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ORIGINAL PAPER

Psychedelic Therapy as Form of Life

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Abstract In the historical context of a crisis in biological psychiatry, psychedelic drugs paired with psychotherapy are globally re-emerging in research clinics as a potential transdiagnostic therapy for treating mood disorders, addictions, and other forms of psychological distress. The treatments are poised to soon shift from clinical trials to widespread service delivery in places like Australia, North America, and Europe, which has prompted ethical questions by social scientists and bioethicists. Taking a broader view, we argue that the ethics of psychedelic therapy concerns not simply how psychotherapies are different when paired with psychedelic drugs, but how psychedelic therapies shape and are shaped by different values, norms, and metaphysical commitments. Drawing from the published literature and interviews with seven psychedelic therapists working in clinical trials in the United States, Germany, Switzerland, and Australia, this article opens the black box of the treatments to consider the values and informal debates currently animating the therapies. Considering questions of patient autonomy, mechanisms of therapeutic action, and which therapies are best suited to pair with psychedelic substances, we examine the ethics of psychedelic therapy as an emergent form of life. To bring this form of life out in fuller relief, we conclude by comparing and contrasting it with ayahuasca use in Amazonian shamanism.

Keywords Psychedelic · Cultural psychiatry · Moral anthropology · Shamanism · Psychopharmacology

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Introduction

No psychotherapy serves the sole purpose of reducing psychiatric symptoms and managing mental illness. In addition, psychotherapies always aim at enabling patients to flourish, to live "the good life," to acquire what the Ancient Greeks called *eudaemonia*. This is also true for psychedelic-assisted psychotherapies, which use a neuropharmacological intervention to boost the psychotherapeutic process. This article addresses the ethical ramifications of using psychedelics as catalysts of ethically charged

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psychotherapies as psychedelic therapies gain global traction.

We write at a time when Australian drug regulators have just approved the medical use of psilocybin for the treatment of depression and MDMA for post-traumatic stress disorder; in the US, both substances are on an expedited path to market approval, and the European Medicines Agency is waiting for clinical trial results to reassess the drugs' therapeutic utility. These regulatory agencies are exclusively concerned with the safety and efficacy of drugs, not of psychotherapies. Market approval will be based on randomized placebo-controlled trials, which compare drug with placebo rather than drug plus one psychotherapeutic modality with drug plus another psychotherapeutic modality—or no psychotherapeutic modality at all. In other words, the contribution of the psychotherapy component to safety and efficacy remains opaque. At the same time, its ethical implications remain unexamined as well.

Some clinical researchers envisage the future of psychedelic therapy as a stand-alone neuropharmacological intervention [34]. Without psychotherapy there is no need to think about how it complicates the medical ethics of psychedelic therapy. Yet others believe that psychedelics differ from established psychiatric medicines in that they have no inherent therapeutic effect but serve as powerful catalysts of the therapeutic effects of psychotherapy [35, 73, 82]. If market approval is granted, psychiatrists might be free to use the drugs to assist whatever kind of psychotherapy they see fit.

"Psychotherapy is not just a treatment method," wrote the editors of *Therapy with Psychoactive Substances*, "but, in (post-) modern societies it also designates a form of life. After the breakdown of traditional systems of orientation (church, village community, party ideology, etc.), for many people it has become an identity-defining project." ([49], p. 38) Following this cue, we adopted the conceptualization of psychedelic-assisted therapy as a form of life, or maybe as an extended family of different forms of life. Across the philosophical and anthropological literature, the term *form of life* is often associated with Ludwig Wittgenstein (1958) who argued that people can only give so many reasons for how they think and talk. Beyond that point they will justify a form of discourse by gesturing toward their form of life, that is, the underlying nonverbal practices and orientations [95].

In the realm of psychotherapy, there has been some debate over whether psychoanalysis should be considered such a form of life, which is distinct from that of, say, biological psychiatry. Arguably, biological psychiatrists also exceed the treatment of mental illness as they administered tranquilizers like meprobamate or antidepressants like fluoxetine to the worried well, as discussed in *Prozac as a Way of Life* [20]. But psychotherapists understand and act upon problems of living very differently. Psychoanalysts, for example, do not prescribe drugs, but make their patients lie down on a couch to talk about themselves; they often interpret what the patient says as containing implicit references to the relationship between analyst and patient, which in turn the analyst considers a key to decoding other relationships in the patient's life that define who he has become and what he is struggling with; they assume that the source of the patient's problems remains unconscious and that making his unconscious conscious will be of more lasting therapeutic value than correcting his brain chemistry, etc. [5]. Of course, many psychiatrists understand both pharmaco- and psychotherapy as short-term interventions rather than identity-defining life forms. And outside of Switzerland where the government issues special permits to use psychedelics in long-term group psychotherapy, medical administration of psychedelics is currently confined to time-limited clinical trials, even though some trial participants subsequently join local psychedelic communities to continue processing with others experiences that many rank among the five most meaningful experiences of their life [37, 71]. But as these trials are paving the way toward regular medical use, they contribute to the emergence of a new form of life, in which psychedelics might occupy an equally important place as Prozac and other SSRIs have in American life in the past 30 years or ayahuasca has in Shipibo life for possibly centuries.

This emergent form of life is shaped by how its practitioners conceive of mental health and the good life. Since psychedelics heighten suggestibility, psychiatrist Sidney Cohen ([12], pp. 182–183) already observed in 1964, the psychotherapist's orientation shapes the material that the patient produces: "It is curious how under LSD the fondest theories of the therapist are confirmed by the patient. Freudian symbols come out of the mouths of patients with Freudian analysts. Those who have Jungian therapists deal with the collective unconscious and with archetypal images. The patient senses the frame of reference to be employed, and his associations and dreams are molded to it" (see also [4], p. 124). Cohen ([12] p. 183) noted that the therapist's pharmacologically reinforced influence also transformed the patient's ethical

outlook: "His notion of what is good and desirable tend to be adopted by the patient." The history of psychotherapy also shows that different schools not only differ in what patients say, how therapists make sense of it, and how they help to resolve their patients' problems of living, but the school of psychotherapy also determines how therapists intervene and institutionalize their work [54]. Understanding differences in treatment methods as differences in forms of life suggests that choosing one over the other is not just a matter of demonstrating superior therapeutic efficacy but gets to a point where medical reasons come to an end. However, this does not mean that therapists withdrew to the Wittgensteinian position of "This is simply what I do" ([5], p. 157). Instead, the seven psychedelic therapists we interviewed for this article explained their practice in terms of a broader set of considerations, including ethical considerations.

If different forms of psychotherapy amount to different forms of life, the pressing question that clinical research cannot answer is what kind of psychotherapy and which form of life patients should pursue. As anthropologists who have been observing the psychedelic renaissance for many years, we will not provide a normative answer to this question. Instead, we will raise the problem and make it an object of moral inquiry by beginning to draw a map of the ethical terrain of psychedelic-assisted psychotherapy that therapists and clients might soon have to navigate.

What came as a surprise to us was that, in the face of altercations between different schools of psychedelic-assisted psychotherapy [7, 75, 97], several of our interlocutors suggested that the different psychotherapy schools that have been paired with psychedelic use might not amount to any substantial differences in therapeutic efficacy. "Everybody has won, so all shall have prizes," Sandeep Nayak and Matthew Johnson ([47], p. 168) quote the Dodo bird in *Alice in Wonderland* who organizes a race and then declares all participants winners. Even religiomagical healing rituals and psychotherapies "with bizarre rationales" like Mesmerism could be effective. It is a strange thing to say for modern medical researchers that it does not matter whether psychedelics are used to catalyze the latest evidence-based treatment modality or an approach that Mesmer's contemporaries in the late eighteenth century had already dismissed as quackery, as if the field of psychotherapy was immune to scientific progress. For the purpose of this article, however, it is important to note that, even if it turned out to be true that all forms of psychotherapy were *therapeutically* of equal value, it does not follow that they are *ethically* of equal value, too. The very suggestibility enhancing effects, which Nayak and Johnson cite to explain how psychedelics could make very different psychotherapies work well, might magnify qualitative differences in meaning-making and ethical orientation, as Cohen's observations suggest. When it comes to the forms of life that psychedelics shape, it makes a world of a difference whether they are used for psychedelic-assisted psychotherapy in Baltimore, USA, for shamanic healing in Iquitos, Peru, for monthly church services in a Santo Daime community in Brazil, or for rites of passage by the Japanese sect Aum Shinriyko, which committed a sarin gas attack on the Tokyo subway in 1995. And maybe it even makes a difference whether they are used for psychoanalysis or cognitive-behavioral therapy.

This article makes a two-fold contribution to the literature on the uses of psychedelics. First, it contributes an anthropological perspective to current ethical debates in psychiatry surrounding the resurgence of psychedelic-assisted psychotherapies. It describes and analyzes some of the ethical stakes beyond the established concerns of bioethicists with informed consent, moral enhancement, safety, etc. (e.g., [19, 46, 84]). Based on our interviews and the available literature, we argue that what these forms of life have in common is a problematization of how to foster autonomy through a psychotherapy assisted by chemical substances whose acute effects appear to undermine autonomy by dissolving the ego, increasing suggestibility, and opening the patient wider than usual to the therapist's influence. We focus on the values pursued by psychedelic-assisted psychotherapies to open the normative black box of these practices.

Second, this article contributes to the ethnographic archive and thus to comparative ethics an account of how psychedelics are coming to be used by psychiatrists and therapists in North America, Europe, and Australia. Our observations chronicle and analyze the emergence of a new and multifaceted psychedelic culture [56]. This is a culture that cannot fall back on long-standing traditions of psychedelic use, although a subset of practitioners is looking to South and Central American shamanism for inspiration (which has given rise to morally and politically charged controversies over cultural appropriation; [3, 23, 43]). Such circulation of practices, ideas, and drugs erodes the conception of cultures as bounded homogeneous wholes. Nevertheless, the contrast between psychedelic-assisted psychotherapy and ayahuasca

shamanism remains stark enough to throw into relief the distinct ethos that is emerging in Western medical applications. One key difference is that, while psychedelic psychotherapists hardly make explicit how their practices engage moral life, Amazonian shamans conflate normative and therapeutic goals openly and deliberately. They administer ayahuasca for the purpose of living a simultaneously beautiful, healthy, and righteous life. We will end the article with a comparison of psychotherapeutic applications of psychedelics with ayahuasca drinking in Amazonia to show that, in both cases, psychedelics are not just administered as medicines but are part of whole forms of life with unique values, social norms, and moral visions—even though these two forms of life differ markedly.

The Black Box of "Psychotherapy on Rocket Fuel"

Since the 2010s, research and development of psychiatric drugs has lapsed into crisis as major pharmaceutical corporations recognized that biological psychiatry had reached an impasse and disinvested their neuropsychopharmacological drug development programs. The one area of psychopharmacological R&D that began to boom during this time was psychedelic research as it transitioned from its preclinical phase to clinical trials [55]. Psychedelic-assisted psychotherapy was presented as a "paradigm shift" away from the established pharmacotherapeutic approach to a treatment model that used powerful psychoactive drugs to augment psychotherapy [40, 70, 82]. The idea was that, unlike antipsychotics or antidepressants, psychedelics had no inherently therapeutic effects but catalyzed a psychotherapeutic process. As one of our interlocutors put it: Psychedelic-assisted psychotherapy "feels like psychotherapy on rocket fuel." This model can be traced back to the 1950s when psychoanalytically oriented psychiatrists administered LSD to patients to reduce their resistance and bring to the fore unconscious conflicts more quickly. However, when psychedelics made a comeback in the 2010s, they returned into a world of psychotherapies that had evolved and diversified for more than half a century. To be sure, there were still some psychoanalysts, but there were also proponents of Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, Dialectical Behavioral Therapy, Motivational Enhancement Therapy, Meaning-centered Psychotherapy, Meaning and Purpose Therapy, Supportive-Expressive Group Therapy, Internal Family Systems Therapy, and numerous competing approaches, which were boosted by different psychoactive agents, from classical hallucinogens like psilocybin and LSD to entactogens like MDMA and dissociatives like ketamine. As the *form* of psychedelic-assisted psychotherapy experiences a renaissance, its *content* isn't what it used to be.

Yet the many psychotherapeutic approaches that make up the psychotherapy component in psychedelic-assisted psychotherapy are not tested for safety or efficacy, only the drugs are. In clinical trials, treatment manuals codify the psychotherapeutic practices to make sure that all enrolled patients receive the same treatment and that, at least in theory, the trial could be replicated by other researchers. In terms of research design, psychotherapy is treated like any other extrapharmacological factor: it is held constant, so that any difference between drug and placebo condition can be attributed to the drug. However, if the drug is supposed to be devoid of inherent therapeutic effects and only "assist" the psychotherapy, then placebo-controlled trials leave the main factor driving the therapeutic transformation in the dark. "We should also characterize and test the psychotherapeutic component as well as the necessity for the specific drug being tested," wrote psychedelic scientists Boris Heifets and Robert Malenka [44]. Considering the powerful mind-altering effects of psychedelics, researchers are already struggling with the question of how to administer these drugs in a way that neither researcher nor subject knows whether the subject received verum or placebo [67], yet conducting psychotherapy without knowledge of either psychotherapist or client is practically impossible (but see [42] for alternative approaches in psychotherapy research). Thus, the role that different schools of psychotherapy play in the success or failure of psychedelics in clinical trials remains opaque.

In 2022, a controversy over which modality was suitable for psychedelic-assisted therapy began to take shape. David Yaden and colleagues [97] argued that psychoanalysis and indigenous healing practices should take a back seat and cognitive-behavioral approaches should become the default because they avoided issues of cultural insensitivity, made minimal speculative assumptions about the nature of the mind and reality, and had the largest base of empirical support for

their safety and efficacy outside of psychedelic therapy. Pointing to the lack of comparative research on competing modalities of psychotherapy, psychiatrist John Burton et al ([7], p. 2) dismissed Yaden's commitment to cognitive-behavioral approaches as "activism and bias masquerading as science", which did a "disservice to patients and practitioners alike." They also objected to Yaden's debasement of psychoanalysis as based on long outdated psychoanalytic and epistemological literature and ignoring the recent confluence of psychoanalytic and neuroscientific models of psychedelic drug action. In collaboration with European colleagues, Jeffrey Guss [41], one of Burton's co-authors, went one step further and made the case *for* psychoanalytic approaches in psychedelic therapy. Reanimating the old opposition of psychedelic and psycholytic therapy, Torsten Passie, Jeffrey Guss, and Rainer Krähenmann view the use of relatively high doses in a very few sessions, which is characteristic of "psychedelic therapy," as compatible with clinical trial designs but not with the protracted and incremental nature of psychotherapeutic transformation. By contrast, psycholytic therapy does not aim at mystical experiences, ego dissolution, and other peak experiences meant to change a patient's life in an instant but repeatedly administers low doses over the course of a long-term psychotherapy to soften defenses and catalyze a talking cure. They conclude that "the currently postulated 'psychedelic renaissance' may well be followed by a 'psycholytic renaissance.'" ([75], p. 12).

As the field of psychedelic-assisted psychotherapies comes to be defined by such antagonistic positioning, we interviewed therapists to tap into informal conversations already happening behind the scenes about which psychotherapeutic practices to augment with psychedelics. Our interviewees come from different schools of psychotherapy: three trained in psychoanalysis, two in third-wave cognitive-behavioral therapies like Dialectical Behavioral Therapy and Acceptance-Commitment Therapy, one in bioenergetic therapy, and a research psychologist working with therapists from different schools chosen to mirror the diversity of the coming industry. We approached representatives of competing treatment modalities because Science and Technology Studies have long known that analyzing controversies provides an inroad for outsiders—be they social researchers, ethicists, patients, policy-makers, or an interested public—to better understand how experts think and make decisions about issues otherwise hidden from view ([59], pp. 1–62,[83], pp. 120–135). Let's open the black box of psychedelic-assisted psychotherapies.

The Inner Healer and Common Factors, or Do Schools Actually Matter?

In contrast to the public controversy outlined above and much to our surprise, most of the psychedelic therapists we interviewed felt that the specific modality of psychotherapy was not all that important. One Swiss interlocutor told us that the opposition of psychedelic and psycholytic therapy was largely historical: they neither used the small doses of traditional psycholytic approaches nor the high doses of the original psychedelic therapies but moderate doses which facilitated psychodynamic therapy while occasionally inducing mystical experiences as well. In the face of recent studies suggesting that mystical-type experiences predicted a better therapeutic outcome [36, 62, 80], this therapist maintained that mystical experiences were overrated and not necessary for therapeutic success but also acknowledged that mystical experiences could reconnect patients with "the good side" of the world, from which their experiences of, say, trauma or cancer had separated them. The opposition between cognitive-behavioral and psychoanalytic approaches posited by Yaden did not resonate either. Many younger therapists had been trained in so-called third-wave cognitive-behavioral therapies such as Acceptance and Commitment Therapy and Dialectical Behavioral Therapy, but they were still welcome in the Swiss Medical Society for Psycholytic Therapy, which even considered a name change to reflect its ecumenical character. What had softened the notorious conflicts between rival schools that had made the field of psychotherapy the subject of many a joke?

The principal investigator of an Australian clinical trial explained that they were hiring psychotherapists from different schools because, once psychedelics were approved as medicines (as happened in Australia in July 2023, a few months after our interview), it would be a free-for-all anyway and therapists trained in very different traditions would enter the field. Hence, not confining trials to one psychotherapeutic modality increased their ecological validity. Yet all modalities had to be adjusted to how

psychedelics changed both mental and interpersonal processes in the treatment room. "All these experienced clinicians", he explained, "are on a very steep learning curve. They all are saying, 'Oh, my God, this is intense. This is new, this is confronting' … everybody's engaged." The team negotiated these adjustments as it developed a manual for the emergent paradigm that would establish common ground between practitioners while allowing for some discretion in how they treated their patients: "We've been through an iterative process with the team," the PI explained. "We've developed a process of building consensus around aspects that need to be clear while also remaining flexible: Everybody has a different way of dealing with things."

Several European interviewees emphasized that psychotherapy researchers had identified a set of common factors that made psychotherapies efficacious (see also [69]). One of them listed the therapeutic bond between therapist and patient, intimacy with appropriate boundaries, and the therapist's authenticity ([92], pp. 55–57). If the choice of psychotherapy was considered part of the therapist's authentic self-expression, she argued, this common factor paradoxically required a diversification, maybe even singularization of therapeutic approaches, which would be at odds with reliance on a set of best practices identified by a professional body.

At the time of our research, Swiss psychotherapists had received a therapeutic use exemption from the government to conduct LSD- and MDMA-assisted psycholytic therapy even though neither drug had been approved as a medicine. But clinicians in other jurisdictions could only administer psychedelics in the context of clinical trials, which require a high level of standardization and do not allow for long-term psychotherapy tailored to the needs of individual patients—or the authenticity of the therapist. One principal investigator of such a trial wondered whether the "psychological support" his team was giving to trial participants could even be considered psychotherapy. In his eyes, the answer depended on whether the rather minimalist work they did with patients—a preparation session, a drug session without targeted interventions, and a subsequent integration session—satisfied the common factors identified by psychotherapy researchers (although they referred to a different set of common factors than the psychedelic therapist quoted above). Against the background of the psychotherapy research literature, he assumed that the impact of school-specific psychotherapeutic interventions on treatment outcomes amounted to no more than 10–20% (see also [49], pp. 32–34). A meta-analysis of psychotherapies even suggested that "there are no significant differences between treatments." ([13], p. 7) If true, the impact of this extrapharmacological factor was too limited to warrant comparison between different psychotherapeutic modalities before market approval was granted for the drugs. This also had the advantage of not complicating the approval process by drawing the attention of regulators to the psychotherapy component of psychedelic-assisted therapies. Moreover, beyond its scientific merits, common factors theory had the strategic advantage of preventing the budding field of psychedelic therapy from lapsing into factional conflicts before therapeutic uses of psychedelics had even been approved.

A further interviewee cited yet another set of factors independent of the specific treatment modality that determined the efficacy of psychedelic-assisted psychotherapies: the power of the substance, the personality of the therapist, and the patient's intrinsic capacity for self-healing. The Czech-American pioneer of psychedelic-assisted psychotherapy Stanislav Grof had already pointed to the integrative function of self-healing in an otherwise divided field: "Modern psychotherapy is plagued by an astonishing lack of agreement among its different schools about the most fundamental questions concerning the functioning and the main motivating forces of the human psyche, the cause, nature, and dynamics of symptoms, and the strategy and technique of psychotherapy," he explained in an interview. But Grof offered an alternative derived from the psychology of Carl Gustav Jung: "If the experts are not able to reach agreement, why not to trust one's own healing intelligence, one's own inner healer. […] The healing then comes from the collective unconscious and it is guided by an inner intelligence whose immense wisdom surpasses the knowledge of any individual therapist or therapeutic school." [39] This idea of an inner healing intelligence has since become so prominent in psychedelic therapy that the Multidisciplinary Association of Psychedelic Studies (MAPS) made it a cornerstone of its Manual for MDMA-Assisted Psychotherapy [11, 65].

In other words, for a variety of reasons ranging from empirical findings of psychotherapy research

and concerns about the approval process to a belief in the self-healing powers of the human mind, many psychedelic therapists played down the importance of differences between psychotherapeutic approaches. As medical anthropologist Katherine Hendy [45] suggests, therapeutic efficacy was either attributed to the drug or the self (with the drug serving as a mere catalyst). Yet this ideal–typical opposition of "chemical-efficacy" and "self-efficacy" leaves open the question of the efficacy of the therapist, her rapport with clients, and her interventions.

The Value of Autonomy

Most forms of psychotherapy, including psychedelic-assisted psychotherapies, emphasize the ethical importance of patient autonomy. Therapists should not tell their patients how to live their lives but help them to find their own ways. Ethnographic comparison with more directive uses of psychedelics reveals that this attitude represents an ethos in its own right, one that values individualism, authenticity, and the freedom to live one's life as one sees fit, not as religious or medical authorities prescribe [31]. Compare this with, say, shamanic uses of psychedelics in the Americas. "The Huichol of Mexico, like the Cahuilla of Southern California or the Tukano of Colombia, returns from his initiatory 'trip' to exclaim, 'It is as my fathers explained it to me!'" wrote anthropologist Peter Furst ([26], p. 16). "One takes peyote, he says, 'to learn how one goes being Huichol.'" More recently, David Dupuis [17] offered an ethnographic and theoretical account of how psychedelics are used in a neoshamanic setting as "tools for belief transmission." Considering that psychedelics have been shown to increase suggestibility [10], it is not surprising that they are not only used for self-discovery and self-realization but also for enculturation. In a psychotherapeutic context, this poses a problem. The use of suggestion has been discussed controversially since the inception of depth psychology. Psychoanalysis was born of Sigmund Freud's abandonment of suggestion for free association (not because of any ethical concerns but for suggestion's lack of lasting therapeutic efficacy; [25], p. 12,[81],but see [2]). If psychedelics make people more suggestible, this neuropsychopharmacological effect raises the practical question of how psychotherapists can minimize suggestion while guiding patients through often challenging experiences. It also escalates a paradox inherent to all outside interventions meant to increase inner freedom: However tacit, any directive to know and become oneself, to gain in autonomy, is still a heteronomous prescription, a particular cultural norm imposed on and constitutive of the subject of psychotherapy.

Transcultural psychiatrist and anthropologist Laurence Kirmayer ([50], p. 236f., 242) argued that psychotherapy not only operates in the intrapsychic but also in the sociomoral realm where it enables patients to reconstruct their sense of selfhood in the image of individualist values: autonomy, self-fulfillment, self-control, self-efficacy, self-assertion, increased responsibility for the self, and idiosyncratic self-expression that transgresses the boundaries of conventional forms. In this framework, psychopathology signifies an inability of individuals to exercise sufficient personal autonomy. Kirmayer contrasts the underlying egocentric concept of personhood with sociocentric conceptions in East Asia and ecocentric conceptions informing shamanic practices, which emphasize the importance of transaction and exchange with other persons, including nonhuman persons in the case of shamanism, for people's psychological and spiritual well-being. If Kirmayer's cultural comparison is correct, then psychotherapy is no value-neutral medical intervention but promotes a particular individualist ethic of autonomy. We will show how such autonomy also shapes the ethos of psychedelic-assisted psychotherapists.

However, before jumping to the conclusion that psychedelic-assisted psychotherapy represents yet another practice promoting Western individualism, we would like to address two problems with this account that have fueled our inquiry. First, as far as psychotherapy in general is concerned, Kirmayer's perspective does not stand uncontested. In the 1970s, medical philosopher Tristram Engelhardt ([87], p. 445) noted that "involvement in a particular ethic would make psychotherapy a form of ethical tyranny." Although none of our interviewees stated it in such crass terms, this assessment appeared to

be behind their uniform insistence that, as psychotherapists treating patients by inducing an especially suggestible state, they did *not* tell them what to do but merely served as midwives who helped patients to make their own life choices.[1] While Engelhardt agreed that psychotherapy went beyond the medical model in that the therapist does not just treat particular symptoms but serves as a teacher, he did not portray the therapist as teaching her patient what actions are good or bad, for that would be ethics. Instead, Engelhardt ([87], p. 444) presented psychotherapy as a metaethical practice, which provides the patient with the "map of a strange city," so "he can orient himself, but not find out where he *should* go." According to Engelhardt ([87], p. 441), psychotherapy does not valorize autonomy as one ethical value among others but as a precondition of ethics itself: "'Being free' or 'making autonomous choices' concerns the possibility of any ethics." In other words, psychotherapy turns humans previously determined by unconscious forces into ethical subjects who can make their own decisions.

Similarly, in contemporary moral anthropology, James Laidlaw ([53], p. 177) argued that freedom was no Western value but a human possibility across cultures, which enabled ethics defined as practices of value informed by thought. Thought thus understood provides "freedom in relation to what one does" and is not simply the prerogative of people in post-Enlightenment Europe and North America ([53], p. 324). Even in the most traditional societies, people have to navigate value conflicts, which requires them to step back and reflect upon their situation ([53], pp. 167–173). However, Laidlaw also recognizes that some ethical projects seek to go beyond ethics as a practice of freedom by voluntarily relinquishing the will. Among the ethical projects that let go of individual autonomy are different kinds of mysticism ([53], p. 154). They include psychedelic mysticism, which aspires to total surrender to an overwhelming experience of unity with God or the universe. In psychedelic therapy, several prominent clinical researchers found that mystical-type experiences predict positive treatment outcomes [48, 62, 66, 80]. Patients are led to encounter psychedelic states by "letting go," "trusting the process" or their "inner healing capacity," thus submitting to something beyond their autonomous self. Philosopher Oliver Davis ([15], pp. 94–95) noticed this tension between the valorization of autonomy and heteronomy in psychedelic-assisted psychotherapy and suggested that the practice aimed at what he calls "'autoheteronomy', an experience of the self as other and the other as self," in which "the most significant other is not the therapist […] but rather that which in the subject exercises autoheteronomous (i.e., both autonomous and heteronomous) healing power once the oppressively rigid ego dissolves." In our conversations with psychedelic therapists, we sought to understand how they navigate this tension and deal with the paradox of autoheteronomy.

"Getting Out of the Way": The Paradox of Fostering Autonomy

Their professed focus on the patient's self-efficacy leads many psychedelic therapists to understand their role as providing a safe setting but otherwise not getting in the way of the patient's process of inner healing. "It looks like we are not doing much," one therapist said, "but people feel supported and as if they gained access to parts of themselves in a way that is helpful." Their colleague explained that another part of the therapist's job was to keep people on target: "Many people come to a point where they avoid confronting themselves with something they fear, for example, certain emotions or memories, and it is your job as a therapist to tell them that, if they resist the process, they will have to deal with symptoms and get into more trouble than if they go through it. Basically, you're the midwife of this process." The therapist guides their patient toward an inner truth and it is this truth, not the therapist, that will provide the patient with orientation.

Similarly, psychedelic therapist Max Wolff and colleagues ([96], p. 9) sought to guide patients from avoidance to acceptance, but emphasized that "acceptance should not be seen as an end in itself, but rather as a requirement for living in accordance with one's chosen values." Another research group also found that psychedelic experiences helped patients to reconnect with personal values that had faded over

[1] Engelhardt's distinction between psychotherapy and ethics might be less clear-cut than he suggests. For making one's own life choices is precisely what an individualist ethic of autonomy would demand and consider a prerequisite of human flourishing.

the years or to discover new ones ([72], p. 759). That psychedelics offer perspectives on how one ought to live and that these insights are understood as healing has also been described in the context of ayahuasca neoshamanism ([28], p. 206). Every clinical therapist we interviewed insisted that it was not them who told their patients what to do. For example, one described the case of a patient who had been abused by a sadistic father but eventually decided to forgive him. Asked whether he had encouraged this ethical decision, the therapist emphasized that he had not even talked about it previously. After many years without contact, his patient had visited her father, discovered that he was suffering of dementia, and recognized that it was no longer possible to talk to him about what he had done to her, that all she could do for her own sake was to forgive him and move on. Other patients made different choices though. "It is not my job to tell them that they must forgive, or otherwise the therapy won't be successful," the therapist explained. "They define their own goals." Like other psychotherapists, psychedelic therapists, at least those we talked to, sought to foster their patients' autonomy.

Bioethicist Paul Biegler [1] noted a shift in what is expected of psychotherapies from *respecting* a patient's autonomy by asking for informed consent to *promoting* autonomy as a therapeutic goal beyond mere symptom reduction. Similar to what Gearin [27] described for Australian underground ayahuasca groups, psychedelic-assisted psychotherapies make autonomy a social practice and thereby contribute to a wider social structure of individualism. In this respect, the psychedelic renaissance represents a chapter in the larger societal transformation described by sociologist Andreas Reckwitz [76] from modern industrial societies with their preference for the general to late modern societies that valorize the singular (previously the dominion of Romantics, artists, and drop-outs, now a quality expected by HR departments and dating app users alike). The goal of psychedelic-assisted psychotherapy is not simply to reduce psychopathology and increase psychological normalcy but to empower clients to find their own truth, to articulate their own values, and to embark on their own journey.

Critical observers might wonder whether psychedelic therapists are really getting out of the way, whether they are not guiding patients more than they admit, especially given that psychedelics have been found to heighten suggestibility [10]. Answering this question would require direct ethnographic observation of therapeutic sessions. But it seems safe to assume that, just as with the pursuit of objectivity as a will to will-lessness in the sciences [14], the therapists' professed ethical self-restraint serves as a regulative ideal that makes a difference even if it can never be fully realized. This hands-off ethos distinguishes psychedelic-assisted psychotherapy from shamanic uses of psychedelics. It should also be noted that the effort to serve as midwife rather than surgeon hardly means that the therapist adopts a passive role and does not contribute to the therapeutic outcome.

Psychedelic-assisted psychotherapy intensifies the paradox of autonomy that is characteristic of much late modern psychotherapy: It adopts a non-directive stance, leaving it to the patient what form of life they wish to adopt, but it thereby directs the patient toward a form of life that is built around the valorization of autonomy. However, what sets psychedelic-assisted psychotherapy apart from other psychotherapeutic approaches is that psychedelic drugs at least temporarily undermine this very autonomy (understood as freedom from external control or influence): not only is the patient under the influence of a powerful, often overwhelming psychoactive drug but, considering that psychedelics heighten suggestibility, she is also under the influence of a therapist, even more so than in psychotherapies without psychedelics. Therapists might want to minimize suggestion. But however much a psychedelic therapist values their patient's autonomy, they recognize that there are limits to how far they can, and *should*, get out of the way.

The Therapist's Engagement

The therapist's engagement in the process comes to the fore when the patient's so-called process threatens to go off the rails. In a psilocybin study on healthy volunteers at Johns Hopkins University, researchers reported that high dose treatments induced extreme fear in 30% of participants [37]. According to one psychologist we interviewed, there was a general assumption among psychedelic therapists that a certain number of patients would experience "unusual or adverse effects, like bodily shakes, crying, screaming, and other difficult stuff" and that such challenging experiences were not only expected but

working through them could even advance the psychotherapeutic process. Another one estimated that about 5% of patients experiencing a psychedelic "got a little thrown off in their orientation to what's good for them." He felt that such incidents were frequent enough to discuss them as a risk factor. If they occurred, they required some form of intervention.

However, therapists differed regarding the appropriate ways to interact with patients in such situations. A Swiss psychiatrist described how he "cultivated a therapeutic atmosphere of appropriate distance" during the session, while adding that "sometimes people really need the closeness of a human being," including a "healing touch" that can reassure the patient that they are safe and not alone. Yet, in the wake of sexual abuse scandals, touching patients has become the object of intense problematization. Research groups developed protocols distinguishing between appropriate and inappropriate touch. Somatic therapists advocated for less constrained approaches to touch than other therapists. Some mixed somatic and verbal techniques to intimately engage the patient's experience. An American therapist described how he would slightly mirror the embodied and affective register of his patients, including "nodding and grunting" with them. He remembered a patient who needed help crying and expressing anger, so he encouraged the patient while directing their feelings towards the patient's mother, saying "you were really upset with her. You're really pissed off with her right now". He wished he could have allowed the patient to cry on his shoulder, but he had previously been reprimanded for violating a trial protocol after putting his arm around a weeping patient. Some therapists in Australia encourage their patients to embrace their anger, scream, and "beat their chest", while mimicking such actions. These interventionist approaches rely less on the patient's "inner healer" and more on the therapist's skills of guiding the patient through difficult affective terrain. Whereas Yaden and colleagues ([97], p. 11) advocate for more interventions during the dosing session, such as employing cognitive restructuring techniques, a German psychiatrist we spoke with argued that such specific interventions were premature given that "we don't know if somebody who is on a high dose of psilocybin is able to comprehend what I will be trying to restructure nor do we know whether such restructuring would be helpful at the end of the day."

Beyond moments of crisis, therapists constantly engage in subtly navigating their patients through the often-bewildering material churned up by their psychedelic experiences. They assemble play lists that set the mood, leading patients to confront their sadness or putting them into a more optimistic mindset. Choosing music might appear a relatively gentle psychological manipulation compared with Mexican psychiatrist Salvador Roquet's practice of showing his LSD-inebriated patients violent or pornographic film material and exposing them in total darkness to sounds of an airplane crashing and machine-gun fire, yet manipulation it is, nonetheless [88]. In the face of a widespread commitment to non-directive approaches, in drug sessions, the therapist is always already engaged in shaping the process by selecting music, furniture, and other psychologically meaningful cues.

What makes psychedelic-assisted psychotherapy a normatively tense endeavor is that the psychotherapeutic goal of autonomy conflicts with the therapist's interventions under conditions of pharmacologically increased suggestibility and the commonly given advice to accept, as one interviewee put it, "that you ingested the substance and, when it is inside your body, it takes over, you lose control over what happens, you cannot stop it." Several therapists expressed unease with how this advice is frequently phrased as a recommendation "to surrender", as the mystically oriented lead therapist of the Johns Hopkins group put it ([77], p. 59), because "surrender is often a feature of traumatic events: you can fight, flee, freeze, or surrender when the perpetrator has finally overwhelmed you." While the implied loss of agency appears at odds with the psychotherapeutic goal of empowering patients to do what they want to do with their lives, everybody we spoke to urged their patients to "let go" or to "trust the process," a process driven by powerful drugs opening up the patient to another person who will hopefully heal rather than harm them.

In the subsequent integration of drug sessions, an almost imperceptible valorization of certain kinds of experiences over others teaches patients which aspects of the psychedelic experiences matter and which they better disregard. In his ethnography of an ayahuasca retreat center, anthropologist David Dupuis [18] describes this "socialization of hallucinations" as an "education of attention": participants learn to pay heed to their encounters with demons and spirits,

gradually coming to attribute their problems to such entities while relying on benevolent beings like angels for help. By contrast, when we asked a psycholytic therapist about his treatment of such encounters with supernatural entities, he explained that they were rare in Western psychotherapy settings and, if one occurred, "we don't judge it, we listen, and then we guide the patient's attention back to the problems they are trying to resolve. We don't want to go into these realms. This is not part of our treatment modality." With a light touch, patients are steered in the opposite direction of where the shamans described by Dupuis wanted their clients to go. Instead of learning to understand their problems as being caused by outside forces, the subject of psychedelic-assisted psychotherapy is taught to understand her predicament in terms of psychological conflicts that cannot be exorcised by another but must be worked through by themselves. Psychiatrist Matthew Johnson ([47], p. 580) urged psychedelic therapists to "create an open and supportive environment where the patient can make her or his own meaning," which can include religious beliefs and concepts. But he insisted that "it is not the role of the clinician or scientists to introduce such concepts." In the ideal case, the patient will emerge from this process with a sense of self-efficacy, more connected to their innermost values, and having found meaning in their life, a meaning that had been there all along, not imposed by the therapist but revealed by the drug. While psychedelic psychotherapists might not instruct patients to forgive their abusive father or divorce their wife, their practices shape patients in the image of a culturally contingent conception of personhood, making them express their true self and take responsibility for who they really are [50]. This presupposes that the self is actually out there, waiting to be discovered rather than constructed and reconstructed in the therapeutic relationship between therapist and patient.

Mysticisms, including psychedelic mysticism, fit into psychotherapy thus understood like square pegs in a round hole. They represent forms of life inspired by and oriented toward self-annihilation. If a drug-induced experience of ego dissolution inspired a mystical life, it would ideally be a life in which there was no more ego to advance its own values and ethical projects. Anthropologist James Faubion [21] called such forms of life "anethical" (rather than "unethical" for unethical behavior is usually selfish within the bounds of a moral order). If patients decide to cross over from forms of psychotherapy that fashion strong autonomous selves into the domain of psychedelic mysticism that seeks to undo the self, the ethic of autonomy requires this to happen of their own accord and without the therapist's prodding.

Psychedelics in the Service of a Different Form of Life

Cultural comparison is the royal road to establishing that any form of life could be otherwise and that all forms of life are based on ethical, anethical, maybe unethical, and often non-ethical (say, economic) choices, deliberate or inherited. When we began to explore the emergent field of psychedelic-assisted psychotherapies, we imagined that different schools of psychotherapy would enable different forms of life. The limited number of interviews we conducted does not suffice to conclusively confirm or disconfirm this hypothesis. Moreover, our exclusive reliance on interviews rather than ethnographic observations of what is actually happening between therapists and patients has limited us to only speaking to how therapists understand their work and what ideals guide their practice, not to whether this practice lives up to their ideals. Based on this preliminary data, it seems as if few psychotherapists shared the strong commitment to one particular treatment modality demonstrated by Yaden and colleagues [97]. The emphasis on common factors that distinguish successful from unsuccessful psychotherapists, regardless of whether they practice cognitive behavioral therapies or psychoanalysis, does not mean that there are no significant differences between psychotherapeutic practices. Yet these differences are not necessarily categorical, they can also take the form of permutations of numerous concepts and practices which psychotherapists adopt and integrate as they take a panoply of training workshops, contribute to clinical trials according to each trial's treatment manual, learn from colleagues, and read broadly. In light of this splintering of difference, we conclude this article by taking a wider view from afar, comparing the whole complex of psychedelic-assisted psychotherapies with a very different form of psychedelic-infused life, namely Amazonian shamanism. Of course, Amazonian shamanism could also be broken down into a multitude of shamanisms that import, exchange, assemble, and reassemble concepts

and practices from within and beyond Amazonia. As Matei Candea ([9], p. 149) remarked about cultural comparisons: "There is always more difference within!" Conversely, this also means that there is *less* internal difference to contend with as we zoom out. While we will continue to attribute ethnographic findings to specific cultural contexts, the purpose of this section is not to bring out differences but commonalities between forms of Amazonian shamanism and to compare this family of life forms with the form of life of psychedelic therapy, as it emerges in the West.

Indigenous ayahuasca shamanism contrasts sharply with psychedelic therapy as a form of life in that shamans do not exercise the same ethical restraint as psychotherapists. "Throughout western Amazonia," consuming psychedelic plants "entails preoccupation with 'keeping right,' being constantly 'put right' with the help of one's guides," explains anthropologist Françoise Barbira Freedman ([24], p. 194). Angelika Gebhart-Sayer ([33], p. 218) described how the Shipibo notion of *quiqui,* which refers to a combined moral virtue of "correctness" and "beauty," can indicate a "good upbringing and appearance" of a person, and the way a sick person is treated by a healer. The term *quiqui* is also used to refer to the abilities of a healer to shape the psychedelic-augmented senses with song and performance, thus conflating the moral and the aesthetic. Here, the healer's use of suggestion during psychedelic sessions is a culturally accepted skillset, even a responsibility. Harry Walker ([90], p. 188) noted how Urarina chants sung during ayahuasca curing sessions may entail general moral maxims, including instructing "listeners not to be stingy with food, not to treat their pets badly, not to let daughters have sex with 'just any boy,' not to hate each other, and finally to live peacefully together like real people." During the 1980s, Aguaruna adults lamented that because their children were no longer learning how to use psychedelic plants, the children were more likely to engage in "antisocial behavior [such] as fighting with close kinsmen, attempting suicide, maintaining an unseemly interest in sexual adventures, and otherwise affronting traditional morality." ([6], p. 49). The drugs are used to help healers, patients, and others become good and beautiful persons, including when these pursuits entail social conflicts. Psychedelic plants can also be used for social harm, in the form of sorcery, making Amazonian shamanism morally ambiguous [93]. What makes it even more ambiguous is that, due to the underlying ecocentric etiology, therapeutic uses of psychedelics are often understood as freeing a patient from an affliction by passing it on to some unnamed other clouded in mystery, or to a distant group such as Whites, a different indigenous people, or some animal species. Hence, one person's healing can be another person's bewitchment.

Amazonian shamans perceive different risks and benefits of psychedelic usage compared to the views of the clinicians we interviewed. Whereas psychedelic therapists usually remain sober and only give the drug to their patients, in some traditional forms of shamanism, it is the healer, not his patients, who takes the mind-altering drug to help him diagnose and cure the patient ([3], pp. 2–3). Here, shamans assume that the ingestion of hallucinogens poses serious threats as they bring the user into contact with powerful beings, so only psychologically healthy and stable people should cross over into the chaotic and sometimes violent visionary world. As they do so, even trained shamans are taking a risk: some break, lose self-control, and become sorcerers who foster discord rather than harmony between people [79]. Given this kind of traditional shamanism (as opposed to forms of neoshamanism that have emerged in the Amazon in recent decades), the psychiatrist treating her patients with psychedelics would hardly be a "modern-day shaman," as Gary Bravo and Charles Grob (1989, p. 124) contended. Instead of being the rearticulation of what non-Western peoples had done since time immemorial, psychedelic-assisted psychotherapy would appear as a distinctly modern practice of Westerners as the first people in history to give psychedelic drugs for therapeutic purposes exclusively to mentally ill people.

To an Amazonian healer, the directive frequently given in clinical contexts to surrender to the inner healing intelligence, including when it involves being overtaken by mystical experience or ego dissolution, would appear perilous. First, in Amazonian shamanic uses, healing is neither attributed to the drug nor to an inner healer but to the shaman himself [3]. Second, whoever ingests the drug must not be deprived of self-command. Amazonian shamans do not follow the by now canonical advice first given by Timothy Leary et al. ([60], p. 6) to "turn off your mind, relax, float downstream." Instead, they whistle, sing, and perform to gain control and steer their own experience

and their patients' experience into the right direction. While allowing their subject position to shift to that of different agents—such as jaguar-personhood or anaconda-personhood—these transitions are nonetheless volitional exercises of personal autonomy [61, 63]. In pursuit of the widespread Amazonian values of tranquility and peace, healers cultivate "rigorous emotional control" and resist "losing one's mind" during psychedelic experiences ([79], p. 322). Simply trusting and surrendering to frightening experiences—and thus forfeiting volition and autonomy—risks opening the Amazonian patient or healer to psychospiritual harm. They cannot simply "trust the process," as many psychedelic therapists advise.

Amazonian practitioners take very seriously the risks of acquiring new illnesses from consuming psychedelics like ayahuasca. The brew implicates them in a visionary social realm populated by actual beings (not just psychological projections or fantasies) that embody an ambiguous capacity for benevolence and malevolence [94]. In his case study of Amazonian ayahuasca tourism, Gearin [32] observed that shamans sought to "dominate" their own scary visions of snakes, spiders, and monsters. They did not conceive of these as reflections of unresolved personal trauma to be worked through but as signs of attacks by powerful sorcerers that had to be fended off. This difference in ontology entails attitudes and practices that contrast sharply with those of psychedelic-assisted psychotherapy and do not allow for the world-view neutrality of psychological models.

While psychedelic therapists emphasize their moral neutrality, Amazonian shamans are more directly involved in the moral lives of persons understood in an ecocentric fashion, managing social relations within their community and between their community and the powerful nonhuman beings that dwell beyond society. The shaman serves as a "teacher of the ethical values of personal autonomy, equality, and tranquility" ([74], p. 171). He fosters other-regarding virtues by telling stories. However, shamans cannot simply tell their fellow community member what to do. If people misbehave or are victims of others, they are considered ill and can turn to a shaman for therapy (which presupposes that they respect his authority). This endows shamanic healing with a moral dimension.

Ayahuasca visions may reveal knowledge that patients, their families, and others seek for the sake of their own safety and betterment. This can implicate healers in the moral dilemmas of their patients' lives. The Shipibo family of ayahuasca healers studied by Gearin ([29], p. 507) made ten times more money treating international tourists than locals, but some healers still responded to wide obligation networks to perform spiritual cleanings and healings for members of their extended family and others. In this kinship structure, healers pass judgements and can become situated in social conflicts that affect ayahuasca healing and sorcery. Social conflicts often surface through the practice of attributing the causation of illness and disease to other people, often unnamed members of neighboring groups. The culprits' identities usually remain obscure, yet if a person is named, this can provoke violent retaliation ([6], p. 63). Social attributions of illness to sorcery or witchcraft are typically related to perceptions of inequality or injustice in Amazonia [8]. In this case, the healer plays the quasi-legal role of managing but occasionally also aggravating social tensions and moral accusations [78, 94]. At least in some Amazonian societies, this role has been problematized. Michael Brown's Aguaruna interlocutors told him that their "community is good" because they did not have shamans and therefore did not have the social problems incurred when a shamanic cure passed on social afflictions to others ([6], p. 63). While Amazonian healers employ strategies and techniques to avoid becoming personally implicated in their patient's moral and social dilemmas, it is not uncommon for this to occur. Consequently, Shipibo healers have described the treatment of international clients at ayahuasca tourist retreats as easy because, unlike their local patients, the foreigners are only struggling with mental disorders, not black magic, and consequently do not require the challenging sociospiritual work of healing the harms inflicted by witchcraft ([29], p. 507). In contrast to psychiatrist Matthew Johnson's ideal of a psychedelic therapist who serves as a mere projection screen for her patients' views, Amazonian shamans do not bracket their own worldview (although they might hold back certain elements such as their belief in sorcery to avoid alienating their international clients; [29]). Implicitly or explicitly, they offer normative orientation within a multispecies "ecology of selves" populated by humans, animals, and other beings [51, 52]. The shaman's job description is to readjust his client's position in the complex and often conflictual

network of relationships that span humans and non-humans, family and friends, strangers and enemies.

While Amazonian ayahuasca shamanism also uses psychedelic drugs to treat distressed patients, it represents a radically different form of life than psychedelic-assisted psychotherapy. And yet, the contrast is not as black and white as, say, the contrast between Western naturalism and Amazonian animism, as purported by Eduardo Viveiros de Castro [89]. Shamanism does not stand psychotherapy on its head by imposing heteronomy instead of fostering autonomy. Quite the opposite: Amazonian societies are based on their own brand of individualism and place extreme value on self-determination and self-control ([74, 79, 90], pp. 94–132). Anthropologist Harry Walker ([91], p. 185) notes that differences in values usually do not give rise to conflicts in Amazonian societies because "people would rarely if ever dream of telling someone else what to do." They are encouraged to pursue their own conception of the good, which usually does not clash with the needs of their group. The autonomously chosen activities are mostly in the service of others (e.g., a man decides to go hunting to feed his family) and cohere with the values of social harmony, conviviality, and tranquility. Hence, the Amazonianist literature supports James Laidlaw's argument that "to portray idealization of autonomy, conceived as autarchy or external independence, as if it were a feature or failure specifically of 'liberalism' is not only a misleading perspective on European thought, but also parochial in relation to the ethnographic record more broadly." ([53], p. 161) Europeans, North Americans, and Australians are hardly the only people who value personal autonomy.

While the ethnographic archive contains detailed analyses of both personal autonomy and ayahuasca shamanism in the Amazon, we failed to find any extensive discussion of the role personal autonomy plays in ayahuasca shamanism or how hallucinogenic drugs are used to promote or counterbalance personal autonomy.[2] We can only speculate that personal autonomy must mean something else in different ontological frameworks. One shaman's spirit world is another psychotherapist's psychological reality. Cognitive anthropologist and philosopher Martin Fortier ([22], p. 31) noted: "If the ayahuasca experience is mainly determined by the will of autonomous non-physical entities, rather than neurobiological laws,"—or psychological conflicts, we might add—"then psychedelic therapies and psychonautic exploration will always remain hazardous". In other words, if the beings encountered in psychedelic-induced visions are believed to be actually out there and to pose real threats, then directing the patient's attention inward and helping her to articulate her own interpretation of what these entities mean to her personally, would be irresponsible. The latitude of autonomous choice is constrained by reality, or by what is taken for reality. To gain greater clarity about how psychedelic-assisted therapy compares with ayahuasca shamanism as two distinct forms of life transformed by psychedelic experiences, more ethnographic work on the underlying ethics, especially their respective prizing of personal autonomy, would represent a significant step ahead.

Conclusion

The norms and forms of psychedelic therapies differ from those of both psychiatric pharmacotherapy and ayahuasca shamanism. This is clear when comparing, for example, ayahuasca use in Amazonian shamanism to clinical psychedelic therapies in North America. But there is further diversity within clinical psychedelic therapies (and within Amazonian shamanism for that matter). As we argued above, these differences should be open to public discussion and debate. Providing greater transparency and understanding of the values and norms of different psychedelic therapies can empower clients to make informed decisions on which psychedelic services best suit their own form of life. If different psychedelic therapies entailed different forms of life, then what responsibilities would therapists and clinics have to provide information on the potential implications of their psychedelic treatments to their clients' forms of life? This ethical

[2] In a chapter on "Mutuality and Autonomy," Walker (2013, p. 123) notes that the pronounced individualism underlying Amazonian shamanism leads shamans to rely almost exclusively on knowledge gained through immediate experience, especially through the consumption of psychotropic drugs. Since every shaman potentially experiences something different, their perspectives can differ widely. Here, autonomy means that they are not intellectually bound by some orthodoxy (as priests of the Catholic Church are).

question opens many social and cultural issues that are hidden in the black box of psychedelic therapies.

When people attend church, they are aware of entering a metaphysical space that has a particular orientation towards life, death, and the universe. But when attending a psychotherapy clinic, they might not assume that whatever improvement they gain in mental health could also amount to a metaphysical and ethical shift in their orientation towards life since that is not what usually happens in other forms of psychotherapy [85]. By contrast, psychedelic psychotherapies are intensely metaphysical and ethical services that often aim at mystical experiences, or at uncovering the unconscious in vivid sensory encounters, while inducing acute fear, awe, consolation, and other existentially charged affects. Psychedelic therapist Stanislav Grof ([38], p. 2) argued that because psychedelic experiences "have the quality that C. G. Jung called 'numinosity,' it is impossible to draw a clear line between therapy and spiritual evolution. With an open approach, the process that initially began as 'therapy' will often automatically change into a spiritual and philosophical quest." These processual notions of spiritual evolution and philosophical quest speak to not only the psychological transformations that psychedelic therapies can occasion but also to deeper shifts in life-orientation and ultimately form of life.

Many enthusiasts and service providers describe psychedelic treatments as potentially "life-changing" therapies. Clients take for granted that attending psychedelic therapy sessions might change their mental health (hopefully for the better). But they could also be life-changing in the philosophical sense of calling into question one's habitual form of life while interfacing with very different sociocultural forms of life. Forms of life are typically not targets of mental health treatments and therefore clients are less likely to expect changes in their metaphysical and ontological commitments during psychedelic treatments. Yet such transformations have been documented and are not always induced with patient consent [85, 86]. The issues that psychedelic-assisted therapies face include those that also complicate ordinary (non-drug) psychotherapies. But the psychedelic element, the "rocket fuel," to use the words of one of our interlocutors, does significantly intensify the issue of how the combination of drug and psychotherapy can reconfigure forms of life in ways that transcend the patient's initial expectations and awareness. Moreover, the peculiar cultural history of psychedelics has introduced concepts and practices into contemporary psychedelic therapy that we do not see in other domains of psychotherapy (think of the mystical ideal of ego dissolution or the activation of the Inner Healing Intelligence). Finally, some of the most powerful proponents of psychedelic therapy explicitly aim at changing our collective form of life (e.g., MAPS founder Rick Doblin [16] recently expressed his hope that fully globalized access to MDMA-assisted therapy could lead to a world of net-zero trauma by 2070).

Approaching psychedelic therapies as forms of life calls for a broader conversation within and beyond clinical research. A recent notice of clinical funding opportunities by the US National Institute of Health emphasized that it "is essential to establish the optimal type of psychotherapy to use with a psychedelic drug" [68], but how to best (or simply appropriately) use psychedelics from a philosophy of life perspective should also be addressed by non-medical researchers and stakeholders because medicine is not in the business of evaluating forms of life. The psychedelic humanities, which include philosophy, anthropology, religious studies, literature, and more, can extend a much needed public debate beyond drug safety and therapeutic efficacy to questions of meaning and morals, of who gets access to psychedelics, etc. [30, 57, 58, 64].

If North America and Europe follow in the footsteps of Australia and approve psychedelics as medicines, one key question will be whether these very different places (often lumped together as "the West") will rally behind a uniform treatment model and thus behind a single form of medicalized psychedelic life, or whether regulatory approval opens the field for a diversification of psychotherapeutic applications. Will psychedelic clinics in Melbourne, Berlin, and New York institutionalize and disseminate the same or different values and philosophies, whether intentionally or unintentionally? Our comparison between "Western" psychedelic therapy and "Amazonian" shamanism highlighted that psychedelic knowledge and practice is very much place-based. As far as forms of life are concerned, one size might not fit all. If that was true, the quest for establishing best practices and treatment manuals to be adopted across the globe might turn out to be misguided. While

standardization has proved effective for surgical procedures or the treatment of heart disease, our argument that psychedelic therapies amount to forms of life suggests that they are inextricably entangled with ethical projects that by their very nature come in the plural. No controlled clinical trial will demonstrate the superiority of one over the other. If we are right about this, the introduction of psychedelics into the late modern pharmacopeia confronts the field of neuroethics with a psychopharmacological intervention that that should ultimately be evaluated as an integral element of entire forms of life.

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Data Availability This study is grounded on qualitative data obtained from interviews and an extensive review of published literature. The interview data that support the findings of this study are not openly available due to privacy and confidentiality considerations to protect the identities and sensitive information of the participants. The published literature that informs this study is fully cited and can be accessed through the references listed in the manuscript.

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