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Importance of Integrating Spiritual, Existential, Religious, and Theological Components in Psychedelic-Assisted Therapies

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IMPORTANCE Mounting evidence supports the role of spiritual, existential, religious, and theological components in mediating psychedelic-assisted therapy, yet integration of these elements into the clinical setting is lagging

OBSERVATIONS Although psychedelic-assisted therapy commonly produces spiritually, existentially, religiously, or theologically relevant experiences for patients, these have not been systematically integrated into the psychotherapies that accompany therapeutic uses of psychedelics. As a key feature and potential mediator of therapeutic effects, evidence-based psychedelic-assisted therapies should include these topics in the treatment model. Research across multiple diagnostic targets and treatment contexts suggests that spiritually integrated psychotherapies are effective, feasible, and produce add-on benefits in spiritually, existentially, religiously, and theologically relevant outcomes, which are particularly germane to psychedelics. Established standards in spiritually integrated psychotherapy may be fruitfully applied to psychedelic-assisted therapy. Objectives for spiritually, existentially, religiously, and theologically integrated psychedelic-assisted therapy based on these standards and informed by considerations specific to psychedelics are recommended.

CONCLUSIONS AND RELEVANCE Spiritual, existential, religious, and theological topics' integration in psychedelic-assisted therapy is needed to ensure culturally competent, evidence-based treatment aligned with the highest standards of clinical care. Neglecting to address these topics can detract from cultural competence, contribute to risks for patients, and potentially undermine treatment success.

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Despite recent application and research within medical settings and a far longer history of therapeutic use outside of Western medicine, psychedelic-assisted therapies (PATs) are currently considered an experimental rather than an established treatment.[1] Nonetheless, PATs show increasing potential as effective treatments for multiple difficult-to-treat conditions. PATs typically involve supervised administration of a psychedelic drug (eg, serotonin 2a agonists, such as lysergic acid diethylamide [LSD] or psilocybin), in conjunction with behavioral support or psychotherapy. Although there is consensus that psychotherapeutic treatment should accompany psychedelic administration, the nature of the psychotherapy is often omitted from trial reporting, and there is little agreement about the nature, components, and duration for such treatment.[2] To achieve an evidence-based, effective PAT, the psychotherapeutic components of treatment must be clearly specified, rigorously tested, tailored to mediators and moderators of response, and optimized for safety. This Special Communication argues for the integration of strategies that address spiritual and existential concerns within PAT based on the prevalence and importance of spiritual, existential, religious, and theological (SERT)[3] experiences in PAT and mounting evidence supporting their mediating role in psychedelic-induced therapeutic change. We propose objectives for SERT-integrated PAT based on evidence and best practices, benefitting from decades of research on spiritually integrated psychotherapies.

SERT Experiences are Prevalent Phenomena and Potential Mediators of Efficacy in PAT

A large amount of literature documents the consistent presence of SERT experiences in PAT, often focusing specifically on mystical-type experiences. The diversity and impact of these experiences is beyond our present scope, but they are richly described elsewhere.[4] Mystical-type experiences can be considered a subset of SERT experiences, specifically as phenomenological states whose characteristics include changes to sense of self, meaningfulness, and connectedness,[5] which acquire existential, spiritual, or religious primacy for individuals or communities. We use SERT as a framework within which to locate mystical-type experiences and other existentially[6] or spiritually relevant phenomena (**Table**) because (1) it includes the values, meanings, and communal contexts that precede and follow the acute phenomenology of PAT, (2) there is consistent evidence for spiritually and existentially integrated (non-psychedelic) psychotherapy that addresses SERT dimensions, and (3) the SERT dimensions are applicable across diverse religious

Table. SERT Components and Their Application in PAT[a]

SERT component	Spiritual	Existential	Religious	Theological
Definition	A concern and relationship with that which is deemed sacred. Spiritual experiences are encounters with sacred domains of life. Spirituality does not presume the sacred to be supernatural and includes (but is not limited to) mystical-type experiences. Although spirituality is often a part of religious life[3] and the 2 constructs are closely related, it is possible to have spirituality without being religious and vice versa.	Questions, motivations, and anxieties that have to do with the experienced limits of human existence, including mortality, connection, uncertainty, and freedom.[6] These existential concerns coalesce around a need for meaning in life, which is supplied by religious and secular worldviews.	Traditional, institutional, and culturally established ways of engaging with the sacred or spiritual. Religions include elements such as communities, collectives, norms, theologies, and practices that develop over time, and they also include individuals' relationships with these elements.	Symbolic, philosophical, or intellectual engagement with meaning systems related to sacred, spiritual, or religious concerns. Theology may be considered the aspect of religion that explains the world, presents an understanding of the divine or transcendent (understandings that evolve through history), and which guides action based on these understandings.
Application to PAT	Studies reliably indicate that acute experiences induced by psychedelics are perceived to have great spiritual significance. Assessing for uplifting or distressing spiritual experiences, and helping patients integrate them, may be especially relevant in PAT compared with other pharmacological treatments (eg, antidepressants).	PATs' impact on existential meaning making has been suggested as an important mediator of their therapeutic effects.[7] Psychedelics' acute and long-term effects can both bolster and undermine individuals' sense of existential security. PAT should support existential inquiry while avoiding destabilization. When patients experience difficulty with existential challenges in PAT, therapeutic techniques that promote existential security (eg, bolstering interpersonal connectedness) may help individuals navigate existential distress.	Patients frequently report religious dimensions to their psychedelic experiences, and psychedelics have historically been administered in religious, ritualized settings. When patients are in a vulnerable state in PAT, it is important for facilitators not to impose their own religious worldviews on that experience. For example, a patient who has disaffiliated with a faith tradition may still experience imagery related to that tradition, but this does not mean that the therapist should impose that tradition in processing the patient's experience.	Although theological questions and categories are often important for patients (eg, Where is God in this illness?), PAT may make theological questions even more salient (eg, in experiences deemed to be supernatural). To skillfully engage with the client's theology in PAT, facilitators must be able to explore theological meanings and provide support for patients to feel safe to explore questions without imposing on patients' value systems.

Abbreviations: PAT, psychedelic-assisted therapy; SERT, spiritual, existential, religious, and theological.

[a] The SERT framework was developed by a team of clinician-researchers, primarily at the Danielsen Institute, and comprehensively reflects the expression of spiritual, existential, religious, and theological priorities and needs by psychotherapy clients across a range of models.[3] We are indebted to this concise and useful framework for delineating relevant issues in PAT; definitions of its comprised constructs are more complex than this brief Table allows, and we refer readers to chapter 1 of Sandage et al[3] for a detailed discussion of these constructs and their relationships.

and nonreligious populations. Notably, the SERT framework does not take a position on the veracity of any particular worldview or its supernatural elements. Rather, this framework recognizes that SERT dimensions are often relevant to health and should therefore be addressed within the pluralistic environments of contemporary medicine, such that patients of all religious backgrounds (including atheism or no religious beliefs) are responded to competently.[8] This consideration is especially salient for a treatment such as PAT, which frequently activates SERT concerns.

SERT experiences are important not only because they are common in PAT, but also because of their potential role as treatment mediators. Careful attention to mediators of therapeutic change is crucial for the development and optimization of effective behavioral treatments. As examples, recognizing the mediating role of parent behavior in developmental psychopathology, and of rapport building in psychotherapy, has been pivotal for the development of evidence-based treatments insofar as this enabled the incorporation of these mediators into treatment models.[9] As noted by Kazdin, "If we know how changes come about, perhaps we can direct better, stronger, different, or more strategies that trigger the critical change process(es)."[9(p4)] Just as neglecting rapport or parental involvement can lose opportunities for treatment gains by excluding important mediators from the therapy, it would be a setback if PAT crystalizes into forms that neglect SERT dimensions.

SERT experiences have emerged as common phenomena across PATs,[10] with substantial evidence for SERT experiences as potential mediators of therapeutic effects. Indeed, 66% to 86% of individuals who have taken psychedelics in a therapeutic setting reported the experience as among the most spiritually meaningful in their lives.[7] There is evidence of a dose-response relationship of psychedelics with the intensity of mystical-type experiences and of associations between SERT experiences and symptom improvement in PATs across different medical and psychiatric conditions.[5,11] This evidence has led to increased recognition of SERT-relevant experiences as a priority in understanding how psychedelics work and for conceptualizing their outcomes.[12] A recent systematic review focusing explicitly on mystical-type experiences as mediators of therapeutic change found associations between PAT-induced SERT experiences and outcomes in cancer-related distress, treatment-resistant depression, and substance use disorders.[5] There is also evidence that psychedelics elicit changes in metaphysical beliefs and that the effectiveness of PATs can to some extent be attributed to these metaphysical insights.[13,14] On the other hand, some have argued that subjective experiences represent a third variable related to, but unnecessary for, an actual, entirely biological mechanism of action in PAT (eg, neuroplasticity[15]). From this perspective, subjective experiences are conceptualized as epiphenomena of psychedelic dosing, akin to the vivid dreaming that may emerge with antidepressant medication,[16] notable to the patient but irrelevant to recovery. However, the great sense of importance that patients attribute to SERT experiences and the lasting impact of psychedelic-induced experiences for better or worse among patients suggests

a high bar for the kind of neurological reductionism required to ignore these experiences within the context of a therapeutic model.

Toward SERT Integration in PAT

If SERT dynamics emerge as mediators in PAT, then they should be integrated into PAT in a systematized, nonsectarian (ie, pluralistic), and scalable way, as is appropriate for any treatment mediator in evidence-based psychotherapy. Here, integration refers to the adoption of strategies for competently and therapeutically responding to SERT content when it emerges, rather than the imposition of SERT beliefs on patients. Unfortunately, although the clinical importance of SERT experiences is widely acknowledged in PAT treatment manuals, facilitator training, and research methodology, SERT components in PAT have not been systematized and their appropriate administration remains to be clarified. A systematic review of psychotherapies used in conjunction with PAT observed a notable lack of consistency among the psychotherapeutic components of PAT,[17] with 45% of identified studies omitting a psychotherapeutic protocol altogether. Another review, focusing on SERT mediators of PAT, examined the treatment modalities used in 10 studies.[5] Across these 2 reviews, there were several trials that included SERT-relevant components. Rothberg et al[18] used motivation enhancement, relaxation, and mindfulness before and after PAT; 2 trials[19,20] included integrative approaches during follow-up; Ross et al[21] offered medication-assisted psychotherapy, which integrates elements of existential psychotherapy, cognitive behavioral therapy, and psychodynamic therapy and encourages patients to bring items with spiritual or personal significance to the treatment. Another protocol, ketamine-enhanced psychotherapy,[22] describes an existential psychotherapy approach and devotes 1 of 3 preparatory sessions to forming a psychospiritual goal.[23] During psychedelic administration, only nondirective support or no support were offered across all trials.

There is currently little guidance on how, why, when, or for whom SERT components should be addressed in PAT.[17] Brokering the role of spirituality is frequently left up to the treatment developers or individual clinicians, who often lack training in culturally competent spiritual care. Ad hoc therapies with psycho-spiritual components that are not based on evidence, or even on best practices in spiritually integrated care, run the risk of inadvertently imposing therapist- or treatment-related worldviews on patients. This issue is especially concerning in light of evidence that psychedelics may increase suggestibility.[24,25]

These concerns have led some to recommend avoiding SERT components in PAT altogether.[26] However, evidence from other modalities and populations suggests that this only displaces the navigation of spirituality and other cultural concerns onto patients and individual therapists. As illustrated by Goodman,[27] any therapy, including those described as culturally neutral, implies epistemic and linguistic frameworks that patients are incentivized to adopt. For example, cognitive behavioral therapy, despite assertions of cultural neutrality, has exhibited challenges to cultural and spiritual acceptability with Native American populations because its treatment models often contradict or ignore important cultural priorities.[28,29] Ignoring issues of cultural and spiritual importance in evidence-based treatments does not make these issues go away. Without adequate attention, biases toward and against SERT perspectives can enter, and detrimentally affect, psychotherapy.[30] Somewhat paradoxically, because PAT can make SERT issues salient, a protective measure against unethical imposition or coercion along religious lines is to develop systematic, deliberate ways of engaging with SERT issues that respect patients' autonomy in a pluralistic treatment setting.[31,32] Such a strategy would be consistent with best practices in other evidence-based treatments.[31]

Drawing on SERT-Integrated Psychotherapy Research to Support PAT

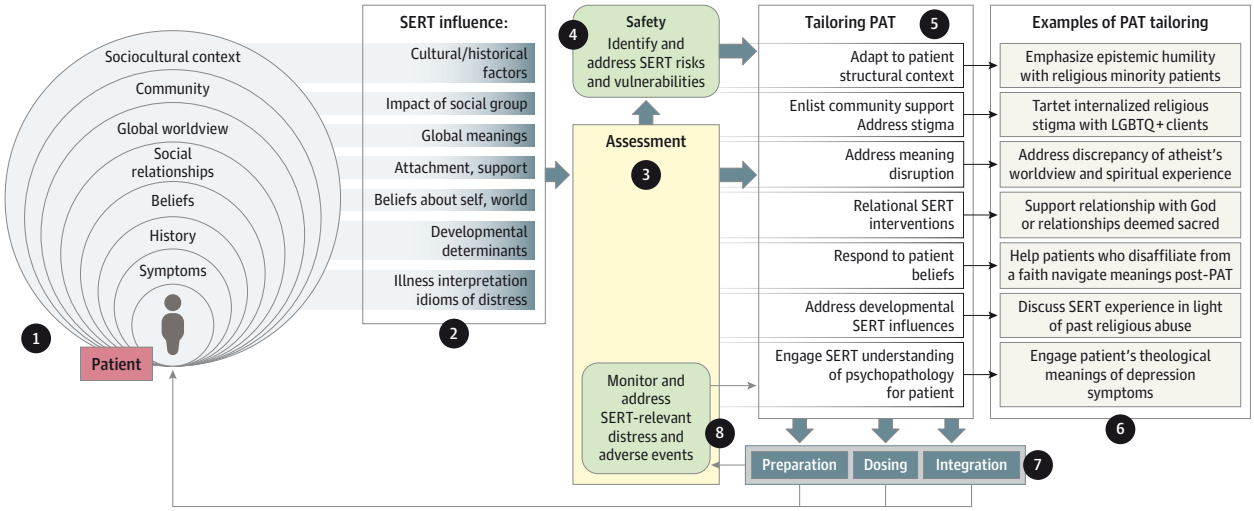
SERT-integrated psychotherapies, including SERT adaptations of evidence-based treatments, have an established evidence base.[33,34] A recent meta-analysis of 97 studies of religiously and spiritually integrated psychotherapies (N = 7181) found that SERT-integrated psychotherapies were superior or equivalent to nonintegrated therapies for improving mental health outcomes, with add-on benefits for improving SERT-relevant outcomes.[33] A systematic review of SERT-integrated psychotherapies in real-world settings observed effective applications for trauma, eating disorders, severe mental illness, and depression.[35] There is also evidence for successful application of SERT-integrated psychotherapies in cancer survivorship[36] and palliative care.[37] These treatment domains overlap with established targets for PAT research,[38] suggesting readiness for systematic approaches to SERT in PAT. The add-on benefits of SERT-integrated psychotherapies for SERT-relevant outcomes are particularly germane to PAT, in which these outcomes appear to play an especially important role.

Spiritually integrated psychotherapy is also an important component of culturally competent care.[39] In a landmark clinical consensus article, Vieten and Lukoff[31] outline spiritual and religious competencies for psychologists within a cultural competence framework. Empirically derived from decades of research in spiritually integrated clinical care, these competencies comprise domains including attitudes, knowledge, and skills necessary for the provision of SERT-integrated psychotherapy. Consistent with these competencies, we do not advocate for uniform inclusion of SERT content for all patients receiving PAT. However, because SERT topics are often highly salient in PAT and may constitute key mediators, PAT should at minimum uphold these competencies by addressing SERT content when it occurs.

SERT Considerations Can Improve Adverse Events Monitoring

Identifying, measuring, preventing, and addressing adverse events in PAT is necessary to strengthen the therapeutic potential of these interventions. Unfortunately, to date, adverse events measurement has been limited to standardized clinical trial harms reporting, self-report survey research (with attendant susceptibility to measurement and reporting bias), or brief assessment of deterioration during or directly after a trial.[40] Further, despite observed reports of psychospiritual distress,[41] these are rarely included in the reporting of adverse events in PAT. Adding complexity to the challenge of adverse effects in PATs is the common impetus to characterize distressing experiences as beneficial.[42] Psychedelic users and participants in PAT trials may retrospectively indicate that distressing, emotionally painful experiences during psychedelic dosing were ultimately positive and relevant to their growth.[43] If patients achieve

Figure. Integrating Spiritual, Existential, Religious, and Theological (SERT) Domains in Psychedelic-Assisted Therapy (PAT)



A framework for SERT-integrated PAT is illustrated here, focusing on different stages of the therapy. (1) Patient factors relevant to biopsychosocial-spiritual treatment are represented, beginning with idiopathic presentation of symptoms and extending through the broader sociocultural context of the patient's life. (2) SERT influences operating on each of these patient factors are highlighted. These SERT influences are a focus for psychological assessment (3), which seeks to identify the ways in which SERT concerns are pertinent for patients with any religious or nonreligious worldview. Information gathered from this assessment can be used to improve the safety of the intervention (4), identifying potential areas of vulnerability (eg, spiritual struggle, religious abuse, stigma), and ensuring the patient is supported in those areas. The assessment also informs treatment planning and tailoring the PAT (5) to incorporate SERT issues that relate to different patient factors. (6) Further examples of tailoring relevant to each patient factor are provided to the right (eg, at the community level, a client who is lesbian, gay, bisexual, transgender, queer or questioning, and more [LGBTQ+] who are part of a nonaffirming religious congregation is at greater risk for religious struggle; this aspect of community may be balanced by affirming spiritual health clinicians). Tailoring can inform each stage of therapy, including (7) preparation, dosing, and integration. (8) SERT-relevant distress and adverse effects are monitored throughout the process and addressed within or after the therapy as appropriate.

positive outcomes, such distressing experiences may ultimately be framed as challenging and transformative; indeed, it is important to acknowledge this potential path for growth. However, some researchers have extended such positive conceptualizations to mean that subjective negative experiences, or so-called bad trips, should a priori be understood as intrinsically valuable occurrences rather than adverse events.[44] However, to our knowledge, there is no evidence of distressing experiences positively mediating therapeutic effectiveness in PAT. Further, such interpretations, made on behalf of patients by interventionists, risk erasing the experiences of those who report emotional and spiritual harms, thereby risking additional harms to patients undergoing PAT. SERT-integrated therapy principles may help to (1) acknowledge distressing experiences, especially with relevance to enculturated understandings of psychospiritual distress, (2) support patients in transforming them into therapeutic and growth experiences, and (3) avoid imposing redemptive narratives on behalf of patients for whom such narratives do not feel authentic.

Recommended Objectives for SERT-Integrated PAT

It is now possible to draw on the extant empirical literature, as well as models of SERT-integrated interventions (eg, spiritually integrated psychotherapy[45] and the relational spirituality model[3]) to begin to establish the desirable characteristics of SERT-integrated PAT (**Figure**). Ideally, SERT-integrated PAT should retain the transtheoretical orientation of existing SERT-integrated psychotherapies, such that "virtually any psychotherapeutic tradition—psychodynamic, cognitive-behavioral, family systems, humanistic, and existential"[46(p161)] would include competency in spiritual approaches. At the same time, SERT-integrated PAT should be directed toward achieving the following objectives.

SERT Responsiveness

SERT-integrated PAT should be responsive to the spiritual and existential concerns and sensitivities of patients based on an understanding of the broader communities and relational contexts within which these concerns inhere and evolve. Accordingly, PAT clinicians should be trained to recognize and respond to SERT concerns in a culturally sensitive and supportive way. This means not only responding to the needs of religious and atheist patients, but also addressing the real possibility of challenges associated with religion, including harms that patients may have experienced in association with religion or spirituality. Following Palitsky and Kaplan's[32] application of the cultural competence principles introduced more broadly by Whaley and Davis,[47] PAT should recognize "that individuals' religious priorities (a) reflect their embeddedness in a culture and community and represent adaptive potential; (b) should inform interventions that stand to interact with these priorities; and … (c) approaches for effectively working with participants' diverse religious commitments should be incorporated into the … interventionist's repertoire."[32(p2080)] The objectives that follow provide some strategies for putting these principles into action in PAT.

Clinician Competence and Personnel Selection

Clinicians who offer PAT should be competent in providing culturally sensitive and SERT-integrated treatment, consistent with standards recommended by Vieten and Lukoff.[31] Unfortunately, this is rarely addressed in the training of mental health clinicians. In a study of 550 US mental health clinicians, nearly 70% reported that they did not have any training in the diversity area of religious and spiritual competence.[48] Even PAT training curricula rarely devote more than a few hours to SERT-relevant issues. For this reason, we recommend collaborative approaches to care that draw on the expertise of mental health and spiritual health clinicians, partnered with the patient(s) as stakeholders in providing culturally appropriate treatment. Leveraging a triad model (patient, mental health clinician, spiritual health clinician) is consistent with current best practices in PAT (which typically recommend cotherapists instead of a singular therapist), while also providing complementary expertise among personnel. In therapist selection, it is important to acknowledge that, although patient-clinician match on religious affiliation is not related to outcomes on aggregate,[49] patients may have preferences for or against clinicians from specific backgrounds, which are important in treatment planning considerations as well as considerations of ethnic and racial, cultural, gender, and other attributes of clinicians that can facilitate treatment alliance and patient safety.

Board-certified spiritual health clinicians (also referred to as chaplains) already hold credentials that make them valuable members of a PAT therapeutic team. Indeed, spiritual health clinicians are trained to respond to SERT-relevant distress among religiously diverse and nonreligious patient populations in collaboration with interdisciplinary medical teams to serve the needs of patients across a range of medical conditions.[50] Strong evidence supports the efficacy of spiritual health clinicians at ameliorating psychospiritual distress.[51] Training of spiritual health clinicians involves at least 3 years post–master's degree clinical experience, including a minimum of 1600 hours of clinical training in an Association for Clinical Pastoral Education–accredited yearlong health care residency and a certification process involving multiple committee appearances and position papers. Spiritual health clinician professional competencies include respecting the cultural, gender, sexual orientation, and religious diversity and differences of patients.[52] Trained to work as members of multidisciplinary teams, spiritual health clinicians are natural partners for developing and providing SERT-integrated care. We recommend that SERT-integrated PAT include board-certified spiritual health clinicians as members of the clinical treatment team.

Appropriate Assessment

Assessments used in PATs vary extensively,[53] especially with regard to SERT concerns. Appropriate assessment is a key part of the therapy and is aligned with the knowledge and skills domains of spiritual and religious competencies for psychologists.[31] Assessments should include not only present-day religious beliefs or spiritual goals, but history taking, strengths assessment, and patient preferences. Established clinical assessments such as the Faith, Importance/Influence, Community, and Address Spiritual History Tool[54] should be incorporated as an initial step in PAT, but importantly, these should be conducted iteratively in a way that informs dynamic aspects of the treatment and postpsychedelic dosing integration work. Several PATs, such as ketamine-enhanced psychotherapy, already incorporate extensive assessment of patients' SERT concerns and histories,[22] although guidelines for such assessment have not been standardized, which is a vital aim for future research.

Safety

PATs often engage, and even challenge, various aspects of patients' worldviews. This may contribute to their effectiveness but can incur additional vulnerabilities if the therapy does not go well. Experiences that impact global worldviews, such as PAT, can contribute to challenges if they are difficult to reconcile with existing worldviews and may require specialized support for integration.[55] Because existential worldviews are an important coping resource, struggles related to worldviews can constitute a double challenge comprising initial distress[56] coupled with reduction in the coping resources that would otherwise help manage the distress.[57] For this reason, it is important to ensure that SERT-relevant concerns are addressed as part of safety considerations, including ensuring that patients have support in making sense of worldview-related struggles. Relatedly, it is important to recognize that while psychedelics may independently affect patient worldviews, respect for patients' autonomy and dignity requires that clinicians take patients' intentions and commitments seriously during PAT. It is important to attend to cultural biases (eg, toward individualism or secularism) in contemporary Western therapies and to ensure that clinicians act with responsibility and fidelity to patients' values and preferences. The power dynamics of medical patient-clinician relationships, when coupled with the effects of psychedelics, may exacerbate challenges to patient autonomy (eg, acquiescing to explicit or implicit expectations in treatment) and should be top of mind for clinicians. This may require specialized training and expertise, such as that received by spiritual health clinicians or mental health clinicians skilled in multicultural and culturally competent therapies. Particular attention should be paid to the inadvertent, or deliberate, imposition of clinicians' worldviews onto patients either through the structure of a therapy or specific actions undertaken by clinicians.

At this stage of psychedelic research, it seems prudent to follow the guidelines set out by Britton and colleagues,[58] specifically that (1) adverse event assessment should be in-depth and tailored and (2) it should seek to identify and address SERT-relevant consequences, as attested by the patient, minimizing any interpretative framing by the interventionist. The psychological impacts of psychedelics are often multifaceted, including aspects of worldview and self-concept, and are not limited to the mental health symptoms targeted by an intervention. Accordingly, assessment of PAT adverse effects should not be restricted to standard pharmaceutical trial-type reporting but should include SERT-associated effects which, while not explicitly emotionally or physically harmful in traditional medical models, may nevertheless adversely impact patients' lives in unforeseeable ways in both the short- and long-term. SERT integration in PAT should facilitate definition, assessment, monitoring, and response to SERT-related adverse effects, which may be missed without deliberate attention to SERT issues.

Evidence-Based SERT Integration

It is important to use the best available evidence to guide SERT-integrated PAT. Although research in this area is growing, treatment developers and clinicians must currently integrate multiple kinds of evidence because clinical trials are not available for every treatment question, let alone to provide data syntheses to guide best practices. This special communication has reviewed evidence re-

garding practices in PAT alongside evidence from parallel areas such as spiritually integrated psychotherapy. However, guidance based on rigorous and systematic study of SERT components in PAT is yet to be achieved. For example, discrete components of the behavioral therapies in PAT have yet to be identified or tested via dismantling studies, a crucial area for future research. Similarly, there is not enough evidence to determine whether SERT integration is best achieved through add-on modules to existing therapies for patients for whom this topic is salient or whether spirituality should be incorporated as a core component of PAT.

The emergence of SERT-relevant concerns for patients undergoing PAT may have a range of consequences. We do not suggest that SERT experiences are always positive. SERT, like any issue with sensitivity, cultural significance, and importance to a patient, may reveal struggles, challenges, or undesired consequences for the patient. For example, a patient who is religious may respond to a challenging psychedelic experience by forming maladaptive religious appraisals, (eg, feeling abandoned or punished by God),[59] which may contribute to poorer outcomes. Some patients may prefer to not consider their experience in light of religion or spirituality; appropriate assessment and a SERT-integrated response would mean recognizing this preference and honoring it. Rather than cheerleading uniform inclusion of religion in psychotherapy, we suggest applying empirical, evidence-based practices that can assess the benefits and harms of different approaches to SERT in PAT to maximize the former and minimize the latter.

Conclusion

Because PATs often activate SERT issues, addressing these aspects of treatment skillfully and intentionally is especially important for therapies involving psychedelics. PAT has broad potential to reduce human suffering, but its successful application will require deeper understanding of the growth-mediating effects of SERT experiences stemming from psychedelic treatment, as well as their potential harms. We recommend carrying forward the existing competencies outlined for spiritually integrated psychotherapy[31] into the specialized approaches used in PAT. Ignoring these key aspects of psychedelic treatment does not render PATs secular or neutral to SERT but instead relegates the management of messages about spiritual, cultural, and existential priorities to the subtext of the intervention. Explicitly incorporating SERT considerations via appropriately trained clinicians conducting PAT will maximize the efficacy of the interventions and enhance their safety in this important yet underacknowledged cultural domain.

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