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Set, Setting, and Structure: On The Social Production of Psychedelic Transformation

By

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DISSERTATION

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DAVIS

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Abstract:

This dissertation examines psychedelic-assisted therapy (PAT) as an emerging and unsettled field of care in which suffering, meaning, and altered states of consciousness are being organized across clinical, ceremonial, decriminalized, and underground settings. Drawing on sixty in-depth qualitative interviews with facilitators and patients, it argues that psychedelic healing cannot be understood through pharmacology or acute experience alone, but must be situated within the social, relational, and structural conditions that shape whether transformation becomes durable, distorted, or impossible to sustain. Across three empirical chapters, the project develops the concepts of *liminal authority* and *psychedelic careers* to explain how facilitators construct legitimacy and how patients learn to interpret and carry forward meanings from altered-state experiences through dispositional and interpretive resources that are themselves unequally distributed, and extends cultural brokerage literature to develop *experiential containment* and *liminal relay* as mechanism-centered concepts that specify the conditions under which health transformations succeed or fail to sediment across the boundary between PAT sessions and ordinary life. Together, the concepts across each chapter provide the analytical language necessary to rethink ‘set, setting, and integration’ as social and structural accomplishments rather than individual or pharmacological ones. The dissertation concludes that psychedelic-assisted therapy reveals both an expanding medical jurisdiction over altered states of consciousness and the limits of biomedical and market-driven frameworks for understanding suffering and transformation which exceed the language of symptom reduction alone, and specifies what a critical sociology of psychedelics must entail in order to adequately analyze the field as it continues to develop.

Introduction

Seeing God on Tuesday: Suffering, Transformation, and the Sociological Stakes of Psychedelic Care

Jeffrey's encounter with "it" happened on a sunny Tuesday morning in Oregon. A soft-spoken IT professional, husband, and father of three in his early forties, Jeffrey had traveled to another state seeking mental health care in secret from his family. Both the secrecy and the state of Oregon were entirely new to him. The most important novelty of his Tuesday, however, was the psilocybin his facilitator would administer at 11 AM. "I was at the end of my rope... and the suicidal thoughts were just getting louder," he explained. "I had heard about the potential benefits from a lot of people, and it really felt like I had to at least try. It's not like my mindset could get any worse."

His decision to travel to Oregon was plotted over several months, through many conversations with potential psilocybin therapy facilitators on the phone, and with considerable concern about how his wife might respond if she found out. Jeffrey described her as holding firm, uncompromising views about drug use, shaped in part from watching her mother struggle with addiction over the years. When he teased the possibility of psilocybin therapy in conversation with her in the months prior, she made her resistance particularly clear. "She said it would be like paying thousands of dollars to wreck my brain... There was no wiggle room for her," he somberly explained. Yet, her dispositions towards drug use had never created a practical obstacle for Jeffrey until now. Having lost his own father early in life to liver failure resulting from decades of alcoholism, drinking was largely an activity he avoided outside of special occasions. And although he had experimented with cannabis as an undergraduate, he felt it

"made [him] way more anxious than anything," and that it "definitely wasn't something [he] could ever imagine being helpful for someone with [his] kind of mental health problems."

When Jeffrey watched a YouTube video of a former patient recounting her legal psilocybin therapy session in Oregon after the passage of Measure 109, he felt that "psilocybin seemed a lot less like a drug in the way I'd always thought about them... It seemed more like a mystery you can't really solve unless you see it for yourself." The patient used a phrase in that video which left him with a nagging curiosity about the potential therapeutic promise of psychedelic medicines: "She said she finally saw where her sadness was coming from and knew what she had to do to deal with it. And she also said that she had this powerful realization that she wasn't beyond hope, and that she finally felt excited to be in her own skin every day... That really resonated with me, because that's the self-dialogue I've had going on in my head my entire life... I've felt that sense of hopelessness for so long, and it's only become worse as I've tried more and more treatments."

A self-described atheist prior to his encounter with psilocybin, Jeffrey had qualified his expectations for the session against much of the spirituality-talk he heard circulating in public conversations about psychedelics. "Plenty of people were saying they were talking with spirits and seeing entities when they did it... all of that sounded pretty looney to me. I was much more interested in the kind of emotional clarity so many people said they were gaining after doing it. But now that I'm on the other side of things, it's so obvious to me that my atheism, and, like, the kinds of tensions my atheism came into contact with during the whole thing, is what made the whole experience so powerful."

And so, into tension Jeffrey's worldview went on that Tuesday. He recalled intense nervousness leading up to that morning, manifesting as "a kind of pit in [his] stomach that was

like nausea, terror, and confusion all wrapped up in one feeling." His facilitator worked to calm his nerves through several strong affirmations, assurances of safety, and validation of his feelings. "She told me if I didn't feel nervous, something is wrong. It's not something to take lightly. Being nervous is a sign that you really do grasp how big of a deal what you're doing to your body and mind is beforehand."

After bracing himself for thirty minutes, Jeffrey signaled his readiness to take his dose, and his facilitator gently pushed a large cup of steaming psilocybin tea across an ornate coffee table towards him. He recalled the sweetness of the honey that lined the bottom of the cup as he slurped up the brew, and a strange feeling that "something was shifting almost immediately, like you feel when you take a shot of some strong booze, but in a way that feels totally different from alcohol."

And within just fifteen minutes, his shift in perception was unmistakable. His palms sweating profusely, his heart rate drastically elevated, and his body "feeling like it was receiving a warm and lovely hug all over," Jeffrey allowed himself to begin easing into the experience, "accepting the feelings that were coming up for what they were and just allowing it all to happen without resistance." Over the following hour, his mind and body were subsumed by waves of feelings, thoughts, and imagery that "seemed like they were coming from somewhere outside of [him], and were just totally captivating... It's like a movie that you aren't a passive observer of... that you're immersed in with *all* of your senses." He recalled experiencing a wide range of visceral emotions and seeing "waves of patterns, faces, shapes, and other bizarre, beautiful things" that captured him in awe. Shortly thereafter, when his dose was at its most potent, Jeffrey's Tuesday led way to a discovery that would abruptly reorganize everything he thought he knew about the nature of reality itself:

"During the peak, I experienced what must be God. And I realized through that experience that God isn't some singular entity. God isn't a he, a she, a them, or whatever. God is an 'it.' And 'it' is in everything. It binds everything together and it animates it all. It is the cloth that we're all cut from. And seeing 'it' for what it is in that moment altered the way I look at everything. I entered this whole thing as a skeptical atheist, but I can't really call myself that anymore. I still don't know how to really define my metaphysical worldview, to be honest. I just know that there's something going on in reality that's so far beyond any person's comprehension, and that it will probably always be that way. And that makes me think there's probably something more to this whole 'life' thing than any scientific theory can possibly capture."

After asking him later in our interview whether his experience with “it” helped alleviate his depression symptoms in the days and weeks that followed, he recalled how the incongruence between his lived experience and the way others could receive it became a source of rapid unraveling. This is because Jeffrey returned from his Tuesday carrying a reorganized relationship to his own existence, and walked directly back into the structural conditions that had produced his suffering in the first place:

"I don't think I'll ever want to kill myself like I used to. I can see beauty in life that I didn't before. It's like, when I think about life in the abstract sense, I see it all as a miracle now in a way I never had. And it just feels like it would be such a waste to end my chance to experience it... So, I held onto this kind of cathartic feeling for a few weeks after my session, and that alone was the most relief I'd ever felt from my depression. But I didn't really have anyone to talk with about what I'd experienced, outside of the couple of integration calls I had with my facilitator. Like, my wife didn't even want me to do it in the first place, so I didn't really feel like I could talk about what I'd experienced with her. And once I started to go back into the world and had to

experience all of the bullshit that's made depression a fixture of my life for so long, I found myself back in the same mental cycles again... Like, think about it this way: *I saw God on a Tuesday, and I still had to go work a 12 hour shift that Thursday*. How fucked up is that? It's not like I could just quit my job, you know? My family needs me. I've got three kids, my youngest has a serious disability, and my wife only makes so much. So yeah, I'm definitely still depressed... I'd say it did help overall, in the sense that my family has someone who's more consistent and grounded. But I still feel pretty empty inside most of the time. It's kind of been maddening going from feeling like there's hope and purpose, back to feeling empty again. It's like, my internal conditions have definitely changed, but my external conditions definitely haven't."

What this project has found is that Jeffrey is not an outlier. Across the accounts assembled in this dissertation, people who have sought out psychedelic-assisted therapy recall such noetic encounters with striking consistency, returning from acute sessions carrying a felt sense that something was revealed to them: something whose content and force resist translation into the reductive vocabularies of biomedicine. His account also illuminates with precision the central tensions this dissertation interrogates. Namely, the tensions between subjective experiences, social contexts, and the structural conditions that contain them. The clinical literature on psychedelic-assisted therapy has developed a framework – broadly imbued with dogmatic weight – for understanding how context shapes these experiences, organized around the concepts of set and setting: the internal state a person brings to a session, and the relational and environmental conditions surrounding it.

That framework has been invaluable in establishing that psychedelic effects are not pharmacologically determined in isolation. It makes clear that what happens in these sessions

depends on expectations, relationships, ritual, and atmosphere. What it has been less equipped to address is the broader structure that surrounds and exceeds the session itself: the economic arrangements, relational obligations, institutional landscapes, and cultural conditions that patients return to once the medicine has run its course. Jeffrey's set was carefully prepared. His setting was thoughtfully designed. His facilitator was skilled and present. And none of it could reach the twelve-hour shift waiting for him on Thursday, the disability that structured his family's finances, or the relational silence that left his encounter with "it" without a community to hold it. Set and setting, as typically theorized, describe the container and its contents. This project asks what the container can and cannot hold for healing to be realized, and what conditions beyond it determine whether the experiences that happen inside become anything more than a vivid and fading memory.

That a secular biomedical apparatus is systematically producing these encounters and measuring their outcomes while remaining almost entirely silent about what they are and what they demand is a problem the clinical literature has yet to take seriously. Where the psychedelic renaissance is often reported as a story of marginal yet miraculous molecules finally finding their rightful place within modern psychiatry, few have asked whether the world these medicines are returning to can sustain the depth of meaning they so often impart, or what such tensions reveal about the conditions under which durable healing becomes possible at all. This dissertation is, among other things, a sustained attempt to seriously engage with those questions.

Psychedelic-assisted therapy is thus re-emerging at a peculiar juncture in the history of medicine. After decades of prohibition that rendered these substances legally untouchable and scientifically stigmatized, a critical mass of phase II and phase III clinical trials has produced findings striking enough to reorganize the field of psychiatric research around them. Psilocybin

reduces depression in patients for whom years of conventional treatment had yielded little. MDMA produces durable reductions in PTSD severity after a small number of sessions. A single high-dose experience, embedded in structured psychotherapeutic support, can transform the relationship a dying person has to their own mortality. The results arrive with effect sizes that specialists describe, with unusual candor, as unlike anything else in the psychiatric literature. And yet the mechanism of change remains genuinely, stubbornly contested. The leading candidate is not a receptor binding profile or a downstream signaling cascade, though those are documented and real. Rather, it is what the pharmacological literature references as the “mystical-type experience” itself, involving the dissolution of ordinary selfhood, the felt encounter with something larger and more binding than the individual ego, and the noetic conviction that something ineffable yet deeply true has been revealed. These experiences predict outcomes across studies with a consistency the field has not been able to explain away, and a growing contingent of researchers have arrived at the uncomfortable conclusion that subjectivity – the very thing biomedicine has spent a century learning to bracket – may be the most active ingredient.

This creates a situation of considerable sociological interest. The clinical apparatus responsible for the medicalization of human suffering – progressively redefining distress as individual pathology amenable to pharmaceutical correction – has found itself in possession of substances that do not behave like pharmaceuticals in any straightforward sense. They often produce experiences that patients describe in the language of the sacred, the extraordinary, and the cosmologically revelatory. They reorganize metaphysical worldviews, dissolve long-held identities, and return people to their ordinary lives carrying the residue of something that no available clinical vocabulary can adequately describe. The field has responded to this

predicament largely by proceeding as if it were not a predicament at all. Dosing protocols are refined, facilitator training curricula are developed, debates are had about the optimal ratio of psychotherapy hours to dosing sessions, and outcomes are measured on validated inventories designed for this wholly different class of interventions. What has gone without sufficient attention is the gap between the ontological claims these sessions generate, the social-structural conditions that determine whether transformation persists once participants return to ordinary life, and what all of this demands of the institutions now organizing psychedelic-assisted therapy at scale. Clinical literature is extraordinarily productive at the level of outcomes. It is almost silent at the level of meaning. Silence at the level of meaning generates problems in patients' healing trajectories that are analytically traceable to the structural conditions they return to. And those structural conditions generate problems that are traceable with equal precision to the absence of cultural infrastructures capable of receiving the meanings patients seek to consolidate in their session's aftermath.

Sociology is well positioned to fill this silence, and the present moment makes doing so urgent. Psychedelic-assisted therapy is not being introduced into a stable institutional landscape. It is emerging within a fragmented, contested, and rapidly evolving field that spans FDA-sanctioned clinical trials, state-licensed service programs in Oregon and Colorado, legally protected religious and ceremonial communities, decriminalized care settings, and extensive underground practice networks that have existed for decades beyond the reach of formal oversight. Practitioners working across these contexts arrive from heterogeneous lineages, including clinical psychology, social work, somatic therapy, shamanism, and peer support, without shared credentialing standards, unified ethical codes, or settled jurisdictional boundaries. The field is, in a structural sense, unsettled. Patients navigate this landscape under conditions of

economic stratification, legal ambiguity, and variable access to the relational and cultural supports that, as this project will demonstrate, are centrally constitutive of therapeutic outcomes. The actors within it are actively and consequentially making the norms, meanings, and infrastructures that will determine what psychedelic-assisted therapy becomes. This dissertation examines those processes while they are still in motion.

It does so through sixty in-depth qualitative interviews; thirty with psychedelic-assisted therapy facilitators and thirty with patients who received care from practitioners working across the full range of contexts described above. The facilitator sample spans licensed clinicians, ceremonial practitioners, and underground guides working across the United States, as well as facilitators operating within Oregon's state-licensed psilocybin framework, assembled through purposive and snowball sampling strategies that provided access to networks otherwise closed to outside inquiry. The patient sample was recruited through a combination of online outreach and practitioner referral, producing a group whose care trajectories span clinical trials, state-legal service centers, religious communities, decriminalized settings, and underground contexts. Sixteen patient participants received care from facilitators who also participated in the facilitator study, creating a relational design that makes it possible to examine the same therapeutic encounter from both sides of the relationship. The sample's demographic profile reflects the current stratification of access to psychedelic care in the United States, insofar as it is majority white and disproportionately middle to upper class. Each chapter analytically attends to what that skew forecloses as well as what it illuminates.

The three chapters that follow develop this project's central argument through three analytical frameworks, each built to address a distinct phase and register of psychedelic-assisted care. Each chapter contains unique, substantive literature reviews which contextualize the

analytical questions posed to each subgroup. Running through all three is a single animating question that Jeffrey's extraordinary Tuesday, and his return to the banality of Thursday, pose together. Namely, what does it mean to build a careful container for transformation inside a world that has not agreed to change?

The first chapter takes facilitators as its subjects, drawing on accounts across a wide range of cultural contexts of practice. Across nearly every interview, practitioners ascribed a central element of their professional legitimacy to their own histories of suffering and the psychedelic experiences that reshaped how they understood healing, presence, and obligation. They described woundedness and psychedelic transformation as preconditions for ethical practice and treated firsthand familiarity with altered states as a non-negotiable credential. The chapter develops the concept of *liminal authority* to name this hybrid form of legitimacy, grounded in personal transformation, ritual fluency, communal recognition, and the capacity to move between clinical, spiritual, and institutional registers without collapsing into any single one. In practice contexts without unified credentialing, embodied recognition functioned as a layer of informal regulation, with peers gauging readiness through tone, restraint, and the capacity to remain present through rupture. Ritual elements, including altars, music, eye shades, and choreographed transitions, operated as deliberate technologies of attunement traced back to lessons learned under the medicine. Resistance to medicalization recurred across contexts as a defense of the slow, relational, unscripted conditions practitioners believed transformation requires, against logics of quantification, certification, and throughput they viewed as corrosive of the work. By tracing how legitimacy, practice, and the moral-political orders of psychedelic care are envisioned by those who administer these medicines, the chapter establishes a necessary

baseline for the subsequent sections to trace how the very sensitivities practitioners describe in the psychedelic-healing process may complicate patients' own health trajectories.

The second chapter then turns to patients. Those who sought psychedelic care broadly arrived only after the conventional battery of psychiatric treatments had been tried and found inadequate. Inside care, they set about constructing working accounts of what the medicine opened, drawing on interpretive materials from practitioners, peers, cultural scripts, and media exposure, assembling frameworks that rarely cohered without effort or negotiation. Whether those frameworks stabilized depended substantially on the relational textures of who held them through dosing and beyond, with the quality, presence, and ethical consistency of the therapeutic relationship functioning as the primary variable shaping whether altered-state experience could be made narratively meaningful at all. Carrying that meaning into ordinary life then emerged as the final and most structurally exposed terrain, with patients embedded in supportive communities able to sustain emergent meanings through empathic communication, shared ritual, and accountability practices, and those returned to thinner social worlds often watching those meanings contract.

The concept of *psychedelic careers* holds this arc together analytically, adapting Becker's "deviant career" framework into a temporally bounded processual account of how patients are socialized into altered-state interpretation, how they reorganize their narratives of suffering across the treatment trajectory, and how the slow work of integration either consolidates or unravels once ordinary life closes back in. Differential learning and differential embeddedness name the cross-case conditions that explain the divergence that Becker's canonical "deviant career" framework cannot account for in this case, the first specifying how patients' layered cultural orientations and prior institutional histories shaped what meanings felt credible and

livable at the encounter's threshold, the second specifying whether the social arrangements they returned to could bear the weight of what their sessions had opened.

The third chapter then draws on both samples to supply a refined theory of cultural brokerage in psychedelic-assisted therapy, specifying the interactional mechanisms that frame the success and failure conditions of health transformations across the treatment arc. The chapter develops two mechanisms, each accomplished through two distinct forms of brokerage work. *Experiential containment* governs the conditions under which patients can enter altered states with a sense of safety and with their interpretive autonomy intact. Before dosing, facilitators calibrated expectations by establishing the limits of their guidance through deliberate worst-case realism and careful consent architecture, making intensity anticipatable and the session's demands legible in advance. During dosing, they held the therapeutic container through minimal, consent-based intervention and disciplined interpretive restraint, keeping the session workable while preserving the patient's authority over the meaning of their experience.

Liminal relay then governed the immediate return to sobriety and later return to ordinary life, accomplished through two corresponding forms of brokerage work. In its first phase, facilitators and patients worked to translate the session's most charged material into provisional accounts coherent enough to act from, yet open enough to survive revision as ordinary life complicated them. In its second phase, the labor turned outward toward making those accounts portable across the families, workplaces, and communities patients re-entered, a task whose difficulty scaled directly with how much those worlds were able or willing to receive the meanings patients attempted to convey from their psychedelic experiences. The enabling conditions for that portability were starkly unequal, shaped powerfully by access to relational and structural resources. Together, the two mechanisms specify what set, setting, and integration

gesture toward but leave underspecified, naming the concrete interactional work that enables or prevents the internalization of meaning and durable health status transformations patients can derive from psychedelic-assisted therapy.

The argument this dissertation develops holds meaning and structure in a single analytic frame, treating the failure to attend to what sessions produce in patients, and the failure to attend to what they require afterward, as identical failures registered at different scales. In doing so, its conclusions carry implications that extend across several domains simultaneously. For sociology, they advance a growing body of work on professionalization, care, and medicalization by specifying the mechanisms through which legitimacy is constructed and contested in unsettled therapeutic fields, how meaning-making and relational labor shape health outcomes in ways that elude pharmacological explanation, and how subjective experience can function as a genuine agent of structural change rather than merely being a product of it. The concept of *liminal authority* contributes to theories of professional jurisdiction by showing how embodied and experiential forms of capital can outweigh credentialed forms under specific institutional conditions, while *psychedelic careers* nuances the interactionist tradition's account of socialization and identity consolidation into a domain where the stakes of interpretive learning are unusually high and the consequences of its failure unusually visible. As forms of cultural brokerage, experiential containment and liminal relay offer a transferable framework for analyzing any therapeutic encounter organized around experiences that resist biomedical closure, pointing toward a critical sociology of psychedelic care that takes seriously the irreducibly subjective dimensions of healing without retreating from structural analysis. Together, these contributions call for a more expansive sociological imagination about what medicine is doing when it deploys altered states of consciousness as treatments for suffering, and what social

conditions determine whether those deployments become genuinely transformative, merely adaptive, or profoundly destabilizing.

For the field of practice and the broader intellectual currents surrounding it, the implications are both concrete and consequential. If psychedelic healing is produced through relational labor, cultural translation, and the slow work of narrative integration, then the dominant trajectory of institutionalization – oriented toward standardized protocols, efficiency metrics, and reimbursable service delivery – poses a structural threat to the very mechanisms that seem to make the interventions work. The facilitators in this study who built the most ethically serious practices are, with notable consistency, also the most economically precarious. This is a pattern that should trouble anyone invested in the field's future. At the same time, the patient accounts assembled here push back against any romanticism about what psychedelic experiences can accomplish on their own. They open windows, sometimes extraordinary ones, but what comes through those windows, and whether it survives contact with the social worlds patients return to, depends on conditions that no amount of careful dosing can guarantee.

What these substances make possible, at their most serious, is a temporary loosening of the grip that social existence maintains on consciousness. They may offer a brief interval in which inherited structures can be *seen as structures* rather than simply *lived as the shape of the self*. Whether that interval becomes anything more than a vivid and fading memory is a question about the quality of care, the depth of relational support, and the willingness of institutions to hold open what the medicine briefly cracks. Those questions, taken together, form the spine of the following chapters. And they all begin, in one way or another, with asking what "it" really is, how others are attempting to describe "it," and what a world more willing to receive "it" might look like.

The following chapter poses these questions to facilitators of psychedelic-assisted therapy across varied practice contexts in the United States. What emerges from their accounts is something stranger and more consequential than a settled professional identity. It is instead a form of authority assembled from personal wreckage, ritual fluency, and the capacity to hold open, without resolving, the very questions that brought them to this work in the first place. To understand how a field takes shape in the absence of shared credentialing standards, uniform ethical codes, or institutional consensus about *what healing even is*, it is necessary to follow the people who are building it from the inside, out of the materials their own suffering left behind.

Chapter 1

Healing in the In-Between: Wounded Healers, Liminal Authority, and the Moral Order of Psychedelic-Assisted Therapy

Psychedelic-assisted therapy (PAT) has re-emerged as a promising and contested development in contemporary mental health care. Substances such as psilocybin and MDMA are central to new protocols targeting conditions like treatment-resistant depression and PTSD (Carhart-Harris et al. 2021; Mitchell et al. 2021). While early clinical trials report striking outcomes (Reiff et al. 2020), the mechanisms of change remain contested. Researchers increasingly argue that subjective effects of the mystical-type experiences psychedelics potentiate are not incidental but central to therapeutic efficacy (Yaden and Griffiths 2021). These experiences predict outcomes across studies yet remain ambiguous and resistant to biomedical explanation (Nichols 2016), raising profound questions about the processes through which psychedelic healing unfolds.

Such ambiguity is likewise institutional. Practitioners work across a fragmented ecosystem of state-regulated programs (e.g., Oregon's Measure 109), FDA-approved trials, religious exemptions, decriminalization efforts, and underground ceremonial practice. In this unsettled terrain, facilitators draw on heterogeneous lineages, including clinical psychology, somatic therapy, shamanism, social work, and peer support, without shared credentialing standards or unified ethical codes. Despite this pluralism, they consistently treat firsthand experience of psychedelic states as a necessary credential for competent care. As bioethics debates ask whether such experience should be built into formal training, this study shows how experiential passage already functions as an informal credentialing standard that organizes legitimacy and ethical authority in practice (Rosenbaum 2024).

This study examines how facilitators construct professional legitimacy through interpretive and ethical frameworks shaped by their own experiences of transformation. Those experiences reconfigure how practitioners understand suffering, healing, responsibility, and care, informing therapeutic presence, ritual practice, and ethical judgment. They also structure informal accountability practices and articulate challenges to professional models grounded in certification and clinical detachment.

This paper develops the concept of liminal authority to describe a form of legitimacy grounded in a practitioner's capacity to integrate and move between multiple foundations, including licensure, lineage, clinical training, spiritual repertoires, and regulatory navigation. Across contexts, facilitators describe personal psychedelic transformation as a passage that reorients their understanding of suffering and responsibility. Even when they emphasize formal education or spiritual training, they treat that passage as the basis of both insight and obligation. Liminal authority is thus less a technique of "holding space" than a social trajectory marked by undergoing altered states, reckoning with their implications, and sustaining a relational and moral orientation that others come to trust. In a field without settled credentialing, it becomes connective tissue across therapeutic, spiritual, and institutional registers, affirmed through ongoing self-work and communal recognition.

This paper proceeds in four parts. First, I show how narratives of woundedness and healing broadly organized practitioners' accounts of legitimacy. Second, I specify liminal authority as a hybrid form blending personal transformation with training, lineage, and institutional navigation, then show how facilitators use these resources to distinguish qualified from unqualified practice. Third, I analyze how liminal authority is enacted through therapeutic conduct, ritual design, ethical orientation, and relational dynamics as facilitators shift across

spiritual, clinical, and communal registers. Fourth, I trace resistance to medicalization as practitioners challenge procedural, diagnostic, and outcome-driven clinical logics. I then discuss the cross-context implications of authority forged through personal transformation as it circulates, shaping technique, recalibrating norms, and redefining legitimate care.

By treating subjective transformation as a mechanism of social change, this paper contributes to sociological theories of professionalization, care, and structure. Drawing on Lo and Stacey's (2008) notion of hybrid habitus and Sewell's (1992) account of schemas and resources, I show how experiences become durable orientations that travel into field-level practice, licensing debates, and struggles over medicalization. Psychedelic therapy thus illustrates how therapeutic fields take shape not only through regulation from above but through meaning-making, embodied authority, and relational accountability forged through transformation.

Literature Review

Despite robust clinical trials and growing scientific endorsement, the mechanisms through which psychedelics produce change remain contested. Researchers debate whether transformation stems primarily from neurobiological disruption, including changes in the brain's default mode network (Carhart-Harris et al. 2012; Gattuso et al. 2023), or from the subjective effects of the mystical-type experiences psychedelics occasion (Yaden and Griffiths 2021; Atiq et al. 2025). Yet much of the causal weight in therapeutic outcomes rests on socially organized conditions, especially preparation and expectations (set) and the surrounding environment and relational frames (setting) which enable the unfolding of mystical-type experiences. These experiences predict outcomes across studies (Nichols 2016) yet resist biomedical classification.

In practice, facilitators often treat direct experience and communal trust as decisive sources of credibility even when scientific accounts remain unsettled.

Since the Controlled Substances Act of 1970, PAT has developed in a regulatory gray zone where clinical, spiritual, and experiential logics collide. Sociological work has begun to sensitize the field to struggles over legitimacy and medicalization (Andrews and Wright 2022). As Halfmann (2012) argues, medicalization is contested and nonlinear, shaped by boundary actors who may resist incorporation into dominant paradigms. In psychedelic care, such resistance often connects to practitioners' own experiences of healing and transformation, which they treat as central to ethical authority.

Professional legitimacy in unsettled fields is built through boundary work (Gieryn 1983). Abbott (1988) shows that professions continually contest jurisdiction and ethical authority; where training standards are thin, legitimacy must be enacted and defended in situ. Extending this insight, Weber et al. (2022) show that boundaries are not only defended or expanded, but also strategically limited and reconfigured under contextual constraints through portfolios of micro-strategies that alternate between defending and accommodating professional claims. Psychedelic facilitators face analogous constraint environments across regulated programs, trials, and underground practice. They shift their claims across audiences accordingly. In some contexts, they foreground ritual expertise. In others, they foreground credentialed competence. They also narrow what they will do or claim in order to remain credible, safe, and accountable. In the absence of centralized oversight, legitimacy becomes an object of interactional work. Boundaries are continually negotiated to manage trust, risk, and professional distinctiveness.

These dynamics echo research on complementary and alternative medicine and spiritual professionalism, where practitioners assemble hybrid strategies to differentiate from and

interface with biomedicine (Cant and Sharma 1996; Hollenberg 2006). Work on spiritual entrepreneurship similarly shows how professionals fuse clinical credibility, moral authority, and authenticity (Heelas 1996; Bender 2010), and how providers inside biomedical settings perform boundary work to preserve distinctiveness (Shuval et al. 2012). In psychedelic care, social interaction shapes what is perceived and how it is interpreted, and heightened suggestibility amplifies the causal force of guidance and suggestion (Dupuis 2022; Dupuis and Veissière 2022). Boundary work therefore hinges on how facilitators legitimate and limit their interpretive authority, drawing lines between ethical guidance and coercive influence. Yet we still lack an interactional account of how that legitimacy is assembled in everyday practice. This article fills that gap by tracing the techniques through which facilitators calibrate interpretive influence across settings while maintaining accountability and credibility.

Recent programmatic work argues for a more interactional sociology of psychedelics attentive to settings, collective life, and the relational production of connectedness (Rose 2024). Building on interactionist insights that drug effects are inseparable from the social organization of use, Rose calls for detailed qualitative work on how experiences are learned, interpreted, and governed (Rose 2025). This article advances that agenda by treating the practitioner as a key site of mediation in psychedelic settings. It examines how facilitators assemble legitimacy and ethical authority in real time by blending clinical, ritual, and experiential repertoires, and how those practices stabilize a provisional moral order in a field with unsettled jurisdictions. In doing so, it complements risk-benefit arguments about “experiential training” by specifying the social mechanisms through which experience becomes a credential, and through which its ethical hazards emerge (Rosenbaum 2024).

To conceptualize legitimacy under these conditions, this study advances the concept of liminal authority. Building on Turner's (1969) account of liminality as a threshold in which roles suspend and recombine, liminal authority names a mode of credibility forged through movement across spiritual and clinical domains, altered and ordinary states, and unstable institutions. Facilitators' authority is situational and relational, combining charismatic, traditional, and legal-rational elements (Weber 1978). Extending Bourdieu's (1986) distinction between institutionalized and embodied cultural capital, liminal authority highlights how, particularly in underground and decriminalized networks, embodied forms of capital, including relational presence, humility, and groundedness, can outweigh formal credentials.

Lo and Stacey's (2008) concept of hybrid habitus further clarifies how facilitators move across epistemic and moral worlds. Where they apply hybrid habitus to patients navigating competing logics of health and illness, this study extends it to providers. Facilitators draw simultaneously on clinical training, spiritual apprenticeship, and personal healing, producing identities organized around managed contradiction rather than coherence. Some foreground lineage in underground work while emphasizing trauma-informed or somatic training in regulated settings. As institutions move toward certification and protocols, hybridity becomes both resource and burden.

This hybrid habitus operates as a cultural toolkit (Swidler 1986), enabling facilitators to draw selectively on repertoires to manage ethical complexity. Yet institutional discourse privileges singular epistemic models, making this knowledge work difficult to formalize. Practitioners describe expertise as intuitive, relational, and ritual, resisting translation into biomedical or psychotherapeutic vocabularies. Their authority thus involves cultivating conditions under which meaning, safety, and healing become possible, aligning with theories that

treat care as situated and emergent (Tronto 1993; Mol 2008). Sociotechnical analyses of “set and setting” emphasize that psychedelic outcomes are co-produced through context rather than reducible to molecules (Dumit and Sanabria 2022) and underscore that mindset and environment are socially patterned and culturally contingent (Hartogsohn 2017; Neitzke-Spruill 2020), making facilitators’ capacity to shape these conditions a core dimension of authority.

Finally, while existing research addresses policy, medicalization, and ritual (Noorani 2020; Andrews and Wright 2022; Rose 2024), it rarely links altered-state experience to field-level transformation. This study applies Sewell’s (1992) theory of structure to examine how psychedelic experiences may reconfigure schemas and resources that organize practice. Practitioners describe these experiences as catalysts for ethical realignment, relational sensitivity, and professional redefinition, shifts that generate new peer networks, symbolic capital, and standards of legitimacy. Emerging regulatory frameworks, including Oregon and Colorado’s licensed facilitation models, stabilize and formalize some of these values through political processes in which advocates and stakeholders shape the architecture of reform, mobilizing claims about therapeutic benefit, minimal abuse potential, and the inequities of prohibition as part of a broader legalization strategy (Stoa 2024). In this view, altered states can function as ‘events’ reorganizing professional logics across scales (Sewell 1996).

Findings

The Wounded Healer as Organizing Schema

Across nearly every interview (28/30), the archetype of the wounded healer emerged as a central narrative through which facilitators understood their identities and responsibilities as psychedelic therapy practitioners. First articulated in modern psychology by Jung (1966), the archetype describes a healer whose capacity to care arises from their own confrontation with

suffering. In psychedelic-assisted therapy, it functions not just as narrative but as organizing schema: a structuring logic for how practitioners interpret care, authority, and ethical obligation (Sewell 1992).

Participants described wounds ranging from childhood trauma and addiction to grief and spiritual crisis. These were not incidental biographical details, but legitimating experiences that marked readiness to guide others. Nearly all participants insisted that without direct exposure to ego dissolution and the demands of integration, one could not ethically “hold space” for clients entering similar terrain.

Wenda, a Lakota shaman and ayahuasca ceremonialist, summarized the link between woundedness and authorization: “To be a shaman, you have to have been wounded. That’s where the medicine finds you. If you haven’t done your own healing, the spirits won’t let you do this work safely.” Robert, a veteran facilitating psilocybin therapy in Oregon, offered a parallel frame grounded in peer trust: “I was broken. Psychedelics brought me back. That’s why guys like me, vets, trust me. They know I’ve walked through that fire.” In both accounts, suffering becomes credential and marker of authenticity others can recognize.

Several clinicians described this authority as embodied and situational. Dr. Ruben recalled “dying herself” in ceremony: “You can feel it in your bones when someone’s going through ego death. You have to have lived through that to recognize it and sit with it without trying to fix it.” Dr. Langley linked his ego-death experience to his capacity to support spiritual crisis: “I had no map when it happened. Now I can be that map for someone else.” These narratives locate expertise in experiential recognition and ethical restraint, not training alone.

Wounded healer accounts also carried a moral discipline oriented around humility. “The minute you think you’re done, you’re dangerous,” said Dr. Willig. “I still sit with the medicine

regularly. It's part of staying ethical in this field." Martha, an Oregon facilitator, warned against mistaking charisma for readiness: "The field is full of people chasing status disguised as service. This work should make you feel small. It should humble you." Across interviews, humility functioned as a community standard, with woundedness serving as both explanation of vocation and a check on ego.

Taken together, these narratives show how personal wounds are transmuted into practical frameworks for care. Carried in the body and reiterated through ritual and relationship, they inform judgments about when to intervene, when to stay present, and how to accompany clients through disintegration and renewal. As cultural schemas, these repertoires organize what feels legitimate in facilitation (Swidler 1986; Berger and Luckmann 1966). Paired with resources such as professional standing, communal trust, and therapeutic technologies, they become structuring devices that define safe and responsible practice in liminal settings (Bourdieu 1977; Sewell 1992).

In this account, qualification is often measured less by formal credentialing than by the depth of self-work and the ability to translate it into ethical presence. The wounded healer archetype thus functions as shared cultural infrastructure through which legitimacy is built, recognized, and policed.

Liminal Authority and Boundary Work

For many facilitators, the redress of personal wounds through psychedelics was described as a catalyst for schematic transformation: a reorientation in how they understood healing, care, and ethical responsibility. This ongoing self-work, marked by continual introspection and integration, was central to what participants called their "readiness" to sit for others. From this readiness emerged a second dominant schema in the field: liminal authority.

Liminal authority is a form of legitimacy grounded in practitioners' ability to navigate spaces between clinical and spiritual domains, personal transformation and public responsibility, and institutional and experiential knowledge. It blends charismatic, traditional, and legal-rational elements. Enacted through presence, ritual fluency, and discernment, this authority is relationally conferred and ethically charged, rooted in the practitioner's traversal of altered states and their capacity to guide others through similar terrain. It also reflects the unstable status of authority in a field that straddles underground and clinical worlds. Rather than relying on certification or institutional affiliation, facilitators emphasized embodied knowing as the foundation of legitimate practice. "You can't hold space for someone in an altered state if you don't know how that state feels in your own body," explained Dr. Harmon. James, a long-time underground facilitator, echoed this: "The thought of someone being a guide when they haven't sat with the medicine isn't just stupid. It's irresponsible." Authority, participants argued, is felt and recognized through interaction, not only documentation.

Facilitators described this authority as read in the body, in tone, restraint, and responses to silence or rupture. "You can't fake depth," said Kathy, an underground guide since the 1970s. "It's whether they've done their own work and know how to be with someone else without ego." In a field lacking shared credentialing standards, embodied recognition became a central axis of peer credibility. "We all talk in these circles," said Dr. Dietrich. "We know who's ethical, who's cutting corners, who's holding space for the wrong reasons. We hear about the newbies pretty quickly. If someone's not ready, word gets around fast."

In underground contexts, reputation functioned as informal regulation. Kathy described a layered process of referral and observation: "Nobody just jumps in. You come in through trust. People are watching how you sit, how you listen, how you move. That's the test." These slow

systems contrasted with what many saw as accelerated credentialism in legal programs. “A lot of these newer facilitators think that doing a six-week course makes them ready,” said Dr. Altman. “They’ve never had their ego stripped away under the medicine.” Michelle, who apprenticed for a decade before leading ceremonies, added: “You can’t rush this. You hold space quietly for years before you’re invited to lead.”

Even in regulated environments, firsthand experience remained a symbolic threshold. Several Oregon-based facilitators criticized peers who completed training but declined to participate in psilocybin sessions. “How can you sit with someone through something so impossible to explain if you’ve never been there yourself?” one asked. “And good luck building a reputation if word gets out you’re one of those people.”

Still, practitioners acknowledged the risk of relying on inner work as a credential. “There’s a difference between having a powerful experience and actually integrating it,” cautioned Dr. Campa. “Some people think five ayahuasca ceremonies make them a healer, which is obviously misguided.” Others worried that clients could not assess whether a facilitator had done sufficient self-work. “It scares me when I hear people say, ‘I’ve done three ceremonies and now I’m offering sessions,’” said Dr. Verhulst. “They haven’t studied trauma; they don’t understand what happens when old wounds open up. That’s where harm happens.”

For many, liminal authority was powerful yet precarious: it centered humility and presence but left clients exposed in the absence of external standards. Some saw emerging certification structures as a way to balance experiential depth with regulation; others feared standardization would erode relational and spiritual integrity. These tensions were especially visible in Oregon’s new legal framework, which formally separates clinical and psychedelic roles. “If you’ve got another degree that would inform you how to practice otherwise, that can’t

be used,” explained Martin. “No mixing allowed.” Practitioners described shifting between regulatory and spiritual registers depending on context: “I know how I have to talk to the licensing board, and I know how I should talk during a session. They’re almost never the same voice.” For some, this ability became a marker of competence.

Facilitators disagreed on how boundary work should be drawn. Some endorsed strict thresholds of readiness; others cautioned against turning liminal authority into another gatekeeping tool. “We have to be careful not to turn this into a closed club,” said Dr. Dietrich. “People need to be qualified, but we also need space for diversity in how this work gets done.” Dr. Stevens added, “For me, it’s about whether the person is serving their community or serving their ego. That’s the line I care about.” These reflections underscore that boundary work is about values as well as competence; who is perceived as serving with integrity versus performing legitimacy for recognition or access.

Several participants warned that liminal authority could slide into performance. “I’ve seen people who know the lingo,” James said. “They talk about doing their work, but they aren’t really in it anymore. They’ve built an identity around being a guide.” As psychedelic therapy gains visibility, participants expressed concern that transformation narratives could be commodified, turned into brands, bios, or social media personas. “It’s becoming a brand,” one interviewee warned. “Once your story becomes a marketing hook, you have to keep telling it the same way. Real growth doesn’t work like that.” Such accounts show liminal authority is fragile and susceptible to distortion. It offers an ethical compass rooted in experience, yet it can be mimicked or co-opted by market and status pressures. For facilitators, the challenge is to sustain authenticity without letting experiential legitimacy harden into exclusion or spectacle.

Despite these risks, liminal authority remains the core schema through which facilitators differentiate ethical from unethical practice in gray-area regulatory settings. Its appeal lies in its relational density. It presumes ongoing self-work, community embeddedness, and ritual accountability. As Kathy summarized, “The work isn’t just about what you’ve done. It’s how you carry yourself in light of it, and who can feel it.” This ethic situates facilitators not as experts standing above clients but as fellow travelers in a recursive healing process.

Liminal authority is the ethical and professional infrastructure of psychedelic-assisted therapy, built through embodied presence, communal trust, and reflexive humility, even as it remains precarious under pressures of regulation and commodification.

Technologies and Ethics of Care: Ritual, Aesthetic, and Relational

Facilitators often described their therapeutic practices as expressions of humility, relational presence, and sustained self-work. Their methods were not decorative but deliberate technologies of care: tools for fostering safety and supporting clients in exploring unfamiliar dimensions of self. Many traced these practices directly to their own psychedelic experiences, viewing them as extensions of the liminal authority that grounded their legitimacy. They are technologies of attunement cultivated through firsthand movement between the ordinary and the extraordinary.

These ritual techniques were often positioned in contrast to biomedical norms. Participants critiqued clinical models for privileging symptom reduction, diagnostic clarity, and emotional detachment, instead emphasizing ceremony, responsiveness, and atmosphere. “The altar, the smudging, the songs... they’re not superficial,” said Michelle. “They’re there to ground people and keep them safe.” Dr. Ruben added, “The clinic has to look like medicine. But what

we're doing in there is a ceremony." Rituals thus operated as boundary objects flexible enough to move between contexts, yet stable enough to signal ethical seriousness to both clients and peers.

In ceremonial spaces, these practices were sacred. In clinics, they became aesthetic or therapeutic. Yet in both, they expressed an ongoing commitment to creating containers for transformation, grounded in lived experience. As Dr. Daniels observed, "Creating a safe container for someone to enter an altered state isn't so different from a shamanic tradition. We might not call it 'sacred space,' but we're still doing all the same things." Similarly, Dr. Ableman described clinical rituals – eye shades, music, guiding phrases – as "modern instantiations of ceremony." Clinical and traditional forms, though institutionally distinct, drew moral force from the same source: the facilitator's embodied capacity to guide others through liminal states.

Facilitators employed a range of aesthetic and sensory elements, such as blindfolds, incense, photos, and symbolic offerings, designed to cue clients into reverence and embodied awareness. "We're cuing the body to know something important is happening," said Martha. "If we can put the body in rhythm with the moment's significance, things unfold more smoothly." Such techniques were epistemic as much as symbolic products of experiential learning about what helps others cross safely into altered states.

Cultural lineage shaped decisions about ritual form. Some drew from Indigenous traditions, others from eclectic or personal sources. Several raised concerns about cultural appropriation or superficial mimicry. "It can feel like people are playing dress-up," warned Dr. Rose. "It makes the experience feel disingenuous from the start." Dr. Langley, who works under Nordic traditions, echoed this: "It wouldn't make sense for me to sing Icaros from the Amazon. That's not my lineage." Such reflections highlight how liminal authority, though grounded in personal transformation, is also measured by cultural discernment and humility.

At the same time, facilitators emphasized adaptability. Rituals were seen as evolving expressions of care rather than fixed canons. “We’re creating new traditions as we go,” explained Dr. Geers, “but we have to be honest about where they come from and why we’re using them.” This reflexive stance – keeping symbolic form and ethical intent in dialogue – mirrored the broader negotiation of boundaries at the heart of liminal authority.

Rituals were also framed as tools for helping clients reclaim agency. Small gestures like a grounding breath or shift in tone were used to redirect attention to the client’s own insight. “The ritual isn’t about the room,” said Dr. Rose. “It’s about helping them see themselves differently... to get them to listen to their inner-healing intelligence.” James elaborated: “I’m not a healer. I’m just blessed to help others find their truth through the medicine, as I did.” Such accounts articulate a therapeutic ethic rooted not in directive expertise but in the ability to hold space while others undergo personal transformation.

This ethic of presence appeared across every interview. Practitioners described their work as one of accompaniment rather than interpretation. “My job is to guide when needed, to listen when needed,” said Dr. Ruben. “It’s not about me. It’s about them.” Alexa added nuance: “There’s a fine line between giving space and abandoning someone emotionally. You have to know when silence is supportive and when it’s not.” Many felt therapeutic skill is defined less by technique than by timing, emotional intelligence, and restraint, all capacities learned through personal encounters with dissolution and integration.

Facilitators repeatedly emphasized that this restraint was learned experientially. Their own psychedelic encounters taught them to trust process over outcome, loosen control, and remain attuned to emotional flux. “The best guides,” said Alexa, “translate what psychedelics teach them into practice... It’s about subtle cues that help clients help themselves. Someone can

look at me mid-session in panic and ask, ‘Who am I?’—and just encouraging them to stay with that question almost always works wonders.” Such reflections capture a defining feature of liminal authority in practice as a sensitivity to process and a comfort with uncertainty.

Across cases, these practices formed a distinct therapeutic rationality grounded in hybrid expertise and relational attentiveness. Ritual, music, and posture become grounds where professional judgment and personal transformation converge. Facilitators viewed these gestures as integral to the integrity of their work; as technologies that communicate safety, invite depth, and make healing possible. Yet as psychedelic therapy becomes increasingly standardized, many fear that these subtle forms of care will be marginalized. The push for procedural clarity and measurable outcomes, they warned, risks eclipsing the slow, affective work of presence and attunement. “They want efficiency,” one facilitator said, “but healing doesn’t follow timelines.” For practitioners, ritual and relational presence are central. They are contested sites where the epistemics of liminal authority are continually negotiated against the encroaching logic of biomedical standardization.

Resistance to Medicalization

Across contexts, facilitators expressed unease about the growing influence of clinical and corporate logics in psychedelic care. For many, mainstreaming promised legitimacy and access while threatening the relational depth, spiritual integrity, and transformative stakes that motivated their work. These concerns were not limited to technique. They were framed as a moral struggle over what psychedelic healing is and who it is for.

Participants described commodification as a reduction of care to product delivery, market segmentation, and efficiency metrics. Dr. Harmon linked commercialization to a broader dehumanizing culture: “There’s a lot of commodification that’s endemic in American culture...

It's kind of sick and wrong. We're much more than that." Several pointed to patenting and proprietary pathways as emblematic, describing dynamics in which inexpensive substances are converted into expensive treatments accessible mainly through clinical infrastructures. Others criticized efforts to produce non-psychedelic analogs as attempts to "take the psychedelia out of it," interpreting them as efforts to extract clinical benefit while discarding what practitioners treated as the core axis of transformation.

Crucially, these critiques were grounded in experiential recognition. Facilitators framed their resistance as emerging from the disjuncture between what their own healing taught them, including humility, vulnerability, relational presence, and what institutions demand, including standardization, control, and outcome orientation. "What I'm afraid we might lose with commodification is the attention to set and setting," said Dr. Dietrich, "the nuances that come from the rawness of human experience." Others worried that professionalization would reproduce hierarchies by defining legitimacy through biomedical jurisdiction and excluding underground or lineage-based expertise. As Kathy, a longtime underground facilitator asked, "There are turf wars... everyone's fighting over who gets to deliver this. But what is psychotherapy, really? Is the shamanic way valid?"

For many, resisting medicalization was therefore a defense of experiential legitimacy and the conditions they believed make care possible. "The medicalization of these experiences would be the wrong way to go," warned Dr. Langley. "Without spiritual grounding, even the most heartfelt intervention can trigger a client in ways you're not prepared for." Dr. Daniels linked harm to ego and credentialism: "The more you put a certificate on something, the more people think they know what they're doing. Real care comes from those who've been cracked open and aren't coming from ego." In this framing, wounded healer narratives and liminal authority

underwrite critique. The ethical basis of care is humility and presence, and medicalization is resisted because it institutionalizes detachment, certainty, and control.

Participants also emphasized how market incentives can distort motive and practice. “The moment you start getting paid a lot, it’s easy to lose touch with the reason you’re doing this,” James said, describing corporate commercialization as “the brutal rape of psychedelics... like something sacred being stripped for parts.” His grief underscored the fragility of liminal authority as an ethic grounded in embodied experience, but which is vulnerable to being packaged or imitated. Others distinguished legal legitimacy from ethical legitimacy and worried that credentialism and liability culture would hollow out the field. “As this becomes a billion-dollar industry, we risk losing the soul of the work,” warned Dr. Ruben. Another facilitator similarly summarized the dilemma: “You can follow the rules and still lose the spirit of the work.” Resisting medicalization was therefore both a structural critique and a means of safeguarding the moral ground on which many practitioners felt their legitimacy rests.

In practice, resistance often took the form of presence over procedure and commitment to relational continuity beyond the session. Robert contrasted a prior ethos of control with what ceremony taught him: “I was taught to manage crises by taking control. Ceremony taught me to let go, to trust people to find their own way.” Wenda framed continuity as communal obligation: “You don’t just send someone home and forget about them. You stay in loving relationship.” For many, institutional systems organized around throughput and optimization were incompatible with the slowness and uncertainty facilitators treated as ethical necessities. “In ceremony, you learn patience,” Michelle said. “That’s not how the medical world works. [It] wants fast results [and] metrics...” In this way, resistance to medicalization is testimony about what facilitators

believe healing requires, and a defense of an experiential moral order in which transformation unfolds through relationships rather than products.

Discussion & Conclusion

Psychedelic-assisted therapy occupies a liminal moment in its professionalization, suspended between medicine and spirituality, scientific credibility and experiential wisdom, credentialed expertise and embodied knowledge. Facilitators across contexts rely on hybrid legitimacy blending institutional training, spiritual lineage, and firsthand transformation. These orientations follow a biographical arc of woundedness and integration, where personal suffering becomes the ground for therapeutic insight and ethical orientation. Across interviews, this relation of wounding-to-healing recurred as a quest narrative in which psychedelic experience marked a turn from fragmentation to reorientation (Frank 1995). While individualized, these narratives have sedimented into the ethical and aesthetic fabric of many psychedelic care contexts, shaping both authority and purpose in guiding others along a path they continue to walk.

Through this shared orientation, practitioners construct meaning, credibility, and care. Psychedelic experiences catalyzed schematic shifts that repositioned suffering as a source of presence and discernment. This ethic of recursive self-work grounded both identity and readiness to support others. “This isn’t something you train for in the usual sense,” one facilitator said. “It’s something you live through.” From these transformations emerges liminal authority: legitimacy that blends personal healing, ritual fluency, institutional knowledge, and communal trust. Practitioners move among charismatic, traditional, and bureaucratic logics, improvising ethical boundaries in an unsettled landscape.

These orientations manifest materially and relationally. Facilitators used ritual and aesthetic forms such as altars, music, and sensory cues as deliberate technologies of care, creating containers for safe transformation. “The smells, the sounds, even the way I arrange the room,” Naomi explained, “all of it communicates safety without words.” Over time these practices crystallized into dispositions that resist narrow clinical models, foregrounding presence, non-directiveness, and co-constructed meaning.

Their resistance to medicalization stems from lived incompatibility between experiential ethics and institutional logics rather than ideology alone. Having learned through transformation that healing requires humility, vulnerability, and relational depth, practitioners find systems built around speed, standardization, and control undermine essential conditions. The critique is both experiential and political. They resist because medicalization negates what they know works. As Michelle put it, “What we’re offering isn’t a treatment plan... It’s an invitation to become intimate with parts of yourself you’ve buried.”

At the same time, liminal authority carries ambiguity. Because recognition of “depth” and “presence” is subjective, its boundaries are porous and uneven. In the absence of standardized criteria, legitimacy circulates through reputation, aesthetics, and embodiment, channels susceptible to reproducing social hierarchies. Who is regarded as “ready,” “authentic,” or “deep” can reflect unspoken norms of race, class, gender, and comportment. Judgments framed as intuitive are socially patterned; resisting credentialism can reinscribe exclusion under the guise of discernment. Authority built through experience can be as exclusionary as authority built through degrees, only less visible.

Even with these limits, the dynamics observed here enrich sociological accounts of care, legitimacy, and professional change. Lo and Stacey’s (2008) conceptualization of ‘hybrid

habitus’ illuminates how facilitators traverse contradictory logics, blending sacred and scientific repertoires without fully assimilating into either. Their authority is enacted in motion, relationally affirmed, contextually negotiated, resistant to closure. Sewell’s (1992) theory of structure clarifies how personal transformation reconfigures institutional possibility. Practitioners described psychedelic experiences as moments of schematic reorientation that reshape symbolic and ethical frameworks for care. These changes percolate through story, ritual, and relational performance, slowly redefining professionalism and healing.

While permanence is uncertain, these shifts resemble what Sewell (1996) calls socially significant “events”: moments when new meanings and practices gain traction and begin to reconfigure structures. Although Sewell’s framework is often applied to macro ruptures, this study shows how micro-level events – personal transformations and ethical realignments – can reorder cultural schemas and redistribute symbolic resources. Facilitators’ reworking of therapeutic norms through relational ethics and ritual practice may not immediately overturn institutions, but such shifts accumulate in discourse and community practice. Oregon’s legalization initiative shows how movement claims and coalition politics can crystallize into policy frameworks that reorganize the institutional terrain of psychedelic care (Stoa 2024), embedding experiential and relational models of care into state infrastructures that diverge from the biomedical paradigm.

The concept of liminal authority also addresses a gap in research on CAM and psychedelic-assisted therapy by developing an interactional account of how legitimacy and interpretive limits are assembled in everyday psychedelic practice under conditions of heightened suggestibility (Dupuis 2022; Dupuis and Veissière 2022). The framework articulated here makes that work visible. Facilitators calibrate interpretive influence in real time, drawing

lines between ethical guidance and coercive suggestion while sustaining accountability and credibility. In this sense, the article extends Rose's (2025) call for an interactional sociology of psychedelics by more thoroughly detailing how practitioners act as key agents of health mediation in psychedelic care settings, and by showing how "set and setting" are actively built and governed through boundary work and moral labor. It also nuances risk-benefit arguments about experiential training by specifying how experience becomes a credential, and where its ethical hazards emerge (Rosenbaum 2024).

These findings also speak to ongoing debates in the natural sciences about the role of subjectivity in psychedelic research (Atiq et al. 2025; Carhart-Harris et al. 2012; Gattuso et al. 2023; Yaden and Griffiths 2021; Olson 2021). The endurance of neurobiological-experiential tension reflects a biomedical paradigm that marginalizes consciousness and emotion as secondary to measurable signs (Dumit 2004). Practitioners here treat subjectivity as constitutive of, rather than ancillary to, healing. Their journeys redefine understandings of care, selfhood, and therapeutic work, underscoring the need for a sociology attentive to psychedelic experiences as both personal and social phenomena. For training and research alike, the implication is that subjectivity should be treated as a central object of practice rather than background noise.

This research has limitations. The sample lacked full racial and socioeconomic diversity, likely reflecting structural inequalities in access to psychedelic practice and recruitment pathways. Initial outreach through MAPS-affiliated networks also may overrepresent facilitators comfortable articulating coherent professional identities, and the narrative consistency around woundedness may partly reflect that recruitment strategy. At the same time, it is plausible that many facilitators share similar trajectories, given the field's continued marginal status and the reliance on informal networks for entry and credibility. Nonetheless, these networks also

provided rare access to underground practitioners, illuminating the communal ethos of the field. Even facilitators aligned with credentialed programs often emphasized relational authority over institutional status, suggesting legitimacy remains deeply networked, affective, and collective.

Ultimately, this study documents a field in motion where practitioners both navigate and transform surrounding structures. Their work shows how woundedness and its redress through psychedelic experience reshapes professional ethics, authority, and critique. Whether these models can withstand emerging institutional pressures remains uncertain. Yet the facilitators in this study articulate a vision of healthcare in which relationship displaces procedural regulation, process is prioritized over product, and healing is distinguished from treatment. Psychedelic therapy, as they practice it, embodies an ethos of care rooted in service and animated by a commitment to hold space for others as they seek to heal their own wounds and achieve self-transformation.

Chapter 2

Learning Transformation: How Self, Relationship, and Structure Shape the Psychedelic Career

A patient might describe their psilocybin session as meeting death, finding God, and forgiving a lifelong enemy, while a clinical researcher describes that same afternoon as a high dose 5-HT_{2A} agonist producing transient network disintegration and neuroplastic change. Yet these radically different descriptions now orbit the same emerging terrain of psychedelic interventions, which have moved from the clinical margins into the heart of psychiatric debate. In phase II and III trials, a small number of high dose psilocybin or MDMA sessions, embedded in intensive psychotherapy, often produce significant, long-lasting reductions in depression, PTSD, addiction, and end of life distress, among other notable afflictions (Griffiths et al. 2016; Ross et al. 2016; Carhart-Harris et al. 2021; Mitchell et al. 2021). Patients and clinicians repeatedly single out “mystical-type experiences” that unfold in carefully staged therapeutic settings. They describe episodes of ego dissolution and unity, encounters felt as sacred or deeply true, intense positive emotion, and a sense of timelessness and being outside ordinary space, all suffused with a striking ineffability and moral or spiritual significance, even in otherwise secular clinical environments (Pahnke 1963; Griffiths et al. 2006; MacLean et al. 2011).

Neuroimaging and pharmacological studies point to candidate mechanisms such as 5-HT_{2A} receptor agonism, neural network disintegration, and neuroplasticity (Carhart-Harris et al. 2012; Olson 2021). Yet the strongest predictors of durable symptom reduction in clinical trials are the “mystical-type experiences” that are hardest to translate into this vocabulary (Griffiths et al. 2006, 2008; MacLean et al. 2011; Nichols 2016), and debates continue over whether such subjective effects are necessary for enduring therapeutic change or epiphenomena of underlying neurobiology (Olson 2021; Yaden and Griffiths 2021). PAT therefore brings into the same

therapeutic space two historically distinct vernaculars: one organized around diagnosis, dosage, and efficacy, and another that leans on idioms of transcendence and personal meaning making.

Rather than casting this as a limited contest between subjective narratives and mechanistic explanation, this chapter takes these tensions as a sociological problem. By mobilizing sociological theories of culture, illness narratives, structure, and learning, I reveal how debates over psychedelic efficacy are inseparable from questions about how subjective experience is cultivated, interpreted, and carried forward in patients' lives.

Literature Review & Theory

Psychedelic-assisted therapy occupies an unusual position in the sociology of health and illness. Psychedelic substances and the states they induce are being folded into a rapidly expanding therapeutics market and drawn into familiar processes of medicalization that redefine human problems as disorders requiring expert treatment (Conrad 2007; Noorani 2020; Andrews and Wright 2022). Clinical and popular discourses simultaneously insist on careful procedural controls for "set and setting" in ways that foreground social and cultural determinants of drug effects, from expectations and prior trauma to music, décor, and ritual form (Hartogsohn 2017; Neitzke-Spruill 2020). Work on medical deservingness shows that clinical encounters are structured by historically specific assumptions about risk, trust, and who counts as a deserving patient (Lo and Nguyen 2021), and related research on psychedelic pharmacology extends this to trial infrastructures, showing how designs, consent procedures, and eligibility criteria encode those same assumptions into "set and setting" itself (Dumit and Sanabria 2022; Neitzke-Spruill 2020). Together, these literatures foreground the need for research that traces how psychedelic experiences come to be understood as health-producing within unequal arrangements of access, expertise, and trust.

Sociologists working in the interactionist tradition have long recognized that drug experiences are irreducible to drug effects. In his foundational study of marijuana use, Becker (1953) demonstrated that the effects of a psychoactive substance are neither automatic nor pharmacologically self-evident. Novice users must learn proper techniques of consumption, learn to recognize and connect drug effects with the states they produce, and learn to define those effects as pleasurable rather than frightening. Each step is accomplished through interaction with more experienced users who supply interpretive frameworks the substance itself does not intrinsically offer. Becker (1963) then extended this insight into a theory of "deviant careers," tracing the sequential stages through which people become committed participants in deviant practices: initial transgression, contact with a subculture, socialization into its techniques and rationales, and deepening embeddedness that stabilizes both practice and identity. Ongoing subcultural participation is what transforms an initial transgressive experience into a durable feature of how someone lives.

Building on that foundation, Rose (2025) calls for a renewed sociology of psychedelics organized around Becker's insight that drug effects are learned through subcultural participation. Drawing on Durkheim's analysis of ritual and collective effervescence, Rose also shows how psychedelic retreats and group settings generate solidarity, shared symbols, and moral energy that participants experience as central to therapeutic change (Durkheim 1995; Rose 2024), treating the retreat as a drug-using subculture in Becker's sense: an organized social environment where novices learn to recognize, categorize, and sustain the meanings that psychedelic experiences produce.

This framework cannot fully address, however, two problems that surface when its assumptions are tested against psychedelic practice stripped of communal structure. The first is a

problem of differential embeddedness. Becker's career model assumes ongoing subcultural participation as the mechanism through which meanings are stabilized, wherein people remain drug users because they remain embedded in communities that supply continued rationales and interpretive reinforcement. Dyadic psychedelic-assisted therapy does not work that way. Patients enter a bounded therapeutic encounter, undergo what can be a profound reorganization of self-understanding, and then return to the ordinary social worlds that preceded care. A truly successful treatment arc, by design, bends toward discontinuation of drug use and eventual separation from the practitioners who first oriented them to the experience. Whether the meanings produced within the therapeutic frame persist once participants are back inside the institutional demands, relational constraints, and structural conditions of everyday life is a question Becker's model was never designed to answer, because it never imagined departure from the subculture as the intended endpoint of the process.

The second limitation concerns differential learning. Becker (1967) recognized that access to interpretive resources is unevenly distributed across institutional contexts, and that subcultural affiliation shapes what knowledge is available to a given user. What that account cannot capture is how layered, cross-field dispositions shaped by race, class, gender, and prior institutional histories arrive at the therapeutic encounter as differential capacities for making meaning from it. Participants do not simply lack or possess the right subcultural knowledge; they bring embodied orientations that determine which interpretive frameworks feel credible, which experiences feel nameable, and which possibilities for self-understanding feel livable (Lo 2010). The same therapeutic context can produce profoundly divergent trajectories not only because some participants received better subcultural preparation, but because the dispositions they carried in structured what the encounter could offer them in the first place.

Both problems require theoretical resources beyond the interactionist tradition. Bourdieu's (1977) theorization of habitus describes how dispositions formed through cumulative social experience structure perception and interpretive practice beneath conscious awareness, organizing which interpretive moves feel natural and which feel foreign. Lo and Stacey's (2008) concept of hybrid habitus extends this by naming a cross-field variant, where actors who have moved across institutional domains develop layered orientations that enable navigation across registers of evidence, value, and legitimacy without resolving into a single coherent framework. Patients entering psychedelic care carry such hybrid orientations, and those orientations shape not only which meanings feel available and credible within the therapeutic encounter, but also which structural resources outside it they can recognize and mobilize in carrying meaning forward (Lo and Nguyen 2021).

Where habitus illuminates the dispositions participants carry into the encounter, Sewell's (1992) theory of structure as composed of mutually constitutive schemas and resources supplies the mechanism for understanding how those dispositions interact with the material and institutional conditions that either sustain or foreclose transformation after the session ends. Central to Sewell's framework is the concept of the transformative event: an occurrence sufficiently disruptive to existing schemas which creates the possibility of reorganizing the resources available to an actor. The psychedelic therapy session is a near paradigm case of a micro-level transformative event. It can rupture existing self-understandings with significant force and speed, rendering previously stable schemas temporarily plastic and opening interpretive possibilities that ordinary life rarely permits. Sewell's framework also specifies the conditions under which such ruptures consolidate into durable change rather than dissipating upon re-entry into ordinary life: new schemas can become durable only if they can be converted

into and sustained by structural resources, the relationships, practices, institutions, and material conditions capable of carrying them forward outside the therapeutic setting. The therapeutic relationship is itself among those resources. Its quality, ethical integrity, and cultural resonance shape whether the schemas produced in a session can be converted into anything the patient can actually use, and its breakdown, through abandonment, boundary violation, or interpretive mismatch, can foreclose that conversion entirely. That conversion is not equally available, and its availability is structured by the same inequalities that shape entry into care in the first place.

The chapter develops this framework across the full arc of treatment, from help-seeking through acute sessions to the uneven work of integration, and across a heterogeneous set of settings that include FDA-sanctioned trials, Oregon's licensed psilocybin framework, decriminalized service contexts, legally protected psychedelic religious communities, and underground networks. The first empirical chapter traced how wounded healer narratives inform facilitators' professional identities, schemas of authority, and ethical stances on medicalization. This chapter turns from practitioners to patients, asking how patients construct meanings around health and healing throughout the psychedelic therapeutic process, from prior experiences of longstanding suffering and failed care through preparation, dosing, and integration, and how that meaning-making is patterned by patients' and practitioners' identities, social locations, and the broader fields in which care is delivered.

Analytically, the chapter treats patients' stories as assemblages in which multiple cultural schemas converge, including psychiatric and psychotherapeutic discourses, trauma and recovery narratives, spiritual and mystical repertoires, and emergent psychedelic cultures circulating in popular media and clinical settings. Established sociological work on illness narratives and explanatory models provides language for situating that convergence across the full temporal arc

of treatment. Bury's (1982) formulation of biographical disruption organizes the help-seeking arc, where sustained distress fractures life plans and forces sufferers into ongoing work of explanation and repair. Frank's (1995) account of illness narratives as moral stories that reorder identity and obligation becomes operative in the interpretive aftermath of sessions, where patients re-narrate who they have been and what they owe themselves in light of what the medicine opened, attending to how sufferers and practitioners improvise culturally patterned frameworks for interpreting illness and remedy.

These frameworks converge in the term *psychedelic careers* which serves as the central analytic device used to address this chapter's research questions. Adapting Becker's sequential career logic to a therapeutic context, the concept tracks how patients are socialized into particular ways of interpreting altered-state experiences, narrating their suffering, and enacting change across help-seeking, acute sessions, and integration. The structure of those careers, however, varies by institutional context. In ceremonial and communal settings, ongoing subcultural participation functions much as Becker's model describes, with meaning stabilized through continued ritual practice, collective accountability, and community embeddedness. In conventional dyadic therapeutic contexts, the career unfolds toward an exit, and what it produces must survive re-entry into ordinary social worlds that the therapeutic frame rarely controls or prepares patients for. It is this latter form that exposes the limits of conventional interactionist frameworks most sharply, and which makes the inclusion of habitus and schema-resource analytically necessary. Psychedelic careers, as a concept, holds both forms in view, making it possible to see healing as a socially organized trajectory shaped at every stage by the hybrid orientations participants bring, the relational conditions of the therapeutic encounter, and the

structural resources available to produce and consolidate meaning forward once the medicine has run its course.

Findings:

Entering Psychedelic Pathways

Across the sample, psychedelic-assisted therapy was never pursued as a first option for mental health treatment. Rather, it frequently emerged as a next step in already long careers of suffering, care seeking, and improvisation in which people cycled through conventional options, cobbled together support, and weighed the risks of these fundamentally different kinds of interventions. These trajectories registered what Bury (1982) identified as the biographical disruption of chronic illness: the way sustained distress fractures routine expectations, destabilizes life plans, and forces sufferers into ongoing work of explanation and repair. PAT entered patients' lives at the far edge of that disruption, after biomedical and psychotherapeutic projects of repair had been tried and found wanting. Marianne captured the basic calculus when she reflected that psychedelics only became thinkable "when [her] desperation for real healing outweighed [her] fear," and when she could feel her guide's "integrity in [her] bones."

For many participants, the path into psychedelic care ran directly through psychiatry and primary care, where diagnoses accumulated and the phrase "treatment resistant" became both clinical descriptor and biographical verdict. May, a middle school English teacher, described living with depression "in one form or another" since college. After a miscarriage and years of escalating distress, she entered what she called a "carousel" of interventions: SSRIs, SNRIs, and combinations her psychiatrist hoped might give her "a better chance." Side effects made her feel she was "trading one problem for another," while cognitive behavioral therapy and EMDR "helped [her] process some of the pain," yet "the depression itself never fully lifted." When her

providers described her case as "treatment resistant depression," the label "honestly felt like a death sentence at the time." New possibilities only became nameable through a support group for women dealing with mental health challenges.

Julian's entry into psilocybin followed a similarly protracted arc. A white, upper-class professional, he summarized his history as "treatment resistant MDD," elaborating that this meant taking "all of the SSRIs and other useless bullshit in the book." These histories show how biomedical institutions helped create the very "treatment resistant" patient careers that made a psychedelic turn both thinkable and morally justifiable for many participants. This is medicalization operating at the level of the patient career. The apparatus that defines distress as individual pathology amenable to pharmaceutical correction simultaneously generates the therapeutic dead ends that make an alternative intervention not only conceivable but morally necessary (Conrad 2007; Cant and Sharma 1999).

Others arrived at psychedelics through more hybrid routes that wove clinical disappointment together with alternative health and spiritual networks. Evan recalled feeling that he had "hit a ceiling with talk therapy and felt dulled out from meds. I was functioning, but I kept getting this churn in my chest that felt like a warning signal was going off in my body all the time." A friend sent him an article about psychedelics and treatment-resistant depression; he then "listened to a couple of podcast interviews with people who described feeling emotionally thawed after psilocybin." What struck him was the practical descriptions of being able "to sit with their feelings without flinching." He stayed "pretty skeptical of anything that sounded like woo-woo enlightenment marketing," and a line he encountered repeatedly crystallized his intention: "the medicine does not do the work for you, it makes the work you need to do clear

and undeniable." He "did not want to be rescued," he wanted "a shot at being honest with [himself]."

That interpretive work unfolded alongside concrete relational and institutional searches. Evan's first psilocybin experience took place with an underground "guide" accessed through a coworker's cousin. He "clocked a few red flags," including a thin intake process and an emphasis on "energetic preparations," yet went forward because he was "desperate to feel something real." Afterward he described the session as "lukewarm" and hollow, later understanding through online integration circles that "set and setting are the containers that make everything else possible. If the container feels fake, your nervous system will know just like mine did." When Oregon's legal psilocybin framework went live several years later, what appealed to him was "not just about the legality, it was the structure of it all," including clear screening, trained facilitators, and safety protocols. He booked consults with several service centers and "asked annoying questions about everything." Evan's sorting illustrates hybrid habitus at work in the pathways phase of a psychedelic career. The configuration of dispositions he brought to this work layered biomedical skepticism earned through years of disappointing psychiatric care, the epistemic discipline of a professional accustomed to sifting evidence, and a learned suspicion of wellness industry rhetoric. That configuration conditioned which accounts of psychedelic experience could register as credible for him and shaped the legal, regulated setting he was eventually willing to enter.

Several participants encountered psychedelics at the intersection of protracted grief and new legal infrastructures. Laura, a high-skill professional in her late thirties, said she decided to seek psilocybin therapy "sometime in the fourth year after my parents died," when she realized that "whatever natural healing I thought would eventually kick in, just was not happening." She

described sitting on her couch after work, "staring at the wall," recognizing that she "had not actually felt anything meaningful in a very long time." Earlier experiments with conventional therapy "felt like talking around the edges of something that couldn't be reached through normal conversation," she emphasized, because "the tools just did not match the kind of experience I was having." Initially dismissing Oregon's psilocybin program as "the kind of thing people grasp at when they are desperate," she also worried that, as a "very rational, atheist" person, believing in psychedelics' transformative potential might feel "almost childish." Over time, however, curiosity displaced her skepticism; she began reading clinical literature and listening to patient accounts, drawn particularly to descriptions of "feeling connected" or "open again." A coworker's framing of psilocybin as helping people "make contact with parts of themselves they had abandoned for survival," combined with the visibility of a regulated state system, allowed Laura to reposition the treatment as morally acceptable and practically possible. Her self-description as a "very rational, atheist" professional was itself a dispositional configuration, layered from her class location, her formal education, and the cultural authority of scientific rationality as she had internalized it. The regulated Oregon framework and the language of reconnection supplied schemas through which a disciplined rationalist could recognize psilocybin treatment as legitimate within her own terms.

Economic, institutional, and familial conditions also shaped who could enter psychedelic pathways and how. Aaron, a middle-aged man in the Midwest, eventually found a ketamine clinic that paired a psychiatrist with an anesthesiologist. "It was like a thousand dollars per injection," he explained, "and then you have to keep going back." Access hinged on his ability to marshal considerable financial resources "just to feel like a normal human being." Sophie, a young woman dealing with acute psychiatric and somatic distress, entered ketamine treatment

through family-based referral when her godparents connected her with a psychedelic therapist who practiced aboveboard as a ketamine provider yet had also been working with psychedelic medicines in underground contexts since the 1970s. Over time, both of her parents, Meg and Steve, entered treatment with the same therapist, who gradually introduced them to other psychedelic substances and underground practices. Kin-based trust, the therapist's hybrid position, and affective desperation opened doors that formal pathways might have delayed or blocked, even as the broader relationships in this family would later become central to how they understood the relational conditions of change and the long work of integration.

These trajectories show that entering psychedelic care was neither a singular decision nor a simple reaction to media hype. Patients arrived at PAT with already thick biographies of suffering, diagnosis, treatment, and economic constraint, and those careers shaped how they understood what was at stake, who they trusted to guide them, and what kinds of transformation they imagined might be possible.

Making Sense of Psychedelic Medicine

Once people had found their way into psychedelic-assisted care, the central problem they described was how to understand what had happened during their experience and what kind of person it made them. The immediate aftermath of sessions was rarely a clean story of symptom reduction. Patients narrated psychedelic medicine as something they had to interpret, wrestle with, and slowly fold into existing stories about self, illness, and possibility, learning both how to be affected by new substances and which vocabularies made those effects intelligible and worth building into a longer career of psychedelic healing. Frank's (1995) account of illness narratives as moral stories that reorder identity and obligation was directly operative across cases. Patients were not only reporting on what had happened under the medicine; they were re-narrating who

they had been, who they were becoming, and what they owed themselves and others in light of what they had seen.

A first cluster of accounts cast psychedelics as reordering the meaning of longstanding distress. Johnny, who had lived for years under a regimen of antidepressants that dulled both pain and joy, drew a sharp contrast between pharmacological blunting and the subjective intensity of his psilocybin work. After treatment, he said he "actually started feeling emotions again, even the painful ones. It was rough at first, but at least I was alive." He retrospectively framed this as a lesson about what health could be: the meds had taught him that "numbness isn't the same as peace," and the session showed him that "feeling everything, even the hard stuff, is part of being whole." This session motivated Johnny to eventually seek membership in a Native American church that hosts biyearly ayahuasca ceremonies, which he now considers his "most important events every year." Eric, who previously described himself as a "functional ghost," similarly came to define health not as the absence of anxiety, but as being "connected to life," present in his own body and relationships even when things were still hard. In these narratives, a "good outcome" meant feeling more alive, even when moods remained uneven. Psychedelic medicine did not simply act on depressive symptoms; it forced a redefinition of what counted as a tolerable life, away from a biomedical ideal of symptom minimization and toward renewed participation in emotional life.

For many, the most powerful interpretive work took the form of symbolic imagery that recast trauma and inherited pain. For Chloe, who traced her chronic anxiety to a lifelong project of keeping quiet in a conservative, conflict-avoidant family led by an abusive father, her social history appeared in her psilocybin session as a dense visual metaphor. She described "this field of black crystals I was carrying," which at first looked like pure poison. As the session deepened,

she realized they were made of "frozen tears," hers and her mother's and "all of these tears of people my father had hurt with his words and silence." The image shifted from a malignant weight to congealed grief, and the "crystals began to melt into a dark river." Then she saw "a great, ancient, towering tree" whose roots drank from that river and whose branches reached into "incredible, golden, loving light... I think I understood in my soul that the tree was me. And it was everyone." She felt her roots were supposed to be within that painful history rather than hidden from it. "That feeling was what helped me make sense of everything I went through," she explained. The session offered both a diagnosis and a moral pedagogy, condensing inherited harm and opening possibilities to internalize new definitions of self and emotional ecology.

Patients also drew on explicitly spiritual or existential vocabularies when other frameworks felt exhausted. Linda, who had long approached life as a skeptical agnostic committed to "evidence and reason," sought psilocybin for grief that had outlasted her usual coping strategies. During a key moment in her first session, the tone shifted to a sense of being held by something larger. "It felt like I was surrounded by a presence," she recalled. "Not a person, deity, or anything like that. It was just something that felt alive and connected and aware. It felt like love but not like any kind I'd felt before... I remember thinking, if this is not spiritual, then I do not know what spiritual could ever mean." Linda did not retroactively redefine herself as religious. Instead, she treated the experience as forcing a revision in her explanatory repertoire. "I wouldn't say I'm an atheist anymore, but I'm still a logic-forward rational kind of person in the same way I was before," she explained. Grief no longer appeared as a purely psychological or biochemical problem; it required a new category of the "spiritual" that could acknowledge feeling "surrounded by a presence" without collapsing into dogma, and that category later oriented the rituals and acts of remembrance she adopted in integration.

Other participants reworked existing religious or familial languages in light of psychedelic encounters. Marissa, a Latina woman raised Catholic, described an intensely emotional psilocybin session in which she felt her deceased grandmother's love as vividly as if they were together in her childhood kitchen. Her facilitator encouraged her to light candles for her grandmother and cook family recipes as ways of "continuing the conversation" that had opened in the session. The medicine did not replace her religious background with a new cosmology; it reconfigured Catholic practices she already knew as legitimate vehicles for integrating what she had seen and felt. Marissa's case makes hybrid habitus visible as a set of available resources for sense-making in the aftermath of psychedelic experience. The configuration of dispositions she brought to psilocybin work was formed across formal Catholic ritual participation, matrilineal familial practices, and informal devotional habits of her household and upbringing, and those dispositions furnished the very materials through which her encounter with her grandmother could be stabilized and carried forward.

In other cases, psychedelic experiences were framed as moral and epistemic training. Jared, a highly educated professional accustomed to approaching his own suffering as "a problem to solve," credited his therapist with helping him develop what he called "sacred curiosity" before his high-dose session. "[That] is the best phrase I have for the mindset she helped me cultivate," he explained. "It was a complete inversion of my normal [operating system]." His usual curiosity was "like the curiosity of an inspector looking for faults," a style of self-analysis he described as "self-aggression dressed up in cheap intellectual-looking clothing." Under his therapist's guidance, the coming experience was reframed "as an exploration of consciousness itself." During the session, when painful memories surfaced, he recalled his facilitator's suggestion to lean in and ask, "What is this? What does this part of me have to show

all of me?" That newfound stance "transformed the way I look at my own consciousness from being this fucked up mess into something I can really learn from... It made me see all my mistakes and failures as lessons instead of these unforgivable moments where I gave up on my own potential." The dose did not deliver insight on its own. It became meaningful because he had rehearsed a specific interpretive posture that turned difficulty into symbolic material redeployable with renewed agency over his internal emotional world.

Other narratives made the stakes of interpretive mismatch especially clear. Walker described an underground psilocybin session in his early twenties as "almost sacred," yet when he spoke with his usual therapist the next day, the story was filtered back to him in "generic therapeutic type language," a vocabulary that felt "way too academic, or like, by the books, to capture what I was talking about." He remembered thinking, "I'm talking about this being a religious experience for me, and this person is almost trying to strip away all the beautiful meaning I could have taken from the whole thing." His therapist's language signaled that some meanings were acceptable and others were not. Years later, Walker sought out a facilitator in Oregon who could hold psychedelic encounters as existentially significant rather than as psychosomatic noise.

Making sense of psychedelic medicine also meant deciding what to do with experiences that were confusing, disappointing, or terrifying. David, drawing on phrases he had learned from peers and his facilitator, summarized a familiar interpretative script in the field: "There are no bad trips. There are just difficult experiences. Difficult things that you sometimes have to see within yourself to find your peace." Confronting such experiences forced him to ask what was "really important" and "absolutely sacred" in his life, framing discomfort as a sign that the medicine was revealing something that mattered. Marianne's ayahuasca work offered a more

extreme example. In one ceremony she was plunged back into memories of a specific episode of domestic violence she had endured, curled into a ball on her mat, sobbing and shaking, then purging in a way she described as "vomiting up the memories themselves." She interpreted this through the ritual logic of the ceremony, experiencing her healer's singing and use of smoke as a spiritual battle on her behalf, narrating the event as a necessary confrontation with "the spirit of the trauma," even as she acknowledged how exhausting and frightening it had been.

Not all sessions felt that charged. Sam, whose first psilocybin session had felt transformative, described his second as strangely empty: "I definitely felt something, but nothing really intense came up like it did the first time. And I realized maybe nothing needed to either." Rather than treating the absence of noteworthy content as personal failure or a defective dose, he read it as a pause in a longer healing trajectory. Even a relatively quiet session became another data point in a broader psychedelic career.

Across these varied cases, making sense of psychedelic experience emerged as an ongoing interpretive process. Patients drew on existing explanatory models from psychiatry, psychotherapy, religion, and everyday moral discourse, and revised those models when experiences exposed the limits of those frameworks. Whether a given experience became a turning point, an instructive failure, or a confusing detour depended not only on what happened under the medicine, but also on the relational conditions and institutional settings that helped stabilize or unsettle its meaning.

Relational Conditions of Transformation

Across the sample, psychedelic treatment and transformation were made possible, constrained, and interpreted through relationships that gave meaning to the experiences such medicines could produce. Those relationships are, in Sewell's (1992) terms, structural resources:

their quality, ethical integrity, and cultural resonance determine whether the schemas produced in a session can be converted into anything durable. Their failure – through abandonment, boundary violation, or interpretive mismatch – can foreclose that conversion entirely. Patients described facilitators, therapists, ceremony leaders, fellow patients, and loved ones who created conditions under which intensely altered states could either become bearable and meaningful or feel frightening, hollow, or ethically injurious. This section traces how those relational conditions worked in practice.

Patients' accounts foregrounded the importance of steady, nonintrusive presence as a precondition for surrender. In one case, a facilitator's entire contribution during onset consisted of small signals of attention. The participant recalled that as the sensations intensified, "I told her I was starting to feel it, and she just nodded and said quietly, 'Good. Keep breathing.'" Rather than offering elaborate interpretation, the facilitator stayed in her chair, occasionally shifting so the participant could hear she was there, a presence described as "steady but nonintrusive" that "make it feel safe to keep going deeper." This sparse choreography of nods, minimal verbal prompts, and audible but distant movement exemplified a form of relational containment that patients repeatedly framed as "the anchor" in an otherwise overwhelming situation.

For Aaron, the contrast between different relational environments was especially stark. His first exposure to psychedelic medicine ¹ came through a high-volume ketamine infusion clinic where staff monitored vitals, asked checklist questions, and cycled patients in and out of treatment rooms with little sense of who they were beyond their diagnosis and insurance. He was led into a room, hooked up to an IV, and left mostly alone. The infusions produced dissociative

¹ Ketamine is not pharmacologically grouped as a 'classic psychedelic,' though therapeutic practices surrounding infusions often resemble those in clinical PAT sessions, and users frequently describe the experiences in overlapping terms. The grouping reflects the ontological instability of this therapeutic moment and the insistence of several interviewees that their ketamine experiences were, in their own understanding, psychedelic in character. The term is used here to reflect that lived categorization rather than to assert pharmacological equivalence.

states and momentary relief, but the setting was "sterile" and "transactional," and no one had invited him to connect the experience to the ongoing strains of work, grief, and supporting ill family members. Whatever benefit the ketamine provided felt unmoored from the realities of his life.

His later psilocybin work in Oregon unfolded in an entirely different relational field. Aaron emphasized that he decided to pursue the psilocybin session only after an unusually lengthy initial phone call with the facilitator, during which she asked detailed questions about his history, family, and obligations and listened as he described what it meant to be "the one everyone else leans on." That conversation made him feel "seen" in a way psychiatric intakes never had, and he framed it as the moment he began to trust that this person could safely accompany him into an altered state. He later described her as "a safe haven... my conduit between both worlds," someone who knew when to sit quietly and when to offer a few grounding words. Where the ketamine clinic treated him as a body to be dosed and monitored, the psilocybin work depended on a relational container that recognized him as a caregiver, a strained professional, and a person whose responsibilities would still be waiting when the session ended.

Group ceremonial settings built a related kind of container. Daniel's description of ayahuasca work with his shaman highlighted how collective ritual and orchestrated care distributed responsibility across many bodies. He remembered the hymns "in a language I did not understand, but I could feel they were doing something to the room," and the moment when, in the midst of deep crying, "a volunteer came and put his hand on my shoulder for a few seconds, then left me to my process." The shaman did not rush in with interpretation when the crying stopped; he "locked eyes" with Daniel: "It was as if to say, I see you, I am here with you." The combination of synchronized song, staged but unintrusive physical reassurance, and an

emotionally attuned leader constituted a shared definition of the situation among Daniel and other attendees in which catharsis and vulnerability were expected and accepted with compassion (Becker 1963).

Relational safety was not only about protection from distress but also about calibrating intimacy and distance. Meg's experience with Kathy, an underground facilitator who also worked with her daughter Sophie, showed how that balance could both support and unsettle. At first, Kathy seemed to answer a long desire for warmth and recognition in medical spaces: "she was different, warmer, more human than the doctors," someone who "looked me in the eye and made me feel like she cared." Over time, however, Kathy "blurred lines," sharing her own problems and filling sessions with stories that felt "comforting but also strange." During a shared MDMA session with her husband Steve, Meg's long-repressed rape surfaced near the end of the day. When Meg said it was "good" she had been unconscious during her assault because she did not remember it, Kathy gently countered that not remembering can sometimes be harder because the body still carries what the mind cannot narrate. With the session nearly over, Kathy suggested they could return to it later but never mentioned it again. Meg remembered this as "a lid put on my deepest problem," and later reflected, "There was power in that moment, but also danger. I do not know that I trusted her completely after that." Trying to internalize a new orientation toward openness, she was left unsure whether that openness was truly safe within such unstable boundaries.

Sophie's relationship with Kathy initially illustrated the transformative promise of more securely held work. After years of feeling that prior CBT-oriented therapists were "just trying to fix [her] thoughts," she experienced early sessions with Kathy as a radical shift: the therapist invited symbolic material, asked about dreams, and did not flinch when Sophie named her

suicidality. In preparation for an MDMA-assisted session, this ongoing attunement built a sense that someone could finally stay with her through the worst of it. On the MDMA day itself, she spent six to eight hours in the same room with Kathy, with "all of those things... able to be out in the open" in a way that made her feel, for the first time, that therapy was "going where [she] needed it to go." Her "overall sense of hope" had been like a flame nearly extinguished by repeated treatment failures; under MDMA, "the flame was glowing" again.

Yet the same practitioner looked very different once Sophie learned how she behaved in other settings. After her own MDMA and psilocybin work, Kathy invited Sophie to a group psilocybin session at her home. Sophie could not attend, but her godmother's sister and a close friend did. According to their account, Kathy reassured a first-time participant that the session would be "fun," then became overwhelmed when the woman panicked, eventually saying she "couldn't do this right now" and retreating upstairs while the group remained under the influence of the medicine. Sophie later learned that Kathy had also taken psilocybin during that session. She also found out that Kathy had begun a romantic relationship with her own intern and had conducted couples' work in which she encouraged a married couple to separate and then started a sexual relationship with the wife. Together, these revelations recast Kathy's earlier warmth and openness as expressions of poorly contained power, sharpening Sophie's sense that relational attunement in psychedelic work is inseparable from basic ethical boundaries.

Across Meg and Steve's accounts, relational conditions extended into the fabric of their marriage. Meg's early work left her "cracked open" emotionally, then sent her back into a home life where Steve did not initially understand or endorse what she was doing. As she continued therapy and began naming long-buried hurts, he felt pushed to choose between familiar patterns and joining her in a more vulnerable way of being, and eventually agreed to his own MDMA

session. Steve remembered feeling like he was "shedding [his] own skin, writhing around on the floor like a snake," and said Kathy's interventions "took it from being that destructive state of mind to a more productive state." At the same time, he and Meg later described another session where Kathy was largely absent, leaving them with the impression that "this woman just gave us some really intense drugs and walked away." The same marriage and the same medicine produced very different trajectories depending on whether the practitioner's actions signaled reliable holding or abandonment.

Other accounts underscored how relational conditions needed to match spiritual and cultural repertoires as well as emotional needs. Daniel's work in ayahuasca ceremonies involved intricate negotiations between his Catholic upbringing and the Santo Daime cosmology. His shaman insisted on extensive preparation, emphasizing that "this is not tourism... you are here to learn how to live better, not to chase visions," and encouraged daily prayer and simple acts of service rather than focusing on spectacular imagery, reframing Daniel's preexisting religious practice as a legitimate vehicle for integrating what happened in ceremony. Rather than positioning ayahuasca as a break from his faith, the shaman functioned as a symbolic bridge who stitched existentially significant experiences into Daniel's psychedelic career as an intensification of religious commitments he already recognized. In the weeks after ceremonies, fellow congregants checked in with each other, asking, "how are you walking with the medicine?," distributing the labor of holding steady across a community rather than concentrating it in a single professional. The dispositional configuration Daniel brought to Santo Daime work was already layered: inherited Catholic devotion, a biomedical grammar of psychological suffering acquired through years of conventional therapy, and the embodied discipline of a professional life. The shaman's ritual pedagogy extended that hybridity by teaching him to hold Catholic

prayer, acts of service, and plant-medicine cosmology as mutually intensifying practices within a single spiritual life, available to him only because the relational conditions of care were designed to sustain it.

These cases show that psychedelic transformation was not a simple function of dose or protocol. It depended on relational conditions that made altered states intelligible, survivable, and actionable in the midst of ongoing lives. Steady, ethically grounded relationships could make overwhelming material feel like something to approach, while thin, inconsistent, or boundary-violating relationships could turn the same material into a source of distrust or injury.

Integration as Practice and Struggle

Across the sample, what mattered most after dosing was the slow, uneven work of trying to live differently over time. Participants described integration as a series of practices, negotiations, and setbacks through which psychedelic insights either settled into everyday life or receded into memory. Even vivid or moving sessions only sedimented into durable change when people could translate them into habits, boundaries, and ongoing forms of care. Integration functioned as the longest and most pivotal stage of patients' psychedelic careers – some participants even describing it as a lifelong process with no definitive endpoint – where people learned, with varying degrees of support, to turn intense experiences into durable shifts in the schemas and resources that organized their lives, and to sustain, revise, or sometimes abandon the futures psychedelics appeared to open.

Several framed integration explicitly as emotional and interpretative labor. Evan said the dosing itself only produced "raw material." In his words, "integration is the real medicine, not the trip. If you do not do that part, you are just left holding all that raw material." For him, the months after treatment involved repeated attempts to embed the session's insights into everyday

routines rather than chasing another peak experience. "The benefits have been steady, not immediately dramatic, all-at-once stuff," he explained. "I am not this totally different person. I am just a lot more honest with my kids, my wife, and with myself. And because of that, I am so much more comfortable with my existence today." Integration meant catching himself in old avoidance patterns and allowing his family to see when he was struggling rather than hiding it.

For Mark, whose psilocybin session partly centered on an image of himself locked away in a fortified inner "castle," integration meant turning that imagery into an ongoing discipline. In his journey, the austere structure transformed into a greenhouse, a place where life and vulnerability were possible without total collapse. "I kept asking, what does my greenhouse need to grow the beautiful plants I want to see bloom for the rest of my life?," he recalled, answering with small repeatable acts: spending time outside, exercising, keeping regular therapy, limiting overwork, and softening the way he spoke to his sons and wife. He pushed back against treating the session as a shortcut: "I spent fifteen years building that fortress I was locked up in during my time in the military. I know I can't expect vines to cover it or flowers to grow in it in just a week or a month." The metaphor illuminates how psychedelics may render *habitus* temporarily more mutable, offering a symbolic reference point for reorganizing military-hardened dispositions that veterans like Mark carry into family and work after service (Bourdieu 1977). The experience had shaken his embodied habits, but only sustained tending could reorient them.

Other participants emphasized that integration was often emotionally raw rather than soothing. Erin, a queer woman with long histories of childhood trauma and self-criticism, described her first post-session meeting with her therapist as both necessary and overwhelming. "She wanted to talk about my past, like the family stuff, the bedwetting, all of that. Just like getting in it and really looking at it," Erin recalled. "I was so vulnerable even after I saw her. I

was crying to myself afterwards, and I think it was this, like, reentry into the whole experience that opened me up even more. I had to truly ask myself: what was that? *Am I okay?*" For Erin, integration did not consist of affirming the beauty of the session or stabilizing a new positive story. It involved returning to stigmatized and embarrassing biographical details, linking them to what had surfaced under the medicine, and tolerating the disorientation that followed. The question "*Am I okay*" marked integration as a moral struggle to recalibrate what counted as acceptable feeling and behavior.

Kimmy's trajectory underscored integration as moral and relational practice. Her psilocybin work had helped her revisit longstanding patterns of self-silencing and the fear of being "too much" for others. In their integration meetings, her guide repeatedly reminded her, "You are not too much. You are brave," a phrase Kimmy said she carried into subsequent confrontations with her family and partner. Those words became a portable resource, something she could draw on when setting new boundaries, leaving a relationship, or choosing to disclose more about her mental health. Her facilitator refused the role of heroic fixer and instead framed Kimmy's ongoing boundary-setting as acts of bravery that only she could perform. Integration, in this account, rescripted what counted as courage and care in Kimmy's everyday life.

Participants also described structural and organizational conditions that made it difficult to sustain gains. Todd, a retired professor with chronic anxiety from the Southwest, spoke warmly about the staff at the psilocybin clinic in Oregon he traveled to, calling them "two of the most caring, loving people I have ever met." For several weeks after dosing he felt "like I was leading a charmed existence," noticing color, music, and social contact in ways that had been blunted for years. Over time, however, "that joy has since faded," leaving him in what he called a "gray middle" where he felt somewhat better than before but nowhere near the transformation he

had hoped for. He remained grateful for the clinicians and bitter about the broader system, describing psychedelic treatment in the United States as "tragically absent" and "not really available or accessible for folks like me who have to travel so far just for a single session." Todd's narrative illustrated partial integration: some symptoms lifted, but in the absence of sustained scaffolding, the experience did not reorganize his habits or social world to the extent a more resourced participant might have found possible.

Several others described stalled or fractured integration in even sharper terms. Aaron characterized his ketamine maintenance model as "feeling better for a while and then watching it slip away" once he could no longer afford ongoing infusions, with no psychotherapy or structured follow-up to help him work with what he had seen. Sophie summarized her own difficulties across several psychedelic treatments with a stark metaphor: "There was no aftercare. It was like Kathy opened up Pandora's box, then left me stranded dealing with all of the chaos." In these cases, psychedelics undoubtedly produced powerful experiences. But in the absence of accessible, ongoing support, those experiences quickly ran up against economic precarity, toxic environments, and thin institutional commitments. Relief became conditional on absorbing boutique-level costs or finding ways to live with upheaval that no one was structurally positioned to help them hold.

By contrast, participants who engaged in psychedelic work within sustained communities often described integration as a collective discipline rather than a solitary task. Johnny found that his annual ayahuasca ceremonies, relationship with his shaman, and bonds with his small spiritual community extended far beyond the nights of dosing. After one especially significant ceremony, his shaman told him to "keep listening, keep working with the hymns, and keep your life clean for a while so the lessons can take root." Johnny qualified this ethos further, explaining

that "the community helps keep me accountable. It is easy after a ceremony to drift back into old habits or forget what you learned. But when you are surrounded by people who are doing the same work, you get reminded to live what you learned." The task of "walking with the medicine" was sustained through exactly this kind of relational pressure. Integration took the form of routine questions from others that oriented him toward restraint in everyday choices about drinking, conflict, and emotional volatility. Even here, however, integration remained a struggle: Johnny repeatedly emphasized how easy it was to "drift back into old habits," and how ceremonies sometimes stirred up painful memories or conflicts that took months to work through.

Marianne made a related point in describing her post-ceremony relationship with her facilitator. After an ayahuasca journey that brought up intense scenes of violence and grief, she remembered feeling "so very fragile" in the following weeks. Her facilitator's role was to "normalize the chaos," treating those states as an expectable part of the process rather than as evidence that she was breaking down. At the same time, he insisted that "you did the work. I only held the lantern." Integration for Marianne involved being held in a structured relational field while taking up responsibility for ongoing interpretation and action, reorganizing longstanding narratives of herself as permanently broken into a story she could carry forward and develop further on her own terms.

These trajectories show integration as a fragile, uneven achievement rather than a natural outcome of psychedelic treatment. Participants who described more durable shifts engaged in repeated practices of narration, boundary-setting, ritual, and relational experimentation, supported where therapists, guides, and communities offered steady accompaniment within clear ethical limits. Economic constraints, clinic design, and cultural disjuncture repeatedly

undermined these projects. In settings that treated psychedelics as a pharmacological maintenance tool, or where aftercare was absent, participants often found themselves, as Evan put it, left holding "raw material." PAT, in its current fragmented form, does not deliver transformation as a discrete event. It offers powerful but unstable shifts in perception that become resources for long-term change only through sustained practice, relational support, and access to structural conditions that make those practices feasible.

Discussion and Conclusion

This chapter has argued that psychedelic-assisted therapy should be understood as a socially organized, morally charged career rather than a singular event or discrete clinical tool. Building on Rose's (2024, 2025) invitation to make the social production of psychedelic effects analytically concrete, this chapter maps the relational and institutional mechanisms that stabilize, redirect, or unravel therapeutic meaning over time. Rose's framework demonstrates how psychedelic effects are learned through subcultural participation and collective ritual, and how communal settings generate the moral energy and shared symbols through which those effects become therapeutically consequential. This chapter extends that account by asking what happens when the subcultural infrastructure Rose describes is absent by design: when careers unfold toward exit rather than ongoing participation, when patients return to ordinary social worlds without a community organized to hold what the medicine opened, and when relational quality within and beyond the therapeutic encounter becomes the decisive variable in whether transformation can be sustained. Drawing on a heterogeneous, multi-sited sample spanning legally operating clinics, sterile research contexts, underground circles, decriminalized settings, and psychedelic churches across the contemporary United States, this chapter offers one of the first systematic, patient-centered portraits of how psychedelic-assisted care is actually being

practiced on the ground today, rather than imagined within any single institutional or cultural frame.

Patients' narratives showed that entering PAT and achieving or failing to actualize self-transformation hinged on psychedelic career progressions, as people learned, tested, and sometimes abandoned new ways of understanding their suffering, relationships, and obligations to self and others. Entering psychedelic pathways required participants to navigate stratified therapeutic landscapes and to reinterpret their conditions in a language where monikers like "treatment resistance" became a moral and existential problem rather than a clinical label. Making sense of psychedelic medicine involved mobilizing shared repertoires of trauma, spirituality, and transformation under the guidance of practitioners, peers, and cultural scripts. Relational conditions of transformation then shaped whether those repertoires could be made livable, while integration emerged as fragile, ongoing work linking acute episodes to more enduring changes in conduct and care. Taken together, these findings suggest that psychedelic-assisted therapy is best understood as unfolding through a socially organized career of meaning-making and relational labor, situated within contested moral and medical economies of care.

The chapter extends Becker's (1953; 1963) classic insights that drug effects and careers are learned rather than given. Patients did not simply discover their "true selves" or naturally internalize universal psychedelic insights; they entered settings and career phases where particular explanatory models, metaphors, and story forms were available and legitimate, and learned to inhabit or resist them over time. In ceremonial and communal settings, the psychedelic career more closely resembles Becker's original model, with meaning stabilized through continued ritual practice, collective accountability, and community embeddedness; Johnny's annual ayahuasca ceremonies and Daniel's sustained Santo Daime practice illustrate this form

directly. In conventional dyadic therapeutic contexts, the career unfolds toward an exit, placing the full burden of meaning consolidation on integration work that the therapeutic frame rarely controls or prepares patients for. It is this latter form that presses most sharply against the Becker framework, and that makes the structural resources available after the session ends analytically decisive. In this sense, psychedelic careers resemble the narrative work Bury (1982) and Frank (1995) describe, where biographical disruption demands repair and where the resources that make a story tellable often determine whether suffering remains chaotic or becomes reorganized. Psychedelic states intensify that struggle by accelerating reinterpretation, raising the stakes of meaning, and producing moments of biographical illumination when past experience is re-read as newly intelligible and action-worthy (Tan 2018). What differentiates these careers is the social organization of care that precedes and follows dosing and the uneven access to human and nonhuman resources that allow narrative and behavioral change to sediment. The psychedelic event heightens narrative work, but it does not guarantee its consolidation.

Psychedelic illness narratives are never purely personal. Explanatory models of health and illness are co-produced between sufferers and clinicians (Kleinman 1981), yet here that co-production is distributed across therapists, underground guides, churches, friends, media exposure, and regulatory infrastructures. Patients' accounts reveal how interpretive repertoires travel between institutional worlds, where trauma frameworks migrate from psychotherapy into ayahuasca circles, somatic idioms of safety and nervous system regulation circulate through Oregon service centers, and scientific tropes about neuroplasticity circulate alongside invocations of spirits and ancestors in the psychedelic underground. The result is a hybrid narrative ecology in which people experiment with multiple vocabularies for what has happened to them. Psychedelic careers, in this sense, are not only sequences of episodes; they are careers

through overlapping regimes of meaning and value in which different authorities compete to define what counts as insight, progress, and relapse.

This analysis also complicates recent accounts of psychedelic governance that foreground individual safety, accountability, and self-management within emerging regulatory infrastructures (Schwarz-Plaschg 2022). PAT is often treated as a technology that enhances patients' capacities to know and govern themselves. The cases here support parts of that picture: patients did learn to monitor moods and triggers, interpret symptoms as expressions of trauma, and assess whether a setting was "safe" or "held." Yet these capacities were taught and sustained unevenly. Some contexts treated dosing as high-throughput procedure with minimal follow-up, outsourcing integration to patients' own resources. Others cultivated intensive relational containment but did so in settings accessible primarily to privileged clients. Psychedelic governance appears as a patchwork of experimental arrangements in which capacities for reflection and self-regulation are produced, withheld, or rendered fragile by institutional design and political economy.

Thinking in terms of habitus and field clarifies the stakes of this patchwork (Bourdieu 1977; 1990). Patients arrived with dispositions shaped by prior encounters with psychiatry, religion, alternative medicine, wellness culture, labor markets, militaries, family units, and much more, and those layered, cross-field orientations determined which meanings felt credible and which possibilities for self-understanding felt livable within the encounter. Lo and Stacey's (2008) concept of hybrid habitus names this dynamic precisely. Evan's layered biomedical skepticism and epistemic discipline conditioned which accounts of psychedelic experience could register as credible and shaped the legal, regulated setting he was eventually willing to enter. Laura's rationalist self-image was sutured to the Oregon regulatory framework in ways that made

a session thinkable without requiring an identity overhaul. Marissa's Catholic dispositional repertoire furnished the very materials through which the memory of her grandmother that surfaced could be stabilized and carried forward. In each case, what the encounter could offer was structured, before the medicine was administered, by the embodied orientations the patient brought in. These shifts unfolded within fields that were themselves in motion, as Oregon's regulatory experiment, expanding ketamine markets, and the growth of psychedelic churches opened, structured, and sometimes closed pathways for continued care.

Sewell's (1992) theory of structure, composed of mutually constitutive schemas and resources, specifies what happens next. Psychedelic sessions function as micro-level transformative events (Sewell 1996), rupturing existing self-understandings with unusual force, rendering previously stable schemas momentarily malleable. New schemas can become durable only if they can be converted into and sustained by structural resources, including the relationships, practices, institutions, and material conditions capable of carrying them forward. The therapeutic relationship is itself among those resources. Its quality, ethical integrity, and cultural resonance determine whether the schemas produced in a session can be converted into anything patients can actually use, and its breakdown can foreclose that conversion entirely. Sophie's and Meg's trajectories after Kathy's boundary violations illustrate this directly: the same medicine and the same setting produced very different outcomes once the relational resource on which meaning-making depended had been compromised. Psychedelic careers emerge where cultural schemas and material resources combine in new ways, but those combinations are unevenly available and always subject to contestation.

These findings also speak to literatures on medicalization and demedicalization. The treatment-resistant identity, as the pathways data show, is a structural product of the

medicalization apparatus. Biomedical institutions define distress as individual pathology, exhaust available pharmaceutical options, and in doing so generate the career dead ends that make a qualitatively different intervention both morally and practically imaginable (Conrad 2007; Cant and Sharma 1999). Yet participants also used psychedelic experiences to question the taken-for-granted aims of psychiatric treatment, including the normalization of emotional flattening as the price of "stability." Some came to treat their diagnoses as partial or misleading descriptions of broader social wounds such as workplace exploitation or gendered violence. Others exited formal treatment landscapes altogether, turning instead to churches and underground circles that refused the distinction between medical and spiritual care. PAT, in this light, appears as a site where medicalization is negotiated, redirected, and sometimes resisted by both practitioners and patients, rather than simply imposed by orthodox medical authority (Halfmann 2012).

These theoretical contributions carry concrete implications for the practice of psychedelic-assisted therapy. Pathways into PAT are already structured by inequalities in financial, social, and cultural capital; participants who managed to build sustaining psychedelic careers were in almost all cases those with the economic means for multiple sessions, the networks to locate careful facilitators, and the cultural fluency to treat psychedelics as legitimate tools. If psychedelic interventions are to function as more than boutique treatments for the already advantaged, practitioners and policymakers will need entry points that do not rely on personal networks or high-priced clinics, and outreach that speaks to communities for whom psychedelic work has historically been dangerous, stigmatized, or irrelevant. Within sessions, meaning-making is constitutive of the therapeutic process, inseparable from its pharmacological substrate. Facilitators who helped participants rehearse flexible explanatory models and who revisited core symbols and images over time made it more likely that acute episodes could

become durable sources of guidance, while settings that treated dosing as standardized procedure tended to flatten experiences into symptom scores or leave patients to integrate disturbing material alone. Training for facilitators should therefore include narrative and relational skills alongside protocol adherence and risk management.

Relational conditions matter outside sessions as well. Family members, partners, peers, and community networks either extended the therapeutic work or undermined it; integration groups, religious rituals, and informal psychedelic kin networks provided settings where people could continue to test new identities and practices. Responsible designs will build formal ties to family education, peer support, and community-based spaces where psychedelic narratives can be worked on collectively rather than in isolation. Integration is the hinge on which both therapeutic outcomes and ethical legitimacy turn. Treating integration as central to the intervention implies funding models that reimburse integration work, regulatory frameworks that incentivize relational continuity rather than throughput, and institutional partnerships that hold patients beyond rigid trial timelines. Some participants described being dropped after protocol completion, left to shoulder the burden of changed perception in unchanged social worlds; responsible design requires that those conditions not be treated as exogenous to the intervention.

The psychedelic careers described in this work show that psychedelic medicine never stands outside of social worlds. It intensifies them. Each apparent existential breakthrough lays bare structural contradictions in the institutions, communities, and histories that are charged with carrying their weight. In this way, the stakes of psychedelic care extend far beyond the scope of the clinic; they are also moral and political, forcing us to consider what kinds of lives social and cultural structures allow the remaking of. The narratives these medicines have altered make

plainly clear that the promises and perils of psychedelic medicine lie not only in molecules, but in the social worlds that enable or prevent learned transformation.

Chapter 3

Cultural Brokerage and the Structural Conditions of Psychedelic Transformation

Psychedelic-assisted therapy (PAT) is being institutionalized amid renewed clinical and commercial interest. Trials and reviews report promise for conditions such as depression and PTSD, while emphasizing that outcomes depend on context, relationship, and meaning-making (Reiff et al. 2020; Mitchell et al. 2021; Carhart-Harris et al. 2021; Davis et al. 2021). As PAT scales, “set,” “setting,” and “integration” can flatten into protocols and reporting domains, stripped of their social production (Hartogsohn 2017; Pronovost-Morgan et al. 2025). This renews a core medical sociology problem: how encounters mediate between standardized medical logics and the interpretive, biographical, and moral worlds in which suffering is lived (Mishler 1984; Bury 1982; Frank 1995). PAT sharpens the problem because the “object” of care is an altered-state episode whose symbolic content is variable and ethically problematic to interpret on someone else’s behalf, so transformation depends on labor that makes experience enterable, ethically held, and portable in everyday life.

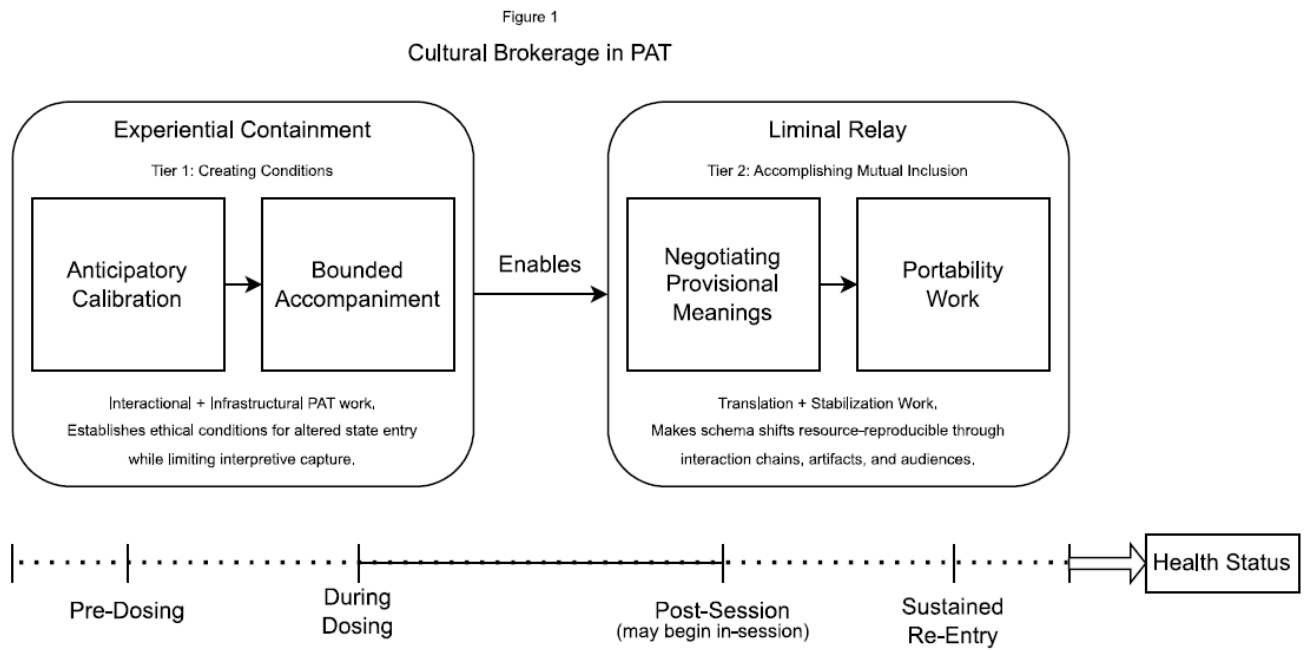
I treat that labor as cultural brokerage: interactional work that bridges divergent interpretive frameworks, moral orders, and communicative expectations in care (Barbee 1987; Hsieh 2006; Lo 2010). In Lo’s (2010) formulation, brokerage enables intelligibility between the voice of medicine and patients’ lifeworlds, where “patient culture” is a flexible, hybrid ensemble shaped by race and ethnicity, class, gender, migration, religion, and other structural conditions. This chapter extends the framework to a field where the medical voice is often hybridized and experientially grounded, and where session meanings resist medical closure. Cultural brokerage

in this care context involves translation and governance of interpretive influence under vulnerability and asymmetry.

This chapter completes the dissertation's analytic arc. Chapter 1 theorized liminal authority as a legitimacy structure in PAT; Chapter 2 showed that change unfolds through learned, recursive work sustained through narrative labor and relational support. Chapter 3 names the interactional labor that converts liminal authority into practice. I develop two mechanisms – experiential containment and liminal relay – accomplished through four forms of cultural brokerage. The first two forms, anticipatory calibration and bounded accompaniment, create the conditions for mutual inclusion of schemas by governing entry into altered-state care and holding vulnerability without coercive interpretive direction. The second two, negotiating provisional meanings and portability work, accomplish the mutual inclusion itself, translating session material into accounts that can circulate across audiences and survive re-entry into ordinary life. Figure 1 provides a visual reference of the temporal sequencing of experiential containment and liminal relay across a standard treatment timeline, along with their concomitant forms of brokerage work.

The chapter is guided by two questions: (1) How do practitioners make liminal experience enterable and ethically held, converting experiential legitimacy into interactional practice while protecting patient authority? (2) How do these practices shape the formation, stabilization, and portability of illness and health narratives across preparation, dosing, and integration, especially under regulatory and market constraints that unevenly distribute time, access, and institutional safety?

Figure 1: Process Visualization of Cultural Brokerage in PAT.



Literature Review & Theory

Medical sociology has long treated therapeutic encounters as sites where unevenly positioned actors negotiate knowledge, authority, and moral accountability. A core concern is the interactional work through which suffering becomes legible as a clinical problem, a moral problem, and a life problem at once (Mishler 1984; Kleinman 1988). Encounters matter even when cures exist because they define credible distress, stabilize actionable explanations, and recognize forms of personhood within institutional constraints (Frank 1995). Work on chronic illness and biographical disruption similarly shows that crisis is not only biomedical; it is interpretive and biographical, requiring ongoing reconstruction of self, futures, and responsibilities under uneven support and constraint (Bury 1982; Williams 1984; 2000). These traditions motivate this chapter's premise: outcomes depend not only on dosing, but on how

dosing experiences are interpreted, authorized, and sustained within relationships and institutions.

Psychedelic-assisted therapy (PAT) foregrounds interpretation because the intervention centers on a brief, high-intensity altered-state episode saturated with symbolic content. Meanings are hard to stabilize, easy to dispute, and often contested across settings as insight, symptom change, spiritual revelation, or adverse effect. Interpretation is further intensified because experiences are often described as both authoritative and ineffable: patients report that “something was revealed” without a clear account of what, exactly, was revealed. PAT therefore offers a vantage point for studying how clinical protocols, psychotherapeutic vocabularies, spiritual idioms, trauma narratives, neurobiological explanations, and popular self-help tropes are assembled into workable accounts of what happened and what it means in a patient’s life. The analytic problem is not which register ultimately wins, but how participants produce interpretations sturdy enough to guide post-dosing action, including decisions about relationships, work, risk, and continued care.

Sewell’s theory of structure, as the dynamic articulation of schemas and resources, provides a useful frame (Sewell 1992). Experiential change matters sociologically when it reorganizes interpretive frames and, through them, the use of resources and the construction of lines of social action. Psychedelic experiences are neither only “inner events” nor mere products of context. They can function as consequential episodes that invite new alignments, but those alignments become durable only when converted into practices, infrastructures, and relationships that reproduce over time. This chapter treats PAT as a field organized around that conversion problem, where transformation depends on rendering experience governable and portable across time and place.

The possibility that psychedelic experiences are schematically generative is supported, first, by patterned phenomenology. Recurring phenomenological dimensions – unity, sacredness, noetic quality, positive affect, and ineffability – are operationalized in measures such as the Mystical Experience Questionnaire and map onto long-standing typologies of religious experience (Griffiths et al. 2006; Barrett, Johnson, and Griffiths 2015). Yet such experiences do not interpret themselves. Participants work out meaning in interaction by drawing on available repertoires. Because many contemporary psychedelic encounters unfold within durable therapeutic, spiritual, and self-help infrastructures, participants often draw on similar interpretive resources and face similar institutional incentives, often producing convergence in narratives even when experiences are idiosyncratic. These infrastructures create recognizable pathways by directing attention toward some meanings, discouraging others, and making certain accounts easier to stabilize and carry forward.

Cultural brokerage in PAT unfolds within contested ecologies of legitimacy, where practitioners navigate tensions between biomedical credibility and experiences patients may describe as mystical, spiritual, or morally revelatory, and where the pluralization of cultural authority means that legitimacy is made rather than assumed (Epstein and Timmermans 2021).

Lo and Stacey's (2008) concept of hybrid habitus helps explain how some actors navigate these cross-pressures by highlighting the embodied competencies that make credibility possible across registers. Hybridity goes beyond simply "holding multiple beliefs." It is a learned capacity to operate across vocabularies of evidence and virtue and to present oneself as credible in settings that reward different sensibilities, aesthetics, and epistemologies. This chapter builds on that insight while shifting the analytic target from hybridity to the brokerage work that makes hybridity consequential. Hybrid habitus helps explain who can occupy boundary positions;

brokerage explains how those positions are used to stabilize patient interpretations, coordinate institutional demands, and manage the ethical volatility of intense altered states. This framework anchors the chapter's two mechanisms of effective practice in PAT: experiential containment and liminal relay.

This framing also clarifies why “set and setting” are important but analytically insufficient terms. Invoked as a rubric, it names context without specifying how contexts are assembled, ethically governed, and prone to failure (Hartogsohn 2017; Dumit and Sanabria 2022). Cultural brokerage re-specifies set and setting as conditions built through labor with identifiable mechanisms, success conditions, and failure modes. A brokerage lens also makes inequality analytically central. Because brokerage presupposes resources – time, stable housing, money for continued care, social environments that can tolerate unconventional healing narratives – disparities in care can appear interpersonal while tracking structural stratification (Shim 2010; Dubbin, Chang, and Shim 2013). I focus on the brokerage work that makes integration operational, treating it not as diffuse personal responsibility but as labor requiring interpretive supports, relational continuity, and audiences where new meanings can be sustained (Sanabria and Tófoli 2025).

Rose's (2024; 2025) call for rich interactionist accounts of psychedelic therapy anchors this chapter's empirical agenda. This chapter extends that program by specifying two mechanisms, accomplished through four brokerage forms, through which transformation becomes durable in PAT, and by treating stratification as a determinant of whose narratives are recognized, whose relay work is feasible, and whose everyday contexts can absorb new meanings.

Experiential Containment

Experiential containment is the interactional and infrastructural work through which PAT makes altered-state experience ethically enterable while limiting interpretive capture. It is how an altered-state episode becomes governable enough to be schematically generative without coercion (Sewell 1992). Altered-state care makes the stakes of set and setting concrete; patients are vulnerable and suggestible, practitioners hold an asymmetrical position, and support can slide into meaning-direction. Containment stabilizes intensity without prematurely stabilizing meaning, protecting patient sovereignty while keeping the encounter workable as care.

This formulation builds from Noorani's (2021: 203) argument that containment has become a central idiom of legitimacy in contemporary psychedelic clinical work. Sessions are rendered publicly defensible as "well contained" through trained personnel, approved protocols, and regulated settings, making them discussable without appearing to "spill out into the streets." Containment is also discursive and ethical. Shared narrative frames (e.g., the "inner healer") can help hold powerful experiences when paired with preparation and explicit attention to altered-state suggestibility.

This chapter extends Noorani's observation by specifying containment as a central brokerage practice: the interactional labor through which facilitators translate between patients' lifeworld fears and the procedural, ethical, and relational demands of psychedelic care, while preventing that translation from hardening into coercion or meaning capture. Where Noorani analyzes containment primarily as a legitimacy discourse, this chapter shows how facilitators accomplish it through identifiable brokerage moves – disciplining expectations, building consent architectures, and governing interpretive influence in real time – that constitute the first tier of

cultural brokerage in PAT, which creates the ethical and epistemic conditions for patients to enter and navigate altered states with a sense of safety and interpretive autonomy.

In the findings presentation, experiential containment is accomplished through two interlocking domains of brokerage work. Anticipatory calibration orients patients interpretively before dosing, disciplining expectations, clarifying risks, and specifying permissions and limits so that altered states can be approached without lofty expectations and with a working sense of what the encounter will and will not permit. Bounded accompaniment governs asymmetry during dosing through consent-based intervention, boundary enforcement, and interpretive restraint, so support remains available without tipping into meaning capture.

Liminal Relay

Liminal relay names how a schema shift becomes resource-reproducible through interaction chains, artifacts, and audiences (Sewell 1992; Collins 2004). Where “integration” is often framed as a diffuse, individual period of reflection or self-work, liminal relay foregrounds the social labor required to carry an altered-state episode back into ordinary obligations, relationships, and institutions. Sanabria and Tófoli (2025) clarify why this distinction matters: “integration” in contemporary PAT discourse can become a depoliticized, individualized container for change, detached from the relational and communal infrastructures that make non-ordinary experience contiguous with everyday sociality.

Turner’s sequence of separation, liminality, and reaggregation supplies refined language to theoretically reframe the post-session phase. Liminality involves a temporary loosening of classification and status that cannot be sustained. It must culminate in reaggregation, when actors re-enter structured relations with recognizable norms and obligations (Turner 1969). Liminal relay names the brokerage work that makes reaggregation possible in psychedelic care without

reducing it to a private psychological task. It treats the “return” as a fragile accomplishment, especially when social worlds cannot recognize the experience, disclosure is risky, or institutional settings demand legible stories.

Collins’s interaction ritual theory specifies how that return is sustained over time. Interaction rituals generate emotional energy and invest symbols with affective charge; rituals also link in chains, so the outcomes of one encounter become inputs to the next (Collins 2004). Liminal relay is the deliberate construction of those chains which involves selecting a limited set of symbols, narratives, and embodied cues from the session, then embedding them in repeatable infrastructures (follow-up conversations, interpretive prompts, relational scripts, and routinized practices) that periodically “recharge” emotional energy and keep meanings portable across contexts. What this adds beyond “integration” is a different unit of analysis and a different causal claim. Durable effects depend on how symbols and emotional energy are socially recirculated, authorized, and made usable within networks and institutional audiences, not only on individual insight or reflection.

Analytically, liminal relay is accomplished through two interlocking forms of cultural brokerage. Negotiating provisional meanings is the collaborative work of translating intense, ambiguous experience into an account coherent enough to guide action while remaining deliberately revisable. Portability work is the downstream labor of making those accounts survivable across social settings and institutional audiences, including disclosure management, register-shifting vocabularies, routines and artifacts that reactivate meaning, and navigation of stigma, legality, work and family obligations, and unequal access to time, money, and ongoing support.

Findings

Anticipatory Calibration

Anticipatory calibration is the pre-dosing work through which practitioners make altered states of consciousness enterable with clarity while constraining the conditions under which interpretive influence can become coercive, proprietary, or misleading. As cultural brokerage, it translates between patients' lifeworld fears and expectations and the procedural risk, legitimacy, and consent scripts of psychedelic care, while preventing that translation from hardening into persuasion or meaning ownership. It operates at the front gate of psychedelic care by disciplining expectations, establishing legitimacy and safety in terms patients can recognize, and setting limits on guidance so support remains credible without becoming directive. In that sense, anticipatory calibration is the first site where the ethical problem of asymmetry is either governed or allowed to drift. When it is done well, patients describe entering the dosing day without feeling sold to, rushed, or interpretively cornered; when it is done poorly or dropped altogether, patients describe being surprised by intensity, feeling misled about what they consented to, or realizing too late that the preparatory frame was quietly doing persuasion rather than containment.

Among practitioners, anticipatory calibration often takes the form of deliberate “worst-case” framing that makes feared outcomes sayable before they arrive, anchoring consent in plausible scenarios rather than optimism or cure rhetoric. In her standard preparation session, Alexa describes “paint[ing] the worst picture” and “put[ting] it all out there” so there are “no surprises.” She offers concrete, unromantic possibilities that patients can later recognize as within the bounds of what they agreed to: bodily vulnerability (“You may wet the bed... We may be crawling to the bathroom”), difficult affect (“You might have what people consider a bad

trip”), and the familiar panic spike where “you’re convinced you’re going crazy.” She pairs that realism with bounded temporality, telling clients it may feel that way “for a little while, but it’s only temporary,” and clarifies her in-session role as “holding the space” without directing meaning: “I’m there to remind you that you’re okay... and to just keep going.” Alexa frames the conversation as a reference point patients can recall during dosing, so that a moment where a patient says, “Oh my God, this is awful,” can be followed by “you told me this might happen,” reclassifying intensity as anticipated difficulty instead of evidence that something has gone wrong.

Kimmy’s account helps specify why this realism functions as calibration. She describes her initial contact with Alexa as “a 45 minute phone call” that was “very logistically oriented,” essentially explaining “this is how we work, and this is what we do,” with space where “she let me ask as many questions as I needed to ask.” Kimmy surfaced a core fear immediately, stating, “I was scared I was going to lose my mind,” and emphasized that Alexa answered “in a way that was reassuring and also factual about what could happen.” She explains her early trust in interactional terms: “there was no effort at convincing me, only straight answers to my questions without any agenda,” alongside acknowledgement that “validated [her] perspective” so she “didn’t feel the weight of a power dynamic” between one another. She also contrasts the call with the pressure she expected, noting that Alexa “wasn’t attached to some kind of outcome... it felt like there wasn’t any time limit on our call,” and that Alexa explicitly left the door open, telling Kimmy, “if you hang up and you have more questions, let me know.” In her telling, this is part of what made her “surrender” on dosing day ethically permissible, since the relationship had already been partially tested for non-coercion and the scariest possibility had already been made articulable without being steered.

A second style of anticipatory calibration works through intention framing that blocks fantasy outcomes and relocates authority to the encounter itself. Kathy, a longtime underground facilitator, describes incorporating intention into the opening of her ceremonies, but “not going heavy on what’s your intention type talk,” because “it has to be held lightly” and “the medicine is going to show you what it shows you.” She contrasts an open-ended intention (“I wonder what I’m going to discover about myself”) with a pre-scripted one (“I’m going to be on a beach with white sand and palm trees”), then clarifies non-ownership: “It doesn’t matter what I’m going to experience in the room. It matters what they’re going to experience.” She also prepares participants for difficulty without converting it into a willpower test, framing the session as a possible encounter with “the dark night of the soul,” while drawing a boundary around her role: “I’m going to help you work through it, but it’s up to you to keep moving.”

Steve’s account is especially clarifying because Kathy was someone he already knew and trusted. His daughter Sophie had benefited from several successful sessions with Kathy, which gave him confidence to schedule his own. Steve felt Kathy could “talk the talk” in terms of holding intentions with seriousness while avoiding over-promising, but his story turns on an irony that makes the boundary conditions of anticipatory calibration visible. In her own account, Kathy treats pre-scripted intentions, including the fantasy of “a beach with white sand and palm trees,” as a problem of entry because it imagines controllability and positions the provider as someone who can deliver a desired scene. Yet Steve describes being recruited through precisely that kind of imagery, with Kathy framing MDMA as a condensed “vacation, like a week of intimacy cram[med]... into a six hour session,” and invoking the same secluded “white sandy beach” atmosphere she cautioned against. Steve was careful about moral accusation, saying he “doesn’t want to call it being tricked,” but he also says he agreed “under the guise” of something

fun and harmless, entering without a credible sense of what intense experiences could surface. He also recalled early intake calls where he found himself giving “the answers that I felt like she wanted to hear,” not the ones he “needed to give,” which meant fear and ambivalence were never explicitly discussed on the front end. When the medicine kicked in and he slid into panic, the experience “immediately became, like, this is not how you guys sold this,” and the gap between the calibrated stance Kathy articulates in the abstract and the inductive entry frame Steve remembers became part of how he understood what was happening in the room.

A third strand of anticipatory calibration appears as legitimacy work accomplished through explicit procedure, especially in clinical and regulated settings where “set and setting” are built as systematized infrastructures. Julian’s entry narrative treats clinically oriented legitimacy as the condition that makes surrender thinkable. Before applying to a clinical trial, he describes a period of “meticulous research,” starting with PubMed and the trials themselves, then tracing investigators and institutions, and finally choosing a pathway that felt “professional,” “rigorous,” and medically buffered. He emphasizes that “the set and setting, the safety, were non-negotiable,” and he recalls spending hours reading the informed consent document because he wanted “every possible risk” and “every detail of the process” to be clear in advance. Within that safety envelope, he also describes intention and fear work that preserved interpretive autonomy without leaving him unheld. One guide anchored physiological considerations by “explain[ing] everything in detail,” while the therapist steered him away from “cure my depression” language and toward an invitation he could inhabit. Julian also recalls naming the fear directly, “I told her bluntly, I am afraid of going crazy,” and experiencing a response that made the fear workable without dismissing it, paired with simple grounding tools and a practiced ethic of “surrendering,” “leaning into,” and “letting the current carry you” rather than fighting it.

Practitioners in state regulated settings often perform similar legitimacy work through rights scripts and role clarification. Dr. Stevens describes Oregon's framework as providing a "semi-regulated and legalized framework" that allows a "safe social workspace around substance use." He emphasizes reading "documents with my patients, like a client's bill of rights," and framed the work as broader than symptom-fixing: "this is consciousness work, it's spirituality work, it's the hard work of healing long-standing trauma," coupled with a clear boundary against "a pill to get a quick fix." He stresses that rights matter, but that "their rights as patients don't provide any guarantees for a specifically positive health outcome." In this register, legitimacy scripting reassures patients that obligations and limits bind the provider, while dampening the expectation that the provider can deliver a miracle on demand.

Anticipatory calibration also works by making loss of control articulable and workable before it shows up as embodied panic. Martin describes a structured, time-intensive consult that begins with rule-outs and contraindications required by Oregon's framework, then moves into readiness as an interpretive and practical problem, including cost, past experiences, and asking clarifying questions like "what are your fears," and "what do you want changed." He encourages clients to journal "fears, anxieties and hopes for this session," because "if you can say those things out loud to me, it can become real enough to work with in session." He poses readiness in stark terms as willingness to be taken "someplace that is out of your control." Heidi articulates the same issue without moralizing it. When clients say, "I'm a control freak," she answers that "your journey is likely going to come into conflict with that part of your character," and she links the pre-dosing conversation to the practical consequences of resistance, noting that "six hours of trying to run from the experience can be challenging." For both Martin and Heidi, the front-end

work prepares clients to treat surrender as a response to anticipated loss of control rather than a sign that something has gone wrong or that they are being harmed.

Yet even the term “surrender” sometimes requires calibration. For military veterans like Mark, the word initially lands as a demand that runs against training in control and situational awareness. His facilitator, Robert, a fellow veteran, retranslated it: “you’re not surrendering to an enemy, my friend, you’re surrendering to a process” – reframing it as “letting the medevac take you to the field hospital.” Robert makes this explicit as anticipatory brokerage work, translating between a military moral register, where surrender invokes defeat, and a therapeutic register, where letting go is a disciplined stance that makes the experience enterable without humiliation.

Conversely, Evan’s first psilocybin experience shows how entry can become ethically unstable when preparation fails to discipline expectations, establish credible legitimacy, and clarify role limits. He describes an underground group session organized around a facilitator who “needed to be seen as the guru,” and emphasizes that this posture shaped entry itself. Evan recalls pushing for clearer screening and risk information and experiencing the response as dismissive, with the facilitator “brushing it off” in favor of generalized “trust in the medicine” language, alongside what he describes as minimal screening and vague consent practices. He entered dosing without a bounded orientation to uncertainty and without a clear sense of role limits, and he describes the facilitator’s charisma as misplaced and unrestrained, setting “the worst tone for everything.” When the session turned difficult, Evan experienced intensity through the lens of an unstable container, with vulnerability heightened by the sense that entry had been organized around deference and persuasion more than carefully constrained preparation. In such cases, translation collapses into deference. Instead of bridging lifeworld

concerns to accountable risk, consent, and role limits, the facilitator's "guru" posture turned uncertainty into a demand for trust that invited meaning capture once vulnerability arose.

Across cases, anticipatory calibration accomplished the first tier of cultural brokerage in PAT: creating conditions for mutual inclusion of schemas by making altered-state care enterable and ethically grounded. Practitioners dampened hype and magic-bullet narratives, framed loss of control as temporary and workable, made legitimacy legible through the resources of their setting, and specified interpretive permissions and limits so patients knew the difference between containment and persuasion. When these calibration moves were rushed or displaced, entry became ethically unstable – preparation collapsed into recommendation or performance, and patients entered overwhelmed, feeling sold, or giving "the answers you want to hear."

Bounded Accompaniment

Bounded accompaniment refers to the in-session work through which practitioners hold the ethical stakes of altered-state care in real time, including vulnerability, power asymmetry, influence, and the recurring risk that support slips into meaning-direction. As cultural brokerage, it coordinates embodied vulnerability and emergent symbolic material with professional authority and accountable ethics, keeping care intelligible and legitimate while preventing influence from becoming interpretive capture. Where anticipatory calibration shapes the entry conditions of the container, bounded accompaniment is the set of practices that keeps the container intact while the medicine is active. It is a practical, moment-by-moment balancing act that involves staying available without intruding, supporting without capturing, and stabilizing fear or dysregulation without prematurely closing what the experience might come to mean. Across cases, bounded accompaniment appears as an ethos of presence that is simultaneously embodied (proximity, touch, tone, pacing) and procedural (explicit consent moves, clear role

boundaries, guardrails against exploitation, and disciplined limits on speech). It also treats influence as something to be named and managed rather than denied, a stance practitioners describe as essential to preserving patient sovereignty under conditions where “portals are more open” and both parties are “easily influenced.”

Dr. Campa describes bounded accompaniment as real-time monitoring of influence paired with low-intrusion interventions that stabilize without narrating meaning. As the journey unfolds, she tracks the room somatically, “check[ing] the waters of the energy in the room,” treating her body as “a barometer for what’s going on.” She adjusts contact with deliberate pacing: if someone has been inward for a long stretch, she will “gently check in” and then step back; if psilocybin pulls a client into extended talking, she may “invite the person to go back in” so the session does not get stranded in explanation. The same ethic shows up in her ritual and sensory practices, including “cleansing throughout the day... with smoke and with bells,” and moments where “we will stop and I’ll do some drumming,” which she frames as grounding and regulating rather than steering interpretation. Within that dosing-day container, Dr. Campa also keeps the influence problem explicit, naming it as part of safety: “This is a really delicate container. You know you’re going to shape how they experience the medicine as you build it with them from start to finish... I try my best to build something that can allow the people I’m serving to find their spiritual liberation while protecting them at the same time.” In her account, bounded accompaniment is staying close enough to help, restrained enough to preserve sovereignty, and transparent enough about influence that the relationship remains ethically defensible as intensity rises.

Dr. Dietrich frames a baseline moral perimeter that has to hold through the most vulnerable moments of dosing, when boundaries matter precisely because the power differential

is extreme. He lists “confidentiality and safety,” and is explicit about the hard line that “no sexual activity will happen between the provider and the patient,” treating these as non-negotiable conditions of ethical care. Mary describes the same problem at the level of organizational design, emphasizing that the setting has to communicate “professional but warm-looking” seriousness because “there’s that power differential and so many stories of facilitators who exploit it.” In her account, aesthetics and Oregon’s institutional norms operate as guardrails that signal limits on provider entitlement and help keep the session legible as protected accompaniment. Consent around touch is often negotiated in anticipatory calibration as part of setting expectations and clarifying boundaries. But when a client is dysregulated or frightened and requests contact, touch becomes a core register of bounded accompaniment, because it requires active, in-the-moment permission to function as reassurance rather than intrusion. Dr. Dietrich and Mary both described moments where explicitly asking before placing a hand on a shoulder or offering a steadying hold made touch feel deeply meaningful for clients, while also noting how easily the same gesture can become disconcerting if consent is assumed, implicit, or not renewed as the session shifts.

Michelle describes bounded accompaniment as offering help without presuming entitlement, using explicit, in-the-moment consent to govern what kind of intervention is allowed and when. Assistance is available but conditional, so action remains authorized by the client. She describes a protocol for panic: “If you do start to panic, we’re going to breathe, I’m going to have you look at me, I’m going to get your permission to touch your hand, I’m going to remind you I’m present with you in the room, and that you are always safe with me here.” She pairs touch and grounding with a claim about continuous presence: “I do not leave the room. My co-facilitator and I do not ever leave. We are constantly there for guiding and for helping and for

holding the space.” These moves clarify how practitioners hold the line between responsiveness and intrusion. They also clarify why patients later describe safety as something made in the room, through permissioned touch, steady presence, and support that does not become surveillance or control.

Patient accounts repeatedly validate bounded accompaniment by describing safety as a felt accomplishment produced through facilitators’ micro-practices. Marissa describes touch and embodied reassurance in terms that align with permissioned support. “She asked for my permission but was not afraid to touch me when she saw I needed it. She was not afraid to like, show me love,” and she recalls holding her facilitator’s hand as a stabilizing signal: “It was like a really tender reminder that she’s there with me in the thick of it whenever I need her.” Daniel makes the same point in a ceremonial setting, where support came from the coordinated presence of multiple facilitators, compressing the mechanism into a straightforward attribution: “The people we did this with... they cared so much. They saw when I was losing it, and they knew exactly when I needed to be grounded... Like, when the shaman touched my chest in that moment, it made me feel so much safer.” Kimmy emphasizes the other side of the balancing act: steady presence without intrusion. Her facilitator, Alexa, “wasn’t, hovering or anything, but she was definitely present, and she knew when to make her presence felt... she was so attuned to what was going on the entire time, it still blows me away.” Together these accounts specify what bounded accompaniment feels like from the inside: touch and calibrated presence that reassure without taking over, so support is experienced as attunement and steadiness while the patient retains interpretive and bodily sovereignty.

Several patient excerpts also show bounded accompaniment as quick, non-symbolic repair that treats the client’s immediate experience as the reference point for action. Todd

describes asking his facilitator to turn off the music “because it didn’t feel good,” and then noticed his state settle and open: “After it quieted, I was just so appreciative of the awareness I was experiencing in that moment.” His request was honored without argument, justification, or reinterpretation. Chloe described a similar form of regulation that stays close to experience without closing meaning. Her facilitator had her “say out loud... what I was afraid of,” and added, “...it helped me focus my attention on what I really needed to work through, a lot.” The move worked by structuring articulation in the moment, lowering panic without converting fear into the practitioner’s story.

Laura’s account shows the same ethic in a slower register, where restraint was practiced as active accompaniment. She remembers dosing as deliberately paced and described how the room was arranged with ordinary supports, like “water, tissues, stones or shells, but none of it was symbolic *unless they became symbolic* for me,” preserving interpretive ownership from the outset. When grief broke open, the facilitator offered permission without rushing to manage it, then stayed with her without filling the moment with words: “He didn’t hand me tissues or rush to comfort me with words... He just let the moment stay open.” When confusion surfaced, he tethered her back to the present without interpretation: “...you are doing well. Just stay with what you are experiencing.” Laura underscores the balance she felt across the session: “He knew when to fade into the background, and I think that’s only really possible if you’ve experienced these medicines as much as someone like he has.” For her, that experientially attuned, calibrated presence – close enough to steady the moment and restrained enough to leave meaning intact – is “what made the experience feel like mine.”

Negative and contrast cases sharpen the stakes of bounded accompaniment by showing how quickly the in-session balance can slip, either through withdrawal at the wrong moment or

through interventions that feel intrusive under heightened vulnerability. Meg's coupled-session account with her husband Steve narrates both competent crisis governance and a later breakdown in attunement. In one segment, she describes watching Steve panic and monitoring the facilitator as a condition of safety: "I just kept looking at Kathy like you're good, right? I hope you know how to handle this... I am in no condition to handle it." She then credits what she experienced as effective containment: "She calmed him down. She did a very good job. I will credit where credit is due." She also describes a structured rhythm through prompts and check-ins: "She started to kind of talk like giving us prompts... then she'd leave us alone... come back and check on us... then give us another prompt," which briefly made a difficult relational encounter feel held without being over-managed. The same structure became unstable when being left alone stretched into long periods of perceived absence: "She let us be by ourselves for much longer periods of time... eventually we were both like, what are we supposed to be doing, right?" At the peak of vulnerability, when a repressed memory of sexual abuse surfaced for Meg, that sense of disengagement was compounded by a hard stop that felt procedural rather than responsive: "I probably would have liked to have gone into it at the time, but our time was up," followed by her blunt appraisal: "It was not the greatest feeling... Kathy really did feel like a money grab." In this account, bounded accompaniment rises or falls through timing decisions that determine whether "space" is felt as respectful restraint or as being abandoned during heightened sensitivity.

A different kind of warning case shows bounded accompaniment as work under duress, where limits must be enforced while the medicine is active. Alexa described facilitating a male client who resisted "going inward" and repeatedly deflected with sexual behavior, including masturbating in session. She recalled the interaction as "really hard" and said it "felt pretty

violating,” even as she tried to respond without shaming him or collapsing into punitive control. In the moment, she reported naming the boundary and the clinical stake at once, telling him the behavior was making her uncomfortable and was not serving him, then redirecting him back toward the work. After the session she described leaving teary and feeling like she had “absorbed all this darkness,” and she treated that aftermath as evidence of moral and emotional cost, which helped explain why she later built stronger anticipatory guardrails, including screening and naming sexuality explicitly up front. This case pushes the mechanism to its edge. It is brokerage under duress: coordinating altered-state disinhibition with the moral-legal order of care so the room remains therapeutic rather than a permissive zone organized around coercion or performance.

Across these cases, bounded accompaniment completed the second creating-conditions form of cultural brokerage: keeping the container intact while the medicine was active by making help negotiable in real time, practicing restraint so meaning stayed patient-owned, and doing quick repair when fear, conflict, or dysregulation threatened the session. Where these practices were thin or inconsistent, patients withdrew trust and the experience became easier to remember as intrusive, abandoning, or not fully theirs. Together, anticipatory calibration and bounded accompaniment specify experiential containment as a sequenced mechanism, not a generic appeal to set and setting: calibration shapes entry expectations, while bounded accompaniment keeps the session workable through consent-based intervention, boundary governance, and interpretive restraint, so guidance remains possible without proprietary meaning. Experiential containment does not guarantee a particular insight or a uniformly “positive” session. It produces conditions where intensity can unfold without tipping into panic, coercion, or retrospective moral distrust, leaving patients with a sense that what happened was survivable and still theirs. Those

outputs are what make liminal relay possible by supporting the later work of translating and stabilizing what meanings emerge from the session, rendering them capable of traveling across time, audiences, and institutional settings.

Negotiating Provisional Meanings

Negotiating provisional meanings refers to the interpretive work through which an altered-state episode becomes narratable, discussable, and usable while its meaning is kept deliberately revisable. As cultural brokerage, it links private, often ineffable experience to shared vocabularies that can circulate across clinical, spiritual, and everyday audiences, while holding open revisability and guarding against proprietary interpretation. In practice, negotiation often began by relocating authority in the practitioner-patient relationship. Facilitators explicitly taught patients to treat their own experience with the medicine, and their capacities for self-interpretation, as more authoritative over their health than the practitioner's explanatory frame. This relocation of authority established a facilitation ethic; if the guiding intelligence is presumed to reside in the patient's own "inner-healing intelligence," the practitioner's responsibility is to protect that capacity from dogma, contamination, and premature interpretive capture. Sometimes the same function was accomplished by relocating authority to the medicine itself. In indigenous registers, shamans like Wenda explicitly displace interpretive authorship away from the practitioner: "True shamanism is always guided by the medicine. Everyone who sits with us in ceremony is taught that this... We believe that plant life is a very ancient consciousness and has much to teach us, but it is up to you, to us, to apply the lessons it offers." Across these idioms, the practitioner is not positioned as the proprietary owner of meaning. The guiding intelligence is either inside the patient or inside the medicine; in both cases, the practitioner's legitimacy rests on disciplined facilitation, not interpretive dominance. That

disciplined non-authorship is what makes provisionality possible. When the practitioner is not authorized to declare what the experience “really was,” meanings can remain open long enough to be worked into forms that are both usable and revisable.

Patient accounts illustrate the practical and symbolic significance of this authority dynamic. Marissa described being told that her practitioners were “only facilitating for [her]” and that “the medicine wasn’t a cure in itself, it was a space they were holding for us to do our own work so we could get in touch with our inner-healing intelligence,” positioning her as the primary locus of insight even while relying on others to hold the conditions for it. That recentering structured how meanings were negotiated after the peak. It enabled brokerage through deliberate non-authorship, translating across authority registers (professional expertise, spiritual idioms, personal biography) while preventing any one register from becoming proprietary over what the experience “really means.” Marisol described the same constraint from the inside: “I did not come out of it with a neat understanding... I did not yet have language for it.” Rushing to interpret would have “flattened it into something like a cliché,” whereas “letting it stay a little unclear for a while actually empowered me to trust my insights more fully over time... Like, I had to be the master of my own narrative.” Even the concrete techniques she recalled served that ethical constraint. When she began “desperately trying to explain why everything suddenly felt so clear,” her facilitators “gently brought [her] back to sensation,” asking “where do you feel that clarity in yourself?”, supporting her in more steadily authoring a workable account on her own accord. Provisionality was thus an interactional accomplishment sustained by moves that redirected attention away from verdicts and back toward embodied, patient-owned description.

A central component of provisional meaning negotiation is the active production of language for experiences that were often reported as partially or wholly ineffable, and sometimes as morally or metaphysically “too big” for everyday vocabularies. Practitioners described integration as word-finding that does not demand premature closure. Dr. Marone is explicit on this point: “Integration is about finding words... sometimes it’s ineffable, and the aim has to be about staying with the profundity of it all long enough for language to emerge, appreciating the profundity for what it is, and trusting that you’ll be able to make sense of it later.” He described a scaffolding style that treats meaning negotiation as a menu of options which “steers patients towards reflection without rendering any conclusions for them... I don’t go any further than offering them some different possible ways of making meaning out of the stuff that doesn’t make sense.” Sometimes the offered frameworks do not fit. In his account, that mismatch is productive rather than failure: “...even the process of rejecting what I’m offering helps them gain some clarity.” In such accounts, disciplined non-authorship meant offering interpretative resources as tentative possibilities, routed through questions, and preserving the patient’s authority to reject, revise, or defer.

Patient accounts show how this word-finding can be the difference between an experience becoming shareable and becoming stranded in privacy. Danny’s entry into psychedelic care came through a referral chain, where a friend connected him to a licensed psychologist quietly doing underground sessions in a space he described as “halfway between a therapy office and a meditation space.” That route organized the relationship around clinical legitimacy: intake-style conversations, “treatment plan” sensibilities, and a set-and-setting frame oriented toward management and safety. Danny experienced the practitioner as warm and well-intentioned, but also as someone whose interpretive range repeatedly snapped back to what could

be justified as professional psychology. Moments of mystery were translated into “textbook therapeutic language,” and the clinician became visibly cautious as conversation drifted toward existential territory. Against that backdrop, Danny described the moment he tried to narrate “what it felt like to have a deeply spiritual experience for the first time” and watched the practitioner reach an epistemic boundary: “He just stayed professional, you know? I could see him weighing what he could say... There was compassion, but restraint too... It made me feel really alone.” Restraint can be read as ethical caution, but for Danny it functioned as a breakdown in relay. The interpretive corridor narrowed precisely when it needed to widen. When his account pressed toward questions about death, ongoing presence, and ultimate significance, the practitioner’s attachment to clinical permission left him “cracked open but totally stranded.”

Danny's account also clarifies the inverse failure mode. Where the first breakdown abandoned meaning through silence, the second foreclosed meaning-making too quickly. Existential material was translated into familiar clinical language before the patient could inhabit it, collapsing the interpretive space just as it opened. In both directions, the hinge is the same: the patient’s authority to hold ambiguity is either left unsupported or overridden, and the experience becomes hard to carry forward in a form that remains both faithful and articulable. These breakdowns are not incidental. They are what good brokerage work is designed to prevent.

For this reason, negotiating provisional meanings frequently depends on translation across epistemic registers. Keeping meanings revisable often requires keeping multiple interpretive languages in play at once (scientific, spiritual, relational, moral) without allowing any single one to monopolize the story. Patients routinely described themselves as moving between frames rather than choosing one. Alex makes this explicit: “The things that made the most sense to me were the biological and scientific explanations when I first started using

psychedelics, way before I ever entered any ceremonies.” At the same time, he insists that “...it was also just so obvious that there was a spiritual component to it that goes beyond those frameworks.” The relay problem is that these registers carry different audiences, moral entailments, and risks of dismissal. Alex named the hazard bluntly: “When you have language, you risk doing violence too. It can totally shut down a conversation... and that’s exactly the wrong thing to do.” The wrong vocabulary does not merely misdescribe. It can collapse the conversational space in which the experience could be metabolized into a durable narrative. This is why meaning negotiation is best treated as brokerage rather than emerging from “insight.” Meanings do not simply arise. They become malleable or brittle in settings where some idioms authorize while others stigmatize, and where a careless label can push someone into silence.

Practitioner accounts show that this translation work often happens through small, disciplined interventions that govern which vocabularies are allowed to circulate and with what moral tone. James, a longtime underground guide, demonstrates this by forcefully rejecting language about psychedelics offering “utility” rather than “meaning.” The correction is minor in content but major in implication. “Utility” smuggles in an instrumental, optimization-oriented logic that narrows what the experience is allowed to be; “meaning” keeps the account closer to lived significance and protects interpretation from premature functionalization. Patients also describe being helped when practitioners refuse reductionist closure without forcing supernatural literalization. Evan captures this middle stance while describing an “encounter with something larger than [himself]” during psilocybin. “I was worried I’d sound crazy,” he said, but as he began to explain, his facilitator suggested he “really could have encountered some kind of being or energy that is beyond our usual comprehension.” The point was not to insist on an ontology, but to protect the experience from dismissal: “It wasn’t necessarily like, ‘Oh, this is just

hallucination,’ and that really helped me feel validated in my experience.” Widening the corridor in this way gave patients room to keep reflecting. It protected them from being pushed into either cynicism or dogmatic certainty, especially when they anticipated skeptical audiences or felt pressure to translate the experience into a single authorized register.

The same dynamics clarify how provisionality can fail when relay resources are policed, either by institutional norms or by skeptical audiences, such that the patient’s authority to hold and revise meaning is re-subordinated. Dr. Jackson, a current clinical researcher and former clinical trial patient, recounts an explicit version of this breakdown. As he began explaining the spiritual significance of his experience to the primary investigator, “It became very clear that he thought of those as primarily delusions and fantasies.” The consequence was immediate self-silencing: “And so I quit talking about that... it absolutely did not give me a space to open that up... I had to go elsewhere to find that kind of support.” The narrowing of meaning Dr. Jackson experienced was imposed via institutional judgment laden with hierarchical overtones. When a register is declared illegible, the patient adapts by suppressing it. The downstream consequence is not simply disagreement, but foreclosure. The experience loses an articulable register, becomes harder to elaborate, and must either be translated into thinner idioms or sequestered into privacy, unable to be elaborated or sustained.

These cases show negotiating provisional meanings as the first brokerage form through which the conditions experiential containment creates give way to the work of interpreting the experience itself. When meaning negotiation succeeded, practitioners and patients produced accounts that held experience as both usable and revisable, translating across registers (clinical, spiritual, relational, moral) without allowing any one register to monopolize the story. When it broke, it broke at the same hinges: interpretive corridors narrowed, relay resources were policed,

and patients either lost access to language or lost confidence that their meanings could remain both faithful and shareable.

Portability Work

Where negotiating provisional meanings produced a usable account of what happened and what mattered, portability work is the downstream labor of making those meanings and practices durable once patients re-enter ordinary worlds that test them. As cultural brokerage, portability translates that account across audiences and institutions (family, work, medicine, law, community) so it remains livable rather than punished, pathologized, or forced into a single ill-fitting register. Families with their own moral languages, workplaces with their own demands, and institutions oriented to legality and reputation can collapse coherent accounts through misrecognition, isolation, or pressure to translate the experience into safer but thinner idioms. Across cases, portability turned on three linked tasks: (1) compressing what is carried so it can survive routine, (2) building infrastructures that reactivate meaning over time, and (3) managing audience and institutional constraints so the story does not become socially untenable.

Portability often began with narrowing carryover, because an experience can overwhelm language and everyday life at the same time. Practitioners treated post-session life as the testing ground, where what felt undeniable in-session had to remain enactable under fatigue, distraction, and social friction. Dr. Altman states the aim directly: “The therapy is not complete without integration... helping them come up with a plan for how to use it in their lives as they leave the room, so that the journey continues.” Scott described the same logic in plainer terms, emphasizing that durability depends on scale: “The real healing is in all the little micro-actions people start to change in themselves... you can’t just become a completely different person through a single experience. It takes a lot of time, and a lot of little steps, no matter how

powerful your experience was.” Compression, in this sense, translated felt significance into a small number of behavioral pivots that could actually be kept once the peak faded and old patterns returned.

From the patient side, compression often showed up as subtle, cumulative change that became legible only across repeated ordinary situations. Jessica described the shift as quiet: “In my case I don’t think any of it was major or dramatic. It was mostly all subtle stuff. I just felt more gentle inside myself, and that allowed me to work on my reactions to things that used to set me off, and my patience increased... I wasn’t plagued with as much anxiety because I was proving to myself every day that I was in control again.” Erin, whose impetus centered on grief after miscarriage, described how translation began almost immediately through a small but consequential “first return” moment: “After the session my partner called me and I was immediately reminded that I wasn’t in this alone... I told him how things went and what came up... but it was still hard to really fully explain what I’d experienced.” What mattered was not a perfect narrative but a relational anchor. He responded with steady commitment, telling her lovingly that he would be there to help her “process everything, always.” Erin described it as a stabilizing reminder that she was “supported through the chaos.” These accounts also underscore that social position shapes what carryover is feasible. Laura and Erin both returned to jobs, partners, and friendship networks that made micro-adjustments easier to sustain because expectations and support were relatively stable.

Once carryover was narrowed into something livable, the next problem was keeping it from dissolving as the experience resurfaced in fragments over days and weeks. Portability then depended on relay infrastructures, material and social supports that preserved sequence, accountability, and reactivation beyond the session. Dr. Willig framed clinical trial integration

protocols as formal recognition of this dynamic: “The session is not the treatment, the session is the experience and it is the beginning of the healing process,” and in trials there are often “at least four integration sessions throughout the following month...” Importantly, she noted the structural dissimilarities between clinical protocols and real-world practice, saying, “...that’s just not what people are usually getting out there on the ground, unfortunately.” Dr. Greynolds described a less formal but parallel approach oriented to dependable follow-up while keeping the patient’s lead intact: “I basically follow their lead during integration sessions... If something comes up, I’m like, ‘Oh, tell me more about that,’ and then kind of following that thread and helping them unravel it as we stay in touch.”

Several practitioners treated portable resources as part of this infrastructure because they create stable reference points patients can return to when ordinary life begins to crowd out the experience. Dr. Cameron described his work as often consisting of repeated sessions with the same person, and described sending materials that could be revisited later: “Sometimes I’ll offer people books to read, or I’ll send people articles to read... I sent a huge list of books to read and articles... about non-dualism, some Buddhist texts, stuff I knew would resonate with them because of what we’d talked about during and after their sessions.” In this register, resources function as reactivation cues and continuity supports, giving patients scaffolds to return to as the experience resurfaced unevenly.

Patients often described the presence or absence of these infrastructures as decisive in the early post-session window, when they felt least sure what to do with what had happened. Aaron wanted a longer tail of integration because a single formal session did not feel like enough support for the first return to ordinary life, even as he also needed time outside scheduled sessions to process. His case shows how informal infrastructure can thicken through the

practitioner relationship itself. When he reached out while still scared and unsteady, Alexa called him back quickly and spoke with him at length, and he described the call as grounding in part because of their shared background and the maternal tone he experienced in her care. When he expressed an impulse to reorganize his life around Oregon during the session, her response was calm and noncommittal and did not ratify the decision in the moment. Over time, he returned for additional sessions, relocated to Oregon, built a new routine there, and maintained a close friendship with Alexa, which remained a stable relational thread as he worked through the tensions of starting over.

As infrastructures accumulate, portability becomes increasingly dependent on managing audience and institutional constraints. Meanings must survive contact with social worlds that can misrecognize them, ridicule them, or demand a translation that flattens what mattered. Chloe captured the bind as a feature of everyday interaction: “Psychedelic therapy is not a fun thing anyone should ever take lightly. You might even lose friends over it,” and “When you have these big realizations... you can’t really talk about it with everyone if you’re coming from a conservative place like I do.” Her solution was selective disclosure as self-protection: “You kind of learn to hold it quietly and live with it,” while trying to preserve vitality internally by “keeping the music alive inside myself even when I can’t share it out loud.” Walker narrated the same problem in harsher terms: “Sometimes it makes you sound like a crazy person when you start talking about it with people who haven’t done it.” For him, survivability depended on audience matching: “I just talk about that kind of stuff with people who have gone through it, but that makes it harder to stay in touch with the feelings in the long run, for sure.” Crucially, these constraints were unevenly distributed. Patients returning to conflictual communities, precarious workplaces, or unsupportive partners faced higher social and institutional costs for disclosure.

That unevenness narrowed the viable pathways for portability and increased the likelihood that meaning would have to be held privately, even when it felt urgent to share.

Practitioners framed this as downstream brokerage in a literal sense, helping patients anticipate where their account would be recognized, where it would be stigmatized, and how to govern disclosure without sliding into self-erasure or defensive over-translation. Dr. Verhulst described return as a cross-context risk problem: “They have to go back to the world... and their relationships and their work and their society. And for it to be accepted, or for it to be respected, it has to be within some sort of boundaries.” She tied that fragility directly to legality and institutional risk: “Many times we are doing it in somewhat legal gray zone, and so I would be really cautious about talking about certain things.” Several practitioners similarly treated public misinformation and moral panic as portability hazards that shaped what patients could say once outside the clinic, which in practice pushed some patients toward euphemism, self-silencing, or translation into safer idioms.

These audience dynamics clarify why portability is shaped by more than individual willpower or an “integration mindset.” As brokerage capacity, carryover depends on access to follow-up support and socially safe contexts for translation, resources unevenly distributed by class position, job risk, relationship stability, and institutional coverage. Patients described social and institutional environments as active forces that either supported consolidation or punished vulnerability, and when those forces dominated, the return to ordinary life could feel like a crash. Todd’s account makes this structural point through absence: “I basically didn’t leave with a toolkit... I felt like they set you up to crash... you can’t just go in and do a mushroom trip and it’s going to change your life. Because it isn’t a pill.” He linked this to the political economy of aftercare and reimbursement: “I remember thinking, how can insurance companies ever justify

paying thousands and thousands of dollars... and not have some follow-up? Like, how are you expecting somebody to integrate this without some follow-up?" In that register, portability is an interpersonal ethic and a structural problem shaped by what kinds of care institutions are willing to fund, recognize, and legitimate.

Failure cases are clarifying because they show portability breakdown as a fragile accomplishment that collapses when infrastructures are missing, misaligned, or priced out of reach, even when the altered-state episode itself was powerful. These accounts locate relay breakdown in unequal support conditions, where meanings cannot be translated into everyday routines and relationships because scaffolds for cross-setting circulation are absent or inaccessible. Sophie offered one of the clearest statements of breakdown as abandonment: "Nothing happened... There were no follow up sessions. There was no like, 'hey, how'd it go?' There was no aftercare..." Sophie felt her facilitator "had opened up Pandora's box, then left me stranded dealing with all of the chaos." She described the downstream consequence as awareness without support becoming its own form of suffering: "You go through these sessions, you leave with a tremendous amount of awareness. And that's it. You sit with it. And that's when all of this existential anxiety starts coming up and you don't know what to do." Jeffrey offered a similarly lucid account of drift when meaning failed to remain carryable. He held onto catharsis for a few weeks, but did not have safe audiences beyond a couple of integration calls. His wife "didn't even want [him] to do it," so he felt restrained about communicating what he had experienced. As he returned to "all of the bullshit" that had made depression durable, he found himself back in the same cycles. The swing from "hope and purpose" back to emptiness felt "maddening." In these cases, the return is not simply difficult. It becomes volatile awareness with no relational infrastructure to absorb it.

Portability also raises a challenge distinct from institutional failure: what to do when family members, partners, and colleagues simply do not accept new meanings. When the people closest to a patient resist the implications of the experience, that friction is a brokerage problem in its own right. The patient's task is not to convert the skeptic but to sustain their own schema against skepticism without requiring the other to adopt it. That asymmetry matters because some meanings can only be kept alive in communities of shared practice, and not everyone has access to those communities.

In the background of these breakdowns sat a broader institutional drift that multiple practitioners treated as a threat to portability itself: mainstreaming that preserves the dosing event while shedding the infrastructures that make the aftermath survivable. This drift stratifies liminal relay, turning brokerage that carries meanings across settings into a premium good, while those returning to riskier worlds do so with thinner support. Dr. Roberts framed this as a design problem that had to be captured by institutions: “You don’t just go in and take the medicine and it gives you a magic wand... the after-care is crucial to support people while they’re doing it. And if you’re going to make this mainstream, you have to capture this in our medical system.” She also warned against converting intensity into immediate irreversible action: “There’s a reason why in ayahuasca ceremonies they often say no major decisions for 3 months,” because people leave with urgency and then regret precipitous change. Dr. Geers framed the same concern through communal accountability and routine: “This is ceremony, this is like church... This is a whole community set up,” and emphasized that “they hold you accountable,” and “if things go wrong... there is a whole process set up to support you through that.” In her account, portability failure followed predictably when social infrastructure was stripped away and people were sent back into worlds that did not recognize what they had lived.

Across these accounts, portability was most likely when patients left with a compressed set of workable commitments, had follow-up infrastructures that reactivated experience over time, and could manage disclosure in ways that protected the story from ridicule or institutional penalty. Portability work completes the second tier of cultural brokerage, extending the usable accounts meaning negotiation produces into the social worlds patients return to. Its enabling conditions – aftercare, social safety, economic security, receptive audiences – are unequally distributed, which means the mutual inclusion of schemas that altered-state care can produce is not only a relational achievement but a structural one.

Discussion & Conclusion

Clinical science increasingly treats set, setting, and integration as protocol components of psychedelic treatment, amenable to standardization and fidelity checks. That orientation can mistake the form of care for its central mechanisms. The ethical and interpretive work that makes altered states enterable, survivable, and portable is complex interactional labor with identifiable success conditions and failure modes. Social and cultural theory has the task of making those processes visible, and without such accounts, institutionalization can compress them into compliance rituals that reproduce the language of safety while hollowing out care.

This chapter has theorized PAT as a distinctive site of cultural brokerage, requiring interactional and organizational labor that links heterogeneous interpretive frameworks, moral orders, and communicative expectations in the production of care (Barbee 1987; Hsieh 2006). It specifies two mechanisms organized by a two-tier logic that mirrors and extends Lo's (2010) framework. Experiential containment, accomplished through anticipatory calibration and bounded accompaniment, creates conditions for mutual inclusion of schemas by governing entry and holding altered-state vulnerability without coercive interpretive direction. Liminal relay,

accomplished through negotiating provisional meanings and portability work, translates session material into accounts that can survive re-entry across audiences and institutions. Together they offer a transferable analytic vocabulary for tracing how altered-state experience becomes ethically governable and socially durable as it moves across settings and unequal infrastructures of support. The two-tier logic, distinguishing the work of creating interpretive conditions from the work of accomplishing meaning across registers, may also extend beyond psychedelic care to other therapeutic contexts where intense experience exceeds biomedical idioms, and where durability depends on social infrastructure rather than individual insight.

These mechanisms clarify a limitation in how set, setting, and integration circulate in contemporary PAT discourse. Set and setting are often invoked without specifying how contexts are assembled, ethically governed, and prone to failure (Hartogsohn 2017). Integration is treated as a normative imperative but rarely specified as a fragile mechanism with interactional supports, institutional preconditions, and predictable breakdowns. Experiential containment and liminal relay re-specify these rubrics as cultural labor with identifiable forms, while the two-tier structure of creating conditions and accomplishing mutual inclusion connects that labor directly to inequalities in who can build and sustain it.

A brokerage framework is essential because, in PAT, brokerage is not ancillary. Altered-state episodes are often treated as ineffable and metaphysically significant, yet they still must be made imaginable and supportable through language, expectations, and situated practices before, during, and after dosing. Practitioners often occupy hybrid positions that draw on clinical training and lived familiarity with altered states, shaping ethical intuitions and communicative repertoires beyond biomedical registers. They leverage hybrid habitus to move across pluralized protocols and repertoires while constraining authority under asymmetry (Lo and Stacey 2008).

This differs from many clinical encounters where biomedical idioms set the terms of recognition and narrow what can be credibly said about suffering and change. Cultural brokerage in PAT is also reciprocal. Practitioners cannot know what occurred beyond what patients can narrate or anchor in partial descriptions, so containment and relay depend on a two-sided exchange that produces meanings that are usable, revisable, and portable across audiences with competing standards of evidence, virtue, and personhood.

PAT is often narrated as producing schema shifts related to health and illness; this chapter specifies how those shifts become durable and consequential. Containment makes the altered-state episode governable as a site of potential reconfiguration. Relay converts emergent meanings into narratives, routines, relationships, and audiences that can sustain them over time. When internalized, schema shifts reorganize how patients identify, access, and mobilize resources in everyday life, including relationships, self-care, institutional supports, and forms of authority they treat as credible (Sewell 1992). Brokerage is where that conversion becomes practically possible, because it is where interpretive frames become credible, commitments become actionable, and supports are assembled or fail.

Psychedelic dosing can open a liminal interval in which classifications loosen and anti-structure becomes experientially available, sometimes generating brief forms of *communitas* that feel clarifying and socially reorienting (Turner 1969). Whether that opening yields transformation depends on how it is held and carried forward. Containment shapes the interval in real time. When organized around permissioned support, interpretive restraint, and boundary governance, it makes anti-structure livable and keeps *communitas* from sliding into fusion, coercion, or meaning capture (Turner 1969). When organized around proprietary interpretation, moralizing frames, or charisma-driven direction, the same loosening can become a conduit for

asymmetrical influence, and liminality can crystallize into borrowed or disordered meanings that later feel alien or unworkable.

The same logic extends beyond the session. Liminal moments can charge symbols and commitments with emotional energy, but that charge decays unless sustained through chains of subsequent encounters that reactivate the story, reaffirm the commitment, and recruit audiences who treat new meanings as recognizable and actionable (Collins 2004). Liminal relay names the work of building those chains through artifacts, prompts, follow-up conversations, and audience management that carry altered-state materials into everyday settings where competing moral orders and institutional demands test them. Where relay infrastructures are robust, liminal insights become practices and relationships that persist long enough for identities and obligations to reorganize. Where relay collapses, intensity remains episodic and private, and the charge dissipates into confusion, disappointment, or individualized responsibility without social traction.

At the infrastructural level, both mechanisms depend on time for preparation and integration, money for continued care, stable housing, supportive relationships, and access to legitimate audiences where altered-state narratives can be held without penalty. These conditions make interpretive restraint feasible, make provisional meanings socially testable, and make portability possible. When absent, containment thins, relay fragments, and patients face higher risks of misrecognition, stigma, and institutional constraint that unravel emergent commitments. This study's sample limits what can be claimed about how these mechanisms vary across race and class heterogeneity. Future work should examine containment and relay across race, class position, gender and sexuality, disability, immigration status, and criminalization. That processual differences in durability and re-entry were visible even within a constrained sample suggests inequality will matter more than these data can fully capture.

These findings also motivate a more decisively *critical* sociology of psychedelic practice. Recent work has helped legitimate an emerging sociology of psychedelic therapy by calling on sociologists to track how expertise, institutions, and repertoires of care are assembled as the field consolidates (Rose 2024; 2025). The account developed here extends that agenda while insisting that neutrality is a risk in this domain. Psychedelic care is emerging on terrain saturated with power. It is shaped by ontological colonialism, including struggles over which realities count and which vocabularies are legitimate (e.g., clinical “psychedelics” versus Indigenous and ceremonial “plant medicines”). It is shaped by structurally produced trauma, since many seek this care as a last resort after lives organized by injuries of stratification that exceed individual pathology. Practitioners often occupy ambivalent in-between positions, carrying professional authority while also bearing histories of harm that can become both resource and vulnerability. Under these conditions, containment and relay do not vary only by individual skill or local style. They become sites where inequality is reproduced, contested, and sometimes intensified, determining whose experiences are treated as credible, whose meanings can be carried without penalty, and whose transformations can be sustained.

The labor of containment and relay presupposes resources that are unequally distributed. What counts as “good engagement” and “appropriate meaning-making” is patterned by classed and racialized competencies of speech, self-presentation, and institutional familiarity, shaping what patients can secure from encounters even under patient-centered ideals (Shim 2010; Dubbin, Chang, and Shim 2013). Infrastructurally, containment and relay require time, stable housing and relationships, money for ongoing care, and legitimate audiences where narratives can be held without penalty. Inequality thus shapes who can obtain high-quality containment, whose experiences can be narrated without dismissal or pathologization, who can access durable

relay infrastructures, and whose circumstances allow new schemas to sediment. In emerging regulated economies, compliance infrastructures and solvency pressures often make time-intensive relational care financially risky, narrowing which forms of brokerage can be sustained, for whom, and at what cost. If PAT outcomes depend on meaning-making and relational infrastructures, then unequal access to those infrastructures is itself a problem of efficacy.

This dynamic was especially clear in my Oregon practitioner subsample. All six Oregon practitioners I interviewed were operating within facilitation businesses organized around time-intensive, relationship-centered care; each is now defunct. Those facilitators still practice, but only as solo contractors, piecing work together across sites rather than sustaining organizational homes that made continuity and accountable teamwork easier. Several described leaving stable careers, savings, or prior livelihoods to pursue this work, so business collapse registered as professional defeat driven by compliance, capitalization, and overhead demands routinized by the Oregon model. Stratification does not only sort patients into unequal capacities for “good engagement.” It also structures the organizational conditions under which “good facilitation” can exist at all. When the most ethically careful brokerage survives only as precarious contracting labor, standards of care become harder to reproduce, scarcity concentrates risk, and interpretive vulnerability predictably falls hardest on those least able to buffer instability with money, time, or protective institutions.

The broader significance is that “best practices” are a problem of social organization, not individual virtue. Debates that move from set and setting to protocols, training curricula, and integration guides risk treating care as a transferable script, even though durability depends on cultural labor that turns scripts into ethical relationships, interpretive constraints, and relay infrastructures across heterogeneous worlds. Legitimacy cannot rest on pharmacological efficacy

alone, because durability depends on socially produced mechanisms that are structurally fragile. If PAT is institutionalized without treating these mechanisms as central, calibration can harden into checklists; accompaniment can thin into minimal presence under time pressure; meaning negotiation can become meaning delivery; and portability can be privatized into individual responsibility or stratified into premium continuity – deforming the practices that keep altered-state meanings workable once patients return to stratified worlds.

The future of PAT hinges on whether institutions build infrastructures that recognize cultural labor as a central therapeutic ingredient to be cultivated and distributed. The question is what worlds will be built around these medicines, and for whom. Psychedelics can open the possibility of radical self-revision for those undergoing intense suffering. Yet if the fields of care that emerge are bent to the market logics that have long ordered biomedical care, those potentials risk mutating into technologies of social reproduction, returning people to the very conditions that made relief necessary.

Conclusion:

The Weight of Thursday: The Medicalization of Consciousness and the Fate of “It”

Eight years ago, the concept for this dissertation felt almost impossible to imagine bringing to completion. Part of that impossibility came from the subject itself. Psychedelic-assisted therapy was still marked by intense cultural stigma, thin legal and institutional infrastructure, and a strange discursive atmosphere that was sparse, unstable, and difficult to enter sociologically. It was hard to know who could even be spoken to, let alone how such a world might be rendered legible within sociology. As an entry-level graduate student, it felt risky in every sense to propose a grounded empirical study of a topic with so little standing in the discipline, so little established research to build from, and so much suspicion still attached to it. Even the practical conditions of access felt fragile, dependent on informal networks, tentative trust, and a field that had not yet cohered into anything like a stable social object of inquiry.

What I initially imagined this project to be was also very different from what it became. I began with a strong sense of the extraordinary power of these substances and with a desire to help social scientists take seriously both their seemingly miraculous qualities and the deeply social character of the experiences they occasioned. I was far more attuned to the interactional and existential dimensions of psychedelic healing than to the structural conditions that shape suffering, recovery, and interpretation. Over the course of this research, that earlier orientation became impossible to sustain. Again and again, the interviews made clear that relief, revelation, and transformation could not be understood on their own terms. They had to be situated within the unequal worlds to which people returned, the formal and informal arrangements that organized care, and the broader medical and market logics that threatened to flatten even

extraordinary experiences into familiar patterns of management, commodification, and disappointment.

That shift in understanding owes much to the people whose accounts anchor this project. Early interviews with patients moving through trauma, family rupture, and failed care made clearer just how tightly the promise of psychedelic healing remains bound to the structural conditions in which suffering is lived. Other interviews centered on profound revelation and its aftermath brought another recurring problem into view: even far-reaching reorientation can collapse quickly back into the banality of ordinary life once it is pushed again into the terms of work, routine, and the unresolved conditions that made healing feel necessary in the first place. If finishing this dissertation has brought any clarity, it is a clarity inseparable from a deepened sense of the scale of the problems surrounding this field. What once seemed improbable because of stigma, access, and academic uncertainty now appears difficult for a second reason. Namely, the closer one looks, the harder it becomes to ignore how many of the deepest tensions surrounding psychedelic care are bound to social structures whose force exceeds any individual treatment, therapeutic breakthrough, or easy story of cure.

The patient accounts presented across the preceding chapters make the severity of this argument clear. Jeffrey's account shows how an experience of genuine metaphysical upheaval can collide almost immediately with secrecy, overwork, caregiving, and the durable conditions that made relief feel necessary in the first place. Sophie's trajectory shows how the openness that often makes psychedelic care feel powerful can also become entangled with dependence, abandonment, and harm when ethical limits and sustained support break down. Todd's experience makes visible in a more subtle manner how a real shift in perception and feeling can occur and matter deeply while still proving difficult to sustain once a person returns to ordinary

life without the relational and infrastructural support that durability requires. Across these cases, something substantial took place. What recurred with unsettling consistency was the strain produced when experiences of that magnitude had to be carried back into worlds that could not adequately receive them. Although each participant's biography differs sharply, as do their reasons for seeking psychedelic care, each points toward the same sociological problem: these experiences are not easy to make sense of even under supportive conditions, and the labor of interpreting them becomes much harder when people must carry it out within lives already saturated with obligation, constraint, and unequal vulnerability.

And yet, some narratives make visible what becomes possible when meaning creation is adequately supported and the mechanisms this dissertation identifies are functioning as they should. Among the study's most compelling accounts were those of participants like Aaron, Robert, Kimmy, and Wenda, whose lives had been fundamentally reorganized in the aftermath of their experiences. Addictions that had resisted years of conventional treatment were abruptly abandoned without relapse. Isolation gave way to social enthusiasm and newly formed relational worlds. Depression was narratively reconfigured as a period of necessary contrast, its depth made newly legible by the changed life that followed. Restrictive social positions were replaced with more liberatory ones. Newfound cosmological orientations opened pathways into communities that provided the relational continuity and symbolic scaffolding through which meaning could be renewed and sustained over time. Such outcomes represented powerful, thoroughgoing self-transformations that demonstrate what happens when psychedelic medicines are sensitively worked with, as James pointedly argued, as “agents of meaning” rather than “sterilized utilities.”

Above all, what distinguished these positive accounts was the presence of conditions that allowed what had opened to be carried forward, openly expressed, and compassionately received over time. The intensity of the acute experience was consistently high across the sample. The relational and cultural infrastructure surrounding it was what varied. Practitioners who maintained ethically grounded, relationally continuous care provided the experiential containment through which disorientation became navigable. Effective cultural brokerage helped translate what could and did occur into meanings that became imaginable and survivable upon the return to ordinary life. Where those conditions were present, the experience went beyond brief dispositional interruptions to become durable improvements in health narratives, with liminal relay extending what had opened into families, communities, and ongoing practices capable of renewing the meanings the session generated (Collins 2004).

The practitioner interviews, however, made clear how precarious those conditions are in practice. Psychedelic-assisted therapy, as it exists on the ground today, is often practiced by people whose own intense transformations drew them into the work and came to organize how they understood care, authority, and responsibility. Practitioners largely described firsthand experience as a primary basis of legitimate authority and expressed deep skepticism toward forms of medicalization that would translate psychedelic care into economically optimized service delivery. Some accepted institutionalization as a necessary condition for expanding access, but even they worried that the forms of care most compatible with regulation, measurement, and scale would place the greatest pressure on the slowness, presence, and relational depth this work requires. In Oregon, such pressures are already proving difficult to withstand. Those most committed to careful, relationally intensive care were also working under

conditions of clear economic fragility, and some of the most sensitive forms of practice proved difficult to sustain within the emerging system.

That pattern matters because the core mechanisms identified in Chapter 3 are especially vulnerable under those conditions. Experiential containment depends on the active construction of relational and symbolic conditions that make altered states ethically enterable. Liminal relay depends on ongoing interpretive labor and on families, communities, and other social worlds capable of receiving what the session opened. Practitioners' resistance to medicalization was not merely ideological. It was tied to an embodied recognition that psychedelic experiences can open something powerful without healing a person outright, and that what follows depends on time, presence, relational continuity, and the hard work of carrying those meanings into life. When psychedelic care is institutionalized in forms that cannot sustain containment and relay, its most important conditions of possibility are weakened by the very systems now claiming to legitimize it.

By the end of this project, the point that had come to matter most to me was that whatever is opened in these experiences remains inseparable from the social, relational, and institutional conditions that must carry it afterward. Psychedelic experiences can occasion relief, insight, metaphysical disorientation, and radical shifts in perception. The interviews leave little doubt about that. The harder question concerns what becomes of those shifts once they must be borne by people whose lives remain organized by fatigue, economic pressure, relational strain, communication barriers, institutional indifference, and histories they did not choose to live within. Even so, a powerful experience may illuminate possibilities that cannot be stabilized. It may generate a reorientation whose force is real while also revealing how little in the surrounding world is capable of receiving it.

The patient trajectories detailed in Chapter 2 give that argument its clearest human expression. They show how psychedelic careers proceed unevenly depending on whether the relevant social, relational, and institutional conditions can adequately foster learned transformation. Across the sample, integration was never a purely individual accomplishment. Where experiences were carefully held, where meanings could be carried forward, and where patients returned to relationships or worlds capable of receiving what had opened, change was more likely to deepen and endure. Where those conditions were thin, fractured, or absent, even powerful experiences could remain unstable, become difficult to interpret, or begin to unravel under the pressure of ordinary life.

Yet the force of these patterns extends well beyond the therapeutic encounter itself, bringing into focus a social order highly practiced in the management of suffering yet far less equipped to register, interpret, and carry forward the kinds of experiences through which suffering may be fundamentally reworked. Many participants returned from their sessions to worlds with few shared symbols, few durable communal rites, and few widely available vocabularies for absorbing encounters that felt cosmologically significant (Berger 1967). They reentered conditions in which meaning is often privatized, suffering is individualized, and the most consequential questions a person can ask about existence lack stable collective settings in which they might be held. At the symbolic and embodied levels, this helps explain the unusual force these experiences seem to carry. They open modes of feeling and perception that exceed the ordinary terms of life, then leave participants to bear that surplus within environments that offer diminishing cultural supports for the durable sedimentation of meaning. They give subjects a brief interval in which the constraints of the iron cage of modernity appear newly permeable,

even as those constraints so often reassert themselves when ordinary life sets back in (Weber 1930).

Earlier social worlds more often situated experiences of rupture within recognizable collective forms. For a brief interval, the ordinary roles, classifications, and expectations through which social life is organized begin to loosen, allowing people to encounter themselves and others under altered conditions of significance. Turner described this movement as a shift toward anti-structure, sometimes felt as *communitas* (Turner 1969). Ceremonial life gave such moments a place. Transitional periods were publicly marked and socially organized. Suffering could be situated within broader cosmologies that located the person within an order extending beyond immediate utility or private distress. Passage into altered states, and passage back out of them, could therefore unfold within shared expectations about what those movements meant and what obligations followed from them. Modernity has left the human capacity for such experiences intact. What it has weakened are many of the ritual and cosmological structures that once organized them. In their place has grown a world shaped more heavily by instrumental reason, administrative procedure, and the practical demands of everyday survival. Within that arrangement, revelation may still occur, but it arrives in settings with far fewer established forms capable of giving it continuity in social life (Weber 1946).

That erosion matters because experiences of radical opening require forms of return. They depend on audiences, symbols, repeated practices, and durable relations through which what was glimpsed can be carried back into life and given some lasting shape. When those supports are missing, reentry becomes much harsher. A participant must carry a transformed or unsettled relation to self and world through social ecosystems that often do not recognize the significance of what occurred or the labor required to live in its aftermath. The central difficulty,

then, is not a simple diminishment of health. The problem is that the surrounding order offers few legitimate places for the force of the experience to go. Across the cases in this study, that absence generates a recurring pattern of compression. Moments of immense depth are pressed back into routines, obligations, and interpretive environments too narrow to sustain them. The slow perceptual graying Todd described, in which something that had genuinely shifted began to settle into what he called a gray middle, traced that narrowing from the inside of a life that had not otherwise changed.

This is one of the central historical ironies of contemporary psychedelic care. The substances now being reintroduced through therapeutic, legal, and quasi-legal channels have long been embedded in practices that treated altered states as socially consequential events. They operated within organized passages that prepared persons for entry, held them through disorientation, and returned them to communal life under conditions that gave the experience continuity beyond the acute encounter itself. The contemporary field has recovered the substances while leaving much of that broader infrastructure broken, marginalized, or translated into institutional forms with very different priorities (Furst 1976; Eliade 1964). Subjects are invited into experiences of extraordinary intensity while having limited access to the ritual, communal, and cosmological scaffoldings that once helped make such intensity socially generative.

That larger contradiction becomes especially visible in the return to ordinary life. Participants often described what they encountered as expansive, connective, and deeply real. The worlds awaiting them were still organized by economic necessity, institutional compartmentalization, and forms of social life that left little room for sustained contact with whatever exceeded them. What begins as a historical problem of thinned meaning quickly

reappears as a practical problem of containment. The pressure of labor is one of the clearest mechanisms through which that containment occurs. Employment gives the issue one of its sharpest reference points, but the pattern extends across the broader organization of social existence through dependence, exhaustion, scheduling, and the durable demands of material survival. Jeffrey's return to a twelve-hour Thursday shift captures this lucidly, and the same dynamic surfaced across many accounts. Revelatory experiences unfolded within lives still governed by the relentless requirement to remain functional inside arrangements that had already helped produce despair. The deeper pattern points back to Marx's harder truth that "it is not the consciousness of men that determines their existence, but their social existence that determines their consciousness" (Marx [1859] 1978: 4). To experience even a brief loosening of the conditions that ordinarily discipline one's inner life is also to viscerally observe the machinery through which those conditions are restored.

Medicalization intensifies that restoration by translating socially saturated distress into individual pathology. Once suffering enters the medical frame, care is directed toward symptom management, functional restoration, and measurable improvement. Psychedelic therapy enters this landscape carrying a more expansive potential than most conventional interventions, yet it is increasingly asked to operate within the same institutional horizon. A familiar narrowing follows. Experiences that unsettle identity, metaphysics, and the felt structure of reality are redescribed through the languages of outcome, protocol, and clinical efficacy. Relief becomes legible within this framework. Reorientation is harder to stabilize within its terms. Questions of exploitation, dependence, loneliness, violence, and existential deprivation remain in place while the intervention is tasked with helping the person live more bearably among them. Within that narrowing, transformative potential is repeatedly converted into adaptive capacity. Interior

reorientation is made to carry the burden that structural change would otherwise have to bear. The sacred or noetic encounter becomes valuable largely insofar as it helps people return, with greater steadiness, to the arrangements that wounded them. In this sense, psychedelic care risks participating in social reproduction with unusual sophistication by acting on subjects' internal metaphysical outlooks while leaving the wider external conditions of suffering intact (Conrad 2007).

The pattern identified here is not without intellectual precedent. Fundamental cause theory argues that socioeconomic position functions as a durable cause of health disparities because it provides access to resources including money, knowledge, prestige, power, and beneficial social connections that can be deployed to minimize both exposure to risk and the consequences of illness (Link & Phelan 1995). Because those resources remain differentially distributed even as specific mechanisms and treatment modalities change, interventions that address only proximate causes leave the underlying association between social position and health outcome intact. The public health tradition has long framed a parallel concern through the distinction between upstream and downstream causes, arguing that attending to downstream symptoms while leaving upstream conditions undisturbed ensures that the same populations will continue to bear the same burdens through whatever mechanisms a given historical moment makes available (Braveman, Egerter, and Williams 2011). The findings presented across this dissertation are broadly consistent with both diagnoses. Access to psychedelic care is stratified by social position. The quality of practitioners, settings, and integration resources available to patients is similarly stratified. And because the intervention is tasked with producing individual transformation without altering the structural conditions that organized the suffering in the first

place, those conditions reassert themselves with considerable regularity once ordinary life resumes.

Where psychedelic-assisted therapy complicates and extends this picture is in two related respects. First, the resources that determine whether transformation endures are substantially cultural, relational, and symbolic in character, extending beyond what socioeconomic position alone captures. What experiential containment and liminal relay require are communities of shared meaning, relational scaffolding, and chains of interaction capable of sustaining the symbolic charge generated in the session over time. These forms of infrastructure do not map neatly onto SES, even if they correlate with it, and the resource vocabulary that fundamental cause theory has developed – oriented primarily toward material and positional assets – does not fully name what this field makes visible as consequential for healing outcomes. Several participants who described the most pronounced post-session instability or narrative foreclosure held substantial financial resources and had navigated expensive, complex care networks with relative ease, yet lacked the relational and cultural infrastructure to carry what had opened forward. They returned to families, communities, and social ecologies that could neither register what had occurred nor provide the interpretive continuity transformation requires, a pattern that fundamental cause theory is unable to cleanly anticipate.

Second, and more distinctively, psychedelic-assisted therapy operates on the subjective side of social determination in a way that most medical interventions do not. Most clinical care works within the constraints of the social order, managing symptoms and returning patients to participation in the arrangements that generated distress. The intervention can render the habituated, embodied dispositions shaped by stratified field positions starkly observable without dissolving the conditions that produced them, and for participants returning to relational and

cultural environments too thin to carry what had opened, the result is not simply the reproduction of existing disparities but the potential amplification of harm, as awareness released without adequate support can become its own source of suffering rather than a pathway through it. Fundamental cause theory does not theorize this possibility. Its baseline assumption is that more resources lead to better outcomes, not that fewer resources can convert a potentially beneficial intervention into an actively harmful one.

Several participants described the loosening of long-installed patterns with extraordinary vividness, giving that observability concrete texture at the level of lived experience. Long-standing patterns became visible in ways they had never been before. Defensive structures could be seen, named, and sometimes felt as mutable. For Jeffrey, the session had briefly loosened the depressive resignation with which he had come to inhabit his own life, forcing recognition of the beauty in fatherhood and in ordinary existence that his suffering had foreclosed. Mark's account offered yet another powerful example. In the session, the fortified inner castle through which he had long organized himself became newly visible as structure, and therefore newly available for revision. That shift did not dissolve years of military discipline or self-protection in a single afternoon. What made it consequential was the support that followed, through the patience of his family as he struggled with resurfacing anger and symptoms of post-traumatic stress, and the slow relational work through which the castle organizing his inner life could begin to give way to the greenhouse he hoped for. Insight, even when profound, often struggles to consolidate for exactly this reason. The experience can interrupt embodied cultural dispositions for a time, but sustaining that interruption requires forms of support and material reorganization far more demanding than a single session, or even a small cluster of them, can ordinarily provide (Bourdieu 1977; Bourdieu 1990).

Without cultural support and material reorganization sufficient to sustain that interruption, the surrounding apparatus of care and ordinary life moves quickly to narrow it again. This restoration of order often unfolds through the ordinary terms of contemporary treatment: brief and bounded care, pressure toward documentation and legibility, limited aftercare, professional and liability constraints, and the expectation that patients return quickly to work, family, and ordinary functioning. Even excellent practitioners can become part of this process, because the problem exceeds any individual intention. The broader clinical apparatus remains organized around stabilization, liability, legibility, and the management of what exceeds routine comprehension. Its procedures can offer real support while still setting firm limits on how long disorientation may remain open, how far an altered worldview may travel, and how deeply care may extend into the social conditions shaping whether transformation endures.

These converging pressures reveal an expanding medical jurisdiction that now reaches more deeply into the governance of consciousness in its most existentially and metaphysically charged forms. Psychedelic care is organized around the deliberate induction, management, and therapeutic interpretation of altered states whose significance often extends into questions of meaning, reality, and personhood. Medicine is increasingly asked to manage experiences that do more than relieve symptoms. It now claims authority over ego dissolution, metaphysical rupture, noetic intensity, and encounters with realities that participants often regard as more fundamental than the ordinary terms of selfhood. This marks an important extension in the history of medicalization. As shared systems of meaning have lost force, medicine now moves beyond the management of distress into the administration of altered states through which people seek to confront questions of meaning, reality, and repair (Conrad 2007).

That expansion of jurisdiction helps explain the conceptual strain now visible throughout the field. Once medicine begins organizing experiences of this kind, it encounters a phenomenon whose force exceeds the terms through which medical authority usually secures its grip. What appears in these settings includes truth claims, ontological disturbance, and moral weight in forms that do not settle easily into familiar categories of diagnosis, treatment, or outcome. At decisive points, those categories misdescribe the phenomenon they are meant to contain. Experiences organized around revelation, noetic conviction, and metaphysical reorientation cannot be fully redescribed as symptom change without remainder. The strain arises not only because these experiences are unusually intense, but because they press against an epistemic order in which what counts as rationally serious is presumed to be what can be stabilized as mechanism, measurement, and outcome (James 1902; Latour 1993; Yaden and Griffiths 2021).

The interviews repeatedly suggest that the meaning these experiences impart derives from the phenomenon itself. Participants did not simply describe feeling better. They described encountering truths about their lives, their suffering, their relationships, and, in many cases, reality itself. They described moments of conviction that carried the weight of discovery, emerging from sessions with the sense that they had touched something binding, sacred, or cosmologically reorienting. Once such reports are placed at the center of analysis, the pressure on existing categories becomes harder to evade. The issue is no longer only that medicine has limited language for describing these events. The issue is that the events themselves trouble the assumptions built into that language (James 1902; Griffiths et al. 2006; Yaden and Griffiths 2021).

To state the problem more sharply, the clinical apparatus has become increasingly comfortable acknowledging that experiences of extraordinary depth correlate with therapeutic

improvement while remaining hesitant to seriously engage *what those experiences are even experiences of*. That hesitation is often defended as methodological caution, but in practice it produces a selective flattening of meaning. The same flattening also helps drive the wider diffusion of medical authority in the digital age, where podcast hosts and therapeutic influencers can carry as much or more authority in public discourse on psychedelics as scientists or ceremonial practitioners, even as that authority is converted into adjacent markets for supplements, coaching, and branded wellness commodities (Epstein and Timmermans 2021). Under clinical conditions, metaphysical upheaval is redescribed as altered cognition. An encounter with “it” becomes an item on a survey instrument. A transformed relation to existence is folded back into the language of follow-up reports. These translations make the phenomenon easier to study, but they also narrow it at the level of description before analysis has properly begun.

The reports gathered here suggest a more demanding conclusion. The noetic quality of these experiences, their felt sense of disclosing something true, is not incidental to their significance. It is part of what participants carried away from them, part of what reorganized their conduct, and part of what made the return to ordinary life so fraught. A framework that preserves therapeutic effects while bracketing the force and content of what was encountered leaves the central object only partially described. It also turns a constitutive feature of the phenomenon into a remainder that secular scientific reason can acknowledge only by refusing to take it seriously on its own terms.

The pressure becomes even clearer once the problem is considered at the level of consciousness itself. Pharmacological explanation can tell us a great deal about receptors, neural pathways, and the material conditions under which altered states arise. It can say something

about why these experiences occur more readily under some conditions than others. It can also trace downstream changes in mood, cognition, and affect. What it cannot do, at least not on its own terms, is explain why particular neural events should give rise to experiences with this kind of felt depth, revelatory intensity, and metaphysical consequence. That explanatory gap matters because the therapeutic force of psychedelic experience appears bound up with precisely what reductionist description leaves behind: the lived content of the experience, the feeling that something has been known, and the durable changes in orientation that follow from that conviction. Much of the contemporary effort to explain these events therefore attempts to break what Chalmers (1995) called “the hard problem of consciousness” into easier problems concerning neural mechanisms, behavioral effects, and therapeutic outcomes. Once that is granted, even provisionally, the language of mechanism remains necessary but no longer sufficient as a full account of what is taking place (Chalmers 1995; James 1902; Yaden and Griffiths 2021).

This is also why the field’s conceptual unease should be treated as diagnostically important. The categories inherited from biomedicine do not merely fail to capture the full richness of these events. They reveal, by their strain, that something consequential is being asked of them. When a framework built for symptom classification and treatment response is stretched to accommodate metaphysical rupture, existential disclosure, and transformed relations to reality, the mismatch is itself sociologically revealing. It tells us something about the limits of the prevailing epistemic order and about the kinds of human experience it is prepared to authorize only after their most disruptive features have been domesticated.

A related problem appears in the status of the substances themselves. The dominant clinical frame treats them primarily as chemical interventions whose significance lies in the

effects they induce within properly managed settings. The interview material points toward a thicker account. Again and again, practitioners and patients described these substances as carrying a force, directionality, or intelligence that exceeded the terms of neutral instrumentation. Some treated that force in explicitly spiritual language. Wenda's insistence that plant medicines are an ancient form of consciousness that provide spiritual instruction belongs squarely in this register. Others approached the matter with more caution yet still spoke as though the substance participated in the experience as something more than inert matter. One need not settle the metaphysical status of such claims in order to take them seriously as data (James 1902). It is enough to recognize that the contemporary field is organized around compounds many participants experience as active presences with distinctive properties that shape what becomes possible in the session and what follows from it afterward. What further distinguishes these medicines as nonhuman actors is the specificity with which they act upon the pre-reflective bodily dispositions that social determination is reproduced through. It acts, however briefly, on habitus itself, which is why the opening it creates differs in kind from what most therapeutic tools can offer.

The medicine, in other words, does not act alone. It enters the room alongside bodies, sounds, ritual objects, guides, expectations, histories, and institutional scripts. Together these elements form a heterogeneous assemblage through which meaning, vulnerability, disruption, and reorientation are produced. Once the molecule is isolated as the purified object of knowledge, the broader chain of mediations through which the experience takes shape becomes harder to see (Latour 1993). That matters because psychedelic sessions can become schematically generative episodes in which inherited ways of interpreting suffering, selfhood, obligation, and possibility lose some of their inevitability and come briefly into view as products

of a life lived under particular social conditions. Whether that opening becomes durable then depends on conversion. Newly available schemas have to attach to resources capable of carrying them into practice through relationships, routines, symbols, authorities, and forms of care that can be drawn on repeatedly until they concretize at the level of habitus (Bourdieu 1977; Sewell 1992). The peril of the present moment is that the institutions now poised to govern these experiences are themselves among the most active agents in the reproduction such experiences may briefly interrupt.

Once the phenomenon is understood at that level, the practical question sharpens considerably. The issue concerns more than safe delivery or better measurement. It concerns the sociocultural conditions under which experiences of this kind might become durably transformative in the lives of those who undergo them. The interview material points toward a demanding answer. Transformation does not reside in the acute experience alone. It depends on what surrounds that experience before it occurs, what interprets it while it unfolds, and what carries it forward once ordinary life begins to close around it again. Meaning emerges through interaction, through the social organization of interpretation, and through the frameworks available for making sense of what has taken place. Any adequate account of psychedelic transformation therefore must take an interactionist lens seriously, because the process turns so centrally on meaning-making and because interpretive failure in this domain can carry unusually immediate existential consequences (Blumer 1969; Becker 1953; Goffman 1959).

What interactionism must explain more precisely in this context is the social machinery through which altered-state experience becomes durable. Terms like set, setting, and integration have been invaluable in establishing that context matters. What such terms leave underspecified is how that context is actually assembled, ethically governed, and sustained once ordinary life

closes back in. The material in this dissertation points toward a more exact account. The experience has to be contained before it overwhelms, and relayed afterward in forms that can survive return. The challenge throughout this field has been to make ineffable experience socially legible without imposing any single vocabulary on patients as they make sense of it. When that work is done well, experiential containment protects patients from panic, abandonment, and interpretive capture, while liminal relay helps carry fragile meanings across families, workplaces, and institutions that may not know how to receive them. When that work breaks down, the consequences extend far beyond reduction. They include stranded awareness, fractured integration, stalled portability, and the rapid contraction of possibility as powerful experiences meet thin aftercare, unequal resources, and social worlds unable or unwilling to hold what has been opened.

At the center of that machinery lies an interpretive and relational problem. People do not simply undergo these experiences and emerge with stable meanings already intact. They enter them with expectations, anxieties, histories, moral vocabularies, and varying capacities to tolerate disorientation. They move through them with the help, and sometimes under the burden, of facilitators whose presence, language, restraint, and symbolic fluency shape what becomes sayable and bearable in the moment. They leave carrying fragments that often remain unstable for some time afterward. What becomes transformative is inseparable from the social labor through which those fragments are named, revisited, tested, and carried into later situations. This is one reason the therapeutic relationship mattered so much across the interviews. The meaning of the experience itself was rarely affectively or symbolically intelligible in any immediate sense. What often determined whether it became legible and eventually internalized was the quality of

the relational work surrounding it, together with access to ongoing settings where the meanings opened in the session could be elaborated upon and converted into new behaviors and practices.

That labor extends beyond interpretation into the reproduction of emotional and symbolic charge across time. Intense sessions often generated moments of immense depth, a felt sense of contact with what mattered most, and symbols newly saturated with significance. Jeffrey's name for what he encountered, "it," is one example. The altar, the music, the objects placed within reach during the session, and the sensory texture of the room are others. In Collins's terms, such moments do not simply produce meaning. They generate emotional energy and charge the symbols gathered around the encounter with a moral and affective weight that can endure beyond the session itself (Collins 2004). Yet that charge remained vulnerable unless it was carried forward through subsequent interactions, repeated practices, shared objects, and durable relations capable of reactivating what the experience had set in motion. Without those continuities, what had felt cosmologically alive could quickly become a memory, then a story, then something increasingly difficult to inhabit. This is why integration cannot be reduced to private reflection or bounded therapeutic follow-up. Transformation requires chains of interaction able to renew commitment, reactivate charged symbols, and give what occurred a durable social presence in the person's life.

The dominant individualization of integration reflects precisely this limitation. When the work of carrying these experiences forward is treated primarily as a private responsibility, the broader conditions of transformation are narrowed in advance. The person is left to manage the afterlife of the experience through journaling, reflection, or a handful of follow-up conversations while the larger arrangements shaping what can endure remain untouched. Such models fit neatly within institutional pressures favoring brief care, standardization, and efficiency. They fit far less

well with the actual demands of durable transformation described throughout this project. What they also risk producing is a longer-term logic of individualized maintenance in which the burden of preserving what the experience opened falls back onto the person as an ongoing project of self-management, even when the conditions required for integration are irreducibly social (Dumit 2012). When Sophie described her experience as the opening of Pandora's box followed by abrupt abandonment, she named something that the clinical language of aftercare rarely admits. Namely, that awareness released without support can become its own form of suffering, flooding a life that has not been reorganized to hold what the session set loose.

The contrast with ceremonial and community-based forms of care is instructive in this sense. In such settings, altered states have often been embedded within longer chains of preparation, ritual return, communal witnessing, and repeated symbolic rehearsal. What is being carried is never only the burden of the individual. It is held in shared forms that give the experience continuity, accountability, and reintegration into collective life. In many Indigenous epistemics, the sense of being connected to something larger is not treated as an extraordinary break from reality, but as one of its most ordinary truths. In late-modern Western settings, by contrast, atomized individuality is so deeply naturalized that such experiences arrive as revelation only to be handed back to people who are then expected to integrate them largely on their own. As psychedelic care is folded into narrow, individualized models of integration, profound experiences are increasingly liable to be translated back into private burdens of maintenance. The broader moral logic is unmistakable. Suffering remains yours to manage, healing remains yours to secure, and the encounter remains yours to carry inside a life whose structural terms have not moved (Dumit 2012; Sanabria and Tófoli 2025).

What matters most, then, is that durable transformation requires infrastructures capable of carrying what the session opens into the world beyond it. In the terms developed across this dissertation, the problem is whether event-like ruptures can be consolidated and whether liminal passages can be held long enough to return something of their force to ordinary life. That is why the organizational fate of the most relationally serious practitioners in this study is so concerning. In Oregon, all six practitioners whose work most clearly approximated this kind of care were operating in facilitation businesses organized around time-intensive, relationship-centered support. All of those businesses are now closed. That fact should be read as more than a local business failure (Thomas 2025). If early state-legal models such as Oregon and Colorado are going to serve as reference points for the solvency and efficacy of psychedelic care infrastructures, then the collapse of these more relationally intensive arrangements is a warning about what the emerging system can and cannot sustain. Their work depended on continuity, pacing, symbolic care, and the slow movement back into ordinary life. The system did not destroy their ethics. It destroyed the infrastructure through which those ethics could be practiced.

What follows from all of this is the need for a critical sociology of psychedelics focused on more than the biomedical narrowing of the field. Such a sociology would ask more than whether these interventions work, for whom, or under what clinical conditions. It would ask what kinds of institutions, fields of care, and political-economic arrangements decide what these experiences are allowed to become, and why the conditions most necessary for durable transformation so often remain the least supported. It would track the unequal distribution of access to preparation, continuity, safety, symbolic legitimacy, and the material resources required to carry altered states back into ordinary life without reducing them to private burdens of maintenance. It would examine how marketization, compliance regimes, professional

boundary-making, and secular epistemic habits together shape what counts as proper healing and what is dismissed as excessive, unscientific, culturally illegible, or economically unviable. It would take seriously the historical normality of anti-structure as part of the human condition, and it would recognize nonhuman actors as genuine participants in the production and sustainment of meaning (Latour 1993). It would also systematize inquiry around a more portable set of problems: the conditions that make containment possible, the pathways through which relay becomes durable, the political economy of their support or collapse, and the unequal social worlds that determine whether those meanings can take hold in ordinary life.

The limits of this project's own sample sharpen that need. Although the participants were not entirely demographically uniform, they were in general disproportionately white and relatively privileged by class position. That fact raises further questions for future work. Scholars should examine more directly how stratification filters the meanings people are able to internalize, carry forward, and enact after their sessions; how it organizes access to the relational and material support durable transformation requires; and whether, for some, those same structural conditions foreclose transformative potential altogether before it can be realized. A critical sociology of psychedelics must therefore proceed as a sociology of the conditions under which altered-state experiences become socially consequential, together with the forces that systematically narrow, privatize, and contain what they might otherwise make possible.

At the same time, the phenomenon presses sociology toward one of its own epistemic limits. If the experiences described here are part of what reorganizes lives, if their noetic force matters to those who undergo them, and if their content cannot be fully translated into vocabularies of symptom reduction without losing something essential, then sociology cannot remain satisfied with treating consciousness as a black box or as a derivative surface of more

fundamental social processes. Explanations at the level of mechanism, outcome, and institutional effect remain indispensable, but they do not exhaust the phenomenon. They leave unresolved how certain experiences come to be lived as truth-bearing, morally binding, beautiful, terrifying, or revelatory, and how social worlds make those meanings durable, contest them, or force them to collapse. A more mature sociology of consciousness would begin from the recognition that altered states are part of the human condition and that their significance is socially organized. It would ask how such states are prepared for, ethically held, interpreted, and carried back into ordinary life; how clinical, spiritual, and everyday vocabularies compete to define what has happened; and how families, workplaces, communities, and institutions shape whether those experiences become durable sources of orientation or fade under the pressure of return. It would also take Indigenous knowledge systems seriously as long-developed empirical and ethical traditions for organizing entry, guidance, risk, and return around consciousness-altering substances, especially where contemporary therapeutic institutions have recovered the substances while thinning the social forms that once helped hold them. Some aspects of these experiences may continue to exceed full explanation while still demanding serious empirical and theoretical engagement. That limit is worth naming clearly rather than hiding behind premature closure.

The broader call of this dissertation follows from that recognition. Psychedelic-assisted therapy is introducing more than a new treatment into medicine. It brings into view a broader sociological problem, revealing how extraordinary experiences become interpretable, institutionally governable, and socially consequential in worlds often poorly equipped to receive them. A critical sociology of psychedelics names that problem at the level of fields, institutions, inequality, and care infrastructures. A more mature sociology of consciousness names it at the level of subjective force, ontological disturbance, and the social organization of experiences that

exceed existing vocabularies of explanation. The two are inseparable. The first cannot fully explain what psychedelic care opens without the second, and the second risks remaining abstract unless it is grounded in the concrete struggles over interpretation, legitimacy, and care that this field makes visible. Psychedelic care is one especially consequential site in which that conjunction can now be studied, but it is unlikely to remain the only one. The same questions are already visible at the edges of research and practice around near-death experience, breathwork, and new forms of technologically mediated intimacy and self-modification emerging around artificial intelligence. The fragile experiments now visible in places like Oregon and Colorado matter for that reason. They do not resolve the contradictions traced here, but they show that alternative infrastructures are already being built at the margins, however precariously, by practitioners trying to hold more than the dominant model knows how to receive.

As I think through the force of these arguments and the conditions they imply, I continue to find myself haunted by the movement between Jeffrey's Tuesday and Thursday, and by the unmistakable bitterness in his voice when he described that transition. I return to the force with which he posed the question of what it meant to encounter something so immense, so reorganizing, so difficult to name, only to be returned almost immediately to a world that had made no room for it. Over the course of writing this project, that movement has come to stand for much more than the aftermath of a single session. A life can be cracked open. A person can be changed. A sense of beauty, truth, or possibility can be made newly available. And still the world waiting on the other side can remain so narrow, so demanding, and so unchanged that the opening begins to contract almost as soon as it appears.

I return as well to the pain of hearing accounts like Sophie's, and to the particular horror of recognizing how easily experiences that begin in the language of healing can move into

destabilization, confusion, dependence, or abuse. Her account, together with the accounts of her mother and father, made it impossible to romanticize care in this field. By the time this dissertation reached its final form, one of the hardest lessons it had taught me was that profound experience does not protect anyone from structure, and that therapeutic intensity does not guarantee ethical seriousness, institutional adequacy, or lasting repair. When those conditions deteriorate, the very openness that makes these experiences feel so powerful can become part of what leaves people vulnerable.

What has stayed with me most is that, while participants like Jeffrey and Sophie are memorable for the clarity with which they expressed these tensions, they are not memorable because those tensions were rare. The longer I sat with the interviews, the more impossible it became to treat these cases as exceptional in any strong sense. Their biographies are specific. Their suffering has its own shape. Their voices remain singular. Yet the patterns running through their accounts appeared with too much consistency to be dismissed as unusual. People returned from these experiences altered, relieved, disoriented, expanded, destabilized, hopeful, confused, and often several of these at once. They returned to aftercare that was sometimes beautiful and sometimes inadequate. They returned to worlds that were often indifferent to what had happened to them. And they returned carrying questions that no quick clinical language could fully contain. These people are not everywhere, but they are far from scarce. Their experiences belong to a broader social reality that this field has only begun to reckon with.

That recognition has changed what I take this project to be about. It began, in many ways, from awe. It still contains that awe. I remain convinced that these substances and the experiences they occasion can disclose something profound about suffering, relation, and the possibilities of human life. What the project gave me, however, was a more difficult form of seriousness. It

taught me that whatever is extraordinary here unfolds inside worlds still governed by inequality, exhaustion, institutional fragmentation, market pressure, and fragile infrastructures of care. It taught me that the field's deepest questions cannot be answered through efficacy alone, through the celebration of mystical depth, or through the hope that powerful experiences will carry their own future forward. They require sustained attention to the worlds people return to, to the forms of care they can actually access, and to the structures that decide whether transformation becomes durable, distorted, or impossible to hold.

For that reason, I leave this project with a sense of completion joined to a deepened sense of responsibility. I do not take Jeffrey's transition from Tuesday to Thursday to be a tragic anomaly. I take it to be a demand. It is a demand that asks what it would mean to build a world in which openings of this kind were not left to collapse back into isolation, overwork, silence, or harm. It asks what kinds of institutions, relationships, and collective commitments would be required for experiences of radical significance to be received well and carried forward without exploitation or abandonment. Finally, it asks what a sociology adequate to these lives and this phenomenon would have to be willing to confront. This dissertation has been one attempt to begin answering those questions. The need for them remains, and so does the force with which they return. And so does "it," whatever Jeffrey touched on that Tuesday; whatever so many others have tried to name in its aftermath; whatever exceeds the languages built to contain it yet still presses itself back into view. If this project has shown anything, it is that "it" does not disappear simply because the world has no stable place for it. It waits there, at the edge of suffering, care, consciousness, and social life, continuing to ask more of this field and the institutions governing it than they have yet been willing to give.

Methodological Appendix

a. Sampling & Analytic Strategy

This dissertation draws on sixty in-depth, semi-structured interviews from a two-sample study of psychedelic-assisted therapy (PAT) in the United States: thirty practitioners who provide psychedelic-assisted therapeutic care and thirty patients who received it. Treating both samples together makes it possible to track how therapeutic meanings are produced, stabilized, and carried across phases of care, while examining how institutional context and stratification shape what forms of interpretive and relational support are feasible. The two samples were developed sequentially but analyzed in relation to one another, and sixteen patient interviewees were former patients of practitioners who met the recruitment criteria for the practitioner sample, creating an embedded relational design across the chapters of this dissertation. For the purposes of this study, "psychedelic-assisted therapy" is defined as structured therapeutic work in which a psychedelic medicine is embedded in an organized process of preparation, facilitated dosing support, and post-session integration or meaning-making support. This definition is deliberately broad, intended to capture institutional diversity across clinical trials, licensed service systems, legally protected religious or ceremonial contexts, decriminalized settings, and underground networks, because the dissertation's core analytical concerns require comparison across heterogeneous legitimacy regimes rather than confinement to any single institutional model.

The practitioner sample includes thirty individuals currently working as psychedelic-assisted therapy facilitators across the United States. Participants were recruited through purposive and snowball sampling between August 2024 and June 2025. Initial outreach began through the Multidisciplinary Association for Psychedelic Studies (MAPS) integration list, which served as a point of entry into the field. From that base, recruitment expanded through facilitator networks and into harder-to-reach corners of the psychedelic underground. This

sampling process reflected the field's communal orientation: facilitators were often hesitant to speak without peer endorsement, and access was frequently contingent on demonstrated relational credibility. The sample was designed to maximize variation across practice contexts rather than represent any single institutional model. Participants included clinical psychologists, psychiatrists, psychotherapists, social workers, psychiatric nurses, nurse practitioners, and licensed psilocybin therapy facilitators, as well as facilitators without formal clinical licensure operating in ceremonial, underground, or decriminalized environments. A subset held hybrid positions, working in legally sanctioned clinical trials or Oregon's state-licensed psilocybin framework while maintaining underground practices. The sample was designed to include practitioners across legal and underground settings, training lineages, and institutional affiliations in order to assess whether shared logics of legitimacy and therapeutic orientation cut across those backgrounds. Interviews ranged from 58 to 127 minutes and were conducted via Zoom or in person following a semi-structured guide focused on professional backgrounds, facilitation approaches, ethical frameworks, perceptions of legitimacy, and personal psychedelic experiences.

The patient sample includes thirty adults who had received psychedelic-assisted therapy from facilitators meeting the same recruitment criteria. Participants were recruited using a combination of convenience and snowball sampling strategies. Fourteen responded to recruitment posts circulated on online forums and social media spaces related to psychedelic therapy and mental health, where a brief description of the study's objectives and inclusion criteria was provided. Others were referred directly by practitioners who had previously participated in the facilitator study. All patient participants were adults who had completed at least one course of psychedelic-assisted therapy within the previous five years. Patients in the

sample received care in a range of settings, including FDA-sanctioned clinical trials, Oregon's licensed psilocybin services system, legally protected psychedelic-religious communities, decriminalized service contexts, and underground practice networks in the United States. Consistent with common demographics of access to these forms of care, the sample was majority white and disproportionately middle to upper class. At the same time, participants were relatively diverse in terms of gender, age, sexual orientation, and religious or spiritual identification, and this heterogeneity allowed for examination of how psychedelic experiences are narrated and evaluated across different social locations while remaining attentive to the classed and racialized limits of the sample and of current PAT access more broadly.

The relational structure of the patient sample also warrants detailed description. Nine patients were direct referrals from nine distinct practitioners, each constituting a one-to-one pairing between a patient narrative and a facilitator previously interviewed. One practitioner provided four patient referrals, so four of the patient interviews are linked to a single facilitator's practice. Another practitioner initially referred one patient; as the research relationship developed, this participant shared that both her mother and father had seen the same practitioner for psychedelic-assisted therapy, and, with their consent, they were subsequently interviewed as well. These three patient narratives are thus associated with a single facilitator, and they illuminate how the same practitioner and therapeutic style may be experienced differently across family members and life stages. The remaining fourteen patient participants had received care from facilitators who met the broader criteria for inclusion but who were not themselves interviewed. Throughout the analysis, the linked patient-practitioner cases were used to refine interpretations about how therapist identities, practices, and institutional locations shaped

patients' meaning-making, and patient narratives were read alongside facilitator interviews to generate cross-sample inferences that neither sample could support alone.

Interviews were conducted remotely via Zoom or by phone, or in person when feasible. Patient conversations were semi-structured and ranged from 52 to 164 minutes in duration. The interview guide for patients invited participants to recount their histories of suffering and prior encounters with psychiatric and psychotherapeutic care, their pathways into psychedelic treatment, their experiences of preparation, dosing, and integration, and their efforts to make sense of what changed in them afterward. Both interview guides were organized around four thematic domains: the impetus for practice or treatment; cultural orientations toward health and illness; the sequence of care across preparation, dosing, and post-session life; and experiences of interpretive guidance and influence.

This project was approved by the Institutional Review Board at The University of California, Davis, and was determined exempt under Category 2. All participants provided informed consent prior to the start of each interview. Pseudonyms were used throughout the dissertation, and potentially identifying details in quotations were altered or omitted during transcript cleaning to protect confidentiality; where affiliations, locations, or other identifying cues appear, they have been masked or generalized. Given the legal and professional sensitivity of psychedelic practice in most U.S. states, confidentiality protections were treated as methodologically central. All interviews were audio recorded with participants' consent and transcribed using Turboscribe, a secure automated transcription service. Transcripts were then checked against the audio, with transcription errors corrected, punctuation standardized, and identifying material removed. After transcripts were checked for accuracy, original audio files were deleted so that no identifying voice data remained. De-identified transcripts are stored on a

secure, access-controlled drive accessible only to the author and project supervisor, in compliance with university data-retention policies.

The analytic process was iterative and abductive, moving between inductive insights grounded in the data and deductive engagement with theoretical frameworks in medical sociology, cultural sociology, and science and technology studies (Timmermans and Tavory 2012). Initial analysis involved close, line-by-line coding of a subset of transcripts, generating *in vivo* codes and other fine-grained descriptive codes to capture participants' own language for suffering, healing, and psychedelic experience. As additional interviews were conducted, the codebook was refined through constant comparison, with codes added, collapsed, or re-specified to reflect recurring patterns and tensions in the data. Descriptive codes were gradually organized into more focused analytic categories linking local narratives to broader questions of structure, inequality, and meaning-making. Throughout this process, analytic memos were written as new transcripts were processed, both to synthesize patterns within and across codes and to develop provisional theoretical hunches, tracking how those hunches shifted in light of discrepant or disconfirming cases. Practitioner interviews were coded for how facilitators manage interpretive influence, establish ethical boundaries, and build conditions for symbolic stabilization. Patient interviews were analyzed as narrative trajectories, tracing entry into care, dosing experiences, and efforts to carry meaning forward under uneven relational and material conditions. Cross-case matrices were constructed to compare how similar interpretive challenges appeared across different social positions and settings and to identify recurring inflection points in patients' psychedelic careers.

My position in the field undoubtedly shaped both recruitment and interpretation. As a university-affiliated researcher who had already conducted an extensive interview study with

facilitators, I was often introduced to patients as someone who took their experiences seriously and was familiar with psychedelic practice. This facilitated trust and depth in many interviews, but it also meant that participants sometimes framed their narratives in ways that anticipated the study's interest in ethics, relationality, and critique of biomedicine. Given that sixteen of the thirty patient participants were recruited through practitioner referrals, the sample likely overrepresents individuals who maintained positive or ongoing relationships with their facilitators. Practitioners, particularly those working in small or hybridized therapeutic settings, tended to refer patients who they believed had meaningful or transformative experiences, which may have shaped the distribution of evaluations present in the sample. At the same time, this dynamic did not produce uniformly positive accounts. Several referred participants offered highly critical or ambivalent assessments of their facilitators, including clear accounts of discomfort, misattunement, or unmet expectations. These cases underscore that referral-based recruitment reflects the relational structure of contemporary psychedelic practice more than it filters out negative evaluations entirely. The analysis therefore treats these referral patterns as a feature of the field itself, illustrating how access, trust, and ongoing relational ties shape who becomes available to researchers and how PAT experiences circulate within emerging therapeutic networks, and not only as a methodological limitation to be managed.

The relative absence of empirical sociological work on these populations reflects not their irrelevance but their inaccessibility. By assembling sixty interviews across sanctioned and unsanctioned contexts, the design supports cross-contextual comparison and reveals grounded patterns in how legitimacy, ethics, and care are enacted under varying institutional constraints. The practitioner sample also may not capture the full heterogeneity of facilitator backgrounds and orientations. Given that recruitment began through facilitator networks and expanded via

snowball sampling, the sample may overrepresent practitioners whose professional identities are organized around personal psychedelic experience, and broader variation in therapeutic orientation likely exists beyond what these thirty interviews can contain. Nevertheless, the findings show strong narrative and dispositional consistency across participants, suggesting that the study captures something structurally generative about the field's current formation, even where it cannot claim representational exhaustiveness.

b. Positionality Statement

Entering the field of PAT and gaining access to the deeply layered networks which comprise much of this study's sample would likely be functionally impossible for any "true outsider." The boundary of experience articulated across each empirical chapter was not merely an analytical concern. It was the same boundary that ultimately enabled the recruitment of several key informants whose earned trust allowed the sample to eventually become a wide snapshot of the contemporary PAT landscape.

As this project has illustrated, practitioners and patients of PAT must navigate complex social landscapes that do not always readily accept the narratives of transformation they seek to articulate in the aftermath of their experiences. Many of them face not only significant risk of stigmatization, but potentially life-altering legal punishment if their work were to become publicly known. Because of this, my responses to incisive questions about my "real motivations" behind this project were directly confirmed by several interviewees as necessary confessions to establish enough trust for official recruitment into the study. In the interest of reflexivity, I openly offer those answers to readers here.

The social trajectories and processes defined in chapters two and three, especially those concerned with integration failures, undoubtedly reflect insights from a personal and professional narrative that preceded this project. My own prior familiarity with suicidality, the "miracle moment" of restitution that these medicines can provide, and the painful experience of gradual drift back into disrepair, in tension with a local culture that could not accommodate the expression of the new truths I longed to share, produced an intimate sensitivity to the relationships between insight, structure, and disorder detailed throughout this project. The desire to understand what happened to me shaped the central questions I asked, the interpretive problems I followed, and the theoretical language I developed throughout this project.

My personal history also shaped the quality of access the project was able to generate. Having undergone psychedelic experiences that included encounters with the extraordinary and the dissolution of ordinary selfhood, I was able to receive participants' accounts with genuine recognition. For many practitioners and patients in this study, psychedelic experience represented the closest encounter with the sacred they had ever known, and with that came a characteristic fervor; a desire to share, to testify, to be genuinely heard by someone capable of understanding what they were describing. An interviewer who could receive those accounts with authentic recognition became, for some participants, an unusually welcome audience, and that dynamic almost certainly shaped both the depth of disclosure and the candor with which people described their experiences. In several pre-recruitment conversations with underground practitioners, sharing accounts of my own experiences that aligned with theirs was itself a condition of access, creating a sense of empathic recognition that credentials and confidentiality assurances alone could not have produced. I did not treat such disclosures as a routine interview technique, but used them selectively in moments where participants explicitly questioned my

relationship to the field, my capacity to understand the stakes of their work, or the sincerity of my motivations. My ability to maintain analytical clarity and theoretical direction alongside the metaphysical vertigo that psychedelic work tends to occasion seemed to register favorably with nearly everyone I interviewed.

That same proximity shaped the quality of the questions the fieldwork produced. My theoretical training in the sociology of race, cultural sociology, and medical sociology deepened my sensitivity to the ways identity positions filter perception, including how participants understand their own health experiences without necessarily naming the structural conditions that organize them. That formation did not produce scripted interview questions, but it did produce lines of inquiry that arose organically at several junctures which a researcher without such training might not have pursued. In at least several cases, those questions yielded analytically significant material. Asking a practitioner whether his own presentation of normative yet safe masculinity was itself a therapeutic resource for a patient who had experienced intense sexual violence, for instance, produced a reflection he had not previously considered in those terms. That kind of questioning is simultaneously a methodological resource and a site of risk. It generates insight the protocol alone would not have produced, and it also raises the possibility that participants' accounts were shaped in part by the interpretive frames I brought into the room.

My broader sociodemographic profile is also relevant. I am a 31-year-old middle-class white man from Bakersfield, raised areligiously by parents who were deliberate about that choice. Growing up in an intensely conservative microcosm of one of the most liberal states in the country produced an acute sensitivity to the ways in which race, class, and gender shape interpersonal communication, and those sensitivities informed my navigation of recruitment and fieldwork at nearly every stage. That upbringing required moving between competing moral and

political vocabularies from an early age, making me especially attentive to coded speech, guarded disclosure, and the ways people adjust what they can say depending on the perceived receptivity of their audience. My communicative confidence and fluency around identity politics and stratification visibly surprised several participants and seemed to ease the conversational dynamic in ways I had not anticipated. At several junctures, those abilities, combined with the legitimacy conferred by my institutional title, enabled me to earn the trust of participants who might otherwise have remained beyond reach.

While my sociodemographic profile and past experiences served as invaluable analytic resources, they also pose methodological risks in equal measure. What my social location enabled cannot be cleanly separated from what it may have foreclosed. No participant directly indicated that my demographic profile closed off a line of inquiry, but the absence of such feedback is not confirmation of neutrality. Online recruitment efforts may have been avoided by prospective participants for reasons I cannot verify from my position, and a small number of practitioners remained notably guarded about their personal psychedelic use histories despite acknowledging the ethical importance of such experience. The sample's composition, roughly 70% white and middle-to-upper class, reflects both well-documented access disparities in PAT care broadly and the particular contours of my recruitment position, and I cannot fully disentangle those two factors. At the same time, access to these perspectives was shaped by the practical limits of a solo dissertation project conducted without institutional funding or a preexisting research infrastructure in a field with little established sociological precedent.

The intellectual trajectory of the project's central argument also bears directly on questions of researcher influence and theoretical construction. I entered this research with a more romanticized image of PAT than the one that emerges across these chapters. What was not

visible to me at the outset was how the erosion of psychedelic-derived meanings should be understood in relation to structural constraints rather than individual failure. That insight developed gradually through data analysis, accompanied by a meta-realization that my own history of attempted transformation had been curtailed by many of the same structural strains my participants described. The critique of "set and setting" that anchors this dissertation was not a conclusion I arrived at before the data; it was one the data made available to me, in part because my own experience had already prepared the ground for recognizing it. My personal history with psychiatric treatment, including pharmacological interventions that worsened rather than relieved my suffering during adolescence, drew me toward the sociology of medicalization from the earliest stages of my graduate training. That history undoubtedly shaped which questions felt urgent enough to build into the research protocol.

Throughout the coding and interpretive stages of this project, I worked against the pull of confirmation by attending closely to disconfirming cases, maintaining analytic memos that tracked my own interpretive movements, and subjecting emerging theoretical claims to sustained critical scrutiny in dialogue with my dissertation chair. What that process of sustained scrutiny ultimately clarified was something I had not fully anticipated when I began.

In particular, there was something powerful about recognizing how many of my participants shared narratives that were similar to my own. It left me feeling less alone in an experience I had long understood as a private failure. But the more analytically generative moments came from the disjunctures. The places where the social locations of those with less favorable outcomes diverged from those with long lasting, profoundly transformative ones revealed with precision what I could not have seen from my own position alone. It is in those disjunctures that the fine-grained relational and structural conditions enabling transformation to

sediment or dissolve became visible, and where the argument that what looks like individual failure is rarely only that came into sharpest focus.

The theoretical frameworks this project has produced leave me genuinely hopeful that the field can respond to what the data shows. I hold that hope with clear eyes. Producing seriously useful knowledge and finding an audience with the institutional will to act on it are different accomplishments entirely. But what I have no doubt about is this: the people this project is ultimately about deserve a sociology that takes the full weight of their situation seriously. Some of them found something in these experiences that changed the terms of their lives in ways that lasted. Others carried something real out of the session and watched it dissolve under the weight of conditions they have no agency in changing. What determines which of those outcomes a person gets is rarely a matter of individual readiness or luck. It is a matter of structure. And the first step toward changing those odds is being willing to name that clearly. This project has tried to do just that.

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