EMDR and Psychedelic-Assisted Therapy:

A Match Made in Heaven?



By Katja Cahoon, LCSW, MBA

Boosted by books such as Michael Pollan's *How to Change Your Mind* (2019), podcast hosts and celebrities sharing their experiences, and politicians from both sides of the aisle advocating for greater access, psychedelic therapy is growing in popularity.

Currently, the only legal psychedelic in the United States (and many other countries) is ketamine. A growing number of for-profit and nonprofit organizations are conducting research into MDMA, psilocybin, 5-MeO-DMT, and other psychedelics.

Those psychedelics are also being used therapeutically and ceremonially in so-called underground settings. For instance, MDMA being used to treat PTSD is underground therapy (unless conducted within a research trial). Traveling to South America to participate in a shaman-led ingestion of ayahuasca represents ceremonial use. Recreational use might occur in settings such as music festivals or parties.

You might be wondering: Why does this concern me? Even if you have no interest in becoming trained in ketamine or other psychedelic-assisted psychotherapy, you might increasingly encounter clients who are interested in these modalities, are seeking legal options, or have participated in underground therapy. Your clients may ask for guidance or bring experiences from their psychedelic journeys—both beneficial and challenging—for reprocessing.

Moreover, the United States and many other countries continue to face a mental health crisis. For example, considering PTSD, nonresponse rates are high (25–50 percent) (Davis et al., 2021), and approved therapeutic approaches and psychopharmacology often fall short (Fremont et al., 2023). Clearly, more options are needed, and psychedelics show promise (Davis et al., 2021).

While reporting on psychedelic therapy has been largely positive, critical concerns have emerged. For instance, the death of actor Matthew Perry, which involved ketamine, has raised questions (Kellermann, 2023; Hunt, 2024). Additional concerns include enduring adverse experiences (Evans et al., 2023), reports of sexual abuse in research and other settings (Cahoon, 2022), and more.

Work also remains to be done to make psychedelic therapy more inclusive and accessible, particularly for Black, Indigenous, People of Color (BIPOC), lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, (LGBTQIA+), and other marginalized clients. The 1970s War on Drugs disproportionately impacted people of color,



perpetuating stigma. People of color are underrepresented in psychedelic research. Coupled with the high cost of psychedelic therapy, accessibility can be particularly challenging (Rojas, 2024). BIPOC and LGBTQIA+ therapists are already underrepresented, a problem even more pronounced in psychedelic therapy. Research by Rojas (2024) highlights that "whiteness in the room" can be problematic. However, openness to discussions about race, racism, social justice, and related topics can help BIPOC and other clients feel more seen, safe, and included.

This article provides general information about psychedelic therapy, its benefits, and risks. It aims to demonstrate that EMDR can help clients prepare for and process experiences from non-ordinary states of consciousness (NOSC). As a result, clinicians who are not trained in psychedelic therapy will be better equipped to have informed discussions with their clients.

PSYCHEDELICS: MECHANISMS OF ACTION AND BENEFITS

A multitude of psychedelic substances have been utilized for millennia by cultures worldwide (Cox, 2024). Research in the United States and other countries began in earnest in the 1950s and 1960s (Lichtenstein & Hoeh, 2024). Psychedelics have been shown to address a broad range of issues, including depression, anxiety (Hull et al., 2022; Kew et al., 2023; Payne et al., 2021), depression in terminal cancer patients (Payne et al., 2021), substance use disorders (Kew et al., 2023), suicidality, phobias, OCD, PTSD (Lichtenstein & Hoeh, 2024), and severe depression in COVID-19 frontline workers (Donohue, 2024).

Psychedelics include ketamine, MDMA, ayahuasca, psilocybin, peyote, ibogaine, LSD, and 5-MeO-DMT. These substances have different mechanisms of action. For example, classic serotonergic psychedelics (like LSD and psilocybin) primarily interact with serotonin receptors. Ketamine functions as an N-methyl-d-aspartate receptor (NMDAR) antagonist, while MDMA increases serotonin and oxytocin levels. Experiences and durations vary significantly depending on the substance—for instance, approximately 10 minutes or less for 5-MeO-DMT versus 10–12 hours for LSD, with ibogaine lasting even longer.

Despite these differences, many effects and benefits are shared. New research suggests that all psychedelics reopen the social reward learning critical period, pointing to a common neurobiological process that may explain their therapeutic effects (Nardou et al., 2023). The social reward learning critical period is a time of heightened neural malleability and sensitivity to stimuli, essential for developing social behaviors, such as attachment, empathy, cooperation, tolerance, altruism, and community building. Learning during this period creates lasting memories. When the critical period closes, treating disorders of the brain becomes more challenging. Psychedelics appear to reopen this closed window, increasing individuals' ability to learn from their social environment (Nardou et al., 2023). As Dr. Gül Dölen, whose lab uncovered this phenomenon, explains:

"We have these habits; they're adaptive so long as the environment is stable. But when there's a radical shift in the environment, it would be adaptive to reopen critical periods and relearn from the environment" (Ferris, 2024).

Other benefits include the softening of defenses, assistance with catharsis, access to childhood memories, acceleration of therapeutic processes, increased openness and psychological flexibility, revision of rigid thought patterns and self-beliefs, and heightened creativity, and compassion (for self and others). Psychedelics can promote transcendent experiences, such as mystical states characterized by unity, connectedness, and meaning (Lichtenstein & Hoeh, 2024; Payne et al., 2021; Batievsky, 2023). Research suggests that ineffable mystical experiences are strong predictors of sustained positive change (Payne et al., 2021). However, other research highlights deep relaxation as a predictor of positive mental health outcomes, emphasizing the importance of being in a safe setting (Calder et al., 2024).

Ketamine can help clients face fears and fearful memories with less anxiety and reconnect with aspects of themselves (Lichtenstein & Hoeh, 2024; Payne et al., 2021). It also has immediate, though short-lived, effects on suicidality and severe depression (Hull et al., 2022; Kew et al., 2023). Ketamine increases brain-derived neurotrophic factor (BDNF), which plays a vital role in synaptogenesis—the formation of new receptors and synapses—a process that is often impaired in individuals with depression (Batievsky et al., 2023). This may explain ketamine's ability to prompt dramatic reorientations toward more adaptive thoughts, attitudes, values, and behaviors (Payne et al., 2021), a concept familiar to EMDR therapists (see Duval Hill's (2020) excellent paper on Adaptive Information Processing (AIP) and its neurological underpinnings).

Ketamine (and other psychedelics) reduces Default Mode Network (DMN) activation (Payne et al., 2021). The DMN is a network of brain regions active during introspection, daydreaming, and self-referential thinking. While it plays a critical role in cognitive functions like social cognition and planning, disruptions in its activity are linked to mental health issues. For example, overactivity in the DMN is associated with rumination

in depression, while underactivity may impair self-awareness and social functioning.

Despite their potential, psychedelics are not a miracle cure. As Richmond (2024) explains:

"People think that ketamine alone can make you feel better without taking part in psychotherapy, without working to improve your social life, your interpersonal relationships, the way you spend your time, and without thinking about side effects. That's simply not true."

Similarly, a systematic review by Drozdz et al. (2022) found that psychotherapy before, during, and after ketamine administration can maximize and prolong its effects. However, there is limited research on which therapeutic modalities are most effective.

RISKS AND CAUTIONS

Lichtenstein and Hoeh (2024) highlight that approximately 10,000 published papers confirm the safety and efficacy of psychedelic therapy. Reports indicate few long-term impairments in behavior and functioning. For example, a Johns Hopkins survey of 1,993 individuals who experienced so-called "bad trips" with psilocybin revealed that only 7.6 percent reported lasting negative effects, while 84 percent felt they benefited despite their challenging experiences. Most of these individuals did not have a therapist or guide present during the experience (Brody, 2024). Payne et al. (2021) argue that the most challenging NOSC experiences—such as intense grief, panic, fear of death, paranoia—can be among the most personally meaningful if they are worked through and processed effectively.

However, risks associated with psychedelic therapy should not be overlooked. Robinson's (2022) report on the website Mad in America

Case Studies

Sunny Strasburg noted in her 2021 EMDRIA Annual Conference presentation that "ketamine does the heavy lifting in the session." I, too, have seen clients benefit from the synergy of EMDR and psychedelic-assisted therapy.

Case One: Raquel*

Raquel, referred by a skilled psychedelic practitioner, is the daughter of a Holocaust survivor and experienced significant verbal and emotional abuse, attachment trauma, abandonment, and neglect. Her upbringing instilled beliefs that she had no value, was unlovable, and that her needs were burdensome. Her early sessions with MDMA and psilocybin were challenging but transformative. She experienced what Internal Family Systems (IFS) refers to as a "spontaneous unburdening" (in EMDR we might frame it as spontaneous memory reconsolidation), connecting with the unlovable part of herself and experiencing self-love for the first time.

Recognizing the complexity of her trauma, the practitioner reached out for therapeutic support. Initially, we worked together, offering mindfulness and IFS techniques while providing a reparative and supportive presence akin to a "kind parental unit." I then continued work with Raquel independently. Despite progress with psychedelics, Raquel remained deeply depressed, immobilized by suicidal ideation and a sense of unworthiness.

In our work, she initially focused on her mother, whom she saw as the primary abuser. Through the EMDR Standard Protocol, we worked on these memory networks, and as those reconsolidated and integrated more, we uncovered idealization of her father, which had acted as a psychological barrier to deeper healing. A pivotal memory involved Raquel telling her father she would kill herself when he died, to which he responded that she must live to preserve his legacy. We processed this memory over several sessions, moving through despair, anger, and finally to adaptive resolution. Shortly after, Raquel participated in a session with psilocybin and MDMA, facilitated by the underground practitioner. In our subsequent integration session, Raquel described a profound healing experience: feeling seen, supported, and cared for—an entirely new emotional landscape for her. This countered lifelong beliefs that her needs were unwelcome, and distress must be hidden. Using gentle bilateral stimulation (BLS), we reinforced her newfound sense of being seen and mattering. Raquel expressed feeling more complete and whole, without the "bottomless pit of neediness" she had feared. This collaborative work, though unconventional, aligns with a harm reduction approach. I worked strictly within my scope of practice, supporting Raquel in integration sessions without administering or engaging with substances directly.

Case Two: Claudia*

Claudia sought adjunctive ketamine-assisted therapy for trauma, chronic depression, and refractory chronic pain. A child immigrant to the U.S., she had endured microaggressions and overt racism. She felt stuck in therapy and unable to find relief from her depression.

Following three preparation sessions, we planned for 3–6 ketamine sessions, each followed by an integration session. Claudia reported an immediate lift in depression after the first few sessions, accompanied by greater freedom and playfulness. During the fifth ketamine session, Claudia spontaneously accessed a previously inaccessible memory tied to her chronic pain. She recalled a moment when someone touched her shoulder, describing it as a transfer of "negative energy," akin to a "voodoo curse." During her ketamine session, she experienced sensations of energy shifting in the same area. Though initially panicked, she allowed the movement to unfold, describing a release of what had felt blocked. In subsequent integration sessions, we targeted this memory. Over two sessions, Claudia's Subjective Units of Distress (SUDs) reduced significantly, her pain lessened to the point of only being present during certain movements, and her Positive Cognition (PC) strengthened. By the sixth ketamine session, Claudia felt she had achieved her therapeutic goals.

These cases underscore the robust versatility of EMDR principles when applied to integration work with psychedelic-assisted therapy. While not every EMDR therapist may feel comfortable engaging in this type of collaboration, these examples highlight how EMDR can support clients in bridging transformative experiences into lasting, adaptive change.

(*Client names and identifying details have been altered for confidentiality.)

describes a case of ketamine therapy gone wrong, resulting in worsened symptoms and diagnoses, additional trauma, instability, and even hospitalization. This underscores the importance of thorough assessments and attuned therapeutic support.

Ketamine can be highly addictive when used recreationally or for self-medication (Hunt, 2024). While misuse is rare in therapeutic settings, evidence suggests it can occur, especially when clients are not adequately informed about the risks and benefits (Richmond, 2024). It is important to closely monitor for signs of misuse.

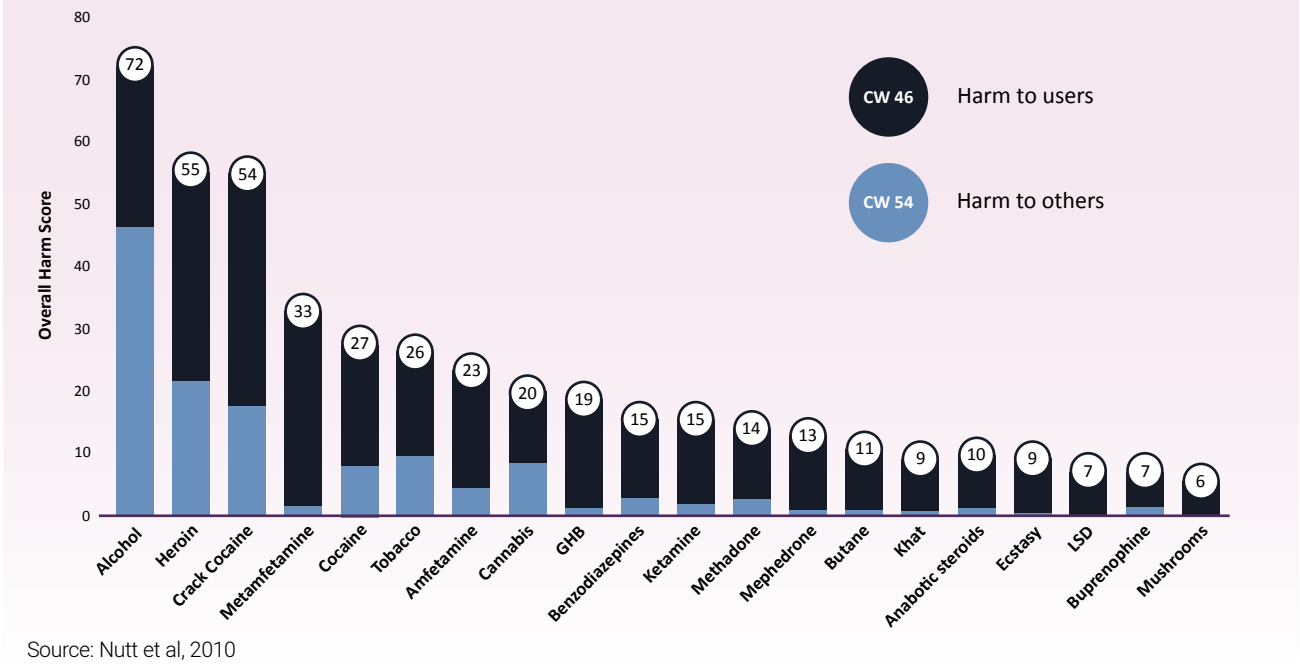
Perspective on relative harm is important. Nutt et al. (2010) analyzed drug-related harms in the U.K. and found that psychedelics rank significantly lower than substances like alcohol, heroin, cocaine, and tobacco in terms of harm to self and others (Figure 1).

Psychedelic therapy is not suitable for everyone. Like other modalities and medications, such as selective serotonin reuptake inhibitors (SSRIs), it comes with side effects and has its share of non-responders. Common side effects include temporary nausea, dizziness, problems with ambulation, and alterations in perception, cognition, and emotions. More serious effects can involve paranoia, panic, or other difficult-to-manage emotions. One rare but significant risk is Hallucinogen Persisting Perception Disorder (HPPD), characterized by flashbacks long after the psychedelic effects have worn off and persistent hallucinations that interfere with daily functioning. Research on HPPD is limited, and its etiology remains unclear (Ellis, 2024).

As with EMDR, certain clients and diagnosis are unsuitable for psychedelic therapy, including an unstable sense of self, psychosis, active mania, untreated dissociative disorders, severe trauma, thought disorders, or severe attachment wounds (Lichtenstein & Hoeh, 2024). A useful heuristic is that conditions characterized by rigid structures and reduced brain connectivity—such as depression, obsessive-compulsive disorder (OCD), and similar disorders—tend to be suitable for psychedelic therapy. In contrast, conditions marked by chaotic mental organization, such as psychosis, schizophrenia, or untreated personality disorders, are generally unsuitable. This framework also explains why unipolar depression is often responsive, while bipolar depression requires caution, and active mania is typically a contraindication.

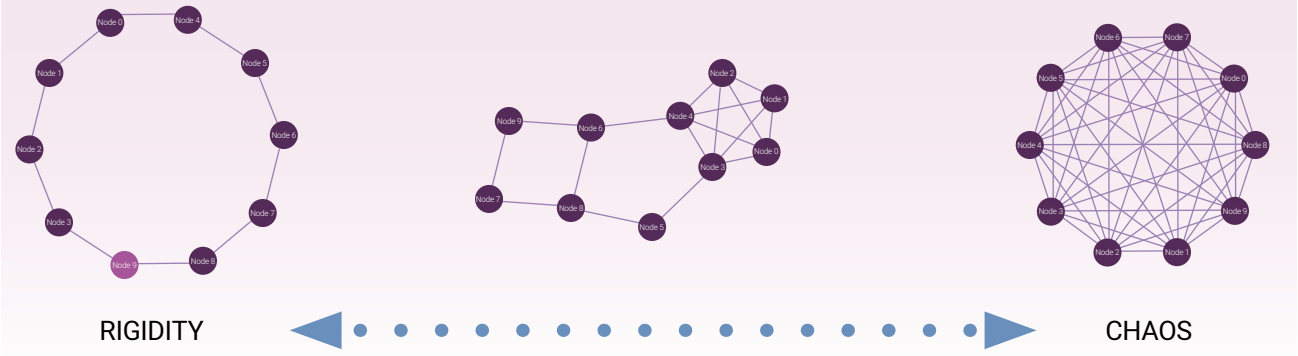
This heuristic aligns with research into hemispheric laterality, or the "diametric model of mental illness," which places autism at one end of the spectrum and schizophrenia at the other. Autism is associated with rigid thought patterns and difficulty understanding novel conceptual combinations, while schizophrenia is characterized by extremely loose associations and chaotic mental organization. These differences correlate

Figure 1



Source: Nutt et al, 2010

Figure 2



Source: Faust & Kenett, 2014

with distinct patterns of hemispheric involvement—reduced in autism and increased in schizophrenia (Badcock, 2015; Faust & Kennett, 2024).

Psychedelics induce temporary hyperconnectivity in the brain, a phenomenon also observed in psychosis and schizophrenia. This increase in connectivity is one of the mechanisms by which psychedelics enable clients to connect with adaptive material, shift perspectives, and promote healing (Petri et al., 2024). The "Rigidity vs. Chaos" model proposed by Faust and Kennett (2024) (**Figure 2**) closely resembles the hyperconnectivity model observed in psychedelics research (**Figure 3**). This overlap underscores the importance of understanding the neurological basis of mental health conditions when determining the appropriateness of psychedelic therapy.

TWO MULTIPHASE MODELS

Ketamine therapy is offered either within a medical or therapeutic model (Hull et al., 2022). The medical model involves multiple intravenous administrations of ketamine over several weeks, with limited or no accompanying therapy. The therapeutic model employs various routes of administration, including oral, and, like EMDR, follows a well-established multiphase framework.

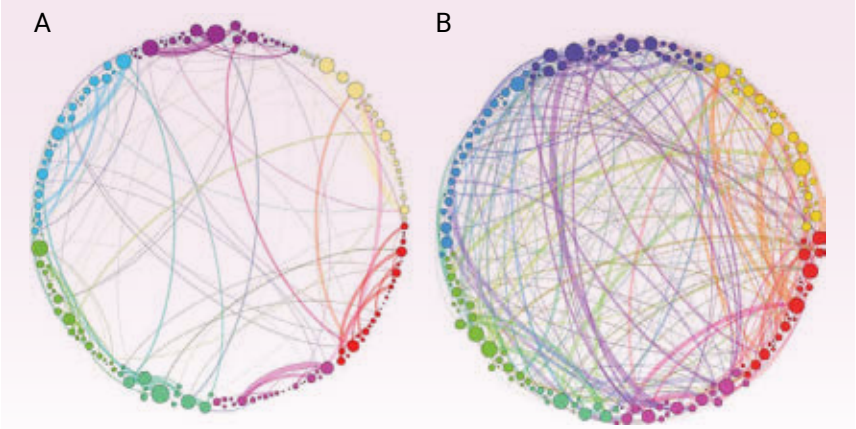
The therapeutic model consists of three primary phases: preparation, active sessions, and integration (Earleywine et al., 2022; Lichtenstein & Hoeh, 2024), preceded by a thorough intake and history-taking phase.

PREPARATION PHASE

The preparation phase has three key goals, analogous to Phases I–II in EMDR:

- **Psychoeducation:** Clients are educated about the range of experiences, including benevolent and challenging states. They are also informed about potential side effects, the importance of mindset ("set") and environment ("setting"), the typical session arc, the role of intentions (which play a similar role than Phase III), and the preparation and integration process. Clients are reassured about the support they will receive throughout.
- **Resourcing:** Therapists equip clients to approach both pleasant and unpleasant experiences with curiosity and openness. This may involve somatic resources, affirmations (e.g., "welcome everything," "trust the process," or "notice what arises, go with it"),

Figure 3: Connectivity with and without psychedelics



Source: Faust & Kenett, 2014

Considerations When Choosing a Psychedelic Therapist

If clients decide to work with psychedelic therapists, Brody (2024) recommends asking these questions to ensure safety and competence:

- What has gone wrong in a session, and how was it handled?
- How are clients screened for suitability?
- What kind of experience do they have in this field?
- How do they ensure the safety and quality of the substances used?
- Additionally, I recommend asking about:
- The therapist's training—where, how, and for how long they trained.
- Whether they are trauma-informed and knowledgeable about working with individuals with a history of trauma.
- Whether they are pursuing ongoing training, consultation, or mentorship to stay current in this rapidly evolving field.

An increasing body of literature also highlights the importance of firsthand experience with non-ordinary states of consciousness (NOSCs) as part of developing competence in this field (Dames et al., 2024).

guided visualizations such as Safe/Calm Space, and, if consented to, supportive touch (e.g., a gentle grounding touch on the shoulder).

- **Building Trust:** Trust is established in the therapeutic relationship, the medicine, and the client's inner healing intelligence—a concept akin to the Self in Internal Family Systems (IFS) and AIP in EMDR (Strasburg, 2021; Fatter, 2024, Duval-Hill, 2020). Betty Eisner's concept of the "matrix" is particularly relevant when building trust with marginalized clients. It refers to the client's broader life context and how it may manifest before, during, and after sessions. (Rojas, 2024).

ACTIVE SESSION PHASE

Active sessions, comparable to EMDR Phases III-VII, last two to three hours. Sessions begin with a check-in, grounding exercises, revisiting the client's intention (target), and confirming touch consents and resources. Most psychotherapists use ketamine lozenges, which clients hold in their mouths for about 20 minutes to facilitate absorption through the mucosa. During this time, therapists often guide clients with meditations, poetry, or other content to help them enter a relaxed, open, and receptive state.

Clients generally feel the effects within 10 minutes, with a peak around 30–40 minutes, followed by a gradual decline known as the "long-tail." Throughout the session, music is played to support the client's experience.

Some clinicians, such as Sunny Strasburg (Strasburg, 2021) and Michele Topel and Danielle Ciccone (*Notice That Podcast*, 2025), use lower doses of ketamine to conduct EMDR during the active session. Others work with higher doses, which tend to make clients more inwardly focused. Toward the end of the session, once the client has mostly returned to baseline, there is gentle recounting, reflection, and initial integration of the journey.

INTEGRATION PHASE

Earleywine et al. (2022) describe integration as:

"A bridge for the psychedelic experience to everyday life that helps clients make sense of their experience in a personalized way, leading to lasting behavior change and a sense of wholeness and completion."

Ketamine induces increased neuroplasticity for 24–48 hours following administration (Galvez et al., 2017; Kopelman et al., 2023). This makes the integration phase especially significant as it leverages the heightened neuroplasticity. Integration sessions may involve Phases III–VIII in EMDR, depending on the client's needs, with the overall goal of directing neuroplasticity toward adaptive and lasting transformations (Vollenweider & Preller, 2020).

KETAMINE AND EMDR SYNERGIES

A common concern about psychedelic therapy is the fear that it "changes the brain" or that we should avoid "messing with our brains." While this is true, it is equally true that mental illness and many therapeutic modalities, including EMDR, induce brain changes. For example, reduced thalamic activation in post-traumatic stress disorder (PTSD) contributes to the fragmentation of sensory and memory processing, distorted cognitive interpretations such as shame and self-blame, over-consolidated episodic memory, impaired semantic memory, hemispheric laterality, and hyper-emotionality in the nervous system (Bergmann, 2008). EMDR addresses many of these elements (Gainer et al., 2020).

Bergmann (2008) hypothesizes that one of the underlying mechanisms of EMDR stimulation—dual-attention stimulation or bilateral stimulation (DAS/BLS)—is thalamic activation, particularly of the ventrolateral and central-lateral nuclei. This activation may facilitate the repair and integration of disrupted somatosensory, memorial, cognitive, frontal lobe, and synchronized hemispheric functions seen in PTSD.

In depression and related disorders, atrophied neurons in the prefrontal cortex (PFC) play a critical role. Ketamine increases structural and functional plasticity in the PFC, which

has an antidepressant effect. Both ketamine and serotonergic psychedelics have been shown to promote synaptogenesis, including enhanced dendritic arbor complexity, dendritic spine growth, and synapse formation (Ly et al., 2018).

EMDR has been shown to lead to structural changes in gray matter. Bossini et al. (2024) studied gray matter volume (GMV) in various brain regions. Pre-treatment, they found smaller GMV in the parahippocampal, parietal, and frontal regions and larger GMV in temporal and parietal regions compared to controls. These regions are involved in processing and storing traumatic events. Specifically, the hippocampus plays a key role in encoding, consolidating, and retrieving declarative memories. Memory disturbances in PTSD often stem from dysfunctions in this region. Following EMDR treatment, GMV increased in the left hippocampal gyrus and decreased in the left thalamus. These changes reflect improved thalamocortical connectivity, which is thought to reduce excessive fear, traumatic memory recall, and the inability to maintain extinction memory. EMDR enhanced hippocampal function and better integrated subcortical and cerebral cortex processes. Traumatic memories shifted from being encoded in emotional/limbic regions to more explicit cortical regions, allowing for processing at a higher cognitive level (Bossini et al., 2024). This is in essence one of the proposed brain mechanisms of AIP (Duval Hill, 2020).

Both EMDR and psychedelics downregulate amygdala activation, expand the Window of Tolerance, and reduce Default Mode Network (DMN) activation (Strasburg, 2021), all of which are changes in the brain that facilitate healing.

Ketamine functions as an NMDA receptor agonist. The NMDA receptor plays a critical role in fear conditioning and extinction by enhancing activation in the prefrontal cortex (PFC) and increasing functional connectivity between the amygdala and ventromedial PFC (vmPFC). Effective trauma treatment is associated with increased vmPFC activation and enhanced connectivity to subcortical areas. A randomized controlled trial (RCT) investigating EMDR therapy demonstrated improvements in fear extinction learning and functional modifications in connectivity between the amygdala and subregions of the PFC. This finding builds upon multiple studies showing impaired fear extinction learning in trauma and the corrective mechanisms of EMDR therapy (Fremont et al., 2023). This overlap between ketamine's neurophysiological effects and EMDR's mechanisms of action (Duval Hill, 2020) highlights potential synergies between these modalities.

A case report by Wilms et al. (2022) illustrates the value of integrating EMDR with ketamine-assisted psychotherapy (KAP). Bilateral stimulation (BLS) was used to extend the therapeutic effects of the ketamine experience. The client demonstrated an increase in dual awareness, improved capacity to view previously distressing experiences from a new perspective, greater access to a ventral vagal state, and an enhanced ability to tolerate negative affect and stress. Additionally, the client reported spontaneous connections with adaptive material, including self-compassion.

A case report by Veraart et al. (2023) involved clients with treatment-resistant depression (TRD) and comorbid trauma. One client, who initially felt too overwhelmed to engage in EMDR, showed marked improvements in mood and emotional stability after esketamine (a type of ketamine) treatments, enabling the client to proceed with trauma therapy. Other clients in the report demonstrated similar benefits, including improved emotional regulation, increased accessibility of emotions, and a greater ability to tolerate trauma work.

Batievsky et al. (2023) combined KAP and EMDR for the treatment of chronic pain and comorbid depression. While the outcomes were positive, the report did not detail how the two modalities supported one another.

Navigating Legal and Ethical Complexities

While it is always preferable to seek legal and regulated options for psychedelic therapy, availability may be limited in some areas. This can lead clients to explore underground options. Pilecki et al. (2021) argue that therapists have an ethical duty to meet the needs of clients engaging with psychedelics, even in underground settings, by providing support within legal and ethical boundaries. Their paper outlines potential risks in underground contexts and strategies therapists can use to mitigate those risks, such as harm reduction practices and integration-focused therapy.



EMDR PROTOCOLS TO SUPPORT PSYCHEDELIC THERAPY

Raine-Smith and Rose (2023) have developed a 12-session EMDR protocol designed to complement psychedelic therapy. The protocol includes six preparatory sessions, during which clients

undergo psychoeducation, resourcing, and stabilization. Afterward, clients receive psychedelic treatments in a separate setting, followed by six integration-focused EMDR sessions. This structured approach aims to optimize preparation and integration phases for psychedelic therapy. Rose (2024) further described three cases where PsyA-EMDR (psychedelic-assisted EMDR) was used to support participants in psychedelic therapy studies. She concluded:

"PsyA-EMDR therapy can be used to widen the window of tolerability for psychedelic treatments. Greater tolerability supports inclusivity. Improving safety outcomes and enhancing access to psychedelic treatments are issues of social justice."

Michele Topel and Danielle Ciccone have developed an approach called Ketamine Assisted EMDR Therapy that involves combining lower doses of ketamine with EMDR to address trauma and other conditions (*Notice That Podcast*, 2025).

OFFERING A POWERFUL PATHWAY

I hope this discussion has helped address concerns and alleviate fears around the use of psychedelics in therapy. With the right client, proper preparation, and thoughtful integration, psychedelics can be a safe and transformative option. By combining these modalities with evidence-based approaches like EMDR, therapists can offer a powerful pathway for healing and growth.

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