

Webinar Title: Foundations of Ketamine-Assisted Psychotherapy

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Lizzie Mears: Welcome, everybody. Thank you so much for joining. It's one o'clock. People are just filtering in. I can see everyone coming in, so that's excellent. I want to make sure everybody is aware of the Q&A button down in your control center for Zoom. That is something that you are welcome to submit questions at any time, and there will be a Q&A session at the end of this discussion today. Thank you.

Jodie: Hello, and welcome to today's webinar, *Foundations of Ketamine-Assisted Psychotherapy (KAP)*. This topical webinar is paid for by Journey Clinical. Journey Clinical empowers therapists to offer ketamine-assisted psychotherapy in their private practice through education, training, community, and in-house medical team to handle all medical aspects of their treatment.

Some important points before we get started today. Doctors Jessica Punzo and Brigitte Gordon have working relationships with Journey Clinical, and as such, they have both a financial and an intellectual interest in the webinar content. The purpose of today's presentation is to provide licensed mental health professionals with a psychotherapy-centered overview of ketamine-assisted psychotherapy. APA does not endorse any products or services. The content was created by Journey Clinical and does not reflect the views of APA or its editorial staff. Email advertising@apa.org to learn more.

Next, today's program does offer a one hour of CE, and a certificate will be issued upon completion of a quiz and a course evaluation following the webinar. The link to the quiz and the course evaluation will be sent to all attendees shortly after the webinar ends. Journey Clinical is approved by the American Psychological Association, MBCC, and ACE to sponsor continuing education. As such, they maintain responsibility of today's program and its content.

A recording will be available 24 hours after today's webinar, and it will come via Journey Clinical's learning management system. That's also where you will obtain the CE certification. CE credit can also be earned by watching the recording. It'll be delivered as an asynchronous distance course. The recording will also be available on APA's website, apa.org, in approximately two weeks. During our time together, you'll be on mute, and you can communicate with us using the Q&A box located on your webinar screen. A link to the presentation slides will be posted in the chat box. If you miss them, don't worry. They'll also be sent with the recording.

Now, let me introduce you to today's presenters. Jessica Punzo, PsyD, lead therapist and instructor. Dr. Punzo is a licensed clinical psychologist and PSYPACT provider with advanced training and leadership in trauma-focused care. She holds a doctoral degree in clinical psychology with a concentration in traumatic stress from Adler University, and currently serves as Past President of Division 56, Trauma Psychology, of the American Psychological Association. Dr. Punzo has extensive experience treating PTSD and complex trauma across diverse clinical settings, including community mental health corrections and VA systems.

Brigitte Gordon, DNP, PMHNP-BC, medical and clinical instructor. Brigitte, Dr. Gordon, is a doctoral-trained, board-certified psychiatric nurse practitioner specializing in adult and geriatric psychiatric medication management and psychotherapy with a subspecialty in integrative psychiatry. As lead clinician at Journey Clinical, she oversees and supports clinicians nationwide in delivering safe, effective, compassionate ketamine-assisted psychotherapy.

Dr. Gordon also serves as the assistant professor in the doctoral program at Columbia University School of Nursing and continues her academic work as a researcher with the Multidisciplinary Association of Psychedelic Studies. Welcome, Drs. Punzo and Gordon.

Dr. Jessica Punzo: Thank you for that great introduction. Welcome, everyone. We're so excited to be having this webinar on ketamine-assisted psychotherapy. We call it KAP for short. Yes, just super excited for you all to be here and be delivering this information to you. Here are our learning objectives for today. Just so you know, this is going to be a really basic foundational overview of KAP. What we plan to do is really talk about the clinical indications, some safety considerations, and the evidence base for the use of ketamine in mental health treatment.

We're going to also review the primary routes of administration with ketamine, and then understand how you might use them in your therapeutic setting and work. Then we'll also talk about some of the core concepts that KAP can incorporate, so talking about therapeutic alliance, talking about preparation, dosing, and integration, and then the roles of both the prescriber, the medical provider, and the therapist.

Dr. Brigitte Gordon: Hi, everyone. Again, thank you so much for that introduction. I'm so happy to be here with Dr. Punzo. Let's dive right in because, as Dr. Punzo mentioned, this is just the preliminary view of a really complex and awesome form of treatment. I'm really glad that you're all here to educate yourselves on something that's so exciting. We'll just get the primary basics here. What is ketamine? Why are we talking about it for mental health? It's a dissociative anesthetic. It was developed in the 1960s and then approved by the FDA as an anesthetic in mid to late 1970s.

On its own, it has a short half-life, meaning that in the system, subjectively, you can feel the medication for about two to three hours when using an IV, and shorter for other routes of administration. Besides its subjective effects, it does have a longer functional antidepressant effect. It is not a traditional serotonergic antidepressant that you would think about, like Prozac or Zoloft, if you guys are familiar with those medications. Its antidepressant effects are thought to relate more to neuroplasticity mechanisms. Again, not more neurochemical changes. However, there is peace to that as well.

It is one of the top World Health Organization's medicines to watch because of its cost, its efficacy, and its widespread utility. It's really, in my opinion, and I think the whole panel here, and the research will support that, one of the most exciting tools in psychiatry right now because it works on multiple core domains on brain health, not just antidepressant or anti-anxiety effects. First, it rapidly restores neuroplasticity, essentially helping the brain form new connections by increasing glutamate signaling, so we'll get a little bit more complex here, and downstream BDNF, which is essentially a protein that helps with inflammation and neuroplasticity.

It allows people to break out of rigid, potentially depressive, and trauma-related patterns, which Dr. Punzo will talk more about. Second, it disrupts maladaptive network activity, particularly in what's called the default mode network, which some of you may have heard about when thinking about meditation and different ways to change the brain. This reduces rumination, negative self-referential thinking, and entrenched cognitive loops that we all go through over and over again, which then further solidifies them, making it harder to get out of.

Third, it appears to really recalibrate emotional and stress circuitry, including the amygdala and prefrontal cortex, helping patients to process emotions with less fear and greater cognitive flexibility. The result is not just symptom relief, but often a window. We call it a window of opportunity. You could call it all sorts of different things, but it is a window where the brain is more able to learn, heal, and integrate new psychological insights. It's really exciting. There is this window of opportunity where your brain has exponential possibilities for growth and change after use of the medication. This is where neuroplasticity, or the chemicals in your brain post-KAP, are most active, where there can be change.

This is why it's so exciting and why there are so many possibilities for it. Let's get a little bit more into how it is used. Today, we'll be talking a lot about its off-label use. It can be used off-label. This is very, very common in psychiatry to use medications that maybe are not approved, but that are found in the literature and the research to be effective and helpful. For instance, ketamine used off-label, meaning it's full chemical compound as ketamine. It can be used off-label orally, so sublingually under the tongue, by swallowing it. It's also used as an intranasal spray.

Then it's also used IV, so intravenous, so directly into the vein, and intramuscularly, directly into the muscle, for the use in depression, bipolar depression sometimes with monitoring, of course, PTSD, so post-traumatic stress disorder, obsessive-compulsive disorder. It has been found to be anti-suicide, meaning it helps with really depressed thinking about ending one's life or self-harm. That is part of a lot of the research. Off-label prescribing, as I said, is legal and common in psychiatry. Safety is determined by dose, screening, monitoring, and setting. That is really important to understand here, is that off-label prescribing, again, legal and very common, but safety is important.

That is determined, again, by dose, screening, monitoring, and setting. Then ketamine, we talked about, can be used in multiple different routes of administration. Each route of administration-- We talked about a route of administration is by mouth, intranasally, IV, IM. There's a few others. That the different routes, each have distinct pharmacokinetics, meaning how the drug affects your genetics, and also pharmacogenomics, meaning how your genetics affect how the medication works in your system. They each have very specific monitoring considerations.

We're going to be talking a lot today about the oral route of administration because that is very common. It does have lower bioavailability, meaning that it is going to be felt a little bit less. However, it is extremely flexible in dosing, and there's higher availability for a wider array of patients due to costs and a couple of other things that we will talk about. Backing up just a moment, that intranasal ketamine can come as the full compound, or it can come in half the compound, which is known as esketamine. It is a patented, FDA-approved form of using ketamine, but it's only half

of the molecule. It's used in a nasal spray. It was approved and tested by the FDA with Janssen Pharmaceuticals.

This is a REMS. It's a little bit hard to explain, but it's a highly overseen or oversought medication that is approved for treatment-resistant depression as well as suicidal ideation. A lot of the literature and the research are based on this FDA-approved form of ketamine. Then moving back to some of the other routes of administration, like oral route of administration that we will be talking a lot about today, we use a lot of that research because it has been found to be so effective. However, extremely expensive and often difficult to get approved.

What we'll talk a lot about today, the route of administration of rapidly dissolving tabs, oral ketamine, these are not FDA-approved for depression. However, when prescribed within a structured medical model with appropriate screening and monitoring, available data suggests a very favorable safety profile comparable to other psychiatric interventions. That's really wonderful and promising in mental health.

Lizzie: Thank you, Brigitte. Before we continue, I just wanted to note we got a couple of requests for you, if possible, to turn up your microphone or speak up a little bit.

Dr. Gordon: Oh, I'm so sorry.

Lizzie: Yes. No worries. Just a recommendation for everyone, if you still are having trouble, if it's possible for you to turn up your volume as well, that would help us all make sure that we can hear Brigitte. I appreciate people giving that feedback.

Dr. Gordon: Yes, thank you so much. I've always been told I have such a loud voice. I'm sorry [chuckles] that you aren't able to hear me now. Is this a little bit better if I speak up?

Lizzie: I think so, yes. Thank you so much, Brigitte.

Dr. Gordon: Okay. Absolutely.

Lizzie: I'm going to advance the slide and we'll continue.

Dr. Gordon: Wonderful. The evidence base for ketamine is really promising and still emerging, with the strongest support for rapid short-term symptom reduction in treatment-resistant depression, while long-term durability and optimal standardization protocols remain under highly active investigation. If you look on the internet at ketamine-assisted psychotherapy or ketamine for depression, you will find a plethora of articles, and you'll find a ton of articles up and coming for all sorts of different diagnoses as well.

A lot of that literature, which I've explored, like recent meta-analyses of oral ketamine, they demonstrate rapid antidepressant effects often within 24 hours, large effect size in treatment-resistant depression, reduction in suicidal ideation independent of full mood response, acceptable short-term safety profile under medical supervision. These are all really important pieces to what the literature shows. It seems like the strongest literature support is for IV infusion protocols, as well as structured repeat dosing models. Data on oral or rapidly dissolving tab routes

are growing. However, the literature is less standardized, so it's really important for us to continue to do that research.

Looking at beyond symptom reduction studies, they show improved occupational functioning, so showing up to work, being able to work, increased cognitive flexibility, enhanced emotional processing, and reduced hopelessness and anhedonia, which is lack of interest or pleasure in doing things that you once found interest or pleasure in doing. Clinically, many patients describe greater psychological flexibility that they feel, increased engagement in therapy, which is extremely important, reconnection with values and relationships after use of ketamine. These functional shifts may reflect the proposed neuroplasticity window created post-dosing.

It's really important to engage in therapy post-ketamine to really talk about why you're using the medicine, as well as the things that you want to work on and enhance in your life. We talked already about a lot of these clinical trials. You can see with the check marks some of the amazing results that we see. Just to summarize again that results of clinical trials really do consistently show rapid antidepressant effects with peak response generally 24 hours post-infusion, response duration ranging from two to three days, up to two weeks or more, especially with psychotherapy, mild and transient, very few adverse effects.

Evidence also supports a unique anti-suicide effect independent of antidepressant response, can be safely co-administered with conventional antidepressants and mood stabilizers. Other indications previously or currently being studied are addiction, so more research is needed on that, specifically alcohol and cocaine. PTSD, so post-traumatic stress disorder, social anxiety disorder, eating disorders, generalized anxiety disorders are among some of the diagnoses that people can benefit from with ketamine-assisted psychotherapy.

This is a graph from a Dor et al study that found that ketamine treatment was associated with significant reductions in depression, anxiety, and PTSD symptoms, with significant clinical meaningful improvements. Importantly, benefits often persisted beyond the acute dosing phase, particularly when ketamine was combined with psychotherapy. The authors highlight ketamine safety, tolerability, and potential as a rapidly acting intervention for individuals with treatment-resistant psychiatric conditions and more.

There was positive correlations with greater treatment response. Greater treatment response was correlated with the number of treatment sessions, so ongoing treatment, symptom severity at baseline, and patient age. Looking again at comparing administrative routes for ketamine, the strongest randomized controlled trials, so the highest research, the gold standard of research, shows that IV infusion because that is the most standardization that we have found, because that is the most utilized route of administration.

There is a lot of growing, and again, less standardized data for intramuscular use, intranasal, racemic, which just means the whole compound, as opposed to half of that compound that we talked about earlier with Spravato or esketamine, and oral RDT models. An important caveat here is that evidence-based differs by route largely because IV was studied first, not necessarily because other routes are inherently inferior. That is certainly true.

Practical constraints that shape the route choice, like, "Why would I use IV versus IM versus RDT versus intranasal?" Cost is a big one for a lot of people. IV and REMS models are significantly higher. IV and intranasal spray are significantly higher cost, as well as a lot more hoops to jump through. Clinical infrastructure is an important thing to take into consideration, so monitoring requirements, staffing that needs to be around for these REMS programs or these oversight models.

Patient access and geography is a big one that is really helpful to have multiple routes of administration, such as oral routes of administration. Time burden, so two-hour observation models like esketamine, IV, IM versus a shorter outpatient model, like what Journey Clinical does, for instance, and insurance coverage variability. These are all important factors to take into consideration.

Why might you use an RDT, for instance, would be flexibility in scheduling, integration within a psychotherapy model that Dr. Punzo will talk about, lower overall cost barriers, personalized titration strategies, so very unique person-based medicine, reduced peak physiological intensity compared to other routes of administration, so less side effects. I think it's important to note here that route selection often reflects a balance of evidence-based, safety monitoring, capacity, access, and patient-centered considerations, not just a one-size-fits-all hierarchy.

Again, rapidly dissolving tablets are often more comfortable for patients because it eases you into the work of using this medicine. Affordability, you can use it with a therapist in a therapist's office and in a therapeutic model. The therapist would be present with you in some capacity, whether it is virtual or in-person when using RDT. There is, yes, a lower bioavailability, meaning you don't feel the medication as much in this model sometimes, but there is a way to increase the dosage and use what we call a weight-based dosing so that you do have a similar antidepressant output similar to IV using calculations.

Dr. Punzo: Great. Thank you, Dr. Gordon. I'm going to talk a little bit about the therapeutic side of this. When we're looking at ketamine in particular, and when we're looking at all psychedelic-assisted therapy in general, usually the effects are highly dependent on set and setting. What is set and setting? You might hear this a lot. It all depends on set and setting. If you've done any psychedelic research, you hear these terms a lot.

Set refers to the mindset of the client when they are coming into a dosing session. What we do in KAP is we prepare the clients to be in a right mindset in order to take the medicine. We usually have, and I'll talk more about this in a couple slides, but usually anywhere from two to anywhere upwards of five, depending on the client and the presentation, preparatory sessions to help them get ready to maximize the experience. We don't want someone coming into a dosing session feeling overly anxious, scared, nervous.

While all those things might be there, I think anyone trying something new for the first time is going to have some sort of anxiety, but that we have at least talked through some of that so it's not super high. We see when people aren't adequately prepared for psychedelics, they tend to have more of a challenging experience. We're trying to circumvent that when we're doing it in a dosing session.

Setting really refers to the environment in which the client is taking the medicine. Interestingly enough, this picture you see right here, I don't love it, if I'm being honest, because that's not really what my setup looks like. Yes, the client is lying down on the couch with the eye shades, and sometimes the headphones, and I'll get more into that in a second, but I'm not sitting that far away ever from the client and behind them in any way. Obviously, we had to do a picture to get you to understand, but typically, I'm sitting right next to the client.

This happens in my office. The setting is in my office. Usually, for my clients who have already been seeing me, it's a place they're comfortable. They've come there, we've established rapport, and I can tailor the setting to whatever makes them feel comfortable. A lot of times I will bring things. I have weighted blankets, softer blankets. I have little stuffed animals if they want to hold on to. Sometimes, some of my clients like incense or candles.

We, in the preparation, talk about, how do we make this setting, the room that we're doing the dosing in, most comfortable to you? I also usually have clients bring in a comfort object that they can have with them. Usually, a client will either bring a stuffy, or a blanket, or a picture, sometimes rocks. I've seen all sorts of things in dosing sessions. We really want the client to feel as comfortable as possible.

Then, obviously, therapeutic alliance is paramount in any psychedelic-assisted therapy setting and is important to safety. Basically, my thought is sometimes clients come to me wanting to do ketamine, and maybe they have an outside therapist. I have to establish rapport quickly. That's where I say sometimes I'll have clients, if they're new to me as a therapist, that we'll spend a couple more sessions getting to know each other so that they do feel a little bit more comfortable going into an altered state with someone who's unfamiliar to them.

Now, when I do this with my existing clients, we already have that deep rapport already built, which really helps accelerate this type of experience. I'll talk more a little bit about some of the prep and integration in a couple of slides going forward. What is ketamine-assisted psychotherapy? It's a model that combines ketamine with psychotherapy. What I want to really highlight for you all today is that it is ketamine-assisted psychotherapy. The ketamine is assisting the psychotherapy. The psychotherapy, the integration, is the star of the show. We are using ketamine as a tool, as a vehicle to amplify what we're doing in our psychotherapy.

Obviously, as Dr. Gordon described, we have the off-label prescription. Usually, there's a couple of different ways, as you've heard, of different routes of administration. If we're talking about rapid-dissolving tablets here, they're given the prescription, they bring that into the session, and then we're doing the therapy alongside of it. I will say that why I chose to get into KAP was seeing that I've obviously been trained in lots of evidence-based therapies. I think sometimes those therapies, while they're wonderful and excellent, sometimes can only take clients so far.

I work with mostly complex PTSD clients who don't always respond to the traditional evidence-based protocols that we have. When I got into psychedelic-assisted therapy, it was really to find another tool to use. I look at ketamine as another tool in

my toolbox. It has really helped me move deeper with clients and really get past stuckness in therapy. I can talk more about that in a little bit as well.

What's the difference between ketamine treatment and ketamine-assisted psychotherapy? Briefly, a lot of people will talk about ketamine treatments or ketamine clinics. These are usually standalone clinics that mostly provide IV or IM administration. They're typically very medical in their stance, so usually go in depending on the place. Sometimes it's not even a private room. As Brigitte talks about, for Spravato, it's a REMS protocol, so they have a very specific way in which the chairs need to be set up. Again, sometimes this is not private, so clients are having psychedelic experiences in a little cubicle. It is what it is. As Dr. Gordon said, it's delivered by a medical professional, so a nurse or a physician.

There's usually no therapy in those settings. Ketamine clinics, straight ketamine clinics, are just infusion-based. The client comes in, they take the infusion, and they go home. There's usually no therapist on staff. That's not to say all of them are like that. There are some places who will have maybe KAP infused, but by and large, ketamine clinics are only going to be get in, get your ketamine, leave.

I bet many of you have heard as many of us get spammed on social media platforms for these at-home or mail-home ketamine treatments. These can be some companies that you may have heard of, would be something like Joyous or Mindbloom, where the client meets with a prescriber, usually virtually, and then gets a prescription of ketamine. Can vary. It's usually a troche, a rapid-dissolving tablet, or there are some now subcutaneous injections being delivered at home. Again, here, we have no supervision. The client is getting this mailed to their home and is taking the ketamine alone in their home. There's usually no licensed therapist.

Sometimes, as you see, there's an option where a guide can sit on the video with them, but that guide usually has no training. I have had clients who have tried this before coming to a traditional KAP experience, and that usually those guides haven't been properly trained and hasn't been adequate support for when real content can come up. Typically, there is no ongoing support or integration happening.

Then, obviously, what we're talking about, ketamine-assisted psychotherapy, is the combination of the therapy, and again, highlighting that the ketamine is not the main star here. I look at it, and when I talk about it with my clients, I said, "Let go of that you're taking ketamine." Even the dosing session. I don't put a lot of weight into the dosing session. It's all about integration.

We're using the priming benefits that Dr. Gordon talked about, the neuroplasticity, antidepressant effects, the increase in glutamate, which for many of my clients who have not responded well to traditional SSRIs, which work on serotonin, respond well to ketamine because it's working on a different neurotransmitter and system. Of course, the shutting down of or reorganizing, as we're still figuring out, of the default mode network, it really is a game-changer. I tell this to my clients, ketamine is just their tool. The real work comes in integration.

Next slide. Obviously, we're working with medicine right here, and so we need to partner with medical providers. As a psychologist, as therapists, we need to stay in our scope of practice, which is psychotherapy, and we need to partner with a

prescriber who knows ketamine well. When I want to offer this in my private practice, I need to have a prescriber. After I did my training-- I did a long training through Integrative Psychiatry Institute and got certified in psychedelic-assisted therapy. At that time, it was a 10-month program. I got the certificate, and I was ready to go. I'm based in Illinois, and right now in Illinois, ketamine is the only psychedelic drug that we have available to us.

I'm like, "Okay, I'm ready to go." Then I'm like, "I need a prescriber." To just blindly look for a prescriber who knows ketamine and knows psychedelic-assisted therapy is hard to find sometimes. Initially, when I started, I partnered with a ketamine clinic. Basically, had introduced myself to them, saying, "Hey, I'm trained in this. If you ever have clients who want a more full protocol, I'd be happy to help."

What I noticed very quickly was even physicians and nurses who are trained in ketamine, not all of them are trained in ketamine-assisted psychotherapy. That is a big deal because they are pushing a medical model, which is very different than what we do in ketamine-assisted psychotherapy as that last slide I showed you. They are really into just push. They look at ketamine as the vehicle for change versus the therapy.

It's really important, if you want to do this, that you find a provider who, one, has been trained and understands ketamine and dosing. Especially if you're doing sublingual route, you want a prescriber who understands the nuances in sublingual dosing because they are very different than IV, and IM routes, and intranasal. That's why I have loved Journey Clinical because it made it so easy for me to be connected with a prescriber who has been trained. Not only ketamine, but also knows the importance of the therapy and who also understands sublingual ketamine, which I can use in my practice.

Another great thing that Journey Clinical does is that in our forum or where we log in, the medical providers are always available to answer questions. I think, Dr. Gordon, it's every other week or maybe it's every week, they have a meeting where you can join in, and come in, and ask medical questions so that you are still staying in the scope of your practice.

Dr. Gordon: Twice a week.

Dr. Punzo: Twice a week, even. Look at that. [laughs]

Dr. Gordon: Twice a week, yes. I lead one, and another provider leads another. Yes.

Dr. Punzo: They're always rapid to response. We can post a question. I remember a client said, "Can I take Advil on the same day as ketamine?" I was like, "I'm not sure." I posted it in our forum, and I got a response right away. That is really, really helpful to make sure I'm staying in my scope as a psychotherapist and that the prescriber is doing their job as the medication provider.

Dr. Gordon: May I add, Dr. Punzo, a little bit about med management? Because I think that this also does add to a psychotherapist practice, that you also don't just have the collaboration all the time as well as the ability to have somebody to provide

your patients with the ketamine, but also med management. It's an ideal option for patients who need psychiatric medications and want care from a provider who is knowledgeable about both standard treatments and ketamine-assisted psychotherapy.

This ketamine-aware clinician can manage medications like antidepressants, mood stabilizers, anxiolytics, along with a ketamine treatment, be able to look over all of the medications, such as you were talking about Advil, and answer those questions about what is safe, what's not safe, not just with ketamine, but with their current concomitant medications, and ensure regimen safety, coordinate, and optimize for therapeutic process with you.

This integrated collaborative model also allows therapists to really feel, I think, confident that medical care is closely monitored and communication, supporting safety, and alignment across all aspects of the patient's treatment. Moving on to some diagnoses that are important to highlight here, that there's ongoing research. I think, at Journey Clinical, we just published a blog on anxiety disorders and ketamine that I edited. Anxiety, such as generalized anxiety disorder, depression, there's lots of different forms of depression, from mild to severe, that have been found to be extremely helpfully managed by ketamine, trauma, obsessive-compulsive disorders, some bipolar disorders, there's literature on eating disorders, among many other diagnoses, because there's such well-rounded care, because of this neuroplasticity. Again, in the box at the bottom of the slide, it's really important to know that the prescriber should be able to oversee and will oversee eligibility. It really is determined on a case-by-case basis by a medical professional looking at all areas of your wellness, not just your psychiatric conditions, but maybe some medical stuff that is going on as well.

Again, just like it's not an all-size-fits-all model, there are some people that are not necessarily a good fit for ketamine-assisted psychotherapy. That's something that the medical provider would be able to review and to consider, such as unstable medical conditions that really need to be focused on and not add a new layer or something that could potentially exacerbate symptoms. Uncontrolled substance use disorders, because again, that also could be quite unsafe.

The number one thing about psychedelic medicine and about ketamine in particular, it's so important to consider safety. Then other contraindicated psychiatric disorders, such as a primary psychotic disorder, for instance. It would be contraindicated to take a medication that can be so uplifting that it could potentially exacerbate something like mania or hallucinations, for instance.

I'll just briefly go over some medical and psychiatric contraindications. Because ketamine is what's called sympathomimetic, it can increase your heart rate and your blood pressure. Mildly, but still, again, we need to focus on safety. Uncontrolled hypertension or really high blood pressure, that could be unsafe. A ketamine allergy, obviously, that's an obvious. Uncontrolled glaucoma, because again, that is a high blood pressure issue.

Severe breathing problems, even though ketamine keeps the airways open, unlike other anesthetics, we would not want to exacerbate current breathing problems that are not under control. We do not often want to prescribe to people who are actively

using ketamine in a more recreational fashion, because again, that could be quite unsafe.

Potentially, I know we talked about how it is anti-suicide, but to Dr. Punzo's point that it's so important to also think about external aspects, not just the medical aspects, but things like if somebody is having active suicidal ideation that is very severe, do they have the infrastructure, the ecosystem in place to fully support this client or this person? Maybe a higher level of care would be important, like going to stabilize a little bit more before engaging in a medicine that could bring up a lot of trauma.

I always think of using ketamine with psychotherapy as I use the dirty room kind of analogy where when you have to clean up a very full closet, for instance, I'm sure you all have done this at some point, you have to take everything out, sort it, throw things away, donate things, get rid of stuff, feel the emotions of seeing different things that are in that closet, and you make a huge mess sometimes before you clean things up. Sometimes, ketamine can do that, where it brings up hard things. It brings up sometimes, not always, but uncomfortable things that need to be addressed first before put away. If that mess is going to exacerbate somebody's symptoms, we don't want to do that too quickly.

Other areas of consideration are pregnancy, trying to conceive. There's a lot of literature on that. Hyperthyroidism that's uncontrolled, that's something to be considerate of. Liver disease because even though rapidly dissolving tabs are not processed through the liver as much as some other routes of administration, it is metabolized in the liver, so you would want to be cautious of liver disease.

Inflammation of the urinary tract or the bladder because some of the ketamine is extruded through urine. Because ketamine is an anesthetic and it also can be a little bit caustic, it can aggravate the bladder system. Then I know somebody early on asked some questions about active substance use disorders or substance use disorders in general. I just wanted to briefly say that we always want to look at the research. We don't want to try new things without the research.

The current randomized controlled trials and meta-analytic evidence suggests that ketamine-assisted psychotherapy is promising for substance use disorders. However, there still needs to be a lot of research. The research is particularly looking at alcohol and cocaine with improvements in abstinence, craving, and relapse prevention, especially when combined with, again, psychotherapy. However, the literature, again, is still really early with relatively small sample sizes. Ketamine should be viewed as an adjunct to evidence-based addiction treatment rather than a replacement at this time.

Dr. Punzo: Great. I am mindful of our time, and I have still a lot to cover. I'm going to try to breeze through so that-- I know I see there are lots of questions in the chat. Myself and Dr. Gordon, like I said, talk forever about this. I'm so excited that you guys are interested. I will try to be brief here. Who benefits from KAP? As we've already mentioned this, but really people who are seeking relief. Who are overwhelmed and maybe have an under-regulated nervous system.

The biggest place that I've seen in my clinical practice has been this stuckness. Where they're hitting a plateau in therapy or just feeling like nothing's working

anymore. That's really the sweet spot that I have found for ketamine. Obviously, in addition to helping with depression, helping with anxiety, and the other things that we've mentioned, obviously, the trying other modalities.

Another big thing that I'll say who benefits and how this works well is the motivated to change. You'll see there, well, it says not seeking a quick fix. KAP is actually a very long process. Typically, we're looking at six to eight dosing sessions, and that's one per week, usually. We have the dosing session plus the integration session per week. Typically, the way I do it in my practice, that's about four hours of therapy, because I structure my dosing sessions for three hours and then the integration for an hour.

Four hours of therapy, six to eight weeks, it's a big treatment. Really, it's not a golden bullet or anything like that. This is really deep functional change. You'll see seeking deeper healing. I also want to say that ketamine is not just for people who are highly suicidal or very dysregulated. As Dr. Gordon said, I actually prefer someone not come to me in that state because this could be destabilizing. A lot can come up in ketamine sessions. We want people to really have a supportive also environment. You'll see who might not benefit.

Usually, if my clients don't have a supportive environment, this is not something that I'm going to do because a lot can come up, and I want them to feel like they have outside support other than me, just their therapist. In general, I feel like we've seen a lot of research coming out that ketamine is great for even just general burnout. I've seen this. A lot of my clients are either therapists or nurses, or doctors, first responders, people who are helping other people and are getting burnt out.

I already mentioned this, but we're staying in the scope of our practice. I just do psychotherapy. The medical professional does all the dosing. The clients come to session with their blood pressure cuff. They self-administer their blood pressure and then tell it to me. I have directions from the prescriber to say it needs to fall within this range before you can proceed. If it falls outside of that range, we don't proceed with ketamine.

They also have to take their blood pressure after for the same purposes to ensure that we're doing. If for some reason there was an elevation, then I could contact the medical staff and get direction on what to do for that. I'm not doing any medical things. I'm not giving them their prescription. I'm not touching the prescription. They bring the ketamine to my office and self-administer that way. I'm just staying in my scope of practice, which I think a lot of people worry about that, but we're good.

This is what a typical phase of treatment looks like. I will say the thing that usually happens before this is I'm usually doing a psychological intake first, and determining, do I feel like this client is eligible for ketamine based on what we've already covered? When and if I think that's appropriate, I'm going to refer the client for the medical evaluation. The prescriber will then do their eval, set the prescription. The client will get sent their ketamine.

Then we have, again, here, our preparation sessions. That's where we're going to review what to expect and how are they going to feel. We talk about how are you going to feel when you're on ketamine? What is ketamine? Some of what we've

covered, we do a ton of psychoeducation in the preparatory sessions. We also talk about how to ground themselves, what are the best ways they know how to ground themselves if they were to get super anxious in the session.

We review their intentions and expectations. It's a huge part of KAP is setting expectations to say, this is not a one-size-fits-all treatment, this is not a quick fix, and really emphasizing the importance of integration. Usually, typically, we'll have two to three preparation sessions. Then we go into a dosing session, which I've already talked about, where the client self-administers the ketamine, and I'm there to monitor them and be there if any challenging things come up.

Then, within 24 to 48 hours, is when we have an integration session. The reason we do so in that window is because we want to build on the neuroplasticity that the client has. As Dr. Gordon mentioned, ketamine is a neuroplastic agent. We're taking that window of time that they have, the window of opportunity, and maximizing that. Sometimes we might process what came up in a dosing session.

Let's say the client said, I saw this. Some clients have visuals, some clients don't. Some clients talk out loud, some clients don't. Sometimes we're processing what came up, but sometimes my clients were like, I just felt really relaxed and calm and nothing significant may have come up in that dosing session. Then we're just using integration and their openness and neuroplasticity to work on the things that they've been stuck with.

Usually, it helps them have a different viewpoint. Many of my clients come in and say, "Oh, yes, I've never thought about it that way," or, "Oh, I had this thought now after we had the session." Sometimes it's not the day after, maybe it's days after, but they're just able to view things from a different lens. As I said, it's about six to eight dosing sessions for the initial protocol. Then if we need more, we can do more, but I actually have many clients, the six to eight is just a perfect range for them.

KAP really can fit into the existing therapy schedule. Preparation and integration are typically billed as our regular therapy, our 90837s or 90834, depending on what you do. The dosing session is what I mentioned is a little bit longer and can be anywhere from two to three hours, I would say. I like to give three hours because it gives me a nice window. I don't want to be rushing to try to get out of there or rushing to get them out. I also don't know how long the client is.

Usually, it's 45 minutes is the arc of the experience of Ketamine. We get in, we do a little talking before that, set our intentions, review all of these things, then do the dosing, and then want to process a little bit debrief after. Then you'll see on here, therapists utilize their clinical expertise. What's really cool about KAP is you can infuse your own orientation into the therapy that you're doing.

If you like IFS or EMDR or whatever type of therapy you like, you can infuse that into the integration. It's very able to be tailored to your approach and what works best for the clients under the general framework of what we do in psychedelic-assisted therapy. We can go to the next slide. Here you can see where it takes place. We've already talked about this. Usually it's done in office, in a therapist's office, but we can also go to a client's home and do this, or often we can do it in a retreat space. You'll

see it's very inviting, very comfortable, very warm, not sterile. That's what we're trying to avoid.

Let's go to the next slide. This slide, in particular, we could spend probably another two hours talking about ethics in psychedelic-assisted therapy. Actually, if you're interested, we had a CODAPAR grant that was last year on educating psychologists on psychedelic-assisted therapy. We did actually do a whole webinar on ethical considerations in psychedelic-assisted therapy. If you're interested in that, you can email me, but it should be posted on Division 12, their website. You can go and take that for free. Again, a free CE.

We actually had eight total webinars, so you can check that out. I'm going to be brief here and just say that ethics is of the utmost importance when we're doing psychedelic-assisted therapy because clients are in altered states of consciousness. When clients are in altered states of consciousness, it can definitely increase suggestibility, vulnerability, transference, and counter-transference. We have to be extra careful.

What's great is when you go through a program like I went through, IPI, or if you take the training that is through Journey Clinical, we get a ton of information and education on ethics and boundaries, and informed consent on how does this work when a client is in an altered space. You'll see on there, we'll go back one second, consent to touch. I just want to highlight that. Obviously, everything else we've already talked about. We do talk about that specifically.

You can go to the next slide, Lizzie, because it's in informed consent, is that a lot of times in the psychedelic space, clients will maybe be having a big experience and need some therapeutic touch. What that typically looks like, that could be holding a hand, maybe putting my hand on the arm or the shoulder, but we talk about it extensively of what that looks like. If the client wants that, we also get consent every single session.

Informed consent, yes, we have a document that says all the things we've already talked about, off-label uses, known risks, side effects, your standard consent. I have a separate informed consent for ketamine-assisted psychotherapy that the client signs, but then we're always talking about consent in each session to make sure that they know what's my boundary, what's their boundary, what's the prescriber's boundary, but that we want to be, especially with touch, it can be super helpful and grounding to the client.

Just to give you a quick example, I had a client one time that had a very challenging experience in a session and requested to hold my hand in the session. She said that was one of the most significant things that has ever happened in her life of being able to ask for help and receiving it and being cared for in that space. It was really life-changing for her because she had grown up in an environment where she was neglected severely.

It was just a small handhold. It wasn't any huge gesture, but it was so impactful even on that space and continued on. Here are our glossary terms. We've already talked about these. I know we only have three minutes, but I don't know, Lizzie, if you have any good questions that are out there, or you want to just go into the other things?

Lizzie: Here's what we're going to do. We're running up against time. There are incredible questions that have been submitted in the chat. What we're going to do is we're going to pull those questions. We'll review some answers with Brigitte, with Jessica, and with other members of Journey Clinical's team and psychotherapists. We'll distribute those to those of you who attended today. I really appreciate you all taking the time to join.

I did want to just share since we are sponsoring this webinar that Journey Clinical, as we mentioned, is a network for ketamine-assisted psychotherapists to collaborate with our Journey Clinical's in-house medical team to be able to offer KAP to your clients. We have all of the training that you need, all of the medical access that you need, and really importantly as well, a community of therapists across the country who are delivering this in their practice.

What I will offer to you, and you'll see this in the email that we send out as well, but you can actually book time with Journey Clinical to talk through what this would look like in your practice. I'm sure you have many more questions. They can try to help answer you there, point you towards resources. We're also going to share out answers to the Q&A, as I mentioned. I put that link just now into the chat.

Again, it will be in the email follow-up that you receive. We have the medical services, the training, the resources, the community, and also increasing insurance coverage to make this more accessible to clients. There's support on the training side on both the therapy and also the business components such as billing and dosing and things like that that got submitted in the Q&A as well. I will pass it back to Jodie to close this out.

Jodie: I just want to thank you, Dr. Punzo and Dr. Gordon, for this incredible webinar today. Clearly, from looking at the questions in the Q&A, this is of great interest to all the people who joined today. I'm so glad that those questions will be addressed in follow-up. I also want to thank everyone who's in attendance today for coming and participating and learning more about KAP. I'd like to thank Journey Clinical for making this webinar possible.

Following today's webinar, please keep an eye on your inbox. There will be an email from Tyson from Journey Clinical and that will contain the link to the quiz and the course evaluation so that you can complete your CE credit. As we mentioned earlier, a recording will also be available in about 24 hours. It will be coming from the Journey Clinical Learning Management System. CE credit will be able to be earned by watching the video at a later time. Then the recording will also be on APA's website, apa.org, in approximately two weeks. Thank you, everyone. Thank you for coming today. Take care.

Lizzie: Thank you, everybody.

Dr. Punzo: Thank you, everybody.

Lizzie: Thanks for all your wonderful questions. Thanks, Jessica. Thanks, Brigitte. Wow, we need to block out an hour and a half next time.

[laughter]

Dr. Punzo: Thank you so much.

Lizzie: Yes. Thanks, everyone.

Dr. Gordon: Bye.

[silence]

[01:01:03] [END OF AUDIO]