

**"Dry Psychedelics™": Going Inward Without Going Alone
Reproducing the Depth of Psychedelic-Assisted Therapy Through AEDP
Without a Substance**

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Abstract: Psychedelic-assisted therapies have demonstrated that extended, inward-focused therapeutic states can produce rapid and profound psychological change. This article presents a single clinical case exploring whether comparable depth is reachable through relational and somatic means alone. Using a format grounded in AEDP and synthesized with a direct-entry approach to dissociative states drawn from other somatic trauma lineages, a client with a complex early history and an over-three-year treatment history with the author entered an extended, eyes-closed session targeting long-withdrawn, dissociated material. Previously unconscious material, core aloneness, self-hatred, and grief, surfaced fully during the session and was processed and transformed using AEDP's four-state model. The client subsequently described the resolution of a self-destructive impulse, a change she attributed directly to this process. While drawn from a single representative case, a similar clinical pattern has been observed among other carefully selected clients in the author's practice. The article proposes the hypothesis that relationally and somatically sustained inward attention may be sufficient to evoke therapeutic processes often assumed to require pharmacological assistance and situates it against findings from MAPS' Phase 3 trials of MDMA-assisted therapy for PTSD. Limitations, including the single-case design and the absence of a standardized measure of comparability, are discussed.

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Keywords: AEDP, dissociation, psychedelic-assisted therapy, trauma treatment, attachment, case study, four-state model

Introduction

Psychedelic-assisted therapies have introduced clinicians to something the field has long sought but rarely had a reliable means of accessing: extended, inward-focused states that produce

profound shifts in somatic and affective processing. Within a single session, clients frequently move through material that might otherwise take months or years to access. Defenses loosen, embodied imagery becomes vivid (Feduccia & Mithoefer, 2018), and clients make direct contact with early attachment wounds and young parts (Simon et al., 2025), often with a felt sense of resolution that extends beyond the session itself (Mitchell et al., 2021, 2023).

The excitement is well earned. But it has also quietly reframed a question I believe psychotherapy should be asking regardless of pharmacology: what, precisely, produces that depth? Is it the molecule, or is it the conditions the molecule tends to create - sustained inward attention, reduced defensive activity, and a deeply witnessed relational context for whatever emerges?

This article describes a format grounded in AEDP, developed to explore that question in practice. I call it "Dry Psychedelics™," a name that describes the structure of the work, not an identical subjective experience. It does not mean psychedelic experience without a substance. It refers to a distinct therapeutic structure designed to access some of the same dimensions through relational and somatic means alone: an intention set in advance, sustained inward attention, extended duration, eyes-closed inward focus, enhanced access to imaginal and somatic experience, emotional processing, and transformative change - all within continuous relational support.

In the case presented below, the depth and phenomenology of the therapeutic process appeared comparable, in important respects, to what is reported in psychedelic-assisted psychotherapy. The hypothesis explored here is that relationally and somatically sustained inward attention, held

within a secure therapeutic relationship and directed at dissociation itself rather than titrated around its edge, may be sufficient to evoke therapeutic processes often assumed to require pharmacological assistance. The case that follows is not offered as proof of that hypothesis. Rather, it is presented as a representative clinical observation drawn from a broader pattern encountered in practice, one that, while not yet systematically studied, invites further empirical investigation. Although this article focuses on a single case, it was selected because it provides an unusually clear illustration of a therapeutic process that has emerged repeatedly across a small number of clients for whom this format was clinically appropriate. These observations remain clinical rather than systematic and are offered as hypothesis-generating rather than as evidence of efficacy.

Why AEDP

AEDP was developed by Diana Fosha as a healing-oriented, attachment-based model that works explicitly with the therapeutic relationship as a change agent, not merely a container for change. Its core techniques, moment-to-moment tracking of affective and somatic experience, active use of the therapist's own attuned presence, and metatherapeutic processing of emerging positive states, were built for exactly the kind of sustained inward work this format requires. Danny Yeung's account of AEDP's experiential work identifies sustained interoceptive awareness as central, describing it as "the sine qua non of AEDP's experiential work" (Yeung, 2024). His formulation closely aligns with this format's emphasis on interoceptive tracking. Where many trauma models are organized around managing dysregulation at the edge of a client's window of tolerance, AEDP is organized around entering experience fully, with the therapist as active companion rather than regulated helper.

Although the footage from this case depicts essential AEDP work, my approach to entering and working directly with dissociative, "cold" states, numbness, blankness, and withdrawal that register in the body as felt coldness, distinct from trauma activation more broadly, also draws on other somatic trauma models I have studied, including the work of Eric Wolterstorff and Saj Razvi (Fox, 2025), building on Peter Levine's foundational work in Somatic Experiencing.

The congruence between these lineages and AEDP is real: all three center accompaniment, witnessing, and the therapist serving as a resource for the client's subjective experience. Where they diverge is in how dissociation itself is treated. AEDP, like most trauma-informed models, has not historically treated dissociative withdrawal as a state to enter and unfold; it is something to accompany the client through, or to approach cautiously at its edges, but not, typically, the direct target of the work. The move to treat dissociation itself as the site to be entered, stayed with, and processed, rather than managed at its edge, is what this format draws from the Wolterstorff and Razvi lineage. That said, working with all interoceptively accessed experience is consistent with AEDP's *moment-to-moment tracking* principle, with its attention to core maladaptive affective experience and self-relational states that must be acknowledged and witnessed before they can be transformed. AEDP's instruction to "go to the body" invites this kind of work without excluding it; what it has not specified is a technique for doing so. The technique used here falls outside AEDP's prescribed methodology, though not outside its principles - AEDP invites somatic work without specifying its exact form. This format, then, is less a departure from AEDP than an extension into territory its own principles leave open but do not themselves develop.

Central to this approach is not only AEDP's relational orientation, but its four-state model: an unfolding process wherein defenses guarding against the core emotion give way to full experience and processing of core emotion, followed by transformational affects, and ultimately to core state - a state with an enlightened, near-psychedelic quality of its own. Together, these elements are what make psychedelic-depth states possible without a substance. Psychedelic-assisted protocols typically pair the drug's effects with therapeutic presence to prevent overwhelm and support integration. In this context, the set and setting serve a substantive clinical work, not merely providing risk mitigation, suggesting that relational and contextual conditions may carry more of the therapeutic weight than is usually credited. AEDP already holds, at its center, a relational methodology built for exactly that kind of moment-to-moment companionship. Combined with the direct-entry stance to dissociation drawn from the somatic lineages above, that technology extends here to a use it had not previously been put to - entering and sustaining a

deeply withdrawn dissociative state as the initial target of the work itself, rather than a state to titrate around.

Some clarification of terms is useful here. Dissociative work refers to clinical engagement with numbing, withdrawal, and blankness as material in their own right, rather than as obstacles to be managed on the way to something else. Most trauma models, including the window-of-tolerance framework introduced earlier, favor working at the edges of such states - approaching close enough to build capacity without exceeding it, then retreating before the client is overwhelmed. Entering into dissociation is a different move. Rather than staying at that edge, the clinician and client move directly into the withdrawn state itself based on the premise that such states are not empty but defended, formed specifically to hold overwhelming material out of awareness, and that what they defend against becomes accessible precisely by entering rather than working around them. Both this orientation and the specific way of engaging dissociation directly are drawn from the work of Eric Wolterstorff and Saj Razvi, somatic trauma clinicians whose lineage centers on this kind of direct engagement.

The Clinical Picture

The case presented here involved a client with a complex early history with multiple caregivers, repeated abandonment, acute trauma, and a core belief - held since childhood - that she was fundamentally unwanted. This case was selected because it offers an unusually clear illustration of the therapeutic process described in this article and because the client consented to the use of session material for publication. While the details of this session are unique to her history, the therapeutic sequence it illustrates has emerged repeatedly in the author's work with other clients selected for this format.

By the time of this session, we had worked together for more than three years, during which she had made greater progress than she had over decades of prior therapy. The alliance between us was well established and tested. Although she was a survivor of acute trauma, an earlier clinical assessment had determined that flashbacks and abreaction were not a significant risk for her, and that she had sufficient internal cohesion to work directly with dissociative material rather than

requiring the more cautious, titrated approach this history might otherwise indicate. These were the conditions under which the extended, eyes-closed session described below took place. As in psychedelic-assisted protocols, this session was preceded by a preparatory session in which an intention was set.

In this session, she was guided into deep interoceptive tracking of pervasive somatic and affective states that she described as always present in the background.

Early in the session, before any of the underlying material had surfaced, she described the onset in strikingly embodied terms - a "burning like a little ball of heat," a tingling that moved through her body, and a coldness she likened to "sticking your arm in snow." She reported that her mind began moving, unbidden, through what she described as a card catalog of past moments, "like I'm looking through a catalog... only the catalog cards have different moments in my life."

These are not descriptions clinicians typically encounter in fifty-minute, present-focused sessions. They are closer to what is reported in psychedelic medicine work - full-body, imagery-rich and temporally disorienting experiences arising through sustained inward attention and relational holding, with no substance involved.

This depth did not emerge in isolation. It was co-created, moment to moment, through the therapist's active tracking, not of ordinary affect, but of the dissociative state itself:

Therapist: What do you notice in your body as you put words to it?

Client: It feels kind of defeated, heavy... My head feels light. I feel a little colder.

Therapist: Feel the cold tingling...

Client: Yes. It's like sticking your arm in snow almost. It's the kind of cold to your bones.

Note that the therapist's questions did not interpret or redirect; they stayed inside the client's own language and sensation, following rather than leading - a stance that let the material continue to deepen on its own terms.

As the tracking deepened, so did the material beneath it. Body sensation gave way to affect and affect gave way to core belief - "I just wish I wasn't me. It hurts." The exchange that followed shows the same accompanying stance at a more painful edge:

Client: I just wish I wasn't me.

Therapist: Oh, such a hard feeling.

Client: I just wish I wasn't me. It hurts.

Therapist: Hurts. Notice the pain. Just really see if you can feel into the pain.

Underneath the presenting anxiety was what she experienced as a felt memory reaching back to infancy - a place she located without prompting - in a crib, cold, and unable to move. She held this material in the body as heaviness, cold, and a sensation she described as moving "like a blob of gelatinous pain" through her back.

As grief surfaced further, she named its source directly - repeated experiences of caregivers who said they wanted her but did not stay, a loss compounded by one caregiver leaving her when she was five, and a sense, formed early and never revised, that "nobody wants me." Even those whose treatment of her crossed into abuse did not escape that conviction - "Even the ones that weren't nice to me didn't even really want me," she said, naming a pattern that extended beyond any single relationship into a global conviction about her own worth.

This is the intensity of material that psychedelic medicine work is understood to access reliably. What is notable here is not that it surfaced - painful material of this kind is, of course, present in many clients - but that it surfaced this fully, this quickly, and this coherently within a single extended session, without pharmacological assistance. It was also transformed within that same

session, processed using AEDP's Four-State model. The clinical significance extended beyond the session itself. What had previously operated entirely outside of her conscious awareness - a core self held in aloneness, self-hatred, and grief - became conscious, and was transformed. She has since described the resolution of a self-destructive impulse that had been active in the period immediately preceding this session, attributing that resolution directly to her younger self no longer being alone.

This mirrors a pattern documented in psychedelic-assisted therapy trials more broadly. In the Multidisciplinary Association for Psychedelic Studies (MAPS') Phase 3 trials of MDMA-assisted therapy for PTSD, a majority of participants no longer met diagnostic criteria for PTSD after just three sessions (67% and 71%, respectively, across the two trials), with roughly a third to nearly half achieving full remission depending on the trial. These outcomes rarely seen at this pace with standard treatment. What is thought to drive results like these is not simply the pharmacological effect, but the surfacing of previously unconscious material and the psychological reorganization that follows. The session described here suggests that reorganization can also occur without the substance, when the relational conditions are sufficient to hold it.

From Aloneness to Being Met

What happened next in the session is where the technique itself lives, and it is deliberately not detailed here. The sequencing, specific interventions, clinical mechanics, and the shift from being witnessed to internal reparenting are more appropriately addressed in clinical training rather than in this publication.

What can be said, in outline, is this: the client moved from being alone inside decades-old grief and self-loathing to a state in which she could witness that younger part of herself from a place of her adult resourced self, and ultimately offer that younger part what she had never received.

The shift was not partial. Numbness gave way to feeling. Shame gave way to compassion. Isolation gave way to an experience she described, by the session's end, as a felt sense of timelessness and permanence:

"It's amazing because it basically means there is nothing that cannot be healed." She closed with an observation that needed no interpretation: "Trauma is not permanent. What is permanent is love." The weight of that closing line rests on the trajectory that produced it, not on the sentence alone.

The Theoretical Frame

Most trauma-informed models, Somatic Experiencing, and Sensorimotor Psychotherapy prominent among them, treat dissociative withdrawal, numbing, distancing, and retreat from felt experience, as a risk to be managed. The clinical instinct is to titrate; that is, to approach the material in small increments at the edge of the client's window of tolerance, retreat when activation rises, and build capacity slowly, often over a great many sessions, before deepening further. The work is regulatory, oriented toward restoring the client to the edge of the dissociative field without entering it. This is sound, evidence-based practice for a great many clients and presentations, and it should remain the default. This format departs from it deliberately, however, that departure is not indicated for many clients. The format in this case takes a different approach. It moves directly into that field, including its coldest and most withdrawn qualities, stays with it, and processes what is found there - in this case self-loathing, pain, and deep sorrow - rather than working at its perimeter. Before a sustained entry into a withdrawn state of this depth can be attempted safely, several conditions must be established - the client requires substantial internal resources, a well-established therapeutic alliance, and careful clinical judgment about the client's readiness. Without those conditions in place, this is not a technique to apply; it is a risk to the client.

To be precise about what that departure is and is not: withdrawal is not treated as pathology to be eliminated, it is understood as a necessary, adaptive defense. It is the client's best available response, formed early, to an environment that did not meet her. It is not what needs to change. What is transformed is not the withdrawal itself, but the aloneness she has held inside it, and the pathogenic meaning she made of that aloneness as a child - that she was unwanted, unlovable, or somehow responsible for her own abandonment.

This distinction reframes the therapist's task. It is not to pull the client out of the withdrawn state, nor to manage her at its perimeter, but to enter it alongside her - tracking her experience moment-to-moment, witnessing what surfaces without flinching from it, and eventually helping her locate, within herself, the capacity to do the same. The work is not exposure. It is accompaniment, first by the therapist, and ultimately by an internal, resourced part of the client herself.

This stance is audible in the session itself. At the point of deepest pain, the therapist's response was not to redirect or soothe it away but to name it and stay with it, "Such a painful core place. A lot of pain that needs to just be witnessed, and you've held in so much."

Issues This Raises for the Field

If AEDP, practiced in this way, can facilitate states this deep, this image-rich, and this reparative without a substance, it raises a genuine clinical question rather than a rhetorical one - what, precisely, is doing the work in psychedelic-assisted therapy that is not already available, in some form, through sustained dyadic attunement?

Is the substance opening a door that skilled relational presence can also open, perhaps through a different pathway or at a different pace? Or is there something categorically distinct happening pharmacologically, a shift in default-mode network activity, fear extinction, or other mechanisms that relational methods alone cannot reach? This format is not offered in opposition to medicine-assisted therapy. For clients who are appropriate candidates and choose to pursue it, psychedelic medicine reaches material that talk therapy alone often cannot, and that access matters. The point at issue here is narrower, the claim made by some strict adherents of psychedelic work, that such depth is reachable only with a substance. AEDP reaches comparable depth through moment-to-moment tracking held within the safety of secure attachment. Psychedelic models built around an inner healing intelligence do not, by design, include that same relational infrastructure.

The implications are worth naming directly. *First, accessibility*: not every client can or should take a psychedelic. Medical contraindications, legal status, personal history, and individual

preference all shape who can access drug-assisted protocols. The legal status is itself worth naming plainly. In August 2024, the FDA declined to approve MDMA-assisted therapy for PTSD (Lykos Therapeutics, 2024). The decision followed concerns about trial blinding and data reliability in that specific application rather than a rejection of the underlying efficacy, which remained strong across both completed Phase 3 trials. The broader regulatory asymmetry is worth noting regardless of how that particular application is resolved. MDMA remains a Schedule I substance with no accepted medical use under federal law, whereas ketamine holds Schedule III status and is available nationwide by prescription, approved for treatment-resistant depression rather than trauma specifically. Clients seeking the substance whose controlled trials most directly targeted their condition may, for now, have far less legal access to it than to a related compound approved for a different indication.

If some portion of the therapeutic depth associated with psychedelic work can be reached through relational means, that depth becomes available to clients who would otherwise be excluded not only by medical or personal circumstance but by regulatory circumstance as well.

Second, mechanism: the MAPS findings discussed above raise the possibility relational attunement carries more of the therapeutic weight in psychedelic work than is usually credited - a possibility that the Dry Psychedelics format described here supports rather than merely echoes.

Third, training and safety: a relational format that requires no pharmacological intervention, dosing protocol, or medical supervision is a distinct clinical pathway worthy of evaluation on its own terms.

None of this is offered as a claim that psychedelic-assisted therapy is unnecessary, or that this format substitutes for it in every case. It is offered as a documented clinical observation: in one extended session with one client, the depth of processing many clinicians associate with pharmacological assistance was reached without a substance.

Limitations

This case, and the broader pattern it represents, carry clear limitations. The evidence presented here is drawn from a single extended session with one client. Related instances in the author's practice, referenced above as a broader pattern, have not been formally documented, measured, or independently reviewed, and should be weighted accordingly. No standardized measure of "comparable depth" was used, the comparison to psychedelic-assisted therapy rests on clinical impression and on the outcomes literature cited above, not on a shared assessment instrument administered to this client. The author served simultaneously as the treating clinician and the reporting observer - a dual role standard in case-study methodology but one that limits independence of observation. This session's footage was presented in clinical training seminars and reviewed by AEDP faculty, who characterized it as clinically significant; that feedback offers some independent corroboration of the clinical picture described here, though it was qualitative and offered in an educational rather than a structured evaluative context – circumstances which do not constitute a formal peer review. Finally, the client's presentation over the year following this session, not simply her own account of it, has been reviewed by a faculty advisor who has consistently characterized it as clinically significant. This assessment remains qualitative clinical observation rather than a standardized or independently measured outcome. Establishing durability and generalizability will therefore require independent verification through measured follow-up and replication across clients. As with any case study, replication across clients, therapists, and settings is the next step toward determining how reliably this depth can be reached and how durable its effects prove to be.

Conclusion

If the hypothesis explored here holds beyond this single case, it would suggest that some of what makes psychedelic-assisted therapy powerful lies not only in the substance itself, but in the relational and somatic conditions that can, under the right circumstances, be created without it. This article presents my approach to accomplishing this. That is not a claim that psychedelics are

unnecessary. It is an invitation to take seriously how much of their power may already be available to psychotherapy through relationship and the body alone, if the field is willing to enter dissociation rather than manage it from its edge.

A Note on the Client

The client's consent for the use of this session material and the broader footage from which it is drawn was obtained prior to any use in clinical writing or training. She has specifically reviewed and authorized the disclosures included in this article. Identifying details beyond what is necessary to convey the clinical picture have been omitted.

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