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ON REDESCRIBING THE INDESCRIBABLE: TRAUMA, PSYCHOANALYSIS AND PSYCHEDELIC THERAPY

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The psychedelic state can be thought about as an interdependent intrapsychic, somatic, interpersonal and spiritual happening which encourages, perhaps both to the relief and dismay of those participating in the experience, the shocking and impressive emergence of one's unconscious desires and traumata's; a state which may be experienced as cathartic or healing, and as anxiety-provoking and confusing. Often, in clinical trials investigating psychedelics in mental health conditions, these go hand in hand. Amid a renewed, at times hyperbolic, interest in psychedelics as a potential treatment for mental ill health, significant gaps of knowledge remain. Additional studies exploring the impact of the extra-pharmacological factors and adjunct therapeutic models on treatment outcomes are needed. Drawing from psychoanalytic perspectives, this paper explores points of intersectionality between psychedelic therapy under investigation and psychoanalysis in the context of traumatic stress. To that end, the psychedelic state will be considered an attempt to make the unconscious conscious by immersing self in a bewildering waking-dream to better tolerate reality; immersing self in a wilful state of vulnerability, to develop trust in one's agency and capacity to trust others; immersing self in an indescribable experience to learn how to redescribe, to self and to others the traumatic past.

KEYWORDS: PSYCHOANALYSIS, PSYCHEDELIC THERAPY, TRAUMA, PTSD, PSYCHOTHERAPY, PSYCHEDELICS

INTRODUCTION

In 2018, in the aftermath of a research psychedelic administration session, I asked an experienced therapist, 'does it still surprise you that people are afraid of losing their "ordinary" minds?'. They took a moment to reflect and smiled, softly saying 'I'm surprised they don't want to do so more often'. I looked around the dimly lit

repurposed hospital room; a painting hung on the wall, flowers, carpets, and an empty bed, in which moments before, a clinical trial participant spent the day grappling with and perhaps learning to experience both fear and love, discomfort and pleasure, omnipotence and vulnerability, reality and fantasy.

In popular culture, madness or insanity, or words that describe mental states that diverge from the so-called ordinary, are used as synonyms to 'losing one's mind'. Joannidis (2013, p. 55) writes that for Winnicott madness 'corresponds to the basic human need to go to the end of something begun—to follow the drive force to its endpoint despite the upheavals this may cause, and without the prudence that usually prevents it from developing'. Intimating that we are, on some level, all in search of and avoidant of an unknown beginning; presumably because finding 'it' will offer us something indispensable, and that the way to arrive at the start of something is via the end of that same thing. One way of understanding something about our adulthood is by understanding something about our childhood; one way to appreciate our first breath is by appreciating our last breath; one way to acquaint oneself with the many, largely unobservable, layers of the so-called ordinary state of consciousness, is by experiencing an extraordinary one. Directly quoting Winnicott, 'Only out of non-existence can existence start' (Winnicott, 1974, p. 106). Or with Buddhist traditions in mind, 'You have to be somebody before you can be nobody' (Engler, 2003, p. 35).

Put differently, temporarily losing our biopsychosocial minds (Bolton & Gillett, 2019), or disrupting our everyday interpretive framework that informs how we relate to self and others, in a safe environment, and with the promise of care, may, for some people, be a beneficial experience. Suggesting that there are healing forms of loss, or that by 'losing our minds', with intentionality and within a trusting therapeutic relationship, the malignant aspects of loss can be experienced or interpreted by the patient as benign or corrective; more akin to Freud's ideas surrounding processes of mourning and distinguishing these from the persistent and non-resolvable violence of melancholia (Freud, 1917). For the traumatized patient, often, this need to go to the end of something begun refers to the wish to recover the idealized pre-traumatic state; a spatial and temporal locality uncontaminated by living; a self shaped not by suffering but by pleasure. To that end, in 1761, responses to traumatic experiences were described as 'nostalgia' (Schrader & Ross, 2021). And nostalgia is also a way to distance oneself from the present moment; to remain developmentally arrested; to stay immobile and absent, as forms of movement and presence can be precarious and lead to contending with a variety of painful losses.

And if psychedelic therapy may, in some participants, catalyse processes of transformative or productive loss and mourning, the title of Michael Pollan's book and series, *How to Change Your Mind* (Pollan, 2018) is of interest. This title may suggest that our minds are some *thing* that first and foremost requires modifying, updating or redesigning. Changing our minds into some thing different or specific may suggest that there are right or wrong, distorted or accurate ways of thinking, of feeling, of relating and of being; that when our minds require changing, it is because it is, or we are, making errors in prediction, perception and interpretation, and that

these errors should be corrected. This seems sensible, however, for practitioners with experience navigating, or more precisely, being navigated by complex, trauma-focused, psychotherapy processes, tensions may emerge.

Firstly, for patients who have suffered trauma, the root of the problem is often more to do with the minds and subsequent behaviours of others; others who have caused a great deal of harm. Patients speak about the minds of others when speaking about their own minds; when describing their symptoms, they are also talking about (or trying not to talk about) what others have done, or not done, to and for them. And therefore, the imagined and certainly easier solution for the so-called traumatized patient has more to do with changing the mind of others. For the chronically neglected 'inner-child', having a parent who was more preoccupied with the child's well-being than with satisfying their own needs, is a better solution than altering one's own mind, and having to negotiate with the frustrating reality that the internalized past mind of others cannot be changed. The patient must go about the challenging ordeal of relinquishing these magical forms of thinking and confronting the unrecoverable reality of their circumstances. Nevertheless, patients who have carefully assembled psychological defences aimed at not bearing witness to that which cannot be changed, volunteer to participate in psychedelic clinical trials.

The book's title may also suggest that there is something about our minds, which is at once 'ours' but also a kind of alienated entity, somehow other than 'us'; a separate thing that we struggle to know what to do with or about; some thing that is overwhelmingly powerful, that demands our obedience; some thing that is ahead of us, leaving us perplexed and haunted by its omnipotence. Our responses to traumatic experiences may enhance this basic predisposition. To gain a sense of safety and control, the patient creates psychic, emotional and somatic distance between tormenting and introjected versions of self and others; a safe enough distance from intense forms of pain via excessive use of denial, splitting, dissociation and so on. Often, the outcome is a kind of fragmented internal organization, creating an experience of inner and outer chaos that prevents or makes it difficult to achieve a sense of embodied coherence and solidity; a sense of belonging in one's mind, heart and body.

Freud's initial notion that the traumatic memory 'behaves like a foreign body, and that the treatment, too, works like the removal of a foreign body' (Freud, 1893, p. 293) evolved into a more nuanced vision of the human experience of pain, one that recognized how traumatic material and our responses to it assimilate into or infiltrate the so-called pre-traumatic organization; recognizing that there is not 'any visible boundary at which the pathogenic material begins' (Freud, 1893, p. 293). And so, introducing a psychedelic compound, which will inevitably further disrupt the patient's perception and experience of their internal world and surroundings (Yaden *et al.*, 2021), may seem counterintuitive or precarious. Nevertheless, patients, who may feel unsafe, disembodied, or caught up in a tantalizing emotional storm, volunteer to participate in psychedelic clinical trials.

Lastly, Pollan's book title may suggest that we know what we want to change our minds into, and that indeed, if we only knew how to change our minds, without

hesitation, we would. Maybe so, and in many ways these assumptions are sensible; we should seek pleasure and avoid pain, pursue comfort over malaise, and as individuals, families and societies, it does seem reasonable to be more gratified by stories of triumph and compassion over chronicles of violence and despair. However, Pollan overlooks what psychoanalysis refers to as 'ambivalence', 'unconscious fixations', 'resistance', 'repression', 'perversions' and so on. Broadly, these concepts suggest that we are not designed to 'make sense' to ourselves, that the supposedly healthy, unified and rational self, the Ego-Ideal, is but a wishful fantasy; a necessary illusion taming forms of intolerable psychic volatility. Further, psychoanalysis suggests that our attempts to be sensible and coherent are more to do with our need and desire to appear so to others. It is easier to love that which we understand, and it is easier to be loved when one is understandable to others. Nevertheless, traumatized patients, negotiating with powerful injunctions to understand the incomprehensible, and to make the incomprehensible understandable to others, volunteer to participate in psychedelic clinical trials.

In these studies, the participant is invited or compelled to contend with, not only with the above-mentioned, which is but a fraction of the range of potential experiences, but also with the demanding presence of the therapist, the unpredictable subjective effects of the psychedelic compound, the unknown trajectory of their psychedelic experience, and the required rigid and time-limited regulatory framework of the clinical trial.

This is a significant undertaking pursued by individuals who have often faced considerable hardship and despite that find within themselves inspiring reservoirs of hope and courage, and so this paper seeks to pay tribute to the so-called 'treatment-resistant' patient who volunteers to take part in these experimental studies, which may, for some now and in the future, offer significant relief and healing, and for others, ample opportunity for further disappointment and disillusionment.

PSYCHEDELIC RESEARCH AND TRAUMA

> There was this huge terrifying creature with a rifle, and instead of running away, I looked at it, and it wasn't as scary as it had seemed. [My] fear subsided, it suddenly seemed ridiculous, I started laughing. If I had avoided it, it would have got more terrifying. (Psilocybin clinical trial participant; Watts *et al.*, 2017)

Psychedelics are partial agonists of the 5-HT2A receptors in the cortex of the human brain (Nichols, 2012; Vollenweider & Preller, 2020). Potentially leading to changes in neuroplasticity (Ly *et al.*, 2018) and modulations to the default mode network, psychedelics seem to impact self-referential processing, including what is described as a 'sense of self' (Letheby & Gerrans, 2017). This process has been linked to the subjectively experienced altered state of consciousness (Madsen *et al.*, 2021), which may include alterations in auditory and visual perceptions, experiences of a sense of 'unity' (Hirschfeld & Schmidt, 2021) and of anxious ego-dissolution and paranoia (Dittrich, 1998).

The word 'psychedelic' translates as 'mind manifesting' (Rucker, Iliff & Nutt, 2018). It is an umbrella term for a range of compounds, with different duration of action, including but not limited to phosphoryloxyN,N-dimethyltryptamine (psilocybin), lysergic acid diethylamide (LSD) and N,N-dimethyltryptamine (DMT) (Schenberg, 2018). Often grouped together within the emerging drug-assisted paradigm of therapy, 3,4-methyl enedioxy methamphetamine (MDMA) is categorized as an 'entactogen' (literally, 'to produce touch within') (Nichols, 2022). Unlike psychedelics, MDMA is an amphetamine derivative, which stimulates the release of monoamines and hormones thought to support trauma-focused psychotherapy by softening defences and increasing feelings of openness and trust towards others (Bird, Modlin & Rucker, 2021).

Psychedelic therapies currently under investigation are a package of psychotherapeutic interventions delivered with infrequent 'dosing' sessions with psychedelics (Modlin *et al*., 2023). Previously investigated through the 1950s and 1960s, 'the golden age of psychedelics in psychiatry and psychoanalysis' (Guss, 2022, p. 454), research was prohibited consequent to the 1971 UK Misuse of Drugs Act (Hill, 2020). Overall, pre-prohibition and modern research support the relative safety and potential effectiveness of psychedelics in medically controlled environments (Rucker *et al*., 2016). In modern studies across diagnoses and compounds, transient nausea, headaches, fatigue and anxiety are the most common adverse events reported (Bender & Hellerstein, 2022). Contraindications include but are not limited to seizure disorder and severe cardiovascular disease, as well as psychiatric conditions such as schizoaffective disorder and bipolar 1 (Frecska, 2007). The relative safety and potential effectiveness of psychedelic therapy is linked to the carefully curated setting in which the treatment is administered within (Carhart-Harris *et al*., 2018), and the presence of feelings of interpersonal safety and trust between the participant and therapist (Johnson *et al*., 2008; Klavetter & Mogar, 1967).

It is not yet well understood how psychedelics facilitate therapeutic outcomes. Studies exploring biological and psychological predictors of change and qualitative studies investigating patients' and clinicians' experience of the treatment are needed (Romeo *et al*., 2021; Breeksema *et al*., 2020). However, proposed psychological mechanisms of change include mystical experiences (Barrett & Griffiths, 2018; Johnson *et al*., 2019), emotional breakthrough (Roseman *et al*., 2019), insightfulness (Davis *et al*., 2021), altered self-perception and expanded range of affect (Breeksema *et al*., 2020). Finally, yet importantly, sociocultural factors are understudied and greater representation of ethnic minorities in psychedelic clinical trials is essential to ensure equitable access to these potentially effective therapies (Michaels *et al*., 2018).

In the context of regulated drug development programmes, 'side effects' largely refer to the unintended, unwanted or to the collateral effects a medication has on the patient. Accordingly, sponsors, regulators and researchers dedicate significant resources to ensure that those inevitable side effects are, to the extent possible, predictable, and conversely deemed to be safe for clinical use. The predictability of the drug effects induces feelings of trust and confidence in the patient and investigator;

supporting better engagement and belief in the treatment, which might lead to better treatment outcomes. Indeed, in both times of wellness or in times of acute distress, certainty is coveted; fending off existential anxieties, feelings of doubt and helplessness, while supporting feelings of safety, hope and resilience.

Further, the word 'side' suggests that these effects, induced by the treatment, have no intrinsic therapeutic value and are not to be considered its primary desired objective. Rather, these can be thought about as a set of usually useless or unpleasant responses or experiences that the patient should endure or tolerate, because presumably, the other, primary benefits of taking said drug outweigh the potential disturbance or harm caused by not consuming it. And if there is anything in the human experience that at once demands our attention and engagement and challenges our capacity to do so, it is a life-threatening event. To that end, we seek treatments that may offer forms of cure, while also risking further physical deterioration due to their side effects; 'if the cancer won't kill me, the chemo might'. This scenario may be applied to trauma-focused psychotherapies too, in which the patient is implicitly or explicitly invited or encouraged to consider or work through their responses to often life-threatening events and associated symptoms, which have become rigidly repetitive and therefore traumatic, to aid healing, despite the likely potential for significant distress.

Modern medical interest in psychedelics was partly born out of clinical trials treating terminally ill and possibly 'traumatized' cancer patients (Carhart-Harris & Goodwin, 2017), exploring whether psychedelic therapy could help them make something out of their anxiety and depressive symptoms; to make something out of their death and dying. When I asked a physician who delivers psychedelic therapy to patients with terminal cancer in research settings, 'what do treatment responders have to say about their death after a psychedelic therapy session?' they responded saying, 'very little … mostly, they now want to, and feel able to talk about their lives'.

In this story, patients who benefitted from psychedelic therapy, and clinical trials clearly show that not everyone benefits from psychedelic therapy (Galvão-Coelho *et al*., 2021), found a willingness and a capacity to confront a kind of pain that most of us seek to avoid; the conscious mind is a death denying system (Langs, 2004). And so presumably, by literally as well as symbolically confronting their existential crisis, some patients were able to make some thing out of what Western sciences generally refer to as annihilation; and that thing did not cure their cancer, and they still suffered a great deal; however, for some it seemed to offer a way to think about the unthinkable and to feel the unfeelable (Belser *et al*., 2017; Swift *et al*., 2017). And by doing so, they might have found and created a variety of individual cures for a universal and potentially traumatizing happening that may render our adaptations to suffering profoundly inadequate. Put differently, some patients may have discovered within themselves a variety of creative remedies for something incurable and destructive, and by doing so, engineered ways to tell us, the appropriately defended but curious listener, something new or different about the often terrorizing unknown.

Correspondingly, clinical trials are now asking, what, if anything, could so-called traumatized patients, who are not terminally ill, make out of brutal life events that are experienced as psychologically annihilating and physically shattering; experiences that systematically dismantled their sense safety in the world, and their capacity to trust self and others; experiences that challenged their conscience or moments in which their tears, as an expression of their most tender and precious humanity, were ignored or judged, or worse, derived pleasure from.

MEANING MAKING OR MADE OF MEANING?

Comparing LSD to heroin is like comparing a speck of dust with a mountain. The difference is that heroin helps you to turn from yourself and LSD shows you how to face yourself. (LSD treatment responder; Savage & McCabe, 1973)

Psychoanalyst and essayist Adam Phillips writes:

> If someone were to invent a drug that is designed to improve people's mental health—and to say that the point of this drug, the whole value of it, was its unpredictable side effects, there would be a public outcry … We would wonder about the motives of the drug designers, and anyone who sponsored them; and indeed about the rationality of anyone tempted to take such a drug. (Phillips, 2006, p. xii)

In this passage, Phillips is not referring to the re-emerging field of psychedelic therapy, an area of intersecting clinical, scientific, socio-cultural, spiritual, and economic realities and agendas. Rather he seems to be describing elements or characteristics of a version of psychoanalysis; positioning it as a treatment that seeks to help the patient turn towards, rather than away from, that which they spontaneously (e.g., unpredictably) discover and find within themselves; the products or the 'side effects' as it were of psychoanalytic psychotherapy. In Winnicottian terms, psychoanalytic treatment encourages the patient to consider what they, unexpectedly, might discover and create (and repress and destroy), within the transference situation, despite and thanks to the demanding presence of the therapist. Unexpected moments which ask, what can the patient bear to think about and feel? Unintended slips of the tongue, which ask what can the therapist tolerate to hold and metabolize? Authentic moments of relatedness, which ask how much pain and pleasure can be experienced and shared, within self the therapeutic dyad? And importantly, what, if anything, can be made of these so-called side effects that will be conducive to healing?

In general psychiatry, Phillips' remarks are prudent. Imagine the public outcry if a psychiatrist knowingly or intentionally prescribed a drug whose side effects are inherently unpredictable to a desperate and anxious patient. Further, the psychiatrist then justified their intervention by arguing that, for the patient to heal, they are required to confront and make use of, or make meaning out of the unpredictable, and the possibly disturbing nature of these effects. Or in other words, that the whole point of the treatment is to do with what people can make of the treatment's

transient side effects, or in psychedelic therapy terminology, the evoked 'subjective effects' (Yaden & Griffiths, 2020).

For example, if the effects of an antidepressant are overwhelmingly uncomfortable to the patient, the physician might consider re-evaluating or ending the treatment. In psychedelic therapy, however, should the effects of the psychedelic become increasingly anxiety provoking and a cause for disturbance, the therapist would first seek to support the participant to leverage these effects, seeking to help them stay with, accept and allow and go 'in and through' their experience (Mithoefer, 2015; Guss, Krause & Sloshower, 2020; Tai *et al*., 2021) following the notion that these effects are symbolically representative of content emerging into conscious awareness that are of significant therapeutic value (Richards, 2017). In this scenario, the aim of the intervention is to do with the inducing of or the enhancement of the side effects. The rationale conveyed to the participant is that '*we want to know about this and explore the meaning of it*' as opposed to rapidly alleviating its impact on the participant and, at times, on the therapist. Further, the therapist working in psychedelic research may seek to help the patient to amplify these effects, as presumably this will facilitate a more intentionally experiential process to naturally unfold and resolve, as opposed to attempting to dampen or reduce its impact on the participant. The guiding notion is that there is meaning and therefore healing to be made and experienced in allowing, rather than controlling, in moving towards rather than away, all available experiences. Therefore, part of the preparation work ahead of the psychedelic administration session is to support the participant cultivate a mindset that values the wisdom of one's own mind and the intelligence of one's heart (Grof, 1988); a way of approaching self, which is imbued with openness, acceptance and curiosity; a mindset that suggests that there are 'other still undreamt of possibilities of therapy' (Freud, 1938, p. 182).

This links to psychoanalytic practice, where all intrapsychic and interpersonal material can be considered a meaningful component of the treatment.

For example, in an analysis (Freudenthal, 1995, p. 257):

> The patient states, 'I can't go on like this. I do want to get better'.
> To which the analyst replies, 'Why aren't you getting better?'
> Frustrated, the patient states, 'I tried everything, nothing works'.
> Perhaps challenging the patient, the analyst asks, 'Did you say everything here?'
> 'Yes, I told you everything already, you forget' responds the patient.
> The analyst continues, asking 'Did you give me an account of every minute in your life?'
> To which the patient, almost falling off the couch perhaps, asks, 'You want me to tell you that I had pizza for lunch yesterday?'
> 'Yes, tell me everything!' exclaims the analyst.

An MDMA-assisted therapy treatment responder suffering from post-traumatic stress disorder (PTSD) said this about their experience: 'maybe one of the things the drug does is let your mind relax and get out of the way because the mind is so

protective about the injury' (Multidisciplinary Association for Psychedelic Studies, 2011). Correspondingly, talking about pizza is safer than speaking and hearing the full and unadulterated description of war, childhood adversity or the death of a loved one. In the analytic example, the 'pizza' is the seemingly useless and meaningless side effect, one that compels the analyst to ask the patient to tell them everything; re-inviting the patient to speak with more freedom and less concern about what the analyst might do with what they have to say, or with less dread about what they, the patient, might experience if they spoke. It is more about learning to immerse oneself, tolerate and make use of the process of describing any and every thing, than with being preoccupied with the outcome of doing so.

Accordingly, the experiences and material discovered or created by the participant during psychedelic therapy, are considered as an inevitable and necessary 'side effect'; those that are central for healing. The side effects are those initially or persistently indescribable experiences that need to be described, in order to be redescribed again, and again, and again. The intentional or conscious redescription of these moments takes place during the so-called 'integration period' (Bathje, Majeski & Kudowor, 2022). The participant is invited to consider the evolving meaning and significance of their experience over time via a range of predesignated activities; time-limited meetings with their therapist, forms of creative expressions, moments of reflection and connection with self and others or, more generally, by living one's life more fully. Importantly, to counter the incessant desire to 'know', which is also an adaptation, a way to survive our natural state of unknowing, the act of redescription should be valued due to its capacity to catalyse symbolic as opposed to concrete thinking; to encourage the person to be a curious student of their experience. Not only for the sake of arriving at conclusions, which in fantasy are the cure, but for the sake of the experience of being a student. The timeless, wordless and shapeless unconscious mind is not to be known, it is to be revered; the unknown within us and within others can also serve as a way to come in touch with our common humanity, our collective predicament of at once being at the mercy of and driven by something we can only, barely, imagine.

Further, for Bromberg:

> In the face of psychological trauma, self-continuity is threatened, and this threat, for most human beings, is countered by the use of dissociation as an evolutionary response that is important to survival. (Bromberg, 2010, p. 113)

Accordingly, the process of describing and redescribing can be considered an attempt to restore or create the conditions for a sense of continuity to be perceived and experienced; where the traumatic pathogen is not removed but rather relocated from the foreground to the background; where it informs the person, rather than defines the person. We may then consider the side effects in dynamic psychotherapies or psychedelic therapy as analytic objects that emerge without a deliberate conscious effort but with seductive conviction; as something potentially alarming that demands our attention, while requiring our disregard; as something potentially shocking that needs to be articulated, but that must remain unintelligible somehow.

With ambivalence in mind, patients and therapists try to avoid and pursue the inevitable; the traumatized patient isolates themselves in an attempt to avoid the perpetrator, only to find a version of this perpetrator operating internally; the neglecting and shaming caregiver, the power hungry and self-mutilating inner critic.

And so, to the psychoanalytic patient or psychedelic trial participant who responds to treatment, the side effects may be those experiences that appear without warning, but, in hindsight, when appropriately held, with a kind of premeditated unconscious intentionality; the psychoanalytic patient may become aware of their experience of shame and alienation to eventually permit the experience of esteem and connection; the psychedelic participant may experience claustrophobia or helplessness to eventually experience expansiveness or empowerment, and so on.

When one listens to a patient trying to describe a traumatic experience, or a participant attempting to locate the most significant aspects of a psychedelic experience, recognizable themes emerge. Themes not specific to the content, which are naturally unique, but rather to the process; the process of finding out what one can bear to say about their lived experience. This process is made of interdependent experiential patterns that emerge within and between the speaker and the listener; somatic, emotional, psychological, and cultural processes that seek definition and elaboration while also pursuing ambiguity and abstraction. 'It's hard for me to know what I mean, if you know what I mean' patients sometimes remark.

For psychedelic treatment responders, one often hears a narrative broadly to do with somehow possessing more internal space to observe, to hear, to feel, and to understand what we refer to as 'self', and that indeed, it was something within that helped them do so (Vaid & Walker, 2022; Grof, 2000). As if treatment responders experience the speaker and the listener as one organism, working in collaboration, towards an 'unthought known' (Bollas, 1987) end point; a symbiotic form of intrapsychic communication may be revealed and experienced, one that appears to be meaningful and helpful, one that may catalyse the possibility of a new starting point. To that end, psychedelic experiences, for responders, can serve as 'the bridge by which a developmental arrest would begin to be healed' (Lindy, 1989, p. 408). Intimating that for the traumatized patient who might feel frozen in time, constantly suspended on the verge of a catastrophe, or stranded on a deserted island, a necessary step is to trust that this so-called 'bridge' exists within; the therapist, the psychedelic compound, the analytic interpretation, the affective resonance, the real and transference relationship, the cognitive restructuring all act as vessels towards discovering and making use of this bridge.

Greenberg writes:

> If trauma creates a separation from the self, a fragmentation of identity, then the process of narrating a trauma mimics this fragmentation. The narration of traumatic memories often differs from that of 'normal' memories, which have a beginning, middle, and end. (Greenberg, 1998, p. 323)

Correspondingly, when approaching the description of traumatic or psychedelic experiences, the initial position the speaker can find themselves in, is one in which

they are lost for words; words seem inadequate somehow, unable to convey the essence of their experience; too far away to reach, and too close to locate. There are either too many or not enough words to describe what they have endured or survived; words that are hard to find because they are in hiding; sometimes hiding in plain sight amongst an overcrowded vocabulary, each syllable competing for acknowledgment and validation while withdrawing and seeking anonymity. Or words that, in a felt sense way, appear hollow and disjointed, stowed away in psychic and emotional localities we struggle to access; suggesting that having access to these areas of our lived experience might entail a reckoning with a range of primitive agonies that constrict our symbolization and expressive capacities. Psychoanalysis, as a general rule, proposes that the experience of being 'lost for words' is also one that is desired, needed and somehow intentional; that finding the so-called 'right' words is threatening to an imagined state of homeostasis; a carefully put together adaptive system responding to our inherit vulnerability; threatening for what these words may evoke within the speaking patient, and the impact these words might have on the listening therapist, and the patient's wider, real world, socio-cultural hemisphere.

ON FREE ASSOCIATION AND REDESCRIBING THE INDESCRIBABLE

In psychedelic therapy in research settings, we invite or compel the participant to enter into an experience that will inevitably evoke powerful feelings of vulnerability; a few hours or a whole day spent with a therapist, in an altered state of consciousness, reclining on a bed, wearing eye shades while listening to a curated playlist of music, with the guidance to trust, let go and be open, and to follow their inner experience (Pahnke, 1969); or, in analytic terms, to freely associate. Considering the psychoanalytic couch and the guidance to freely speak the contents of one's mind, the patient is invited to not only withstand their responses to this exposure, but to leverage it for healing. In both disciplines then, the patient is asked to trust a fantasied version of Freud's paradise, before 'shame and anxiety awoke, expulsion followed, and sexual life and the tasks of cultural activity began' (Freud, 1900, p. 244). We ask participants to permit, to accept whatever may emerge; we invite them, for a few hours at least, to the extent possible, to live freely, without or with less fear about what their own minds and the minds of others may be made out of; to under interpret and not arrive at conclusions, not to avoid or escape thinking and feeling, but as a means to over interpret; to 'over' experience life as it were. And in the context of trauma therapy, the capacity to 'over experience' may serve as an anecdotal glimpse into a self-state also capable of tolerating associating rather than dissociating; a body also capable of calm rather than hypervigilant states; a heart capable of feeling, rather than of numbing; a mind capable of organizing experiences, withstanding the persistent pull of disintegration.

The title of this essay, 'redescribing the indescribable' suggests that traumatic experiences are indescribable insofar that they, on some level, seek to defy description. We seek to avoid their re-experiencing by not describing them; the patient and

therapist re-enact the unfelt and unthought about experiences so as to alleviate the burden of being exposed to what Bion might have referred to as 'nameless dread' (Bion, 1962). Psychedelic experiences, on the other hand, seem to compel the person to speak, despite the often indescribable, baffling, challenging or evocative nature of the so-called altered state. Further, in the aftermath of a meaningful and therapeutic psychedelic experience, often one observes in the participant a profound wish to re-visit or to not lose elements of the experience; not in the sense of seeking another experience, but rather an anxiety about the potential for any insights or corrective emotional states to dissolve or fade away—to somehow mean less, over time. If traumatic experiences are so entrenched and memorable, they must be forgotten; if psychedelic experiences are so transient and forgettable, or hard to keep in mind, they must be remembered. And the wanting to remember, rather than forget, is curative in and of itself. It is an associative rather than dissociative state; it signifies a curious stance towards self and the experiences that have shaped self; it is a style of relating that permits a desire for intrapsychic and interpersonal intimacy, symbolic of pro social feelings of safety, acceptance and compassion, between, what Constance Newland, an LSD patient in the 1960s called, 'myself and I' (Newland, 1965).

For psychedelic treatment responders then, the momentary alteration of consciousness, potentially resulting in insightfulness, catharsis, the sense of universal connectedness or enchantment, is something that wants to be preserved; and the act of preserving it may represent an internal reparative intention and process. For the trauma survivor, the wish to nourish self or the knowledge that one can be nourished by self is, potentially, profoundly healing, and meaningful. Further, the desire to symbolically protect the fantasied unspoiled authentic self or the innocent life-loving inner child, against the backlash of the so-called ordinary state, one that is also imbued with the traumatic and the unchangeable, is, if nothing else, empowering; finding the capacity and will to re-parent oneself not only induces feelings of safety and belonging, but also produces a sense of courageousness and knowledge of and trust in one's own internal resources. To that end, psychedelic therapy and psychoanalysis can be viewed through the lens of immersing oneself in an altered, non-ordinary state, in service of learning how to negotiate with and avail oneself to the pleasures and burdens of the so-called ordinary state.

Psychoanalyst Joyce McDougall wrote:

> psychic reality will always be structured around the poles of absence and difference; and human beings will always have to come to terms with that which is forbidden and that which is impossible. (Viorst, 2010, p. 81)

This may suggest that speaking about trauma and ingesting a mind-altering compound is an act of subversion. It is subversive insofar as both require the patient to negotiate with and overcome powerful internal injunctions and well established social contracts whose function is to keep matters unchanged or at bay; to maintain a silent and non-disturbing equilibrium. In trauma work, the psychological notion of a 'comfort zone' or the biopsychological construct of the 'window of tolerance'

suggest that there are safe and unsafe places for us and others to inhabit; and so the danger is that by speaking, we may fall into those places, without anything within us or outside of us to guide us back to Bowlby's secure base (Bowlby, 2012).

In the myth of Sisyphus, Albert Camus writes, 'seeking what is true is not seeking what is desirable' (Camus, 1942, p. 28). Bearing our ambivalence, we seek to know and to forget; to excavate and to bury; to clarify and to obscure all that which has left us somehow scarred. To that end, the material and experiences that require a 'turning away from' can be considered 'traumatic' but 'truthful'. Suggesting that for the patient and therapist, the therapeutic process, may or must, entail a series of encounters with a kind of truth; a disturbing psychic reality, or a contending with what was lost, with what will never be recovered, or with what was never present in the first place. The patient and therapist negotiate how much truth can be found and digested at any given moment; truth in this story refers to the conscious and unconscious affects, cognitions and somatic states that require a defending against; or that they are, unthinkable, unspeakable or unrememberable, and therefore, at times, indescribable. The describing of these encounters and experiences requires a great deal of libidinal energy; both a wish and a willingness to make contact or come in touch with the more unknown or abstracted versions of self and the other; and accordingly, they also require a great deal of trust; of courage; and of hope.

To find the right words is an under-appreciated act of defiance; one that may be easily overlooked by the ambivalent speaking patient, and less immediately impressive for the ambitious, recovery-oriented ears of the therapist. In psychedelic therapies under investigation, the act of volunteering for a clinical trial which requires the ingesting of a mind-altering psychedelic is often belittled by the so-called treatment-resistant patient. In psychotherapy, the act of freely associating, of speaking and feeling with less fear of condemnation from the other, is often undervalued.

We are more interested in the fantasied painless or pain-free outcome of our treatments, than in the often painful or pain-eliciting process of healing. In psychedelic therapy or psychotherapy, summoning the required trust in oneself and the other, be it a compound and/or the therapist, or daring to hope after years of disillusionment, or exercising courage after years of fearfulness, is a rebellious act against the tyrannical meaninglessness of trauma; a symbolic way to defy the traumatic injunction to escape from, remain silent and immobile, or to be at war with our past, our present and our future. At their best, both psychedelic therapy and psychotherapy are less concerned with the attainment of insight, emotional breakthroughs, reparation of attachment wounds, cognitive restructuring, behavioural activation, or the coveted mystical experience, and more interested in supporting the patient to be appropriately, as opposed to destructively, disturbed by that which is incomprehensible and indescribable; the primary descriptors of that which we label traumatic. Therapies that facilitate a process in which one becomes less defensively preoccupied with making sense of their minds or physiological responses to trauma, and more open to develop an interest in their experience, not in pursuit of an imagined true or idealized version of self, but rather to become once again, or for the first time, enchanted by the mysterious ingenuity and multifaceted nature of their selves. To develop

benign or constructive forms of narcissism that are curative insofar as they might suggest to the patient that they can become absorbed and engrossed in an experience, without or with less concerns over their safety, and by metabolizing, or taking in, not only the effects of the compound, or the analysts' interpretations, but the experience of deeply being with the multiplicity of self-states within. For treatment responders, this may signify a profoundly emotive, somatic, non-verbal and intimate happening; the intrapsychic and interpersonal acting out and in of Winnicott's notion of the quiet union between baby and mother where objects are created and found in service of 'the initiation of an affectionate type of object relationship' (Winnicott, 1971, p. 1).

From an interpersonal perspective, Sable (2000, p. 164) highlights Casement's notion of psychological trauma as something 'that which can't be managed alone'. This makes healing trauma difficult because trauma is also about potentially devastating forms of interpersonal and institutional betrayal (Smith & Freyd, 2017). To that end, de Zulueta quotes Lindemann in 1944, who stated, 'psychological trauma can be defined as the sudden uncontrollable disruption of affiliative bonds' (de Zulueta, 2006, p. 335). In this context, the side effects of psychoanalysis or psychedelic therapy are these inevitable moments of surprise, of shock, of powerful emotionality or bodily excitation that take place in front of a hopefully interested and compassionate audience. Within the positive transference, this is the witnessing therapist, the nurturing parental object. These moments also take place in front of an imagined group of internal spectators, the mental representations or ego structures of the patient and therapist; moments that, like traumatic experiences, can be so unignorable or unforgettable that they require ignoring or forgetting. At times, the patient and therapist ignore or forget about these intrapsychic and interpersonal experiences by not being impressed or interested in them; they do not seem to have any therapeutic value or meaning, or indeed they may somehow be experienced as harmful and threatening.

Accordingly, these moments demand a different kind of paying attention to; one that is persistent in its ethical practice, in its humility and curiosity, in its patience and its relentless belief that everything matters a little more than we think. For example, for the patient and therapist as one, the act of being together, rather than separate, in proximity, for 6 or 8 hours, may evoke powerful feelings of idealization, of desire, or paranoia; these relational perspectives require careful clinical management (Meckel Fischer, 2019; Murphy *et al*., 2022; Rundel, 2022). Further, for the patient to be in need of forms of agreed upon handholding while reclining on a bed and wearing eye shades, trust becomes more than a construct; it becomes a vehicle for self-discovery. And so the traumatic memory may become more than an abstracted or deadening state of hopeless pathology, but an enlivened and animated happening that can also serve as a platform for growth and healing. For the psychedelic trial participant and the psychoanalytic patient then, one of the tasks is to make something out of these occurrences; to want and to be open to the possibility and capacity of these evolving stories to mean some thing; to soothe, to inform; to challenge; to evolve.

And stories or narratives are only meaningful, when shared; whether it is a parent telling a bedtime story to their child, or a group of adults sitting around the fire together (Dass, 1973), we depend on our ability and willingness to make use of others, and on the ability and willingness of others to be of use, and make use of us in return. Put differently, at times, human relationships have the capacity to be 'the best antidepressants' (Panksepp, 2014) while simultaneously, and perhaps more acutely for survivors of trauma, a cause for cyclical torment. The protagonists in James Norbury's book *Big Panda and Tiny Dragon* (Norbury, 2021, p. 12) succinctly highlight this, stating, 'which is more important', asked Big Panda, 'the journey or the destination?' 'The company', said Tiny Dragon.

CONCLUDING REMARKS

Soon I'll find the right words, they'll be very simple. (Kerouac, 1997, p. 280)

Psychoanalysis is arguably interested with how we perpetuate forms of discomfort or disturbance in service of keeping at bay, or moderating, other, more disturbing internal realities. Our symptoms, that are often what we want to change about ourselves, are self-created protective stories, a kind of emotional membrane, mediating the effects of intentionally unknown circumstances we cannot, or rather do not want to or know how to contend with. Through this lens, the anxieties we observe in clinical trial participants before and during a psychedelic therapy session, are not so much about coming into contact with what is readily available or conscious, but rather, more preoccupied with the ramifications of meeting something that needed and needs still to be indescribable; there is safety in silence; in non-thinking; in not remembering. 'One can only study what has first been dreamed' states psychoanalyst Ofra Eshel (2013, p. 38); perhaps intimating that the dream-state is where and when we allow some of that which must remain indescribable to emerge, in order to make something of it as opposed to be used, or subjugated, by it.

The process of describing something that potentially matters so much means that, at times, we are compelled to make it, or large swaths of it, appear somehow obscure and hollow, or grandiose and magical, and by doing so we make the 'healing thing' we supposedly wish to describe, meaningless. That is to say, one of the problems with describing the events and circumstances that shape our internal and external realities is that the problem does not want to be resolved or that it needs more time until forms of resolution are available and appropriate. An experience described is an experience that resists becoming something else or different; and this may dictate how we relate, feel and think about ourselves and the world. Put differently, a story told is a story with an end, and a story with an end confronts us with the reality of loss, where our omnipotent and omniscient selves are limited and vulnerable.

A story with an end, even if it is a good ending, is still a story about loss. And loss for the traumatized patient we all were, are, or might be some day, is best experienced together. One of the key healing processes that psychedelic therapy may offer then to treatment responders is to do with the happening that often, after

psychedelic experiences, in any context, people want and indeed feel compelled to talk about what they observed and experienced, with others present. Or as Zinkin stated, 'one becomes real through recognition by other people' (Zinkin, 2008, p. 396). And so, the so-called otherworldly or ineffable psychedelic experience is made real, and real in this context refers to its capacity to be used by the psychedelic trial participant to make their lives better, when it is recognized and metabolized by another self. And recognition by the other entails tolerating being touched and moved by people, and in return, tolerating the reality that others will be touched and moved by one's suffering, one's pleasure, one's life and one's death. There are distinct defensive and narcissistic elements to this propensity, however, in the context of traumatic stress: the patient might recognize that they require support in 'holding' their experience in mind. That it is, like traumatic events, 'too big' to work through or make sense of alone; implicitly encouraging a willingness to be with and make use of others and an acceptance of our most primordial, object seeking, desires and yearnings; moving away from an overly defensive or alienating style of relating to a more integrated form of object relations.

Correspondingly, the traumatic injunction to conceal and remain silent is worked through via the private and public description of the psychedelic experience. The psychedelic experience itself becomes an analytic object, separate enough from self that it can be thought about and spoken to and from. Psychedelic trial participants might take up time and space to consider their words, implicitly suggesting a degree of respect to that which one wants to express; relinquishing, if for a moment, a shame-induced or degrading stance towards their needs and wishes, their humanity. Before, during and after speaking about their experience, participants internally validate the relevance, resonance and meaning of their words; experimenting with the unfiltered description of ineffable or absurd moments or narrating highly regressive states in which vulnerability and frailty are absolute. This perhaps suggests a way of relating to self that is not excessively objectifying or dehumanizing, that is less driven by outcome, or the arriving at premature explanations or interpretations, and more concerned with paying a benevolent form of attention to self; an enchanted child, playing with, rather than being governed by the immediacy of experiencing, the expectation to understand and the injunction to make sense to others.

Chwelos and colleagues wrote this about those participants who responded to treatment, 'one learns to walk by walking so one learns to love by loving' (Chwelos *et al*., 1959, p. 590). Walking and loving are both key developmental, life-long, processes; they carry the risk of failure and pain, and the promise of ecstasy and freedom; they require a steady and reliable container; demanding an encounter with the unknown and the confrontation with our inherent, humanizing and humbling vulnerability. And so, we can imagine the psychedelic participant who responds to treatment, to be one that is learning to think, to feel, to relate to and to speak about the unknowable and the known, within and without, by learning to redescribe the indescribable, and by doing so, learns to re-humanize that which has been dehumanized, by self, others, and the world.

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