the condition, it was seldom treated with the same respect and consideration as physical afflictions. It stands to reason, then, that a biological approach, which views mental disorders as more or less simply "disorders of hard wiring" (Gask, 2004, p. 60) akin to disorders of, for example, the kidneys, would provide considerable relief for patients suffering from stigmatization. Not only are they not to blame for their affliction, but they are acknowledged rather than ridiculed for suffering from what is now recognized as a real and serious condition. Moreover, many patients find it significantly more reassuring and understandable to be told that they are suffering from a physical condition rather than an intangible, mental one (Gask, 2004). On both an individual and a societal level, then, the perception of the mental and the physical as being closely related can be quite beneficial.

Furthermore, mainstream psychiatry's close relationship with hard sciences like biology and medicine brings an important methodological advantage. Specifically, the

discipline closely follows the scientific method and proceeds with a consistently evidence-based cadence that has, at times, been missing from alternative approaches like psychoanalysis (see Chapter 2). This rigorous attitude has led to undeniable and tangible progress. For example, the meticulous classification of mental disorders into the *Diagnostic and Statistical Manual of Mental Disorders (*DSM; American Psychiatric Association, 2013*)* resolved long-standing problems in the field regarding the standardization of mental conditions, thereby enabling uniform communication and diagnostics around the world, and further contributed to the destigmatization of these conditions. Additionally, and even more impressively, the development of novel drugs and related medical interventions that were enabled by the evidenced-based, biological approach of recent psychiatry has revolutionized the treatment of myriad mental disorders that were, until then, untreatable and catastrophic. Consider, by way of an example, the problem of suicidal ideation. Before the advent of anti-depressive medication such as selective serotonin reuptake inhibitors (SSRIs), health care had very little chance of stabilizing individuals who were experiencing a suicidal breakdown. Whatever the overall balance sheet of drugs like SSRIs, they do seem to present an effective tool for short-term stabilization against profound feelings of hopelessness ("Depression: How effective are antidepressants?", 2020). Similarly, drugs like lithium carbonate and Thorazine, once discovered, transformed and continue to transform the lives of countless individuals suffering from bipolar disorder and psychosis, respectively (Ruffalo, 2019). Undoubtedly, without these and similar advances, the plight of people afflicted with various mental illnesses would have been significantly closer to being unbearable.

1.2 Psychotherapy

The overall historical development of psychotherapy or, as the discipline is more formally known, clinical psychology, exhibits a somewhat similar pattern as psychiatry, albeit for, in my estimation, slightly different reasons. For a long time, psychotherapy was what Thomas Kuhn would have described as a pre-paradigmatic science (Kuhn, 1962/2009). Essentially, this means that many different schools of thought existed in parallel with one another without any one school possessing a claim to superiority or universality. Freudian psychoanalysis coexisted with behaviorism, Gestalt psychology, and other approaches like the ones developed by Carl Rogers, Victor Frankl, and Carl Jung, each of which exhibited vastly different philosophies on everything from etiology to treatment of mental conditions. This pre-paradigmatic situation changed with the advent of what psychologists call the Cognitive Revolution (Gardner, 1985). This movement, starting in the 1950s, was and is fundamentally

based on – and depends on – the adequacy of essentially equating the human mind to a computer. At the risk of being charged with undue speculation, I suspect that one reason this development was so attractive at the time (and remains attractive to this day) is that psychology has historically suffered from something of an inferiority complex when it came to its scientific credentials. Too many people had expressed skepticism through the decades about psychology's desert as a discipline to be inducted into the ranks of proper sciences (for a contemporary example of this, see Jogalekar, 2013). Criticism of the unfalsifiability of Freudian claims about the unconscious mind had, for example, already inspired behaviorism to dispense with all unnecessary metaphysical postulations and, in its extreme form, even the mind and consciousness itself (Richards, 2010). However, behaviorism clearly overshot its goal in this regard and thus limited itself in applicability, thereby preserving the field's pre-paradigmatic *status quo*. With this underlying insecurity in mind, it stands to reason that the discipline would leap on the opportunity to compare its own subject to the hardest of sciences, i.e., mathematics and engineering.

Whatever the reasons, the cognitive approach became the dominant framework in psychology over the ensuing decades (Richards, 2010) – so much so, in fact, that all the other, pre-paradigmatic schools of thought were more or less left behind in the wake of psychology's newfound scientific authority. To illustrate by way of an anecdotal example, my own psychological education included much discussion of Freud and his system; however, these discussions always exhibited an undertone of derision, even ridicule, and never failed to emphasize the purely historical – because unscientific – relevance of his approach. In place of these disgraced approaches, what dominated both my own university education and the therapeutic field in general was Cognitive-Behavioral Therapy (CBT). Growing out of the cognitive approach – as the name suggests – this therapeutic framework assumes that the causes for most mental ailments are maladaptive cognitions (i.e., thoughts) and behaviors. Therefore, to treat such ailments, it should be sufficient to replace the offending thoughts and behaviors with better, more adaptive ones. At this point, we can retrace many of the steps we took in our earlier discussion of psychiatry.

Firstly, a fundamental advantage of psychiatry applies here, as well: the cognitive-behavioral approach is evidence-based and therefore unquestionably scientific. This has allowed clinical psychology to launch standardized, large-scale investigations into the efficacy of talk-therapy that had never been possible before. The reason that CBT is so attractive for scientific inquiry is that it is methodologically easy to implement in large-scale studies. The incumbent maladaptive thoughts and behaviors – which represented the focus of

attention in approaches like psychoanalysis – are practically irrelevant, because the new, adaptive replacements can be written into a script that can be universally applied to any patient and therefore enable a consistent scientific procedure. By contrast, consider psychoanalysis, which unavoidably requires a fundamentally individual analysis of how any one person came to their current state of distress. Such individualized engagement is anathema to scientific methodology. Therefore, in the interest of conserving psychology's scientific authority, all such approaches have been relegated to the margins of the field, while CBT inhabits a position of more or less complete and exclusive dominance.

In addition to its compatibility with scientific methodology, the consistency and relative simplicity of CBT, reminiscent of (and, indeed, in conjunction with) the previously mentioned DSM, also enables consistent and reliable treatment even for patients who may have to change their therapist during the course of their therapy. Since the cognitive-behavioral scripts can be relatively devoid of individuality, elusive variables such as therapeutic alliance, i.e., the personal chemistry between a therapist and their client, can (hopefully) be minimized. This, along with its strong evidential base, can ideally take much of the heretofore rather intractable guesswork out of psychotherapy and represents a substantial improvement to the previous, pre-paradigmatic *status quo*, in which it was common to find that any two therapists exhibited fundamentally different methodologies and philosophies, and in which the efficacy of any approach was more or less purely anecdotal (Westen et al., 2004).

1.3 Criticism

The current iterations of mainstream psychiatry and psychotherapy have clearly led to substantial progress in both fields, and have undoubtedly improved the lives of many people. Nevertheless, despite their very real and commendable advantages, much has been written about the shortcomings of both fields from an empirical standpoint. During the last two decades in particular, critics have started to attack some of the intricacies and outcomes of the approaches. A considerable amount of this attention was directed at the previously mentioned DSM, the catalogue of mental disorders published by the American Psychiatric Association and widely used for diagnostic purposes. One example of this criticism is the 2007 book *The Loss of Sadness* by Horwitz and Wakefield, which argues that some of the DSM categories – specifically depression, but also adjustment disorder, conduct disorder, and others – insufficiently distinguish their symptomatic profiles from what should be considered normal reactions to environmental challenges, and hence mistakenly over-pathologize healthy

behavior. Others have argued, among other things, that the DSM has too many categories (George & Klijn, 2014; Vanheule et al., 2019), that the separation of those categories is unrealistic and does not account for the high rates of comorbidity (Van Os et al., 2019; Westen et al., 2004), and that the cut-offs that decide who is considered disordered and who is considered normal are too arbitrary to be useful (Khoury et al., 2014). More generally, a group of experts convened by the Belgian government additionally concluded in 2016 that the biomedical approach did not reduce stigma as much as initially hoped (Vanheule et al., 2019).

Furthermore, the pharmacological aspect of psychiatry has often been a point of contention, as well (e.g., Gøtzsche, 2013). While it is undoubtedly true that psychotropic medicines, some of which are described above, have revolutionized the lived experience of many patients, discussions about potential side-effects of and life-long dependencies on various substances which, in some cases, could be worse than the disease, have always been a constant companion of the field (e.g., Jakobsen et al., 2017; Lally & MacCabe, 2015). On the other extreme, the question whether anti-depressants are actually clearly distinguishable from placebo in clinical outcome studies is, incredibly, also not yet definitively settled (Gøtzsche, 2013). As for cognitive-behavioral psychotherapy, commentators have, for example, pointed out that the outcome variable of "symptom reduction" commonly used by clinical trials extolling the benefits of CBT is far from synonymous with "recovery" for those patients. In other words, the studies ostensibly showing the efficacy of CBT interventions may be using simplistic outcome measures that inflate their actual effects (Westen et al., 2004). Additionally, the symptom reduction measured by these studies usually depends on the already discussed relatively arbitrary cut-offs in the DSM entries of the relevant conditions. In summary, then, many issues seem to remain with the current paradigms from a purely empirical angle.

None of these critiques, however, pertain to what I see as the more fundamental, underlying problematic presuppositions that both biomedical psychiatry and cognitive-behavioral psychotherapy depend on. Specifically, both fields exhibit a rather one-dimensional picture of what it means for a human being to be "healthy" and how best to treat "unhealthy" people. The focus for both approaches lies here on what I would call "functionality" at the expense of many other elements of the human experience that deserve more attention. In both disciplines, this emphasis on superficial functionality manifests in a profoundly symptoms-based approach that is, in my estimation, doomed to continue to merely scratch the surface of the conditions it is attempting to conquer. This is because

neither pharmacological interventions nor cognitive-behavioral scripts exhibit much concern for the underlying reasons any one person is presenting with a disorder.

In the case of mainstream psychiatry, the assumption that the brain is an organ just like any other and can therefore be treated on a physical basis makes any questions as to the lived experience of the patient obsolete. Happiness, purpose and meaning, and other inevitable struggles of human existence are relegated to irrelevancy as long as one substance or another can enable the patient to be a normally functioning member of society. No attempt is made, in other words, to grapple with the facts and tragedies of life. To me, this evokes Nietzsche's eerie description of the perpetually eventless and creepy, numb conformity of the "Last Men":

> A little poison now and then: that makes for agreeable dreams. And much poison in the end, for an agreeable death. … Everybody wants the same, everybody is the same: whoever feels different goes voluntarily into a madhouse. … "We have invented happiness," – say the last men, and they blink. (Nietzsche, 1883/1978)

The problem, of course, is that such a symptom-level approach leaves the underlying causes of the disorder intact. To provide just one example of this in the real world, consider that antidepressants in most cases neither solve the underlying causes of depression, nor do they really make people happy. But even if antidepressants had the ability to make any and every depressed person permanently euphoric, the underlying frictions and dissatisfactions that caused the depression would still remain unaddressed. Consider, by analogy, the natural grief a person feels at the occasion of the death of a loved one. Is it the healthiest course of action in such a situation to rush into an artificially created state of bliss, or would it perhaps be wiser to acknowledge and sit with the underlying emotions? It is common knowledge that a flight into alcohol and other "illicit" drugs in such a situation is ill-advised, yet psychiatry essentially sells the same idea.

Admittedly, this may seem like an unfairly simplistic caricature of psychiatry, since psychiatrists do not commonly prescribe antidepressants for simple grief (although see Horwitz & Wakefield, 2007). Nevertheless, as Johann Hari recently argued in his book *Lost Connections* (2018), psychiatry's strategy to treat depression over the last few decades has been to try and erect a simple neurotransmitter calculus under the assumption that all a depressed person is lacking is serotonin. This unfortunately ignores the fact that individuals presenting with depression do so for a plethora of different reasons, each of which is intimately connected to that specific person's lived experience and history. Although I do not want to dispute that anti-depressants have their place and can be an important first-line

measure in some cases, I submit that a blanket application of this approach across the board is likely to be harmfully simplistic.

Similarly, cognitive-behavioral psychotherapy may not assume a fallacious equality between physical and mental afflictions, but nevertheless commits the same foundational offense of ignoring many of the most crucial aspects of human existence in favor of a superficial focus on functionality. Since CBT operates by way of more or less uniform and pre-determined scripts of new thoughts and behaviors to replace the old, maladaptive set, not much consideration is given to the question of where the old set came from in the first place. To illustrate, consider the example of social anxiety. One of the most prevalent methods to treat this condition in the CBT framework is exposure therapy (Weeks, 2014). In this technique, the patient and the therapist jointly produce a hierarchy of increasingly anxiety-provoking situations. These situations are then gradually confronted, starting with the least difficult and working one's way up the hierarchy. The underlying theory is that this gradual exposure will – to slightly reinvent psychologist Lev Vygotsky's term – lead to a "zone of proximal development" (Vygotsky, 1930-1934/1978) for the patient that sufficiently challenges without becoming overwhelming, and that the patient's resilience would thereby gradually increase until the anxiety is fully conquered.

Taken purely on its own, this technique can be extremely effective and has been exceedingly well established in the literature (Powers et al., 2008). Nevertheless, it is clearly incomplete in so far as the patient does not gain any understanding of why and where the anxiety originated in the first place. Some might argue at this point that, as long as the technique is effective, insight into the condition's origin is of merely academic interest, but I would disagree. Speaking from personal experience, insight into the origin of one's condition can be crucial in the event of a relapse. More fundamentally, such symptom-treatment approaches always leave the patient vulnerable to the sudden appearance of new symptoms, which will necessitate new treatment. Until one has grappled with the actual causes of a problem, one will forever remain in its shadow and subject to its arbitrary explosions. Unfortunately, the actual causes tend to be buried in complex networks of existential, social, and emotional struggles that are unlikely to be resolved through a superficial focus on short-term functionality.

A second and related, but subtly different, underlying presupposition of biomedical psychiatry and cognitive-behavioral psychotherapy is the assumption that the individuality and, more strongly phrased, radical subjectivity of patients can safely be ignored. In the case of psychiatry, the fallacy must once again be located in the assumption that the treatment of

mental illness can be equivalent to the treatment of physical illness. Since the essential apparatus of a knee, liver, and, in this philosophy, the brain is the same between individuals, a treatment that works for one person should work for everybody. This, again, seems overly simplistic to me, and fails to acknowledge the fundamental dignity and breadth of human phenomenology. In John Milton's words: "The mind is its own place and in itself, can make a Heaven of Hell, a Hell of Heaven" (Milton, 1667/2005, p. 24). With respect to CBT, the same point essentially applies, only that the reason seems to be located elsewhere. In this case, the fallacy does not lie with a bad analogy, but with the belief that the highly valued scientific purity of the discipline necessitates a group-level approach that is irreconcilable with individual engagement between a therapist and a patient. To be more precise, the assumption at work here is that proper scientific methodology requires a manualized approach that maximally standardizes the experimental procedure. Therefore, therapists participating in a clinical trial will have to follow a manual as consistently and invariably as possible, since every idiosyncrasy in the interactions between therapist and patient will come at a cost to the inferential power of the study. In other words, if therapists go off script too much, the study loses its ability to adjudicate on the efficacy of the manual. Obviously, however, this implies that individual factors are unimportant. Unfortunately, as with psychiatry, a band-aid, uniform solution for every patient fails to acknowledge the diversity of human mental life. Superficially similar symptoms (e.g., depression) can be caused by a vast array of different mental conflicts and disturbances that will not be solved – or even engaged – by the application of an invariable protocol developed solely on the basis of the symptomatic profile.

1.4 Closing Remarks

Lastly, before closing this chapter, I would be remiss if I did not emphasize again my conviction that both psychopharmacology as well as CBT, despite all my criticism, can be extremely effective and, more to the point, precisely what is needed in certain situations. In my own life, I have met many people who had grown dissatisfied or even disillusioned with their (non-CBT) therapy, because, in their experience, all the analytic dissection of the problem did not lead to any noticeable results. They would complain that they understand why they are the way they are, yet that knowledge did not help them in the least. For such individuals, the reliably effective techniques of CBT can undoubtedly reinvigorate their introspective pursuits and noticeably increase their well-being in a relatively short period of time. For that reason, CBT will, and should, remain an essential tool in the therapist's toolkit.

Similarly, psychiatry's medical nature is equally indispensable in certain situations (e.g., suicide prevention, acute psychosis), and should therefore also never be discounted. My criticism is simply that these approaches are incomplete and should hence not dominate their respective fields as fully as they do. One aim of this thesis is to raise awareness of the fact that psychological care is not a uniform field. Despite the dominance of certain schools of thought, other options still exist. Therefore, a person's first and only encounter with therapy should never be seen as representative of the entire field of possibility. Unfortunately, too many people conclude precisely this and, if they did not get lucky the first time, become cynically disillusioned with the prospect of seeking psychological help. As a result, many people tragically never receive the help they could have received. This I hope to rectify.

In summary, then, both psychiatry and psychotherapy find themselves dominated by a line of thinking that is certainly useful, but fails to respect important aspects of the human experience. In dialectical opposition, both fields have faced contenders and critics that have attempted to provide alternatives to these mainstream approaches. It is these alternative conceptions that the next chapter will explore.

Chapter 2

An Introduction to Alternative Approaches

In keeping with the Hegelian dialectic, this chapter presents the respective antitheses that have been proposed to replace the current mainstream versions of psychiatry and psychotherapy. As in Chapter 1, I will present the historical developments and specific challenges to both fields separately. However, as will become clear, the fundamental argument in both cases is similar, and ultimately largely congruent with my own criticisms detailed above. Specifically, both fields have been accused of ignoring important aspects of humanity in their quest to achieve scientific purity. To remedy this, numerous alternatives have been proposed. I will provide a brief overview of the most important challengers, but will direct most of my focus to the existential and humanistic versions, as they are most germane to my overall argument.

2.1 Psychiatry

Historically, one of the earliest and most influential critiques of the biological approach to psychiatry was psychoanalysis. The ends of both the 19th and the 20th century exhibited a substantial movement of psychiatry towards a biological focus. In the latter case, this focus still holds today. In the former case, Freudian psychoanalysis appeared on the scene around the beginning of the 20th century to provide a counter to the biological methods popular at the time (Gask, 2004). In contrast to the later challengers that we will discuss, psychoanalysis did not necessarily intend to provide a more holistic picture of mental illness, but rather presented an alternative focus. Instead of the belief that all mental illness was caused by physical causes remediable by physical means, the focus now shifted to a similarly reductionist view in which all mental illness was caused by unconscious drives and urges, and the conflict between those urges and the rules of society (Carver & Scheier, 2012). The Freudian system is vast and somewhat convoluted, and a full discussion of it would detract from the intended focus of this chapter. However, by way of a brief and selective summary, Freud believed that every individual passed through certain invariable stages in the course of their psychosexual development. If, during one of these stages, a conflict inherent in that stage was improperly resolved, this conflict would become a subconscious locus of suffering for the adult individual. These conflicts the psychoanalyst strove to uncover and resolve, thereby curing the individual of their mental distress.

One important aspect of this theory that I want to point out for the purposes of the present discussion is that the Freudian system and the off-shoots it went on to engender in the

ensuing decades represented a clear improvement to the biomedical model in at least one regard: the system was explicitly searching for the (non-physical) causes of mental illness. As described in Chapter 1, biomedical psychiatry is quite content to ignore such causes in favor of a symptom-level approach, or, at least, searches for causes exclusively on a physical level. Human subjectivity and phenomenology are more or less entirely neglected. Psychoanalysis, on the other hand, acknowledges the psychological, lived reality of the patient as a valid place to search for the source of the problem. Unfortunately, however, despite the commendable focus on underlying causes rather than symptoms, the psychoanalytic approach, at least in its Freudian iteration, presents the same underlying dogmatism as the biomedical approach in that it similarly believes that mental illness is caused by only a very narrow set of factors – in this case, repressed forbidden urges. To find a broader alternative, therefore, we will have to look further.

Another, more recently proposed alternative to biomedical psychiatry that deserves mention is the biopsychosocial approach. This approach, as the name suggests, intends to combine the biological, psychological, and social dimensions of an individual's life in the etiology and treatment of mental illness in order to integrate the reductionistic biological model into a more general framework (Gask, 2004). This, of course, is precisely the point of the present thesis, and, to psychiatry's credit, has mostly become the dominant contemporary model taught to new generations of psychiatrists. It could seem, then, that the present thesis is redundant, and that what I am proposing has already happened. Unfortunately, however, the model has been criticized for merely paying lip service to a holistic approach, but unduly prioritizing and emphasizing the biological aspect in practice, thereby regressing to what it was intended to supplant (Slade, 2009). Moreover, even if that were not the case, the explication of the three elements by one of the approach's developers, Anthony Clare (1980, as cited in Gask, 2004), shows that the "psycho" part of the biopsychosocial method is supposed to focus on such elements as interpersonal relationships and childhood development. This, then, sounds more like an integration of biomedical psychiatry with psychoanalysis, and still ignores many of the deeper aspects of the human experience to which I want to draw special attention with this thesis (e.g., existence, phenomenology, self-actualization).

The most radical critique of biomedical psychiatry, and the one on which I want to focus insofar as it comes closest to raising the issues I am attempting to raise, came from the movement of anti-psychiatry. This movement, the beginning of which has been attributed to such figures as R.D Laing (*The Divided Self*, 1960/2010), Thomas Szasz (*The Myth of Mental*

Illness, 1961/2010), and David Cooper (*Psychiatry and Anti-Psychiatry*, 1967), but undoubtedly also owes much to the writings of Michel Foucault (*Madness and Civilization*, 1961/2013), attacked the very fundaments of psychiatry. It should be noted at the outset that this collection of authors by no means represented a uniform set of opinions. They formed, rather, only a loosely bound group with substantial differences between them. In fact, Laing hated the term anti-psychiatry and often tried to repudiate it (David, 2010). What united them, however, was the belief that psychiatry was profoundly dehumanizing, did not respect the core of the human being, and should be fundamentally reformed.

For Foucault, psychiatry, particularly in the context of institutionalization, represented an essentially evil instrument of social control. His genealogy of madness from the classical age to the end of the Enlightenment period presented a view on psychiatry that was fundamentally involuntary, repressive, and cruel. An empirical basis for some of these critiques certainly exists. One powerful demonstration of some of the rather unpleasant aspects of mental institutions came from a study by Rosenhan in 1973, which infiltrated psychiatric wards with pseudo-patients in order to test the reliability of psychiatric diagnoses and observe the conditions within these institutions. The pseudo-patients reported auditory hallucinations to gain access to the wards, but, once inside, behaved perfectly authentically and honestly. Despite their obvious sanity, the pseudo-patients had to stay in their respective institutions for an average of 19 days (range: 7-52 days) before being considered eligible for discharge, and all of them were discharged with a diagnosis of schizophrenia in remission. While inside, the pseudo-patients took notes, and later reported an atmosphere of profound dehumanization and deindividuation combined with a bias on the part of the staff by which even normal behaviors were invariably interpreted in a pathological framework. For example, a patient who reasonably expressed anger at being mistreated by a staff member would unquestioningly be assumed to be merely expressing a symptom of their pathology rather than be given a fair hearing. In other words, no amount of evidence for normal psychological functioning was enough to overturn the label of schizophrenia. This, the author argued, created a palpable *Catch-22* situation for the patients. He emphasized, however, that this situation should not be attributed to malice or callousness on the part of the staff, but should rather be located in the dysfunctional context these institutions tend to create.

This idea of the overwhelming power of context in such a situation had already famously been demonstrated two years earlier by Haney et al. (1973) in the Stanford Prison Experiment, in which psychologically normal students were caught in an intense and quite sinister dynamic of domination and submission through the simple act of randomly assigning

some participants to the role of prison guard and others to the role of prison inmate. This division was enough to create a dynamic between the camps so powerful that the experiment had to be prematurely aborted on account of the intensity of the abuse and stress experienced by the participants. The relevance of this demonstration of the debasing repercussions of a pathological context to the case of psychiatric institutions should, I hope, be obvious without further explication. Another, perhaps even more shocking, demonstration of the abuses of psychiatry comes from a century earlier, but is nonetheless instructive. In 1851, Samuel Cartwright coined the term "drapetomania" to describe the supposed psychiatric illness of a black slave in the American south who wanted to escape from their owner (Willoughby, 2018). Clearly, Foucault had a point when he claimed that psychiatry can act as a sinister tool for social control.

For Szasz, the very concept of mental illness was problematic. He claimed that psychologists and psychiatrists deal, first and foremost, with moral and philosophical problems and therefore err by following the medical and scientific method. He aimed to reintroduce questions such as "How does man live?" and "How ought man to live?" back into psychiatry. Further, he criticized the determinism and historicism of both medical psychiatry and psychoanalysis, and wanted to put discussions of freedom, choice, and responsibility back on the agenda. Here, then, we see the first instance of a psychiatrist advocating for investigations into some of the deeper aspects of human being to which I alluded earlier. Laing made this turn towards existential-humanistic concerns even more explicit. His book, *The Divided Self (1960/2010)*, aimed to reconceptualize madness in existential terms, and represented a rage against the "objective" tradition, which he claimed saw the person not as an individual, but merely as a diagnostic entity. In his time, actually engaging with a patient was often seen as useless, since the insane could not possibly have anything of value to say. Laing, on the other hand, sought to understand the patient's situation as a justifiable response to existential despair and the stress of having to live in intolerable circumstances. His writing additionally contained much discussion of the "Us-Them" dichotomy, which he intended to supplant with an inclusiveness that presupposed that the mentally ill are struggling with concerns that apply to all of us to varying degrees, and thus make the mentally ill a less segregated community.

These critiques and others engendered a temporary atmosphere in the 1960s that was much less disease-oriented than was previously the case, and instead turned its focus towards existence and the inevitable struggles of life and society. Combined with significant concomitant advances in psychopharmacology and the movement of community psychiatry,

which believed that psychiatry should abandon the asylums and focus on treating the mentally ill within the bounds of normal society, this atmosphere led to a wave of mass discharges of patients from mental hospitals. As we will see below, this turned out to be ill-fated. However, for now, the important point to note is that anti-psychiatry attempted to raise awareness of deep philosophical and psychological elements of the human experience that had hitherto gone ignored in the field of psychiatry.

2.2 Psychotherapy

As described in Chapter 1, psychotherapy existed as a pre-paradigmatic discipline for a long time. As such, the approaches I will describe in this section did not so much originate as challenges to the cognitive approach, but rather predate it. During the first half of the 20th century, the two most dominant manifestations of psychotherapy were psychoanalysis and behaviorism. The first of these was already discussed in the previous section, so I will refrain from repeating myself here. The only addition I would make is that Freudian psychoanalysis spawned numerous off-shoots through the decades, some of which certainly exhibited considerably more breadth in their treatment of human suffering. These Neo-Freudians include such figures as Carl Jung, Alfred Adler, and Erich Fromm. Jung's approach, for example, undertook a deep exploration of what he called the "collective unconscious," i.e., the stories, myths, and archetypes that we all seem to carry within us, and which may guide us in the exploration of our individual lives. This, in my estimation, is a big step from the rather one-dimensional focus on sexuality and repressed urges which makes up the essence of Freudian psychology. Nevertheless, I will not focus on these Neo-Freudian approaches, since the elements that I would argue represent an improvement to the Freudian approach are more fully captured in the humanistic and existential traditions, which will constitute the majority of this section. In fact, *The Handbook of Humanistic Psychology* (2015) refers to the Neo-Freudians as quasi-humanistic. Thus, I will reserve a full discussion of these elements for a later point.

The second major force in the field of psychotherapy during the first half of the 20th century was behaviorism. This movement, associated most prominently with figures such as John Watson, Ivan Pavlov, and B.F. Skinner, represented an emphatic rejection of everything in psychology that did not conform to hardline positivistic science. Thoughts, emotions, and even consciousness and the mind themselves were regarded as unnecessary and unscientific (because unobservable) hypothetical entities that were discarded in exchange for an exclusive focus on behavior as the only measure of the human. Countless experiments, famously

involving an untold number of rats, pigeons, and dogs, showed the efficacy of classical and operant conditioning, whereby a stimulus can be paired with a desired response by repeated simultaneous exposure. This simple procedure, the behaviorists believed, could be extrapolated to explain the entirety of human action and culture. Accordingly, their idea of psychotherapy consisted of little more than de-conditioning, i.e., the pairing of a stimulus that elicited an undesirable response with a new, more adaptive response. For the purposes of this discussion, it should be clear that behaviorism does not present a particularly attractive alternative to the cognitive-behavioral approach, as it is a forerunner of the latter with the addition of a considerable amount of even more narrow positivism.

The two approaches I want to focus on instead are humanistic and existential psychology. The first of these two originated as an explicit criticism of both psychoanalysis and behaviorism and called itself the "Third Force" of psychology (Davidson, 2000; DeCarvalho, 1990). Frustrated with these two approaches for many of the same reasons for which I now criticize the cognitive-behavioral approach, humanistic psychology aimed to address the topic of human suffering from a much more philosophical angle. It may be useful to note at the outset that humanistic psychology is not synonymous with, nor does it really originate in philosophical humanism, although the two can certainly be said to be somewhat related (for a fuller discussion of this matter, see Davidson, 2000). The approach was explicitly phenomenological in nature, i.e., it assigned an indelibly primary position to human subjectivity and the lived reality of patients, and rested, according to Bullock (1985, as cited in Wertz, 1998), on three foundational pillars: first, it believed that the human being was more than the sum of its parts, and stressed such experiences as creativity and love as manifestations of this irreducible humanity. Second, it emphasized the freedom and dignity of the person as inalienable and profound, and lastly, it distrusted abstract principles and constructs, and strove to replace them with concrete human experience. The title of one of the foundational books of this discipline, Abraham Maslow's *Towards a Psychology of Being* (1962/1999), illustrates quite well the overall attitude of humanistic psychologists. Instead of superficial (observable) symptoms or hypothetical systems of unconscious urges and constructs involving stages and the like, they focused on the concrete and individual human experience (hence: phenomenology) of the human being in front of them in a therapy session. Similarly, the goal of these therapy sessions was neither to instill new behaviors that had previously been deemed adaptive by a cold, scientific procedure, nor to uncover *a priori* determined unconscious systems, but rather to provide an atmosphere of freedom and unconditional empathy that would allow the patient to look inward and determine for

themselves what they thought was important in life, and who they wanted to be. The underlying presupposition of this procedure was that all human beings strive towards what the humanists called "self-actualization," and that neuroses and unhappiness are caused by an alienation of the individual from who they really are.

The person most closely associated with this approach to therapy is Carl Rodgers, who called it "client-centered therapy" to emphasize the fact that the client – Rodgers disliked the word "patient" – and their experience was the focus of the therapy, and that it was them, not the therapist, who needed to do the work. He believed, in an idea that he partially adopted from Kierkegaard, that all learning capable of influencing behavior necessarily needs to be self-discovered rather than externally imposed (Winston, 2015). This idea is also expressed in the 2010 movie *Inception*, in which an externally planted idea is rejected by the human mind as foreign, but an internally generated one is not only accepted, but viewed as significantly more profound (Nolan, 2010). In order to achieve an atmosphere in which the client would have the freedom to generate such internally discovered truths, Rodgers believed and taught that the therapist should unfailingly provide unconditional positive regard for the client. The presupposition behind this was that most human beings go through their lives with never-ending external guidance in the form of positive or negative feedback as to which behaviors, thoughts, utterances, and so forth were acceptable and which were not. A situation in which an authority (i.e., the therapist) would give unconditional support and warmth to the client no matter what they thought, said, or did, was meant to break this life-long paradigm, and enable the client to finally look inward and determine for themselves who they want to be and who they feel they really are. Compared to the rather one-dimensional and narrow belief systems behind the approaches discussed in Chapter 1, I submit that this humanistic approach to therapy represents an immense increase in psychological and philosophical depth and breadth.

In a somewhat different but related manifestation, this depth is also unmistakably apparent in the last approach to psychotherapy that I want to mention in this section. This approach is called existential psychotherapy and is, in contrast to humanistic psychology, deeply and inseparably connected to its philosophical *pendant* of the same name (i.e., existential philosophy). While humanistic psychology was a primarily American invention that was born out of frustration with the dominant psychologies of its day, existential psychology originated in Europe as a direct descendant of the works of existential philosophers such as Kierkegaard, Heidegger, Sartre, and Merleau-Ponty. Owing to this multifaceted intellectual lineage, and the fact that these thinkers each exhibited decidedly

unique approaches in their thinking, existential psychology is not a particularly unified or easy to define field. To illustrate, *The Wiley World Handbook of Existential Therapy* splits its contents into four major sections, each introducing a unique system of existential thought (Van Deurzen et al., 2019). These sections are: Daseinsanalysis (based on the works of Heidegger as explicated by Binswanger and Boss), Existential-Phenomenological Therapy, Existential-Humanistic and Existential-Integrative Therapy, and Logotherapy and Existential Analysis (based primarily on the works of Victor Frankl).

Because of this diversity, it is not easy to arrive at a unified definition of existential psychology, and any attempted definition will undoubtedly be contested. However, with this caveat in mind, I will try to provide a provisional sketch of the field that will hopefully capture most of the important similarities while leaving enough room for the differences. In essence, existential psychotherapy resembles humanistic therapy in its belief that the key to human suffering lies in an examination of deeply philosophical, phenomenological, and radically subjective problems. However, the specifics of which problems each approach views as most relevant differ. While for humanistic psychology, the question of "Who am I really?" is central, existential psychology focuses on the question of "What does it mean to exist?" (Winston, 2015). Irvin Yalom, in his book *Existential Psychotherapy* (1980), further splits this question into four major areas of investigation: First, what does it mean to live with the constant awareness that death is inevitable? Heidegger called this problem our *Being towards death*. As Christopher Hitchens put it, we must realize at some point in our lives that we are "expelled from [our] mother's uterus as if shot from a cannon towards a barren door studded with old nail files and rusty hooks" (reasonparty, 2011, 1:50). How does this knowledge of what is coming influence our existence? The possible profundity of this existential conundrum is even acknowledged in mainstream psychology, albeit in a characteristically detached manner, under the name of "terror management theory," which assumes that much of what we do in our psychology is an effort to avoid thinking about death (Routledge & Vess, 2019).

The second major area of investigation following Yalom is the problem of existential freedom. This idea is (not exclusively but) prominently associated with Kierkegaard, who believed that the knowledge of our unlimited freedom in this world begets potentially unbearable existential anxiety and dread. For him, one must either live blindly by never knowing this dread, be crushed by the knowledge of it, or, ideally, learn to embrace it and thereby learn to live life to the fullest. In his words: "Whoever is educated by anxiety is educated by possibility, and only he who is educated by possibility is educated according to

his infinitude" (Kierkegaard, 1844/2000, p. 154). In turn, this also means that each of us is fundamentally responsible for constituting our own life and reality. Nobody is there to take care of us or tell us what to do. It is entirely up to us, and there is no ground beneath us on which to stand. The works of Jean-Paul Sartre are often associated with this latter idea (Sartre, 1943/1992).

The third area on Yalom's list is isolation. This does not refer to common episodes of loneliness or physical isolation, but rather to the existential realization that, ultimately, we are all alone in this world. Not only are we born alone and will, at the end of our lives, die alone, but in the intervening time, we are constituted like islands of land with unbridgeable chasms between us. No matter how intimate we get with some of the people in our lives, there will always be a distance between us and the other that cannot be transcended. Ultimately, we are the only one with access to our own mind, and nobody else, no matter how trusted, can ever truly understand what that place is like. Accordingly, nobody in the world experiences life quite the same way we do, and therefore we have nobody with whom to really share. Learning to live with this existential truth is Yalom's third basic concern of existential psychology.

The last item on Yalom's list is meaninglessness. This refers to the profound conflict of a meaning-seeking and meaning-making being such as ourselves who is thrust – *Thrown*, as Heidegger would put it – into a meaningless world. How do we reconcile our desire for purpose in life with the awareness of an apparently random and uncaring universe? How do we create a meaning that we can live for, and how can we make this purpose sturdy enough to withstand the vicissitudes of life inherent in an indifferent universe? This idea relates strongly to the work of Victor Frankl, who, while in captivity in a Nazi extermination camp, realized that, no matter how dire the circumstances, there is a final impenetrable bastion of human freedom that cannot be taken away by any amount of external degradation: the ability to create our own purpose and choose how we want to see the world (Frankl, 1946/2008). After the war, Frankl went on to introduce the world to logotherapy, his existentially minded approach to therapy, which assumes that much of the psychological suffering apparent in the world is a result of a lack of purpose in life.

This brief inventory of existential concerns is by no means intended to serve as an exhaustive list of everything existential psychology cares about. Rather, it is intended merely as a selective illustration of how this approach to psychotherapy thinks, and how fundamental its concerns are. As with humanistic psychology, it will be obvious that this represents a profound departure from the detached, objective modes of thinking discussed in Chapter 1. In

fact, when commenting on the *raison d'être* of existential psychotherapy, Yalom states that the mainstream-oriented lexicons of psychiatry and psychotherapy "snickered at [him]" (Yalom, 1980, p. 12) when he queried them for such terms as freedom, responsibility, purpose, etc. Both humanistic and existential psychology, in their own ways, try to rectify these omissions.

2.3 Evaluation of Existential and Humanistic Approaches

From a historical perspective, the fields of humanistic and existential psychology both originated around the same time period, and were both reactions of opposition against the dominant streams of the day. For humanistic psychology, this opposition was against psychoanalysis and behavioristic psychology. For existential psychology, the opposition was mostly against biomedical psychiatry, and is accordingly related to the movement of anti-psychiatry. Both movements diagnosed insufficiencies in the mainstream versions of their respective fields, and both attempted to remedy these insufficiencies by raising awareness of important and deep philosophical questions concerning the nature of human being. As will undoubtedly be obvious from the preceding pages, I consider this broader and philosophically deeper approach to be an important and indispensable improvement to the detached attitude of mainstream psychology and psychiatry. The focus on holistic being, existence, self-actualization, and all the rest displays, I would contend, a certain wisdom and intimate familiarity with what it means to be a human being that opens a possibility for an inherently authentic sort of communication between a therapist and a patient that is simply missing from the scientifically purer versions of these disciplines. In the words of Carl Jung (1928): "Learn your theories as well as you can, but put them aside when you touch the miracle of the living soul" (p. 361). An emphasis on scripts and medications, chemical imbalances and conditioning procedures does not, in my estimation, offer the same opportunity for this sort of authentic encounter between two human beings. Instead, the therapist or psychiatrist is more or less reduced to a machine dispensing either scripts and instructions or drugs. This, I think, wastes much of the potential of a therapeutic encounter. Differently phrased, while the mainstream versions of the two fields focus on functionality, these alternative approaches focus on existence and fulfillment. Given the choice, I would expect most people to have a rather clear preference for the latter.

Another core tenet of anti-psychiatry, humanistic psychology, and existential psychology is that the disease-model of mainstream psychiatry and psychotherapy is, at best, an incomplete way to frame mental distress, and, at worst, a positively harmful one. Instead,

these approaches aim to dissolve the "Us-Them" dichotomy by postulating a number of inevitable struggles and aims that every human being faces, and identifying mental illness as just an extreme reaction to these struggles. This is a beautiful idea, and certainly provides an antipole to the much criticized DSM approach in which, as discussed earlier, even ordinary sadness can, under certain circumstances, be interpreted as resulting from a pathology.

However, these approaches are also far from perfect. Taking the previous point about de-pathologizing the disease-model, I do not think that a blanket categorization of every mental affliction as just a manifestation of a normal conflict is any more accurate than a mainstream belief that over-pathologizes normal behavior. More likely, the truth lies somewhere in the middle. Surely, many problems presented to psychotherapists and psychiatrists (e.g., many forms of depression) are expressions of existential and humanistic despair that the alternative approaches are well-equipped to handle. But just as surely, many other problems of the mental realm are also more acute and intangible, and do not necessarily have much to do with humanistic-existential conflicts. For example, I would mark as suspect any approach that categorizes bipolar disorder and acute psychosis as entirely due to philosophical dissatisfactions. The historical fate of anti-psychiatry here provides a useful case study. As mentioned in a previous section, anti-psychiatry, combined with psychopharmacology and community psychiatry, led to a wave of mass discharges in the 1960s that were based on precisely this conviction of the inadequacy of categorizing any mental affliction as a disease. It was believed that even conditions such as schizophrenia were normal reactions to living in unhealthy circumstances (Laing, 1960/2010), or, even more extremely, that the "insane" were not the people inside the asylums, but rather the people outside of it (Laing, 1960/2010). Unfortunately, the resulting mass discharges did not confirm this idea as much as the anti-psychiatrists had hoped. It soon became clear that most former asylum patients did not manage well at all in the confines of normal society, and that the community did not have the wherewithal to effectively deliver to these individuals what they needed (Dain, 1989; Gask, 2004). Ironically, worse outcomes from this episode were prevented by psychopharmacology, which, of course, depends on the very disease-oriented and biomedical model that anti-psychiatry considered with such disdain. Thus, anti-psychiatry has entered the history books as a movement that mortally wounded itself by virtue of its own impracticably extreme nature.

Fortunately, existential psychology did not meet the same fate as anti-psychiatry, and is, along with humanistic psychology, still a very real contender in the field of mental health care. Nevertheless, these two approaches also exhibit problems that have led to their

marginalization. The main issue in both cases is that the approaches are not commonly as evidence-based as one might hope. This is closely related to our earlier discussion of the manualization of CBT. Where the cognitive-behavioral approach sacrifices contentual depth for scientific purity, the existential and humanistic approaches take the opposite route. Scientific purity is considered expendable as long as the philosophical and psychological depth is preserved. In fact, Yalom (1980) even explicitly states that empirical study is not only unnecessary, but positively impossible. In his words: "The basic tenets of existential therapy are such that empirical research methods are often inapplicable or inappropriate" (p. 22). This is because every human being – every *Dasein*, in Heideggerian terms – constitutes their own reality and no amount of empirical study can touch the superordinate person that is studied. Yalom believes further that this empirical intangibility of psychotherapy not only applies to the existential variety, but rather applies to all forms of psychotherapy. "[W]hen no one is looking," he says, "the therapist throws in the 'real thing'" (p. 3). In other words, he claims that studies of even the most manualized versions of CBT fail to really identify the elements of the therapeutic intervention that actually do the work. This is because so much of the therapy's efficacy, according to Yalom, lies in the right intuition of the therapist.

This idea – that the efficacy of therapy is complex and multifaceted – is acknowledged in mainstream psychotherapy, as well. In fact, one study from 1994 estimated that the technique of psychotherapy accounts for only 15% of the intervention's efficacy, while 30% was attributed to the relationship between the therapist and patient (i.e., therapeutic alliance; Lambert & Bergan, 1994). The problem of how to grasp these elusive factors in a scientific manner is difficult and may not have an easy solution. The difference between the schools of thought, however, is that CBT is trying (if simplistically), whereas existential psychology seems to have given up and resigned itself to basing its approach fundamentally on intuition. While I do not think that CBT's attempt to eliminate all factors besides technique is a promising one, I also do not believe in the wisdom of resigning oneself to an unscientific framework.

In the case of humanistic psychology, a similar distaste for scientific rigor is readily apparent. As Davidson (2000) suggested, humanistic psychologists tend to be suspicious of any type of systematic study out of fear that it will invariable fail to do justice to distinct and irreducibly human phenomena. In his words: "Growing up in the era of behaviorism, with its rat and pigeon experiments, humanistic psychology has been wary of the application of scientific methods when this is done solely to serve the purpose of being scientific" (p. 25). Considering such rhetoric, it is not surprising that humanistic psychology, more so than

existential psychology, has, throughout its history, exhibited recurring episodes of active and at times quite intense anti-intellectualism. The most famous example of this is the encounter movement in the United States during the 1960s. This movement was intimately associated with the humanistic psychology approach and strove to organize meetings that would offer the kind of connection, emotional intimacy, and self-disclosure that the organizers felt was missing from ordinary society (Smith, 1990). In itself, this sounds like a laudable goal. Unfortunately, it led to countless stereotypes of humanistic psychology as excessively "touchy-feely" and unfit for academic science. Not all of these stereotypes are deserved, but a kernel of truth – specifically as regards the anti-intellectual attitude – is certainly contained within them.

Furthermore, despite much talk of the superiority of their approach as compared to the mainstream academic approach, one of the biggest criticisms of humanistic psychology still remains that, in half a century, it has not produced much of tangible value (Davidson, 2000). Notwithstanding all my criticism of the mainstream scientific approach, this same criticism cannot be levelled at CBT or biomedical psychiatry. The challenge, then, is to find a way to unify the scientific virtues of the mainstream approaches with the psychological and philosophical depth and authenticity of the humanistic and existential frameworks. My own proposal of what such a unification might look like is the subject of the third and last chapter of this thesis.

Chapter 3
Psychedelic-assisted Psychotherapy

This chapter introduces some of the burgeoning developments in the fields of psychotherapy and psychiatry that I see as a possible Hegelian synthesis of the ideas of the first two chapters. Based on the preceding discussions, any such synthesis will have to display two essential features: it will first have to show that it does not commit the same mistakes as the mainstream approaches – i.e., ignoring fundamental aspects of the human condition – and secondly that it does this without falling into unscientific or even anti-scientific territory. In a phrase, we are seeking an evidence-based, scientific approach that does not throw out the existential-humanistic baby with the unscientific bathwater. The candidate I will put forward for this purpose is the nascent field of psychedelic-assisted psychotherapy. For context, I will begin by providing a brief history of this field, followed by my own account of how and why this approach fulfills both of the above conditions.

3.1 History and Development

Despite the existence of hundreds of psychedelic compounds, nearly all of the current scientific discourse pertaining to psychedelic-assisted psychotherapy surrounds only four substances: psilocybin-containing mushrooms, the traditional South American brew ayahuasca and its active ingredient N,N-Dimethyltryptamine (DMT), lysergic acid diethylamide (LSD), and 3,4-Methylenedioxymethamphetamine (MDMA or "Ecstasy"). The first two of these are either entirely naturally occurring (psilocybin), or consist of naturally occurring ingredients (ayahuasca), and have – it has become a cliché to assert – been used by human cultures for millennia (Pollan, 2018). The latter two, on the other hand, are artificially synthesized and have only been known to mankind since 1938 and 1912, respectively (Hofmann, 2009; Shulgin, 1990). Furthermore, the last of these four, MDMA, technically does not even belong to the class of psychedelics, but is rather more commonly referred to as an empathogen. Nevertheless, it is usually mentioned in the same breath as the other psychedelic compounds, and will, owing to its prevalence in the current scientific discourse, be prominently featured in this chapter. Due to their importance, I will spend some time introducing all four of these substances before sketching a more general history of the field.

In scientific discussions of psychedelics, one is likely to witness the phrase "classic psychedelics" used to refer to LSD and psilocybin. Along with DMT, which, in its usual manifestation of ayahuasca, always seems like a somewhat more exotic or eccentric alternative, these three substances show extremely similar biochemical effects. In particular,

all three substances exert their effects on the brain by functioning as partial agonists on the 5-HT_{2A} (serotonin) receptor (Nichols, 2016). Despite this biochemical similarity, the effects of the three substances are – though comparable – by no means identical. For example, whereas a psilocybin-induced experience usually lasts between four to six hours, the acute effects of LSD can take up to 12 hours. Nevertheless, all three substances are known to reliably induce profound and often life-changing experiences that consist of hallucinations, intensified emotions, as well as altered thought patterns, perceptions, and perspectives (Nichols, 2016). Owing to these experiences, psychedelic substances are also often referred to as hallucinogens. In contrast, MDMA exerts its effect on the brain by releasing excessive amounts of serotonin and norepinephrine, which usually has a euphoric effect. However, the effect most commonly associated with MDMA is that it tends to massively increase feelings of empathy and love. This is why it is often called an empathogen – i.e., engendering empathy. At normal doses, it does not induce hallucinations, but rather leads to an atmosphere of boundless openness, in which emotionally difficult memories and ideas can be accessed and communicated much more easily than during normal waking consciousness ("Guide to MDMA," n.d.).

The first wave of scientific interest in these compounds came during the 1950s (Williams, 1999). Initially, scientists were interested, first and foremost, in the "psychotomimetic" properties of LSD. In other words, scientists saw in the LSD experience a window into the lived reality of psychotic patients. Ironically, at the time, the discovery that a chemical substance could induce states of consciousness closely resembling psychosis fueled a renewed interest in the biological origins of such diseases. The second avenue of research into LSD during that period was famously CIA-funded and saw in LSD an opportunity to develop a "truth drug." Both of these research approaches saw the psychedelic experience as something rather negative. During the 1960s, however, LSD and psilocybin became much more widely known, popularized by such figures as Aldous Huxley and Timothy Leary, and ultimately became staples of the 1960s counter-culture movement (Williams, 1999). During this time, interest in the potential of these substances for psychological healing and growth flourished. An awareness had developed that psychedelics can induce subjectively profound and life-changing experiences. Myriad studies, many of them unfortunately only imperfectly scientific, were conducted to research the potential of psychedelics to increase creativity (Krippner, 1985), change one's perspective on life and death (Kast, 1967), and provide relief for a variety of mental conditions from alcoholism (Grof, Soskin et al., 1973) to depression (Grof, Goodman et al., 1973).

However, as the counter-culture movement unfolded in the United States, concerns over the illicit use of these substances grew, and, combined with myriad political developments that are the subject of debates to this day, all of the above substances were eventually made illegal and placed under heavy regulation. In fact, all four substances are, to this day, categorized as Schedule I drugs by the United States Drug Enforcement Agency (DEA), which means that they are classified as possessing no medical use and carrying high potential for abuse and addiction (Drug Enforcement Agency, n.d.; Drug Enforcement Agency, 2021). As a result of these legal developments, scientific research utilizing psychedelic substances was more or less summarily shut down for half a century. The origin of the recent resurgence of interest in psychedelic research is difficult to precisely locate, but the fact is that around the turn of the second decade of the 21st century, more and more studies on the topic started to appear, while psychedelics concurrently once again became more widely discussed in popular culture (Richert, 2019). To the limited degree that causality can be inferred, it appears that one of the many reasons for this development was James Fadiman's 2011 book *The Psychedelic Explorer's Guide, which, along with* several podcast appearances, launched a trend of psychedelic microdosing that was subsequently picked up in Silicon Valley and thereby further popularized ("Microdosing psychedelics," n.d.; Sahakian et al., 2018). A few years earlier, Roland Griffiths and his team at the Johns Hopkins University had already published a number of studies investigating the subjective experience associated with psilocybin administration (Griffiths et al., 2006). These studies were among the first experiments utilizing a psychedelic compound to receive ethical approval since the substances' illegalization 50 years earlier.

In the ten years since these developments, psychedelic publications have considerably increased in number, and scientific institutes dedicated to the study of psychedelics have been established at such universities as the earlier mentioned Johns Hopkins University (https://hopkinspsychedelic.org/), the Imperial College London (https://www.imperial.ac.uk/psychedelic-research-centre/), and the University of California, Berkeley (https://bcsp.berkeley.edu/). Most notably, however, in 2017, the non-profit organization MAPS (Multidisciplinary Association for Psychedelic Studies; https://maps.org/) received a breakthrough therapy designation[1] by the United States Food and Drug Administration (FDA) to conduct studies on the potential of MDMA-assisted

[1] The phrase "breakthrough therapy designation" means that the FDA views the novel approach to be tested as sufficiently promising as to fast-track its testing and development, as it could provide substantial advantages over existing treatments.

psychotherapy to treat post-traumatic stress disorder (PTSD). If successful, these studies could make MDMA a legally available and recognized treatment for this condition. The last phase of these studies (Phase III) is currently underway, and legalization of MDMA for PTSD is expected to proceed as early as 2023 (Multidisciplinary Association for Psychedelic Studies, n.d.). Simultaneously, similar clinical trials are currently being conducted to investigate the potential of psilocybin-assisted psychotherapy for treatment-resistant depression that could, if successful, lead to the medical legalization of psilocybin in a comparable time frame (Compass Pathways, n.d.). Other studies currently investigating the potential of psychedelics and psychedelic-assisted psychotherapy include, but are not limited to, studies on addiction – specifically, alcohol (Krebs & Johansen, 2012), nicotine (Johnson et al., 2016), opioids (Argento et al., 2019), and cocaine (Thomas et al., 2013) – anxiety (dos Santos et al., 2016), obsessive-compulsive disorder (OCD; Moreno et al., 2006), pain (Castellanos et al., 2020), and eating disorders (Lafrance et al., 2017). More than 50 years after their initial illegalization, psychedelics have once again begun to capture the public's as well as science's imagination, and much hope is clearly being placed in them to potentially revolutionize psychiatric and psychotherapeutic care (Nutt et al., 2020).

3.2 Holistic Orientation

With this history in mind, the most immediate question in need of an answer becomes the question of what it is about these substances that appears to be so special. What is it, in other words, that is so promising as to convince the United States FDA to grant breakthrough therapy status to two substances currently in the most heavily enforced class of illegal drugs (i.e., MDMA and psilocybin)? I believe that the answer to this question lies in the uniquely altered state of consciousness these substances induce, and, in turn, the unavoidably holistic therapeutic modality that results from this state. Specifically, I would argue that the experience one has under the acute influence of a psychedelic automatically accomplishes many of the aims of existential and humanistic therapy that I discussed in Chapter 2. Recall, for example, that both the humanistic and the existential approaches prioritize a phenomenological view of therapy, and that both believe that any learning that is to have any real effect should be self-discovered rather than externally imposed. In non-drug therapy, this has always presented something of a challenge to therapists. After all, how can a therapist – an external entity – teach a patient something that the patient will subsequently interpret as self-discovered? If self-discovery was easy, the therapist would not be needed. Hence, the therapist is presumed to possess some knowledge that, if properly communicated, could have

a beneficial effect on the patient. To navigate this problem of communication, therapists usually employ Socratic questioning in an attempt to stay within the patient's framework rather than straightforwardly telling the patient what they think (Van der Molen et al., 2014). In so doing, they hope that they can guide the patient through the lessons while still letting the patient do most of the work.

Unfortunately, this procedure is heavily dependent on the patient's astuteness and reflective abilities. A patient can easily (and sincerely!) respond to every one of the therapist's questions (e.g., "How did you feel when x happened?", "Why do you think you responded in this way?") with, "I don't know," and the therapeutic discourse will wind up deadlocked. It is this process of reflection that psychedelic substances can, in a sense, supercharge by providing an experience that encourages (to put it mildly) introspection on deeply personal, philosophical, existential, and humanistic concerns that carries with it a level of subjectively felt profundity that is often said to be "ineffable" (Barrett et al., 2015). In fact, William James used the term "noetic" to describe the quality of such experiences that make them feel like they are truer and "more real" than ordinary states of consciousness (James, 1902/2002). Equipped with such inordinate amounts of access into their own consciousness, patients following such an experience can speak to their own problems with an incomparably larger degree of reflection and introspection. Moreover, since the experience is so inherently phenomenological and radically subjective in nature, no attempt needs to be made any more on the part of the therapist to try and make the therapeutic conversation more subjectively relevant for the patient. The experience itself ensured that the patient feels profoundly addressed by the therapy, partly because insights are internally generated (rather than externally imposed).

It should be noted that this preceding description does not hold entirely true in the case of MDMA. As an empathogen, MDMA experiences do not exhibit the same level of spontaneous philosophical and existential insight as classic psychedelics. Nonetheless, MDMA induces a state of emotional rawness and authenticity that can provide access to repressed and difficult memories and creates an atmosphere of openness and love in which such memories, traumas, and difficulties can be expressed and processed in a manner that can be extremely confronting, but is not as impossibly overwhelming as it would be during ordinary states of consciousness. This extraordinary access to unprocessed material in the patient's own lived experience is what makes MDMA so promising for sufferers of PTSD, since the hallmark of this condition is a state of perpetual terror directed at unintegrated past events (for a powerful demonstration of this, see Karni, 2017). Despite the lack of certain

characteristic elements of the psychedelic experience, MDMA nonetheless induces a deeply personal and emotionally compelling (noetic) experience that provides access to parts of the patient's consciousness that normally remain inaccessible and thereby exhibits similar phenomenological features as normal psychedelic experiences. Moreover, since one of the primary aims of humanistic psychology is to enable the patient to be more in touch with themselves, MDMA is perhaps the best example of a quasi-psychedelic approach to therapy that stays true to the humanistic tradition in particular.

This idea of looking within and being in touch with oneself is, of course, also present in existential psychology (Yalom, 1980). However, in that case, one is supposed to be in touch not so much with one's personality, but rather with one's existence. This existential and philosophical focus is more or less absent from MDMA experiences, but is extremely prominent in experiences induced by classic psychedelics. In fact, it has been well established by the aforementioned Roland Griffiths and others that the personal benefit attained by participants in studies utilizing classic psychedelics is strongly correlated with their reports of having what scientists call a "mystical experience" (Griffiths et al., 2008). This concept, usually assessed with the so-called Mystical Experience Questionnaire (Barrett et al., 2015), measures the extent to which the patient experienced such states as boundlessness, ego dissolution, transcendence of time and space, and feelings of unity with themselves and the world while under the influence of the drug. All of these states, I would argue, are intimately connected to existential philosophical concerns, as all of them provide a new perspective on oneself, the world, and what it means to exist. More directly, psychedelics have also been known to induce reflections on such quintessentially existential concerns as death, isolation, and meaninglessness (Ross et al., 2016). Furthermore, one of the most prominent emotions frequently experienced during psychedelic states of consciousness is the strong feeling of awe for nature, the universe, and everything that exists (Hendricks, 2018). Insofar as the feeling of awe is usually intimately associated with the sensation of feeling small and insignificant in the face of something vast and incomprehensible, I would argue that awe is also an inherently existential feeling. Next to this, *The Handbook of Humanistic Psychology* (2015) dedicates multiple chapters to the feeling of awe, as well, showing that this emotion has a place in both existential and humanistic schools of thought.

A final parallel between the philosophical approaches to therapy and the psychedelic approach that I want to mention is their conceptualization of the process of therapy. Specifically, both existential psychology and psychedelic therapy believe that, as Thomas Hardy put it, "if way to the Better there be, it exacts a full look at the Worst" (Hardy, 1895-

1896/2017, p. 141). More simply put, both approaches acknowledge that therapy is not supposed to be a universally positive experience. For Yalom, existential therapy is a "painful but ultimately healing" (Yalom, 1980, p. 14) adventure. More generally, according to Burston (2003), whereas mainstream psychology and psychiatry see suffering as a nuisance to be removed, existential and humanistic psychology see it as an opportunity to grow. In order to transcend one's suffering, one must first acknowledge it by giving it a deep and thorough examination. This same idea was powerfully expressed in the psychedelic realm in a study by Carbonaro et al. (2016), which found that, in naturalistic psychedelic use, a positive relationship existed between the degree of difficulty of the experience and the degree of perceived sustained increases in well-being derived from it. Moreover, the authors emphasize that the distribution of responses to the questions concerning degree of difficulty and degree of perceived personal meaning derived from the experience were remarkably similar with 62% of participants reporting that the experience was among the ten most challenging experiences of their lives, and 60% of participants reporting the experience to be among the ten most psychologically personally meaningful experiences of their lives. Overall, 84% of participants reported having benefited from their challenging experience. Clearly, then, the psychological research field shares the existential and humanistic sentiment that views psychological suffering not merely as a nuisance, but rather as a call to action and an invitation to examine one's life on a deeply philosophical and personal level.

In summary, I hope to have shown in this section that the field of psychedelic-assisted psychotherapy exhibits many parallels to the approaches discussed in Chapter 2, and therefore does not commit the same offenses as the mainstream approaches of psychiatry and psychotherapy. On the contrary, it could be argued that the field of psychedelic therapy in fact reaches even deeper than conventional humanistic and existential psychology, as the experience itself can provide access to a philosophical dimension that is not ordinarily accessible during normal waking consciousness.

3.3 Scientific Credentials

In order to serve as a promising synthesis of the first two chapters, the psychedelic approach does not only have to be holistic, but will also need to demonstrate impeccable scientific credentials. The most obvious parallel of psychedelic-assisted psychotherapy to the discipline of mainstream psychiatry as discussed in Chapter 1 is the fact that both fields work by way of an administered chemical. However, the details of the workings of these respective chemicals show profound differences in favor of the psychedelic approach. Specifically, biomedical

psychiatry in the form of psychopharmacology prescribes substances that not only merely treat the symptoms of a condition, but also usually require constant and regular administration, possibly leading to life-long dependencies, and furthermore often require continual increases in dosage as the body develops a tolerance to the drug (The Withdrawal Project, n.d.). Without intending to sound excessively Marxist, this state of affairs clearly benefits the pharmacy companies more than anybody else. In contrast, psychedelic-assisted psychotherapy usually works by way of one or two – in the case of ayahuasca sometimes as many as six – drug sessions, preceded and followed by one or two (drugless) preparation and integration sessions, respectively. This is the extent of the therapy, and no more drugs need be consumed after completion of these sessions. In my estimation, this fact alone is remarkable enough to explain why some have started to herald psychedelic therapy as a potential revolution in the field of psychiatry (Nutt et al., 2020).

In terms of the scientific rigor of psychedelic-assisted psychotherapy, I will refer back to our earlier discussion regarding the nature of the psychedelic experience. More precisely, I argued in the previous section that the experience induced by psychedelics automatically and unavoidably accomplishes many of the principal aims of humanistic and existential psychotherapy. As such, and from a purely conceptual standpoint, I would argue that it stands to reason that the scientific rigor – which humanistic and existential psychology distrusted so much for fear of its tendency to reduce irreducible human phenomena – can do less harm regarding the philosophical profundity of the approach than it could in the case of existential and humanistic psychology. This is because the very idea of the approach rests on the phenomenology of the psychedelic experience. No amount of standardization, manualization, and forced detachment in the interest of scientific purity will be able to jeopardize the intrinsic profundity of the experience itself. As a consequence, I believe that this field can, so to say, "get away with" more scientific rigor than its humanistic and existential counterparts.

This conceptual argument seems to be borne out in the scientific literature. As discussed in the historical section of this chapter, the last decade in particular has seen a dramatic increase in the amount of clinical studies conducted on psychedelic-assisted psychotherapy. Along with these studies, countless manuals, standardized instruments, neuroscientific investigations, and other hallmarks of hard science have appeared in the literature. To provide just a few examples, MAPS, the organization in charge of the FDA-approved clinical trials investigating MDMA for PTSD, released a 69-page manual for therapists participating in the studies (Mithoefer, 2015). This manual provides in-depth guidance on the therapist's role in the overall process, the aims, guidelines, and procedures of

all the involved stages (preparation, drug sessions, integration), as well as particular techniques to apply and much more. A similarly extensive manual (79 pages) has recently been released by Yale University to support the use of psilocybin for depression (Guss et al., 2020). One could object at this stage that traditional existential and humanistic therapies could compose such manuals, as well; however, I would argue that, without the intrinsically phenomenological experience of the psychedelic, these approaches were right to fear the allure of standardization as a force extracting the philosophical authenticity from their procedures.

As for standardized instruments, scientists have developed numerous rigorous measures to assess such things as the degree of difficulty (Barrett et al., 2016), the spiritual and mystical quality (Barrett et al., 2015; Studerus et al., 2010), and the long-term effects (Griffiths et al., 2006) of the experience. Additionally, the clinical trials utilize standard assessments of such conditions as PTSD and major depressive disorder (MDD) based on the DSM. As explained above, this is certainly not ideal. Nevertheless, it clearly shows that psychedelic-assisted psychotherapy cannot be accused of the same anti-scientific orientation that limited existential and humanistic psychology. Next to the rigorous clinical trials, another productive outgrowth of this field is presented by psychedelic neuroscience. Scientists in this discipline, most notably Robin Carhart-Harris' laboratory at the Imperial College London, have begun to uncover some of the neural mechanisms involved in the psychedelic experience that seem to be responsible for its profound effects on human consciousness. Although this area of research is still very new, fascinating theories have been proposed such as the entropic brain hypothesis (Carhart-Harris et al., 2014), which reconceptualizes various mental illnesses as a function of the amount of chaos present in the brain, and the REBUS model (Relaxed Beliefs Under Psychedelics; Carhart-Harris & Friston, 2019), which locates the subjective profundity of the psychedelic experience in the interactions between various brain networks. The difference of this line of research to the biomedical psychiatry model criticized in Chapter 1 is that the vast majority of researchers in the psychedelic community do not assume the phenomenology of the experience to be secondary to the physical mechanisms. On the contrary, a recent paper by two of the most famous researchers in the field, David Yaden and Roland Griffiths, argued that the subjective effects are not only important, but may well be the most crucial of all the variables (Yaden & Griffiths, 2020). All in all, then, it does not seem unwarranted to assert that the field of psychedelic-assisted psychotherapy, while maintaining a holistic view of the mind,

nevertheless, in its methodology, stays true to the scientific rigor of the mainstream approaches.

3.4 Notable Caveats

Before closing this chapter, several important caveats should be mentioned. Most importantly, it must be noted that I am in no way suggesting that psychedelic-assisted psychotherapy is a panacea. For some problems like anxiety, depression, PTSD, existential despair, substance abuse disorder, and many others, this approach could, as suggested multiple times above, become a revolutionary development and help millions of people. For other disorder, however, psychedelics will most likely always remain profoundly inappropriate. The most obvious candidate for such a condition is usually held to be schizophrenia. In fact, most, if not all, studies utilizing psychedelics to this day have taken ample precaution to exclude participants with a personal or even familial psychotic background. This is due to an as-of-yet unconfirmed suspicion that psychedelic use could potentially trigger psychosis in at-risk individuals. In the framework of the previously mentioned entropic brain hypothesis, this is explained as a function of the amount of chaos present in the brain (Carhart-Harris et al., 2014). Specifically, this theory proposes that disorders such as depression or OCD are characterized by an excessive amount of order in both the brain and the lived reality of the patient. Psychedelics, in turn, are assumed to introduce a radical amount of chaos into this ordered state, thereby giving the patient an opportunity to subsequently find a healthier balance between order and chaos in their lives. Following this theory, it stands to reason that the introduction of excessive amounts of chaos into a brain that is already primarily characterized by chaos (as is assumed to be the case in psychosis) would be more likely to do harm than good. Although this is only one specific theoretical interpretation of currently available data and may not ultimately prevail, the idea that psychedelics should not be administered to individuals at risk for psychosis (even if only distantly) is accepted in every psychedelic framework that I am aware of. One other example commonly accepted as a wise exclusion criterion for psychedelic studies is bipolar disorder. Beyond these two, however, the precise extent of the category of conditions unsuitable for psychedelic therapy still remains to be researched.

Furthermore, psychedelics do not only present dangers to individuals at risk for certain mental disorders, but have, at times, been associated with negative mental health outcomes in psychologically adjusted individuals, as well (Carbonaro et al., 2016). Although enduring negative consequences are quite rare and physical toxicity of these substances –

except MDMA – is generally believed to be extremely low or even non-existent (Nichols & Grob, 2018; Passie et al., 2002), the importance of what Timothy Leary called "set and setting" in psychedelic experiences has been well established (Hartogsohn, 2017). In short, this phrase refers to one's physical environment (setting) during the experience, and the frame of mind (set) with which one comes into it. In the words of Stanislav Grof, psychedelics function as "unspecific amplifiers" of what is already present (Grof, 2008, p. 299). As such, if the physical or mental environment in which one attempts to have a psychedelic experience is unsafe or otherwise unconducive to a deep exploration of consciousness and the world, the risk of having an unproductive and possibly even traumatizing experience is increased. One famous example of such experiences are the reports of violent sexual encounters with hallucinated crocodiles detailed in Rick Strassman's 2001 book *The Spirit Molecule*. To avoid such episodes, it should be emphasized that psychedelic-assisted psychotherapy does not equal recreational psychedelic use at, for example, a nightclub. On the contrary, the set and setting of a psychedelic therapy session should always consist of, at a minimum, an atmosphere of unconditional positive regard, openness, and trust (as per client-centered therapy), as well as be preceded by intensive preparatory sessions to ensure that the therapist knows the patient's history and concerns, and the patient feels comfortable and safe with the therapist. Moreover, therapists should always receive additional training to familiarize themselves with the psychedelic state and learn how to properly and responsibly supervise patients going through such an experience.

Psychedelics are extremely powerful substances and should accordingly always be handled by science with a great degree of care, caution, and respect. Moreover, despite their immense potential to revolutionize the treatment of many mental health conditions, some conditions will likely always remain beyond their scope of applicability. As such, I want to close by emphasizing that, ultimately, the field of mental health care will require elements of everything discussed in this thesis. Traditional psychiatric medications, cognitive-behavioral scripts as well as psychoanalytic, existential, humanistic and psychedelic approaches all have a legitimate place in the attempt to cure mental illness. The main argument advanced in this thesis is that no one approach should be in a position of exclusive dominance over the field. Different patients will always require different approaches, and no therapist should be educated in only one domain. In order to create a maximally effective discipline, therapists should, on the contrary, be well versed in all of the ideas presented in this thesis, and be qualified to use any of them at the proper moment.

Conclusion

The present thesis argued that the fields of psychiatry and psychotherapy are unduly dominated by mainstream approaches that are commendably scientifically rigorous, but fail to acknowledge fundamental aspects of the human experience. Although alternative approaches exist that do not commit this mistake, these alternatives have tended to limit themselves by adopting an unscientific methodology. To unify the respective strengths of these two extremes, I have introduced the burgeoning field of psychedelic-assisted psychotherapy. Although this approach, too, will not solve all the problems of mental health care, it presents an opportunity for at least a portion of conditions to radically transform the way they are treated. Much remains to be discovered in this field, and any conclusions must still only be drawn tentatively. Nevertheless, I believe that the upcoming decade will exhibit a fundamental change in the way society as well as mental health care view and discuss the topic of psychedelic drugs. Half a century after their initial illegalization, I believe that psychedelics are now once again on the verge of being discovered and acknowledged by the world for the immense potential that they carry.

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