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Top Ten Tips Palliative Care Clinicians Should Know About Psychedelic-Assisted Therapy in the Context of Serious Illness

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Abstract

Psychedelic-assisted therapy (PAT) is a burgeoning treatment with growing interest across a variety of settings and disciplines. Empirical evidence supports PAT as a novel therapeutic approach that provides safe and effective treatment for people suffering from a variety of diagnoses, including treatment-resistant depression, substance use disorder, and post-traumatic stress disorder. Within the palliative care (PC) field, one-time PAT dosing may lead to sustained reductions in anxiety, depression, and demoralization—symptoms that diminish the quality of life in both seriously ill patients and those at end of life. Despite a well-noted psychedelic renaissance in scholarship and a renewed public interest in the utilization of these medicines, serious illness-specific content to guide PAT applications in hospice and PC clinical settings has been limited. This article offers 10 evidence-informed tips for PC clinicians synthesized through consultation with interdisciplinary and international leading experts in the field with aims to: (1) familiarize PC clinicians and teams with PAT; (2) identify the unique challenges pertaining to this intervention given the current legalities and logistical barriers;

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(3) discuss therapeutic competencies and considerations for current and future PAT use in PC; and (4) highlight critical approaches to optimize the safety and potential benefits of PAT among patients with serious illness and their caregivers.

Keywords: anxiety treatment; demoralization; depression; LSD; MDMA; palliative care; psilocybin; psychedelic-assisted therapy; psychedelics; serious illness

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Introduction

PSYCHEDELICS ARE ''MIND-MANIFESTING'' psychoactive substances shown to intensify sensory perceptions, alter mood, expand consciousness, affect cognitive processes, and elicit mystical experiences.[1,2] Emergent psychedelic science demonstrates promising outcomes for many of the psychosocial, spiritual, and existential challenges relevant for palliative care (PC) populations.[3–6] As the ''psychedelic renaissance'' evolves, both health professionals and the public are increasingly aware of the safety, efficacy, and indications for psychedelic-assisted therapy (PAT).[7] Psychedelic decriminalization is occurring internationally and will undoubtedly impact how PAT is accessed and utilized in PC practice.[8–10] In fact, the current research paradigm is on track to inform the rescheduling of these compounds and therapies for availability in PC within the next several years.

Conventional psychopharmacotherapies in PC may take weeks to prove efficacy, if at all, and then only with daily adherence to prescribed regimens.[11] By comparison, the PAT model has demonstrated the ability for a single dose and experiential session, embedded within a brief course of preparation and psychotherapeutic integration, to generate shifts in consciousness, provide personal meaning-making, and significantly and sustainably reduce depression and anxiety.[12] We provide expert- and evidence-informed tips to familiarize clinicians with key concepts and considerations to optimize PC for all potential PAT participants in the future.

Tip 1: An Evidence-Based Psychedelic Treatment Involves Medication and Therapy—the Psychedelic Agent Is Not a "Stand-Alone" Intervention

Psychedelic compounds belong to a variety of either naturally occurring or synthesized molecules that modify consciousness over a limited period of time (Table 1).[1,13] These molecules and the ''nonordinary state of consciousness'' they induce are not necessarily therapeutic by themselves and may be harmful or traumatic if not experienced in a conducive environment (see Tip 4 on ''set'' and ''setting'').[14] Thus, in a therapeutic context, psychedelics should not be used as a stand-alone treatment but as an adjunct to therapy for patients willing to engage in a reflexive, introspective psychological process while in a therapeutic relationship.[4] In this way, PAT is an extension of the holistic care, empathy, and guidance that PC clinicians already provide to patients, and offers a pathway to deepen the meaning and effect of this care.

PAT is informed by many traditions, practices, and theories rooted in indigenous medicines,[15] humanistic psychology,[16,17] somatic approaches (e.g., body-centered approaches),[18] existentially based psychotherapies,[19–21] and psychiatry and the neurosciences.[22,23] PAT requires trained facilitators to support and guide patients through the therapeutic process, which classically includes two to three preparatory sessions, one dosing session, and several postdosing (or integration) sessions.[18,24,25] All emotions and somatic sensations are welcomed and respected during PAT, including those often judged as negative or uncomfortable. Areas of psychological pain and suffering may emerge, but with therapeutic support, significant emotional healing may be experienced.[24]

Tip 2: There Is Strong Preliminary Evidence Showing PAT May Help Patients Cope with Serious Illness and Manage Anxiety, Depression, and Existential Distress

Data supporting the safety and efficacy of PAT to relieve suffering in patients with serious illness are robust. It includes findings from studies conducted before the 1970 U.S. Controlled Substances Act,[16,25–29] which criminalized psychedelics and hampered research for decades, and findings from psilocybin-, lysergic acid diethylamide (LSD)-, and 3,4-methylenedioxy-methamphetamine (MDMA)-assisted therapy trials published in the past decade.[12,30–38] Together, these studies provide a solid groundwork supporting the safety of PAT in the PC population. They also reinforce the potential efficacy of PAT to rapidly improve difficult-to-treat conditions such as anxiety, depression, and existential distress (in particular demoralization and death anxiety) and improve quality of life and spiritual well-being. Pain and adjustment disorders are other areas deserving further empirical exploration.[4]

To our knowledge, only one trial of psilocybin-assisted therapy in a carefully screened serious illness patient population has reported a drug-related serious adverse event (SAE) (e.g., severe anxiety exacerbation in one patient).[38] Other PAT trials in patients with serious illness have not reported drug-related SAEs to date, although adverse events (AEs) and SAEs related to the underlying disease have been described.[34]

The most common PAT-associated AEs are mild and self-resolve and include elevated heart rate and blood pressure, transient anxiety, headaches, and nausea. In the two most robust studies ($n = 29$ and 51, respectively), 80% of participants showed clinically significant decreases in depression and anxiety at six months and more than 60% achieved remission.[12,39] This therapeutic effect was mediated by the intensity of mystical states patients may experience during dosing sessions.[12,40,41] Long-term follow-up data (3.2 and 4.5 years) of 15 patients in one study indicate lasting remission in 60%–80% of participants, while 100% of patients endorsed the experience as spiritually significant.[33]

Tip 3: Careful Screening Is Required to Ensure Participant Safety and Eligibility for PAT

Researchers have generated promising data on the tolerability and safety of psychedelics, but PAT is not without potential harm.[31,42,43] In addition to the physiologic effects psychedelics produce, they have profound psychological effects, including increased suggestibility and the ability to

Table 1. Classic and Nonclassic Psychedelics[76,77]

Classic psychedelics (naturally occurring or synthesized from natural compounds)	
Psilocybin	Naturally occurring Schedule 1 tryptamine and 5-HT_{2A} receptor agonist found in many species of mushroom, used widely as a sacrament for spiritual healing, most notably among the Mazatec peoples of Oaxaca, Mexico
	Clinical and research use is favored due to the relatively short duration of action (four to six hours) and favorable safety profile with FDA Breakthrough Therapy designation in 2018
	Currently in phase 2 clinical trials for various mental health indications including major-depressive disorder, treatment-resistant depression, generalized anxiety disorder, and tobacco- and alcohol-use disorders
	PC indications currently in phase 2 study include cancer-related anxiety, depression, and demoralization at end of life as well as depressive symptoms in COVID-frontline health care workers
LSD-25	Schedule 1 chemical derivative from ergot alkaloid in 1938, but psychoactive properties were not discovered until 1943 ushering in the first wave of public and psychiatric interest and experimentation in psychedelics in the 1950s and 60s
	A 5-HT_{2A} partial agonist with additional 5-HT_{1A} agonism and dopaminergic effects, a duration of action of 8–20 hours may limit potential clinical applications
	Studies suggested benefit for pain, existential distress, anxiety, and depressive symptoms among patients with life-threatening illness
Ayahuasca	Traditional brew composed of *Banisteriopsis Caapi* vine and a variety of other psychoactive plant species, used ceremonially by Indigenous throughout the Amazon basin or within syncretic churches and increasingly in underground circles throughout Europe and North America
	It contains many psychoactive agents acting synergistically, most notably *N,N-Dimethyl*, *tryptamine*, or DMT (schedule 1) and a class of B-carboline compounds with MAO-I property allowing for oral bioavailability
Nonclassic psychedelics (not naturally occurring synthetic compounds)	
Ketamine	Schedule 3 dissociative anesthetic with NMDA antagonism and dopaminergic action
	May be administered via lozenge, intramuscular injection, intranasally, or by intravenous infusion at regular intervals and subanesthetic doses, with or without concurrent psychotherapy
	Racemic esketamine was FDA-approved in 2019 for use in treatment-resistant depression under the trade name, Spravato.
MDMA	Schedule 1 substituted amphetamine and empathogen, which stimulate release and reduce reuptake of the monoamines serotonin, dopamine, and norepinephrine while also increasing oxytocin levels
	Under investigation in Phase 3 clinical trials as an adjunct to psychotherapy for the treatment of various anxiety-related conditions, most notably post-traumatic stress disorder receiving the FDA Breakthrough Therapy designation in 2017
	Phase 2 clinical trials suggest benefit in terms of anxiety reduction among patients with life-threatening illness

NB: schedule I substances are illegal outside the research context in the United States.
FDA, Food and Drug Administration; MAO-I, monoamine oxidase inhibition; MDMA, 3,4-methylenedioxy-methamphetamine; NMDA, N-methyl-D-aspartate; PC, palliative care.

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alter one's ego structure and shift one's worldview.[44,45] As PAT is embedded in the context of psychotherapy, patient safety is not simply a matter of proper screening and safe drug dosing, but requires ethical therapists with strong therapeutic boundaries practicing within their professional scope.[18] Furthermore, existing clinical trials have used rigorous screening of potential participants and extensive exclusionary criteria that—in their current iteration—may limit the applicability of psychedelics in seriously ill patients receiving PC.

Potential PAT participants must be assessed based on their mental and physical health. Prior clinical trials of psilocybin-assisted therapy and MDMA-assisted therapy exclude patients with severe cardiovascular disease, including uncontrolled hypertension and prolonged QTc,[46] as well as significant renal and hepatic impairment.[47,48] Individuals with cancer metastatic to the brain or primary brain disease,[49] as well as patients with a personal or family history (first degree relative) of psychotic disorders or bipolar illness, were also excluded from participation. Given that psychedelics may produce profound visual and sensory changes, there is concern these substances may trigger psychotic or manic episodes in individuals who are predisposed.[50]

Apart from these clinical trial exclusion criteria, PAT trials often exclude patients at the judgement of investigators or study facilitators. Subjective exclusion is typically for participants perceived as not having a stable sense of self or who are at risk for not developing therapeutic rapport with facilitators. Therefore, facilitators with a keen ability to recognize psychopathology are critical to safety. While more work is needed to understand the personality traits that place individuals at risk of harm from PAT, existing research recognizes the role that neuroticism has in predisposing participants to challenging psychedelic experiences (e.g., ''bad trips'').[51] Larger trials are needed to better understand the patients best served or potentially harmed by PAT.

Tip 4: "Set" and "Setting" Are Foundational Components of Safe and Supportive PAT Environments

''Set'' and ''setting''[52] are cornerstones of PAT safety.[14] ''Set'' is defined as an individual's mindset and intentions

Table 2. Set and Setting: Extrapharmacological Factors Impacting the Psychedelic-Assisted Therapy Experience

(Mind)set	Personality, personal narrative, and biographical meaning-making
	Preparation in the art of ''navigating in the internal world'' with strategies for managing challenging experiences as they arise through grounding or mindfulness techniques
	Expectations create the context, and clear intention setting establishes a focal point for the unfolding experience
Setting	Trained facilitators (often working together in dyads) establish interpersonal grounding and empathic abiding presence to serve as a safe container for vulnerability and emotional expression
	Therapeutic space is often supported by gentle instrumental music to create structure and flow to the experience while providing psychological input and support
	Physical space should provide safety, comfort, and minimal noise and distraction
	Social and cultural environment is established by the medicalization and demedicalization of the interactions between the participant, environment, and facilitators

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when engaging in PAT and ''setting'' is the physical and psychological environment in which PAT takes place. In short, the PAT intervention should not be misunderstood as psychedelic medicine administration without attention to context as contextual factors such as preparation, patient intentionality, facilitator/client relationship, and a physically safe and therapeutic space all drive the overall PAT experience (Table 2).

PAT facilitators must consider what the patients are bringing with them into the experience to cocreate the ideal set (e.g., immediate life situation, current stressors, specific intentions, social support, worldview, understanding of self and others, core beliefs, capacity to trust, let go, be open, and readiness for engaging psychedelics). Ultimately, there is an art to ''navigating in the internal world'' that is taught by the facilitator during preparatory interviews. With that knowledge and honed intention, the facilitator can validate patients' worries and encourage them in overcoming fears and challenges that may emerge.

The PAT dosing session is ideally delivered in a setting that minimizes medicalization of therapy (e.g., similar to a clinical psychologist's treatment space vs. medical examination room). Participants must perceive that they are in a safe environment to minimize distress during the experience. In most PAT studies, the sessions have included two clinicians—at least one primary facilitator (guide) and an additional sitter (witness). Because participants have taken a psychoactive substance, they are extremely vulnerable during PAT. Having an additional person present as a witness to ensure safety and the respect of both patient and facilitator boundaries is essential for the protection of all involved. Despite the two clinician norms in clinical trials, group processes are increasingly investigated as potentially more scalable delivery models.[38,53,54]

The environment should be both physically comfortable and comforting and include limited noise and distractions, licensed clinical staff who are accountable for all actions, and clear procedures to handle potential medical or psychiatric complications. It is the staff's responsibility to earn patient trust and to discuss anxiety, paranoia, ontological shock, and how to manage challenging moments. Pain and anxiolytic medicines should be available as needed, music playlist should follow a psychedelic's pharmacokinetic profile and should be meaningful, and adequate fluids, snacks, and a change of clothes should be available.

Tip 5: Become Familiar with the Logistics Regarding Legality and the Structural Barriers Impacting Access to PAT

In the United States (U.S.), the majority of psychedelics are recognized as Schedule I substances and thus are illegal outside of clinical trial applications or religious ceremony use.[55] However, several U.S. cities and countries outside the U.S. have begun to decriminalize the possession and use of certain psychedelics.

Oregon is the first U.S. state to fully legalize therapeutic psychedelics. Some patients may have participated in PAT from another provider and seek further integration work from their current care team. This fluidity of patients heightens the need for PC clinicians to understand psychedelic experiences and their structure and assist patients in limiting potential harms of psychedelic use (e.g., by providing advice on set and setting or integration guidance), much as clinicians may do for patients using other controlled substances.[56] Furthermore, clinicians are urged to have a firm understanding of their local, state, and federal laws regarding the use of psychedelics, in addition to their professional association's guidelines regarding providing medical advice on treatments that remain illegal.

Given the current legal status, PAT access is limited for the majority of individuals. In addition, some groups face greater challenges in accessing PAT. For instance, modern academic PAT research has not engaged Black, Hispanic, Indigenous, and Persons of Color, limiting the generalizability of results to date.[57,58] The lack of diversity within the PAT field has been recognized and efforts have been initiated to better address barriers to participation.[59] Proposed areas of focus include building treatment teams with diverse backgrounds, community engagement, justice, equity, diversity, inclusion training, and development of culturally informed approaches to participant recruitment and treatment.[15,57,59]

A key component of promoting inclusion within PAT among seriously ill patients is the need to understand and respect patients' different cultural and religious attitudes toward death and the hereafter, psychedelics, and nonordinary states of consciousness while also addressing cultural differences surrounding preferences and expectations for care.[60–62]

Tip 6: PAT May Be a Useful Intervention for Patients with Serious Illness, as well as Their Family Members, Caregivers, and Loved Ones

PAT may offer help and healing beyond just the index patient. There is a need for caregiver-focused PAT

research.[63] PC philosophy attends to patients and families as a unit of care, be they families of origin or chosen families.[64] To date, PAT research has not explored the potential benefit of PAT for caregivers in serious illness care, although this may be an important next step.[65] Exploring the impact of PAT on caregiver distress, depression, anticipatory grief, and bereavement might assist us to better understand the impact of PAT on the larger population impacted by serious illness and loss.

Caregivers' ability to achieve positive outcomes associated with PAT—acceptance, meaning-making, and spiritual transcendence—may offer assistance to loved ones who face anticipatory grief, distress, and burden in the course of a serious illness journey. Pediatric PC providers should be aware that PAT, even if not approved for children younger than 18 years, could still be deployed in the future to help parents or family members who might be struggling during a child's serious illness trajectory.

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Tip 7: It Is Essential for PAT Facilitators to Develop Therapeutic Presence, Self-Awareness, and Self-Reflection and Healing Practices—Beyond What Is Typical for PC Clinicians

Psychedelic medicines can blur boundaries between self and other, highlighting the importance of a supportive, responsible, and present facilitator/guide.[66] PAT facilitators must therefore be active participants in their own personal and professional development. While the mechanics of PAT sessions may be well-defined in published research protocols, the facilitator role is nuanced. Successful facilitators maintain self-awareness to guide without imposing and are knowledgeable of transference/countertransference dynamics.[18,66] They are attuned to their own attitudes surrounding illness and death while cultivating a sense of openness, equanimity, joy, and nonjudgement.

In addition, facilitators should be committed to lifelong examination and transparency regarding self-held biases, prejudices, and stereotypes about marginalized groups or risk impairing the treatment process.[67] Core competencies for students within PAT training programs have been proposed to develop many of these essential skills and create healing therapeutic alliances built upon safety and trust (Table 3).[18]

To bring an authenticity, attentiveness, and presence to PAT, facilitators should maintain self-care practices that are personally meaningful (e.g., meditation, journaling, gardening, creative expressions, and acts of service). In addition, facilitators serving an active role in PAT may draw upon their own guided experiences with nonordinary states of consciousness to further cultivate trust and empathy.[18,66]

In the case of MDMA-assisted psychotherapy training, facilitators have been able to gain personal experience with the medicine in a guided setting via enrollment in a clinical trial.[67,68] This model may be emulated within training programs involving other psychedelic medicines. If legal access is not possible, knowledge of alternate states of consciousness may be cultivated through deep meditation, fasting, breath work, or solitude experiences. Finally, partnership, mentorship, and supervision are important to ensure good practice, accountability, continued growth, and commitment to the highest ethical standards within the field.[18]

Tip 8: It Is Ethically Incumbent on Providers to Honor Indigenous Traditions That Inform Psychedelic Heritage

Psychedelic medicine cultures are rooted in the healing and spiritual practices of Indigenous peoples.[15,18] Examples of Indigenous cultures with long-standing knowledge of medicines that are the subject of modern psychedelic clinical trials include the following: Mazatec people in Mexico (psilocybin-containing mushrooms), members of the Huichol culture in Mexico and the Native American Church (mescaline-containing peyote cactus), Huni-Kuin people in Brazil (ayahuasca), and adherents of the Bwiti religion in west-central Africa (ibogaine-containing shrub). As psychedelic medicines are developed, providers are charged with understanding the Indigenous origins and the significance that they may carry.[15]

Members of Indigenous communities who have cultivated practices involving psychedelic compounds should be considered important stakeholders, partners, and teachers in the field.[15,57,69] Humility and respect should be prioritized when working with psychedelic medicines, as what can be seen as a novel treatment modality to an allopathic provider may carry sacramental importance for others. Doing so may promote equity while facilitating better science with thoughtful, just, and nonextractive consideration of Indigenous wisdom. Ways to acknowledge the debts to Indigenous traditions and meaningfully incorporate reciprocity in the PAT model are still works in progress.

Tip 9: Given the Person-to-Person Variability of Response to These Agents, Expect Participants' Healing Processes to Be Nonlinear; Expect the Unexpected

While common themes have been uncovered across many PAT experiences,[33,36] it is well-documented that PAT may yield a wide range of responses, from subtle and gentle to monumental and transformative.[70] Nonordinary states of consciousness, such as those experienced in PAT, can catalyze profound insight, yet these healing processes are often nonlinear. This nonlinearity may present as profound shifts in symptoms within a short period of time, apparent regression as part of the process, and unexpected healing pathways being revealed. Working with nonordinary states of consciousness, including PAT, requires both facilitators and participants to cultivate trust in inner healing intelligence. It has been observed that if the psyche is allowed to follow its own natural course toward healing, participants can experience a meaningful progression of memories, feelings, images, and somatic experiences that will guide them toward resolution of symptoms and psychological growth.[71]

Suspending judgments, practicing patience, and working directly with ''what is'' in the present moment can support the unfolding of these unique PAT experiences.[72] Evidence supports PAT's efficacy in increasing trait openness and cognitive/psychological flexibility, which may act as a mediator of therapeutic outcomes.[73] This increased flexibility may open participants to new insights and transformations both during PAT sessions and in ongoing integration.[74] Thoughtful facilitation of integration sessions may include meaningful conversation about a participant's illness, life,

Table 3. Competencies of the Therapist Guide for Psychedelic-Assisted Therapy (Adapted from Phelps[18])

Competencies	*Concepts adapted from Phelps*[18]	*Considerations for PC clinicians*
Empathic abiding presence	''empathic responsivity that has been leavened into a cultivated embodiment of a calm, abiding presence during [PAT]; 'abiding' here is purposely used to convey aspects of a witnessing of the mystery of life in action during [PAT]''	PC clinicians bear witness to the suffering of patients with serious illness and practice the same ''unconditional positive regard'' regardless of a patient's treatment choices or goals of care. Our role is in supporting patient's decisions, rather than imposing a belief system or treatment agenda.
Trust enhancement	''enhancing trust in three areas: the volunteer's view of the therapist as a trustworthy guide; the participant's trust in their own inner healing capacity; and the ability to reliably normalize for the participant that paradoxical transformations and radically unexpected moments in sessions are to be expected''	Trust is the bedrock of therapeutic relationships. PC clinicians build trust through active listening, attunement with patients, and validating distress. Primary goals in PC often include encouraging patients to trust their experiences, providing education around symptoms and a patient's own internal state, and preparing them for what they might face during illness.
Spiritual/transpersonal intelligence[78]	''knowledge and values that be described as a spiritual intelligence that 'goes beyond conventional psychological development. In addition to self-awareness, it implies awareness of our relationship to the transcendent, to each other, to the earth and all being'''[79]	PC clinicians work closely on teams with spiritual care providers and assess and refer for spiritual distress. PC clinicians may feel more comfortable speaking about a patient's spiritual experiences during illness and express an openness to the unknowable quality of what happens at the time of death.
Knowledge of the physical and psychological effects of psychedelics	''components of this expertise range from knowledge of the anthropology of shamanism; neurobiology; neuropharmacology; and drug dispositions; skills in the creation of safe and artful sets and settings; and optimally, knowledge from subjective, phenomenological experience of personal [PAT]''	PC clinicians are experts in symptom management and incorporating knowledge of medications frequently used off-label in the management of several symptoms, as well as incorporating nonpharmacologic management where feasible and appropriate. PC clinicians would need to learn about the effects of psychedelics, much like they are required to learn about the multisystem effects of other potentially consciousness altering medications used regularly in PC (e.g., opioids, benzodiazepines, and antipsychotics) while incorporating awareness of and sensitivity to the phenomenological experience of taking such substances.
Therapist self-awareness and ethical integrity	''relates to six components of the therapist's acumen related to: self-awareness of personal motives for this work; integrity in protecting boundaries with the volunteers; well-developed capacities for building therapeutic alliances; skills in attachment theories, and transference-countertransference analysis; and personal self-care (which protects both the therapist guide and the volunteers).	PC clinicians receive specialized training in communication skills and frequently approach practice with a deep desire to holistically care for patients. Most PC clinicians do not receive specialized psychotherapy training, but the core principles of psychotherapeutic practice such as recognition of boundaries, attachment, and transference/countertransference are directly applicable to PC work.
Proficiency in complementary techniques	''skills and knowledge that form a toolbox of complementary therapeutic methods to use in various phases of the therapy and research… [these may include] Holotropic Breathwork; stress inoculation, therapeutic body work, and touch; techniques of eye-gazing at a mirror or with the therapist; felt sensing and focusing; and somatic experiencing and sensorimotor therapies''	PC embodies the whole-person approach in medicine, frequently using the ''total pain'' paradigm of symptom management to identify sources of distress. This same approach can be modified to think about sources of potential healing and therapeutic methods to support patients in their illness journey.

PAT, psychedelic-assisted therapy.

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and healing process, as well as somatic practices. It is vital to cultivate trust in the organic, nonlinear unfolding healing process, letting go of expectations and practicing being present with ''what is.'' Gaining trust in one's own healing intelligence can be a foundational part of successfully supporting the nonlinear nature of PAT experiences.

Tip 10: Allow for an Inner-Directed Approach and Intentional Guidance to Support the Highly Unique and Personal Nature of Each PAT Experience

Contrary to many standard therapeutic techniques, PAT calls for a nondirective, or more aptly named ''inner-directed'' approach. In this approach, facilitators support and encourage the innate healing process of the participants they are working with, rather than imposing their own expectations of how the process ''should'' unfold.[72] In an inner-directed approach, the locus of therapeutic action is centered within the participant rather than the facilitators.[75] In practice, this may look like stretches of time where participants are encouraged to ''go within,'' being present with their inner experience. This approach requires a strong therapeutic relationship and ongoing trust of the participant's innate healing intelligence.[18]

The importance of a trusting relationship between facilitators and participants cannot be overstated. The therapeutic alliance can be nurtured throughout the PAT process by cultivating an empathetic abiding presence, genuine curiosity, explicit practices of consent, and recognition of shared humanity between a therapist/facilitator and the participant.[66] It may be tempting for facilitators to have a fixed set of beliefs about how a PAT session will go, yet holding these expectations lightly and tracking the natural unfolding healing process can be powerfully supportive.

Interventions may be necessary to maintain the safety of participants, and active guidance may be offered to question, redirect, or provide support throughout the process, although guidance is to be offered in the spirit of collaborative inquiry and invitation is recommended.[75] An open, welcoming, nonjudgmental stance seems to optimally support the highly unique and personal nature of each PAT experience and is philosophically aligned with PC.

Conclusion

PAT is quickly gaining appeal as a potentially novel, safe, and effective therapy that addresses the psychological, spiritual, and existential distress commonly experienced by patients with serious illness. However, this treatment modality requires unique considerations and preparation of the patient as well as the provider not seen before in PC interventions. An understanding of this therapeutic process is necessary for all PC providers, whether they are involved in directly providing PAT themselves or supporting patients who have participated in PAT in other contexts. As interdisciplinary PC teams integrate PAT knowledge within their work, the PC culture at large can proactively create models of care that optimize the potential PAT benefits for the patients we serve.

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