Clients in the Driver’s Seat, not Asleep at the Wheel: A Qualitative Study of the Client Role in Transpersonal Psychotherapy

Phyllis Alongi
Monmouth University, West Long Branch, NJ, USA

Jenny Wade
California Institute of Integral Studies, San Francisco, CA, USA

Follow this and additional works at: https://digitalcommons.ciis.edu/advance-archive

Part of the Arts and Humanities Commons, Medicine and Health Sciences Commons, and the Social and Behavioral Sciences Commons

Recommended Citation
https://digitalcommons.ciis.edu/advance-archive/92

This Article is brought to you for free and open access by Digital Commons @ CIIS. It has been accepted for inclusion in International Journal of Transpersonal Studies Advance Publication Archive by an authorized administrator of Digital Commons @ CIIS. For more information, please contact ksundin@ciis.edu.
Clients in the Driver’s Seat, not Asleep at the Wheel: 
A Qualitative Study of the 
Client Role in Transpersonal Psychotherapy

Phyllis Alongi  
Monmouth University  
West Long Branch, NJ, USA

Jenny Wade  
California Institute of Integral Studies  
San Francisco, CA, USA

Despite the power of the therapeutic alliance in effective therapy and its larger-than-the-individuals-comprising-it (transpersonal) qualities, the client’s contribution to the therapeutic process has been largely overlooked in both conventional and transpersonal literatures. This study asked 35 transpersonal practitioners, what is the role of the client in transpersonal psychotherapy? The study examined client traits, attitudes and role demands in Jungian therapy, sandplay therapy, dream analysis, guided imagery, regression and hypnotherapy, nondual psychotherapy, and psychedelic-assisted psychotherapy using inductive thematic analysis. The results distinguish transpersonal therapy clients from conventional ones, indicating that the transpersonal client role characteristics and behaviors are unavoidably more developed by the very demands of transpersonal modalities—as are the demands on the therapist. For most, but not all, transpersonal modalities, the therapeutic alliance is a peer relationship, with the client firmly in the driver’s seat. The findings suggest that transpersonal psychotherapy may be adjunctive or complementary to conventional therapy, and that conventional therapy may only work for some clients up to a point. Finally, transpersonal modalities could be integrated into conventional therapy based on client need and therapist openness to trans-egoic dynamics.

Keywords: transpersonal psychotherapy, client role, therapist role, transpersonal modalities, dream analysis, guided imagery, Jungian therapy, nondual psychotherapy, psychedelic-assisted psychotherapy, regression therapy, past-life regression, sandplay therapy, therapeutic trance.

The therapeutic alliance (TA) refers to the quality and strength of the collaborative relationship between client and therapist in a purposeful partnership (e.g., Ackerman & Hilsenroth, 2013; Cheng & Lo, 2016). It is a substantial, consistent contributor to client goal achievement in conventional psychology (e.g., Bordin, 1979; Duncan et al., 2010; Geller & Porges, 2014; Orlinsky et al., 2004; Stargell, 2017), but little is known about how it occurs, much less how the client contributes to such a relationship. Indeed, the literature privileges the therapist’s role as cultivator and facilitator of the alliance (Siegel, 2013), and the client’s role is still only marginally incorporated (Geller et al., 2013; Sackett & Lawson, 2015; Spencer et al., 2019), even though core contextual aspects of the TA are co-created by client and therapist (Ackerman & Hilsenroth, 2013; Cheng & Lo, 2016; Geller & Porges, 2014; Horvath, 2001; Molbak, 2013; Phelom, 2001; Timulak & Keogh, 2017).

Arguably the TA is inherently transpersonal, as a relationship co-created by, and transformative for, client and therapist (Phelom, 2001, 2004; Richards et al., 2015; Schneider, 2015). Transpersonal psychotherapy questions the authority of the therapist, explores the role of the client, and values mutual exchange, striking a balance or synthesis between the individual and the relational (Brown, 2017). Transpersonal therapeutic approaches offer a comprehensive lens through which to view energetic, nonverbal exchanges between client and therapist and provide an expansive framing of the TA (Boorstein, 2000; Cortright, 1997; Hartelius et al., 2013). Transpersonal psychotherapies view the TA as a vessel that can sustain the weight of difficult transferences; that holds the client’s conflicts, past
and present, as well as the potential for client illumination, change, and ultimately healing; and that enables a client to feel protected where conflicts are accepted nonjudgmentally and held by the therapist for client exploration (Boorstein, 2000; McCormick, 2000). This vessel contains both client and therapist, as the client releases limitations and debilitating beliefs and room is made for a new, healthier sense of self to emerge (McCormick, 2000, p. 25).

According to Rodrigues and Friedman (2013), transpersonal psychotherapies consider the vital role of consciousness and may employ altered states of consciousness (any mental state facilitated by various psychological, physiological, or pharmacological components that ignite an identifiable deviation from the norm in an individual’s psychological functioning and subjective experience during waking consciousness; Ludwig, 1966, p. 226) in the therapeutic process. Such states include changes in perception, cognition, agency, temporality, meaning, and body image, and sometimes heightened suggestibility (Kokoszka, 2007; Ludwig, 1966; Shalit 2012). With greater understanding of neurological correlates of consciousness, it has become clearer that earlier psychological theories of the “unconscious” or “subconscious,” such as Jungian analysis of symbols and other images evoked during dreaming, daydreaming, and the like, involve right-hemisphere (nonverbal) and limbic system processing and contents (e.g., Wade, 1996), always present but subliminal for most people owing to the dominance of the narrative left hemisphere in conscious awareness. Transpersonal psychotherapy emphasizes processes and modalities that more directly access these parts of the brain as opposed to conventional “talk therapy,” which works with ego-focused, narrative, rational left-hemisphere awareness. Transpersonal modalities often deliberately invoke alterations from normal awareness in session.

Rodrigues and Friedman (2013) described transpersonal psychotherapy as a relational process including both the client’s and therapist’s perspectives and the “interactive nature of events between them” (p. 582). Within this healing field, both, individually or together, are believed to be in a changed state of consciousness. First, the client and therapist co-create the therapeutic container by collaborative rapport building. The therapist views the client as the authority in the dynamic and expects the client to lead by establishing relevant session content and setting treatment goals. The client ignites transformation by exhibiting a willingness to explore their most intimate spiritual and/or subconscious material (Seigel, 2013, 2019). Although transpersonal psychotherapy is not a spiritual practice per se, several authors (e.g., Caplan, et al., 2003; Ferrer, 2017; Rodrigues & Friedman, 2013) documented the benefits of bringing spirituality into psychotherapy.

Even in the transpersonal literature, no modality has identified the role of the client in the therapeutic process, but the practices discussed below illustrate the client-focused and client-led features of the therapeutic dynamic in modalities employing transpersonal methods. Many existing psychotherapies could be considered transpersonal by virtue of their approaches, techniques, and such, but they might not specifically be referred to as transpersonal (Boorstein, 2000; Friedman, 2014).

**Jungian Psychotherapy and the Client’s Role**

Jungian analysis falls under the transpersonal umbrella as one of the first psychotherapeutic models to situate the human condition in the unconscious and the numinous (Cortright, 1997; Phelon, 2001; Singer, 1994). The client’s role in Jungian psychotherapy is to be willing and ready to explore and uncover their deepest, most intimate parts. According to Welwood (1977), this can only begin from the client’s openness at the personal and transpersonal levels. The client must be willing to overcome the fear of exploring unconscious material. Jungian analysis features an expectation that the client be willing to shed or “let go” of egoic restrictions and explore the transpersonal dimensions of Self. The client’s intrinsic willingness, presence, and receptivity to the process drive the psychotherapeutic situation. The therapist’s role is that of observer. The therapist must stay submerged in the psychotherapeutic encounter, yet refrain from participating in it (Brown, 2020; Hopcke, 2013; Jung, 1989). Jung’s theories and psychoanalytic methods were elaborated into specific techniques further developed over the decades. All involve symbolism and the use of altered-state material.
Sandplay Therapy and the Client’s Role

Sandplay therapy, a Jungian derivative, uses archetypal symbols in a structured process to work with symbolic material. Sandplay includes transpersonal aspects of client growth or transformation, such as spirituality, unconscious aspects of personality, personal complexes, the shadow, and the Self (Mandelbaum, 2006). The modality was developed in 1966 by Jungian psychotherapist Dora Kalff, a student of Margaret Lowenfeld, who first introduced the notion of using miniature objects and sand as therapeutic tools. During sandplay sessions, clients create three-dimensional displays by placing miniature objects in a standardized tray containing sand that can be manipulated and shaped to represent different things (Kalff, 1980).

Sandplay therapy illustrates the unconscious material of the client’s psyche through the objects chosen and their placement in the sand. The objects symbolize both the client’s personal unconscious, shaped in part by their experience, and the collective unconscious, the pre-existent forms Jung called archetypes, archaic or primordial universal images and dynamics (Corey, 1990). The sand, the container or tray, and the objects reflect the client’s internal and external experiences, guided by both conscious and unconscious logic. Upon completion of the sand tray, the client provides a narrative interpretation while the therapist is silent. The client’s role is therefore to demonstrate how the archetypal forces at play in their psyche are structured. The client’s personal experiences and identity formation constellate the images and patterns by which archetypes are catalyzed in the personal unconscious, but they do not exist in the personal unconscious. They are merely patterns whose fractals can be found there. This spontaneous self-directed process is generated exclusively by the client and is thus a client-led modality that depends on the client for content, context, and interpretation. According to Kalff (1980), the TA develops from the therapist’s nonintrusive role in a safe and protected space unconfined by the therapist’s thoughts, agenda, or bias.

Dreamwork and the Client’s Role

Historically and cross-culturally, dreams have been recognized as a unique state of consciousness sourced outside of ordinary space and time believed to be a universal expression at the core of human existence (Deslauriers, 2013). The basic premise of dreamwork in psychotherapy is that dreams represent a pathway the client unconsciously uses to satisfy unfulfilled demands in specific parts of the unconscious that cannot be realized in waking life. Many theoretical orientations include dreamwork. The imagery and “felt-sense” are believed to be directly related to the individual’s central emotional issues (p. 513). Thus, dreamwork depends heavily on the client, as the consciousness in dreams is self-referential and self-organizing. This interaction of experiencing and processing dreams allows the client to gain the self-knowledge and self-understanding that ultimately lead toward self-transformation (pp. 515–516; cf. Ellis, 2013; Eudell-Simmons & Hilsenroth, 2005; Hill, 2004).

According to Ellis (2013, 2020) common methods in implementing dreamwork have the client tell the dream while staying within the landscape of the dream; have the therapist ask for associations to the dream; have the therapist ask the client to revisit the dream from an interesting element or perspective of the dream; have the therapist and client tease out the metaphors, symbols or myths and their connections to waking life; and finally have the therapist invite the client to consider making a change based on the dreamwork (pp. 31–37).

Somers and McCormick (2000) described the client’s role in dreamwork as “gatekeeper,” the one who must be prepared to face the work, have the patience to stay with it, and be prepared to let go (p. 172). The demands of the therapeutic work are on clients to reveal parts of themselves through dream-telling and arrive at their own understanding of, and insight into, the dream. The therapist supports the client, acting as a “consultant” (Hill, 2004, p. 140). The therapist understands dreamwork as an organic, transformative unfolding, listening to that unfolding and letting it unravel in the client’s own time. The client makes their own deductions and comes to a subjective understanding without the therapist’s objective interpretation, contrary to conventional psychotherapy. The therapist’s role includes fostering the client’s autonomy in
formulating their own meaning and connecting the dreamwork to their waking life rather than depending on the therapist’s analytic interpretation (Craig & Walsh, 1993).

**Modalities that Induce Altered States**

Altered-state-induction modalities involve the client’s deliberate entering of an altered state of consciousness during a therapy session. Altered states are temporary, organic occurrences that include states occurring naturally in daily life (e.g., daydreaming, drowsiness, orgasm, sensory deprivation; Shalit, 2012), as well as those produced by special activities (e.g., meditation, ingesting psychoactive substances). As noted, transpersonal psychotherapists use altered-state modalities to help clients access unconscious material (e.g., Nardini-Bubols et al., 2019) and produce clinical benefits, such as reducing the severity of anxiety and dystonia; improving symptoms of posttraumatic stress disorder (PTSD); increasing relaxation and pain relief; and improving quality of life (pp. 2187–2190). Many different altered states may be induced for therapeutic purposes utilizing different means. The largest documented group involves trance induction.

**Hypnotherapy and the Client’s Role**

Hypnosis is a heightened state of awareness in which the conscious mind shifts into the background and the subconscious mind comes into the foreground of consciousness. The term hypnotherapy was coined in the 1980s for hypnosis as an adjunct to conventional psychotherapy (Elkins, 2017). Clinical hypnosis includes the therapist’s helping the client reach sufficient relaxation to access early memories, vivid imagery, increased process thinking, and an acceptance of logical inconsistencies (“trance logic;” p. 214). Hypnotherapy research has illustrated the potential of hypnotic suggestion as an adjunct to psychotherapy to model and influence noncontrolled conscious states, such as pathological states (Hastings, 2007; Lemercier & Terhune, 2018). Hypnosis has been shown to be a viable modality for therapists to assist clients in resolving emotional and cognitive conflicts (Bahrami & Haidari, 2021; Valentine, et al., 2019). The Jungian approach to hypnotherapy, often referred to as hypnoanalysis, includes some of the same components as Jungian dreamwork, such as active imagination, association, and amplification (Hall, 1989). Hypnotic states are used to access the psyche’s imaginal abilities as reflected in active imagination and dreaming (Hall, 1989; Hartman & Zimberoff, 2013).

The therapist’s role in hypnotic suggestion therapy is less passive than in some Jungian modalities (Hall, 1989; Hartman & Zimberoff, 2013). Once the client commits to enter the altered state, the therapist must offer containment through unconditional acceptance and sustaining the client’s projections without reaction. It is typically the therapist’s responsibility to produce some kind of verbal instruction that will help produce a light hypnotic trance and to assess whether the client is sufficiently “under” to proceed productively. The therapist determines when to initiate the production of unconscious material and then interacts with the client’s freely surfacing unconscious material to facilitate dialogue. The therapist assists in the client’s inventory of implicit and explicit memories, helping the client identify self-defeating patterns. Finally, the therapist guides the client to the specific complexes that need to be addressed. The therapist temporarily assumes the responsibility of the ego itself to support the coherence of all the understood facets of the ego’s composition. That is, during hypnotherapy, the client experiences factors that are normally inferred but in a more focused way as the therapist helps maintain the fluidity and consistency between implicit components of the ego’s structure. The therapist’s role is to guide the production and experience of the trance to bring a certain clarity to behavior patterns in the client’s life (Hartman & Zimberoff, 2013, p. 25).

**Regression Therapy and the Client’s Role**

Hunter and Eimer (2012) described hypnotic regression as the language of the unconscious in which the client moves back in time during a hypnotic state. Psychotherapists use hypnotic regression to unlock the negative beliefs, fears, and patterns in the client’s unconscious by accessing early memories, thoughts, feelings, and perceptions (Nash, et al, 1985). This revisiting of memories, known as revivification, often leads to an abreaction,

A focus in age regression therapy involves revisiting pre- and peri-natal experiences. Along with Otto Rank (1999), Nandor Foder (1955) suggested that all people experienced birth trauma but developed amnesia to the experience, such that traumatic birth memories were buried deep in the unconscious only to be retrieved through an altered state. Pre- and peri-natal trauma has become a focus of caretaker and infant/child therapy since children can recall early trauma in their normal state up to about age five (e.g., Cheek & LeCron, 1968; Stevenson, 1983; Wade, 1996), whereas adults usually access such memories through a trance state.

Regression therapy may also encompass material commonly regarded as outside the client’s biological, biographical lifetime, such as so-called past-life regression (PLR) therapy (Amoroso 2012; Netherton & Schiffrin, 1978; Weiss, 1988; Woolger, 1987, 1988). Although nontranspersonalists often consider this fantasy material, practitioners regard it as symbolic, unconscious material like dream imagery, which clients cannot directly face except as a metaphor, in this case the metaphor of another person’s life at another time (O’Neil, 2018; Weiss, 1992). In PLR (Amoroso 2012; Netherton & Schiffrin, 1978; Weiss, 1988; Woolger, 1987, 1988), the client works through progressive layers of “past life” imagery until they can face the biographical dynamics at the core of their complex. Belief in reincarnation by client or therapist is not necessary for effective therapy, nor is the past-life material assumed to be “true” (despite independent research supporting the validity of reincarnation—e.g., Amoroso, 2012; Haraldsson, 2003; Matlock, 1990; Mills & Lynn 2000; Stevenson, 1974, 2000; Tucker, 2005—but that is beyond the scope of this paper). The short- and long-term results of PLR are congruent with conventional psychotherapies: alleviation of conflict and crisis, improvement in relationships, self-esteem, and personal contentment (Lucas, 1993).

Guided Imagery and the Client’s Role

Guided imagery is a variety of techniques, from visualization and direct imagery-based suggestion during trance to narrative storytelling and metaphor (Prabu & Subash, 2015). Guided imagery is widely used, and its efficacy is supported by research with diverse populations (e.g., Scherwitz, et al., 2005; Weigensberg, et al., 2009; Wood & Patriciolo 2013). In interactive guided imagery (IGI), the therapist is a “guide” who induces the required relaxation state and provides general assistance with the client’s (Heinschel, 2002). The therapist must allow the client autonomy to make choices while maintaining a balance between structure and non-structure in a session. Heinschel concluded that the therapist’s caring and competence, as experienced by the client, catalyze not only the induction of the altered state but also the therapeutic work. Although Heinschel does not outline the client’s role, it is clear the client is responsible for the onset and success of treatment outcomes. For example, the client must possess the vulnerability needed to enter and sustain an altered state of consciousness.

Psychedelic Modalities and the Client’s Role

Pschotropic substances have been used to induce altered states in healing historically and cross-culturally (Buckley & Galanter, 1979). Since 2013, government agencies, university researchers, and private donors have helped develop research
on the use of psilocybin (mushrooms), 3,4-Methylenedioxymethamphetamine (MDMA; ecstasy), lysergic acid diethylamide (LSD), and ketamine in psychotherapy. Psilocybin’s therapeutic use has focused on end-of-life anxiety, smoking cessation, depression, opiate use disorder, anorexia nervosa, and symptoms of Alzheimer’s disease (Carhart-Harris et al., 2012). People who ingest it may experience mystical or transpersonal events (Garcia-Romeu et al., 2016; Johnson & Griffiths, 2017).

LSD is a complex hallucination that can produce mystical, transformative, insightful, or transpersonal experiences characterized by a sense of all-inclusive unity (Garcia-Romeu et al., 2016; Grob et al., 2011). Clinical applications include treatment for substance use disorder, anxiety, depression, and pain management (Krebs & Johansen 2012). Research (Dyck, 2005; Garcia-Romeu et al., 2016; Mithoefer et al., 2013) shows MDMA is useful in treating trauma-related disorders. Ketamine’s clinical applications include the treatment of opiate addictions, cocaine dependence, depression, suicidal ideation, and other mood disorders (Garcia-Romeu et al., 2016). The available literature fails to identify client factors necessary for effective psychedelic-assisted psychotherapy, but certain factors are implied.

During the session, the therapist maintains a supportive, nondirective role as an empathetic witness (Goldsmith, 2011, p. 5) who helps navigate the client’s journey without dictating the therapeutic content or direction. The therapist ensures the setting conduces to safety and relaxation, assists the client through the onset of the altered state, and supports them through waves of emerging sensations, thoughts, perceptions, and feelings with calming reassurance. Because the client’s defenses are down, the therapist must help the client make sense of the experience. The therapist’s role includes observing previously undiscovered patterns and keeping the journey work on track. The therapist must also take care of the client’s physical needs, such as providing help to the bathroom. The therapist stays with the client, validating the client’s discoveries for the extent of the experience (Coleman, 2017).

There is wide-ranging agreement that response to psychedelics depends significantly on factors known as “set and setting,” including the type of drug, dosage, history of mental illness, current mood, intention or response expectancies, and environment (Lemercier & Terhune, 2018, p. 40). The setting space supports the client and the therapeutic work. However, the client’s preparedness and intention dictate the experience. The client must be willing to let go of preconceived ideas and allow the process to unfold. The client sets the intention for which issues need to be exposed for healing. The client must be willing to be under the influence of a mind-altering substance and surrender all control; maintain the desire and courage to embrace sensory experiences, pleasant and unpleasant; and allow themselves to recall and analyze early experiences and traumatic events. During the psychedelic journey, the client may connect with larger, “cosmic” issues and experience a profound dissociation from personal identity and physical experience. The client’s implicit knowledge is the true psychotherapist in psychedelic therapy (Coleman, 2017; Goldsmith, 2011).

Nondual Psychotherapy and the Client’s Role

“Nonduality” literally means “not two,” and it refers to a state recognized by Eastern and Western contemplative traditions of unmediated, nonegoic unity with all that is (e.g., Wade, 2018, p. 80), commonly called by names associated with different traditions (e.g., nirvana, samadhi, enlightenment). Nonduality is experienced simultaneously as profound love and innate wisdom, including effortless feelings of joy, compassion, and identification with everything (Prendergast et al., 2003). Subjectively, it is neither an altered state nor normal consciousness but a synthesis that is neither and both (Wade, 1996, p. 206).

Prendergast (2003) described nondual psychotherapy as shedding the innate limitations the client believes they are. The nondual psychotherapist does this by asking the client to consciously remove the old, false identifiers from their belief system that have caused suffering. According to Nixon and Sharpe (2009), nondual therapy differs from conventional methods in that the primary goal is not to fix or correct the client’s paradoxical, limiting beliefs, but to allow the client to accept and embrace the paradox as well as challenge it.
In nondual therapy, the sense of separation from everything, including the relationship between client and therapist, is invited to melt away to one consciousness. The separate self is believed to hold both client and therapist back as it is a false belief. Nondual psychotherapy includes the notion that suffering is optional: when the client drops the separate self, they awaken and realize that they are infinite consciousness (Nixon & Sharpe, 2009) free of limits, conflicts, and suffering (p. 5).

In this approach the therapist’s skill must be experiential, derived from their own knowing of nonduality (Spira & Pendergast, 2019). Once the therapist has attained their own awakening, they can transpose that to the client, much like the “transmission” of enlightenment by spiritual masters in some traditions. This empowers the client to access and stabilize their own awareness of nonduality while obtaining the capacity to tap into it repeatedly. The therapist disidentifies with the limiting role of “therapist” and what remains is a natural, transparent, unconditional acceptance of where the client and therapist are in the process. The therapist is not seen as a fixer of problems by the client. The therapist’s role is witness to the client’s journey. Johnson (2017) emphasized therapists’ allowing themselves to be led down the path of suffering alongside the client, refraining from deterring or distracting the client from emotional pain to allow its eventual passing. As issues surface, the client experiences a profound emptiness ignited by the desire to hang on to the separate self (Fenner, 2003; Johnson, 2017) and in time understands the emptiness as a lifelong defense of limiting identities and beliefs. The client’s role includes an intense willingness to awaken and lose their judgmental mind, allowing life as they know it to crumble away and surrendering to a deep knowing of true self (Johnson, 2017). The client commits to embodying the newfound awakening in daily life, independent of the therapeutic setting.

**Summary**

The paucity of empirical research on the client’s role in psychotherapy is a significant gap in the literature. The fact that the client’s role is largely missing in the conventional psychological literature appears the more glaring when much information can be gleaned from implicit but consistent reflections in the transpersonal literature of client-led, client-centered processes. It is important to distinguish what the client brings to the therapeutic alliance and process because it has been almost completely overlooked, and because the therapeutic alliance involving the client has been credited empirically with successful treatment. Therefore, the purpose of this study was to obtain as much information as possible by asking what is the role of the client in transpersonal psychotherapy?

**Methods**

The research design involved interviewing transpersonal psychotherapists about the role of the client. It may seem contrary to the aim of the study to interview therapists rather than clients, but therapists are considered more knowledgeable about aspects of the client’s role from their greater knowledge about psychotherapeutic dynamics than clients, whose perspective may be limited by education and perhaps a narrow range of personal experiences with a single therapist or modality (Horvath, 2001; cf. Ackerman & Hilsenroth, 2013; Cheng & Lo, 2016). A qualitative approach was chosen since virtually nothing is known about this phenomenon (Creswell & Poth, 2018). The elusive, subjective, novel nature of this topic required an open-ended approach for discovery (Creswell, 1998; 2003), in this case inductive thematic analysis, a valuable method for psychotherapy research (Roberts, et al., 2019), which codes data without fitting it into a preexisting model. This approach allows data to be described and interpreted for meaning to produce insightful, sensitive, trustworthy findings by applying rigorous methods (Braun & Clarke, 2006; Clarke & Braun, 2018; Roberts, et al., 2019).

**Participants**

The sample was to be a mixed group of practitioners who use transpersonal modalities, i.e., approaches employing a combination of holistic, transformative, and ego-transcendent practices that value the role of consciousness, ego awareness, emotions, thoughts, and spirituality as the essence of what it means to be human (Rodrigues & Friedman, 2013), including the use of altered states in session.
Transpersonal modalities included but were not limited to: sandplay therapy; Jungian analysis; dream analysis; regression therapy; guided imagery; nondual psychotherapy; and psychedelic-assisted psychotherapy.

Inclusion criteria were: being over 21 for legal informed consent; having a minimum 3 years’ experience working in the specific transpersonal modality and conducting individual sessions with adults; being currently engaged in therapeutic practice in an outpatient setting; identifying as transpersonal practitioner trained in and/or routinely practicing at least one of the above modalities; having masters’ and doctoral level credentials in psychology or a closely related field, such as social work, for US participants or for others, degrees and/or professional certifications commensurate with the standards of their country; and speaking fluent English. Participants may have but were not required to hold a terminal license in counseling or social work in addition to a specific certification or equivalent in one of the transpersonal modalities (e.g., organization, state, or board-certified hypnotherapist). Selection criteria included therapists who may or may not be terminally licensed based on existing American Psychological Association and American Counseling Association education, training, and licensure requirements that exclude transpersonal psychology (Bourg, et al., 1989). Both organizations refuse to acknowledge transpersonal psychology and psychotherapy as an integral part of the Council for Accreditation of Counseling and Related Educational Programs standards and accreditation process (Branthoover, et al., 2010). It was understood that some therapists working with psychedelics might not be able to do so legally and therefore might have an underground practice (Coleman, 2017; Marsden, 2001; Metzner, 1998; Stolaroff, 2004). However, they had to be qualified therapists who had undergone appropriate training that included education, supervision, and psychedelic-assisted experiences firsthand.

Practitioners who identified primarily as having a shamanic practice were excluded because neo-shamanic practices usually require client and practitioner to be in a trance state simultaneously or that only the practitioner be in the altered state; furthermore, many are conducted in a group setting: both variables confound the client contribution to psychotherapy (e.g., Waldron & Newton, 2012; Wallis, 2003; Whisker, 2003; Winkelmann, 2012). Therapists working exclusively with chronically mentally ill patients who are often prescribed psychotropic medications were excluded since those conditions may interfere with the client’s potential to contribute to the TA. There were no racial/ethnic, sex, sexual orientation, or religious/spiritual exclusion criteria because these factors are not known to affect the TA’s quality.

Recruitment
Recruitment targeted transpersonal practitioners through professional associations, internet search, and referral networking. A recruitment document was posted on the International Institute for Humanistic Studies website, and a recruitment letter was sent to individuals listed on the web-based professional member directory of the Association of Transpersonal Psychology, The European Transpersonal Psychology Association, Sandplay Therapists of America, Jungian Psychoanalytic Association, Nondual Therapy Directory, National Association of Hypnotherapy, Past Life Regression & Hypnosis Directory, The Weiss Institute, The Australian Hypnotherapists Association, The Association for Pre- and Perinatal Psychology and Health, The Newton Institute for LBL Therapy, Alternatives for Healing/Guided Imagery, American Society of Ketamine, and the Multidisciplinary Association for Psychedelic Research (MAPS), among others. Individuals on those lists with the most appropriate credentials were contacted. Practitioners from organizations such as MAPS who might use psychedelics were contacted exclusively by referral to protect confidentiality. The principal researcher conducted an internet search for therapists who advertised as transpersonal and sent them a recruitment email message also sent to the researcher’s professional and personal contacts. Volunteers were contacted via email and then telephone for a short screening. Recruitment continued until saturation was reached.

Procedure
Qualified candidates were sent Informed Consent forms via email, and upon consent, were scheduled for a maximum 60-minute, semi-
structured, one-on-one interview via the first researcher’s secure HIPPA-compliant professional Zoom account with back-up audio recording application Voice Recorder and Audio Editor (Appendix A). The first researcher journaled her experience, insights, and reflections throughout the interview process and data analysis.

Treatment of Data

Interviews were digitally recorded on a Microsoft Surface Pro tablet and a cell phone voice recorder for backup. Both formats were synchronized for security and storage. Data were transferred to a password-protected file and uploaded to an encrypted Universal Serial Bus (USB), checked for quality, and immediately deleted off phone and tablet. The USB was stored in a locked cabinet in the researcher’s home, only accessible to the researcher. Only participant pseudonyms appeared on digital and physical documents. Participants who engaged in psychedelically-assisted therapy where it is illegal used pseudonyms on their informed consent forms to protect their identities. A pseudonym/identity key was kept separate in a locked cabinet in the researcher’s home.

All interviews were conducted, recorded, and transcribed by the first researcher. Demographic data were examined for trends. The first researcher prepared the data for thematic analysis (Braun & Clarke, 2006): reading through each transcript several times to gain the general idea, tone, depth, and usefulness of the content, making notes of general thoughts, impressions, and interpretations; identifying topics by repeated patterns; listing and combining topics by similarity; assigning codes to each, which were then classified and defined; and arranging codes into themes by synthesizing several sources of data and the perspectives from participants to identify the constructs involved (Roberts, et al., 2019). Themes were compared to the data extracts and the full data set for relationships between themes (Clarke & Braun, 2018). Demographic factors were compared to extract the most salient frequency counts (Clarke & Braun, 2018). The reflexive journal tracked the researcher’s reasons for methodological and analytic decisions, which guided the reporting process and addressed authenticity (Korstjens & Moser, 2018; Nowell et al., 2017).

Results

Recruitment lasted from October 2021 through May 2022. After completing 25 interviews, an additional 10 participants confirmed the study reached saturation with a final sample of 35 qualified participants.

Sample Demographics

The sample was mostly white and female, including only 11 males and 4 people of color. No one identified as gender non-conforming. Therapist age ranged from 33–75 years (M = 53.5; SD = 11.46). Men and women were about the same age (men, M = 53, SD = 12.9; women, M = 53.7, SD= 11). Most practiced in the United States; other countries were Canada (4), Chile (1), and Greece (1).

Twenty-three participants (65.7%) had master’s degrees compared to 12 (34.3%) with doctoral degrees. The proportions of degrees attained were roughly symmetrical between sexes. The most common license among terminally licensed participants was professional counselor (67%). Fourteen (40%) were not licensed but held certifications in specific modalities, such as certified hypnotherapist. Sixty-seven percent held licensure or the equivalent in other countries. All but one psychedelic-assisted trained therapist working underground were either licensed and/or modality-specific-certified. The most common certification, regardless of licensure, was in hypnosis (19%).

Therapists averaged 13.8 years (SD= 8.9) of experience practicing one or more transpersonal modalities. Men had on average 15 years of experience (SD= 11.6), and women 13.2 (SD = 7.6). The primary modality was distinguished from the modality the therapists reported using most (Tables 1 and 2). While use of modalities varied considerably, psychedelic-assisted therapy and guided imagery were most frequent (17.1% each). Jungian analysis and Jungian dreamwork were tabulated separately. However, if combined under a broader Jungian therapeutic framework, they constituted the largest modality (20%; Table 1).

Thematic Analysis

Demographic factors were examined for trends, but only therapeutic modality possessed explanatory power. To examine differences by
modality, the sample was divided into subgroups: psychedelic-assisted modalities (N = 6; 4F, 2M); nondual modalities (N = 5; 2F, 3M); symbolic modalities (N = 11; 8F, 3M) comprising Jungian dreamwork (N = 4; 4F); Jungian analysis (N = 3; 1F, 2M), and sandplay (N = 4; 3F, 1M); and non-drug-induced trance modalities (N = 13; 10F, 3M), comprising guided imagery (N = 6; 4F, 2M), past-life regression modalities (N = 4; 3F, 1M), and hypnosis (N = 3; 3F). Consequently, frequency counts are broken out by sex as a convention only, with significant trends by modality reported separately.

Sixteen participants (46%; 11F, 5M) reported making an intentional, informed decision to identify as a transpersonal practitioner, pursue further education and certification, and use transpersonal modalities. The majority using non-drug-induced trance modalities had made this intentional decision for a wide range of reasons, including dissatisfaction with conventional, mainstream modalities; using a transpersonal modality that resulted in positive clinical outcomes; personal interest in a particular modality; helping clients reach their highest potential; and finding that the transpersonal approach validated their therapeutic work with clients.

I didn’t know anything about it [transpersonal psychology]. My orientation has always been somatic and holistic. I always wanted a doctorate. I found a school’s description of transpersonalism as holistic and including spirituality, sexuality and not denying it as a whole, and I knew I found what I was searching for. It was amazing to me how naturally transpersonal fit into my perspective and what I’ve been trained to do and my experience with people. (Cynthia)

I’d been studying different modalities, and meditative approaches, and then I learned about transpersonal. I didn’t really know about

<table>
<thead>
<tr>
<th>Therapeutic Modality</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Psychedelic-Assisted</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Guided Imagery</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Nondual</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Jungian Dreamwork</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Past Life Regression</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Sandplay</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Jungian Analysis</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hypnosis</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>11</td>
<td>35</td>
</tr>
</tbody>
</table>

Table 1. Primary Modality of Therapy by Participant Sex. Nearly half (43%) used more than one modality, and guided imagery was the modality used most often (29.1%).

<table>
<thead>
<tr>
<th>Therapeutic Modality</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>n</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Psychedelic-Assisted</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Guided Imagery</td>
<td>12</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Nondual</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Jungian Dreamwork</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Past Life Regression</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Sandplay</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Jungian Analysis</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hypnosis</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>17</td>
<td>55</td>
</tr>
</tbody>
</table>

Table 2. Overall Frequency of Use of Transpersonal Modalities.
transpersonal until I started looking into it, and that’s when I came across the terminology and looking into ways to formalize what I was doing with clients. (Samantha)

I jumped in and discovered that I was interested in finding a way of working with people that would include my spiritual unfolding and be able to make a living. I wanted to be of service. I wanted to have a livelihood that was congruent to what was most important to me. (Jeff)

I’ve been in therapy a long time and started exploring because I didn’t like traditional therapy at all. I was on the search for something because I really needed it, I couldn’t find anything in the mainstream that worked for me. (Claire)

Thirteen (37%; 10F, 1M), including more than half the nondual therapists, reported a personal positive experience that led them to identify as transpersonal.

I had a nondual experience that was so profound it set me off in a new direction…I had gone down the path of looking deeply into what happened to me. I discovered all sorts of wonderful teachings that were pointing to the same [nondual] experience I had. (Victor)

I’ve had nonordinary and mystical experiences since as early as I can remember. That’s why I studied spirituality and consciousness. Western psychology had very little interest in the stuff I was interested in. (Mario)

I was very lucky as a hypnosis client. My practitioner allowed my soul to go in any direction. I was going into the spirit realm, and other planets, and past lives all very organically. That’s why I became a practitioner. (Leslie)

My own personal experience with psychedelics and transcending with the use of psychedelics. I knew firsthand they were a powerful tool. (Kari)

Six (17%; 5F, 1M) gravitated to transpersonal psychology because of a transformative, crisis experience, such as an illness, spiritual emergency, or drug-induced psychosis.

I had a tremendous amount of trauma in adolescence and early adulthood. I had a significant amount of anxiety that morphed into PTSD. I was using LSD at the time; it was incredibly helpful. It offered me transpersonal experiences. (Charlotte)

I had my own experience of being very sick. I had my own transpersonal experience coming from a six-month period where I was experiencing steroid psychosis. I realized the powerful and impactful realization I got from those episodes. It felt realer to me than anything that is out there. (Carrie)

I was a clinical social worker at the time, so everything was traditional. Then I had a peak experience which dismantled my sense of reality. That is when I learned about alternative therapies that offered information about peak experiences and what I was going through. (Lara)

About half (18; 51%; 13F, 5M) characterized the clients attracted to their practice as spiritual, with the proportion of nondual and non-drug-induced therapists closer to 60%: “A lot of people I see are on a very spiritual path” (Barbara); “My clients are spiritual. They have a spiritual sense from somewhere in their life” (Kari).

About one-quarter (10; 28%; 7F, 3M) said their clients are looking for alternatives to mainstream modalities, specifically transpersonal modalities. Eighty percent of nondual therapists’ clients fit this category.

Many of my clients are seeking alternative modalities….transpersonal ways of understanding their own experience. (Carrie)

They are interested in alternate forms of therapy. Maybe they heard or read something that felt expanded, like psychedelics. That’s the kind of psychotherapy clients tend to want. (Miranda)

My clients have a sort of interest in the transpersonal. They have had some positive experience with the transpersonal and want to explore it. That is what they are looking for, the transpersonal in their therapeutic experience. (Izzy)
Six participants (17%; 3F, 3M)—mostly nondual therapists—said their clients were looking for alternatives because they had been dissatisfied with conventional therapies.

I attract people who have been in the mental health cycle for years, and nothing's helped or changed, and they are desperate and willing to try things that are alternative and outside the box. (Steve)

I have clients that have been in conventional psychotherapy for 20 years and didn’t even know what they were working on when they came to me...My clients tend to be more interested in taking things to a deeper level. (Demi)

Ten (28%; 7F, 3M) described the clients they attract as high functioning, intelligent, well-educated, and successful: “They are really smart, very educated, successful problem-solvers” (Leslie); “I get a lot of clients who are high functioning and have the same education level as I do” (Izzy); and “All my clients are very accomplished. Most of them are very well educated, and they are high functioning” (Tara). These clients commonly presented with trauma (14, 40%; 11F, 3M), anxiety (11, 31%; 10F, 1M), relationship issues (9, 25%; 6M; 3M), depression (6, 17%; 5F, 1M), life purpose (4, 11%; 3F, 1M), and grief (3, 8%; 3F). Half or more psychedelic and nondual therapists reported clients working with trauma, and half of psychedelic practitioners’ clients were working on relationship issues.

Factors that identified clients as not appropriate for transpersonal modalities included client resistance, severity of mental health issues, psychosis, and alcohol or drug addiction. Forty percent (12; 8F, 4M), including more than half of nondual and trance therapists, stressed client resistance, defined as unreadiness to embark on the therapeutic journey characterized by defensiveness, rigidity, and general unwillingness to engage in the therapeutic process.

When a client isn’t ready and very rigidly attached to a perfect outcome. Those clients aren’t willing, they are resistant. They have the most disillusionment. (Kari)

So, it’s a resistance, a lack of willingness to explore, and it’s the client’s defensiveness... that doesn’t work in nonduality. (Remi)

When a client admits they are not ready. It is fear based, and they are not willing to look at the whole picture and are resistant to the process. (Maria)

A fifth of the sample (7; 20%; 5F, 2M) said that the severity of the client’s mental health condition would preclude the modality. Half of psychedelic therapists said severe mental health issues would exclude clients. “Current medication and a degree of the presentation of the severity of the client’s illness would signal the client is not appropriate for psychedelic work” (Steve). “When a client has severe anxiety, they can’t regulate. The client has too much anxiety to reach the state of regulation needed in nondual therapy.” (Barbra).

Another fifth (7; 20%; 4F, 3M) said a client experiencing psychosis would not benefit from the modalities they typically use, and yet another fifth (7; 20%; 5F, 2M), including almost all the psychedelic therapists, excluded clients actively using or abusing substances. “If a client reports currently abusing alcohol or drugs, psychedelic work is not an option” (Steve); “Addiction is a roadblock for the kind of work I do with clients” (Bill).

The following analysis treats how transpersonal therapists experience and conceive of the client’s role in the therapeutic process. Responses focused on personal qualities the therapists considered vital components of the client role and fundamental to client outcomes in the transpersonal modalities used: openness, curiosity, authenticity, and self-awareness.

Openness in some form was a unanimously mentioned quality clients are expected to demonstrate in their role, generally defined as being receptive to and interested in creative, imaginative, and novel ideas and suggestions, as well as free from self-limiting, restrictive attitudes. “Their role [The client’s] is to be open to allowing discovery to unfold beautifully. Open-minded clients have more access to awareness and are more self-reflective” (Jeff) “They have to open. Open to being here
and open to letting me guide them through the process” (Donna). Most stressed particular types of openness. Fourteen (40%; 9F, 5M), including more than half the trance therapists, stated that openness to non-ordinary experience is essential.

Basically, clients are open to a new psychotherapy. They are open and interested in alternate forms of medicine and alternate kinds of psychotherapy that are much more expanded…Openness is the dominant factor. (Miranda)

There needs to be an openness…it seems there is no way around exploring some of the spiritual elements that come up. It’s [openness is] the framework to help people interpret whatever they may encounter on and under the influence of a second [psychedelic] medicine. (Bill)

They have to open to be able to suspend their own disbelief for a period of time and be transported to a different space…to be open enough to accept messages from the client’s spirit guides. (Carrie)

Seven (20%; 6F, 1M) stressed openness to exploring traumatic, dark, or disturbing material:

Clients have tenacity and an openness, to be open to discovering a different part of themselves that experienced their life differently, to be open to their addicted or their traumatized self. (Claire)

It’s an openness that the client has to be willing to be challenged by whatever comes up [from the unconscious] open to those complexities, to know the good, the bad, and the ugly. (Kari)

It’s really important that clients are open to whatever comes up to the surface. It’s the openness that allows it [trauma] to come up…that’s the core of what needs to be explored. (Leslie)

The three past-life therapists (42%; 2F, 1M) said the client’s role involves openness to exploring traumatic, unconscious material specific to past-life memories.

The client is very open to allowing me into that space [trance], so we are moving into places that can be very disturbing. During past-life, life between lives, the client is more open to go where they are being taken and be put into a position they have never been mentally. (Carrie)

A client’s openness to actually go to the subconscious mind. [For example] if something is painful you might not want to look at it or remember it. But once that’s gone and the client is in the unconscious you can access all those painful memories…My clients actually go there. They can be in the womb or facing the fear from a past lifetime. (Regina)

Five (17%; 3F, 1M) emphasized an openness to exploring unconscious material in general, traumatic or not.

Interested and open to discovering and exploring unconscious work...The role of the client is being able to be really interested in their own unconscious and their own psyche and get to reflect on that work...open to the kinds of dynamics inwardly [unconscious] that shape their worldview and sense of self. (Mark)

In this work [psychedelic-assisted] there seems to be no way around exploring the unconscious. Clients are already open to discovering what they encounter. (Steve)

Openness is the role of the client, being really open and interested in their own subconscious work, trusting the process…let whatever comes up, [from the unconscious] come up and be open to looking at it. (Lori)

Five (14%; 4F, 1M) referred to openness to change: “A client brings an openness to see themselves and make the transformative changes” (Demi); “I think openness is the main factor when the client is open to really seeing themselves and open to changing and transforming” (Dominique).

Another critical part of the client’s role in transpersonal therapy is curiosity, defined as a natural, innate curiosity (7; 20%; 5F, 2M).

A client is curious, maybe they have read about a specific kind of therapy and want to know more. It’s much easier to work with a person who is already curious. It [curiosity] leads to the
realization that maybe the interpretations about their condition are not actually true. (Remi)

When you are doing this kind of transpersonal work, there is a kind of client who is genuinely curious and wants you to tell them about a message from above. They want to learn and digest and consume that information. They want the messages from their spirit guides, deceased ancestors, and past-life experiences. (Izzy)

Five respondents (14%; 4F, 1M) reported that authenticity, a client’s genuine awareness of and/or their honest sense of self, is part of the client’s role.

[The client has] a means of bringing that honesty and authenticity to say what’s really going on here helps us go deeper in the process. (Barbra)

The client who is more interested in living their authentic self and is more introspective makes the most progress. (Maria)

The client contributes by being their genuine self with the therapist, in the moment, and authentic. (Charlotte)

Eleven participants (31%; 8F, 3M), including 80% of nondual therapists, stressed that a client’s self-awareness is an important component of their role.

It’s not just their relationship with their own inner process, but the relationship with their outer lives. I think clients are bringing a combination of both—an awareness of self and how somebody relates to their outer family and community. (Mark)

Overall, there would be an awareness on the part of the client that they had a deeper spiritual nature and that they were interested in recognizing it and uncovering it and living it in their ordinary life... So, most clients bring in a capacity for mindfulness, for self-awareness. (Jeff)

The most important thing in nonduality a client has is to be aware, that you [the client] are aware and to rest in that self-awareness, which provides an open invitation to start the therapeutic process. (Remi)

A second set of qualities essential to the client role in transpersonal psychotherapy involved behaviors and behavioral sets: willingness, self-reflection, engagement, and showing up. The majority (33; 94%; 23F, 10M) mentioned willingness in some form while nearly half (16, 45%; 13F, 3M) mentioned general willingness. Sixteen (45%; 13F, 3M) said the client’s role involves demonstrating an overall willingness to participate in the therapeutic process, defined as commitment to doing the hard work and allowing the process to unfold naturally. Willingness was especially important to psychedelic therapists.

The client has to be willing on multiple levels to step out of their minds, let go of patterns, and their thinking minds, and let the process just happen so they can do the therapeutic work. (Miranda)

This is their [the client] responsibility, their willingness to take charge, to be in charge... even though they hurt badly they have to be willing and responsible for themselves and the healing. (Dominique)

The client must be willing to open up, step into their unconscious and commit to the therapeutic work. (Heidi)

Nine therapists (26%; 5F, 4M) stressed willingness to face any painful and difficult material that surfaces as key to the client’s role.

Bottom line, it [is] the client’s willingness to see things that are hard to discuss, face things that are difficult to process and get triggered by them. (Cynthia)

The only way to release something is to actually feel the pain of it. Clients need to be willing to turn it around and to look at it. The client has to be willing to look at it to heal it, to just go there even if they [the client] knows it is going to be scary. (Regina)

My clients, seekers of transpersonal modalities are more willing to explore their unconscious mind and willing to face their fears, to look at the hard stuff. (Roger)
Six (17%; 5F, 1M) specified that the client’s willingness to change, readiness to engage in an action that results in the desired change, is integral to the process.

Psychedelic work requires the client to be disciplined and very, very willing to change, and make constructive changes in their lives, that willingness that’s the key to what’s going to make the life change ultimately. (Steve)

It’s willingness, willingness to have that mirror reflected to them and willingness to change what you [the client] just discovered. (Donna)

Clients have to be willing to change, to know that their brain, thoughts, being, spirit, and perspective can change and be willing to accept that change. (Rose)

Four (25%; 1F, 3M) mentioned willingness to set aside or let go of preconceived ideas about their life and the world. “A willingness to give up what they think they know ... to suspend their existing belief system” (Bill). “Nothing in hypnotherapy happens against anyone’s will ... an ability, a willingness to suspend disbelief, the ability to go wherever you’re being taken and the ability to imagine” (Carrie).

“Most of my clients are able and willing to, at least intellectually, get a hold of the idea that they are living some kind of dream or map and willing to let go of those assumptions” (Mario).

Four (11%; 3F, 1M) stressed that clients brings a willingness to integrate or continue the therapeutic work outside of session. “Clients bring a willingness to work outside the sessions. To look at the strategies discussed in session and go home and apply it” (Cynthia). “To be willing to look at what they learn and synthesize into their real life, to translate it into the day to day” (Tara).

Ten therapists (29%; 5F, 5M) reported that client self-reflection, the capacity to evaluate their own cognitive, emotional, and behavioral processes, is a key part of their role.

Their role is to reflect on questions or issues that we are raising and be reflective. To be self-reflective about what’s going on in their psyche and their own bodies. (Roger)

I love when clients come with some ability to reflect on themselves and have some insight. I think they bring some amount of self-reflection and objectivity about their own process. (Mario)

Eight (23%; 6f, 2M) said the client’s role involves engagement, a level of maintained interest, attention, and motivation.

It’s [engagement is] difficult to describe, but there’s something that happens for clients. There is a profound motivation that comes about from their willingness, and the client becomes profoundly engaged in the therapy, understands the value of it, and sees the change. (Liz).

Clients are fully engaged during the hypnosis process. Their engagement is evident because the client is doing the narrating. (Leslie)

A client contributes by engagement, and a transpersonal client is even more engaged. They [clients] are more motivated to transform in the transpersonal. (Maria).

Another eight (23%; 6F, 2M) stressed the client’s ability to show up as part of their role. Showing up is defined as client presence, commitment, and consistency. Two-thirds of the psychedelic practitioners endorsed this theme.

Part of their role is to show up, not just for the appointment part but for the entire process. I just need them to show up. (Dominique)

Therapy is something they [the client] have to work on, on being ready to show up and consistently engage in therapy. Showing up is a big, big, part of it. (Steve)

Their job is to show up, not to miss their appointment and to really be here, even if the part of them that doesn’t want to show up shows up it’s okay. (Claire)

Most participants (30; 85%; 18F, 12M) encourage clients to prepare for the therapeutic work. Responses typically included more than one activity. One-fifth (7; 20%; 4F, 3M) endorsed meditation to prepare for sessions. “The only thing I would ask a client to do before is to meditate. It
[meditation] helps open the mind” (Demi). Four (11%; 1F, 3M) identified **breathwork** as a useful preparation: “I always ask clients before they come to do some breathwork because it slows them down” (Ron); “Breathwork because breathing can be such an important part of navigating a psychedelic experience” (Steve). Another four (11%; 4F) endorsed **journaling** is a beneficial preparation, and three recommended (8%; 3F) **bodywork**. “If they went to dance, or yoga, or any kind of movement, it would help clients connect the mind and the body” (Jeni).

Four participants (11%; 1F, 3M) said clients should **read** about the modality before engaging in it, and another four (11%; 3F, 1M) recommended that clients attend workshops, classes, or review audio/visual materials specific to their modality. But seven (17%; 5F, 2M), mostly the trance therapists, said **preparation for session is not necessary or even possible** for their primary modality. “It [preparation] is not necessary. I think preparing can be a hindrance” (Carla). “How do you prepare for vulnerability? How do you prepare for authenticity? There really is no way for a client to do that” (Cynthia).

Participants were asked to differentiate transpersonal and conventional or mainstream therapeutic modalities in terms of the demands on the client’s role. Eighty percent (28; 20F, 8M) described the transpersonal process as **client-led**, which was broken down into three subthemes: the **client is the expert manager of change**; the **client’s transpersonal dynamics create the space in which the therapist must work**; and the **client is in charge**.

Thirteen (37%; 10F, 3M) said that in a transpersonal process, the **client is the expert manager of change**, not the therapist. This contrasted to the perceived role of the therapist as expert directing the client through the change process. Transpersonal modalities position the client as able to mobilize and manage their own change with the therapist’s technical assistance.

In conventional, the therapist gives a diagnosis, advice, and medication referral. They...therapist takes the lead. In transpersonal the client leads. (Regina)

In conventional therapy...a lot of the time there is a client reliance on the therapist to be the knower of everything, and have all the wisdom, and all answers and have all the techniques. Not like transpersonal, where the client is in charge. (Steve)

Mainstream is about declaring what’s “wrong” with a client and then putting the responsibility on the therapist to help fix them. In transpersonal the client is responsible for their own healing and owns their own deeper self-exploration and discovery. (Carla)

Eight respondents (22%; 4F, 4M) described how the client’s transpersonal dynamics create the space in which the therapist must work. These dynamics include unconscious material and spiritual and transcendent experiences. This theme was particularly important to psychedelic-assisted therapists.

It is the client who is letting me know what is important, what they want to work on what awakening means to them, what their pantheon and worldview is, and what their path is in the transpersonal...They inform me of what they are trying to transcend....their goals, and understandings, and their spiritual search. (Mario)

They [the client] have to go into their subconscious mind, which is nothing more than a file cabinet holding all their memories since their conception in this lifetime with all their thoughts, emotions, and actions attached to it. That’s the room I work in in transpersonal. All that comes from the client, their loved ones, spirit guides, masters, not the therapist. (Regina)

A client who is interested in transpersonal work is interested in including an unconscious and spiritual dimension to their work. More emphasis would be on that kind of work in the transpersonal and that work comes from within the client not the therapist. (Jeff)

Seven participants (20%; 6F, 1M) said the **client is in charge of the process**, not the therapist, who merely facilitates the process the client directs.

It’s their therapy. They are in charge. They are a major part of the role. The client is in control of
everything. I am there just to facilitate. (Demi)

It’s like they [client] come in and they have a purpose. It’s like the client says it’s not okay to do something to me. I am in charge. I am [therapist] just there with my tools ready to assist. (Dominique)

Everything is about them. The client is the starring role, it’s their show, it’s their work, it’s their exploration to lead. I am just the supporter. (Claire).

I really want to emphasize...that my clients actually lead where they are going. (Roger)

In contrast, some (6; 17%, 6F) said that conventional therapy is a more structured, cognitive-based approach, which excludes client-driven unconscious material, spirituality, and altered states of consciousness.

Conventional therapy seems more of a top-down methodical approach, where you have to follow a formula,...a more cognitive, traditional approach. (Donna)

Conventional therapy is the dominant cognitive-based treatments. Conventional is more intellectual and doesn’t include getting answers from a client’s spiritual source or unconscious. (Miranda)

Asked how they make important decisions about the therapeutic process, almost all (94%; 23F, 10M), including all nondual and symbolic therapists, said that the client actively decides what issues to focus on in session.

The focus [of sessions] is on the client completely...All of that [the goals] is established by the client. (Jeff)

I always start with the client informing that completely. ...I have no idea what direction we are going into, and the client decides what we focus on and what the treatment goals are. (Miranda)

The client tells me in the first few sessions what we are going to be working on and in what order we are going to start addressing those goals. (Dominique)

According to three-quarters of the therapists (26; 74%; 17F, 9M), clients identify the treatment goals, direction, and focus of sessions through a client/therapist dialogue, as opposed to a formal intake. This dialogue was most important to symbolic therapists, followed by trance therapists.

A client comes in, and usually in the first fifteen minutes they tell me what they are here [to do] and what they want to work on. (Regina)

We spend a lot of time discussing what the issue is, how it affects the client’s life, what their goals are and how to achieve them. This happens very conversationally. (Demi)

What the issues are unravels very organically within our dialogue. (Ron)

In describing the therapeutic alliance, 54% (19; 15F, 4M) said it was a non-hierarchical partnership. Symbolic therapists lagged the other modality groups in endorsing this position, but most nondual therapists and trance therapists said their alliances were non-hierarchical: “The alliance is fifty/fifty. It is equal” (Izzy); “We are in it together. We are on a level playing field. There is no hierarchy” (Remi); and “This relationship is mutual; it [the alliance] is not a hierarchical relationship. We are on an even plane” (Jeni). Indeed, some (4; 11%; 4F) characterized the therapist role in the TA as supporter. “I want my clients to know everything they need to do this work is inside of them. I’ll be the support” (Maria). “The client is in the driver’s seat, I am just here to support them” (Miranda). Three (8%; 3F, 1M) referred to their role as teammates: “We are definitely together in it. I am a teammate. I take the team approach” (Samantha); and “The alliance is a like two teammates playing the game together. We are two people on the same team” (Ron).

An equal number (3; 8%; 1F, 2M) described the TA as transpersonal—that is, occurring within a mutual intersubjectivity with permeable (or no) boundaries between therapist and client.

It is an exchange of information, an understanding conceptually with emotional empathy, and energetic resonance on the deeper unconscious level of the client and the therapist together on
the nondual level. There lies the sense of nonseparateness. (Jeff)

The therapeutic alliance is actually engaging in transpersonal work because we are influencing each other in ways that are far beyond conventional. We are engaging in a mutual encounter, consciousness to consciousness. (Mark)

But not everyone viewed the therapeutic alliance as a relationship of equals. Seven (20%; 6F, 1M) felt that the therapist had a leading role, with trance therapists viewing themselves as guides for the client. “I guide, I hold up the mirror and keep pointing them in the direction they tell me they want to go” (Samantha). “My role … is to guide. I provide the guidance if they get stuck, I guide them off that stuck place” (Carrie). And still others (3; 8%; 2F, 1M) described the therapeutic alliance as a student/teacher relationship. “It’s a teacher/student relationship. I see the client role as more of a student” (Tara).

One-third of the therapists (12; 34%; 7F, 5M) said that appropriate therapist self-disclosure is important in creating a sense of safety and trust with clients, but it was not important to psychedelic and nondual therapists.

I am very interpersonal and transparent. I want to be able to share my experience with clients of what’s coming up for me [in session], but not making it about me, but to serve them. So, I disclose what I think is important about me and my experience. (Kari)

I am extremely open with clients, I share my life, I answer questions about my experience. That helps build the trust, and the transparency helps to create it. (Victor)

In the transpersonal, there is no boundary, no role recognition, so there will be more self-disclosure for the therapist when it is helpful and appropriate for the client. (Jeff)

One-quarter (9; 26%; 7F, 2M) try to create a sense of safety for clients, characterized as a safe space/container in which my clients get to discover what they want and what’s in the way of getting what they want” (Claire). Six (17%; 5F, 1M) said their function is to create a deep sense of trust with clients.

I spend a lot of time just establishing trust; because we are all growing and changing so much, establishing a trusting environment is everything. (Lara)

It [the alliance] is all about the trust. The client has to trust me from the beginning. So that the [therapeutic] work can start. (Rose)

The same number (6; 17%; 5F, 1M) said that their role was to hold space for the client. Holding space referred to being fully present, practicing deep listening, and maintaining a stance of non-judgment.

I am a big space holder, the idea of holding space is holding [the client’s] emotions for them, holding really hard stories, hearing really difficult things and just making everything acceptable. (Cynthia)

When you are holding space for them, you are making sure that they know you are present and listening and you’re keeping them in a healing moment by holding all of that. (Janie)

Discussion

The study design had several limitations and delimitations, including the representativeness of the sample to the population under study. The requirement that participants speak fluent English skewed the sample toward Anglophone countries, and in conjunction with snowball sampling, the study involved primarily therapists from the eastern United States where the first researcher practices and California where she attended graduate school. However, these geographies may actually have been representative. According to the Sandplay Association of America (Ritu Tandon, personal communication, October 24, 2022), 68% of all certified sandplay therapists are located in the northeast and the West Coast of the United States, and the majority in the sample were from New York and New Jersey. Similarly, therapists whose modalities were primarily nondual or psychedelic-
assisted were predominantly from California and Canada. According to Carhart-Harris and Goodwin (2017), the first programs for psychedelic-assisted psychotherapy were in California and Toronto, and MAPS has conducted groundbreaking psychedelic research since 1986 in California (https://maps.org, 2022). Participants were mostly female, Caucasian, highly educated, and middle-aged, which, although it limits generalizability, actually is fairly representative since 87% of all licensed psychologists in the US are Caucasian and 86% are female (Goforth, et al., 2020).

Recruiting methods skewed toward those who were internet-savvy, economically advantaged, and identified with a particular association or marketable niche. Participants’ personal transpersonal experiences and mastery of transpersonal modalities allowed for familiarity with transpersonal terms, concepts, and approaches to psychotherapy. Since participants held a transpersonal orientation, it was assumed that the very nature of their therapeutic work would include a spiritual dimension and activate unconscious material presumed beneficial for psychological growth (Schneider, 2015). Given this delimitation, the results are not likely generalizable to mainstream therapists, especially as relates to participants who induced altered states during therapy rather than limiting their practice to talk therapies and given the rejection of conventional modalities stated by a majority of the sample.

Therapists from transpersonal theoretical orientations are delimited in unknown ways as likely sharing a unique perspective on therapy and its contextual components, especially the client’s role. For example, Jungian and sandplay therapists’ training may give them an increased understanding of the relational dimensions of the therapeutic alliance. In this study, participants whose primary modality was Jungian talked more about the client/therapist relationship and its components than others, using similar descriptive terms, such as empathy and congruence. Nondual, psychedelic-assisted, and trance-induced therapists have most likely experienced firsthand the role of client in their own training, which may result in skewed data, as transpersonally-oriented therapists may be more likely to understand, experience, and articulate the client role than conventional therapists, who are not required by state and/or licensing boards to experience therapy as clients.

The sample was not representative of the entire population of transpersonally-oriented therapists, modalities, or client populations, though persisting until saturation was reached provided some reliability and validity in the results. Some modalities that may have been considered transpersonal were not included, such as somatic modalities and holotropic breathwork, which might have yielded richer results. The sample was grouped by modality, and although saturation was reached, recruiting more participants in different trance modalities would have avoided condensing some into a single category. Since the second largest participant category (31.4%) comprised symbolic modalities, it may disproportionately represent a Jungian theoretical orientation, and practitioners who use psychedelically-assisted modalities were likely under-represented. Moreover, different drugs produce very different effects, making it impossible to equate the therapeutic use of ketamine, for example, with LSD or MDMA. Practitioners were not queried about the types of drugs used in their work, but such differences might have affected their perception of the client role. Furthermore, the dynamics of using psychedelics, most of which require very long sessions compared to induced-trance sessions, when the therapist can control the time the client is in an altered state, may have influenced the results in unknown ways. That is also true when comparing all trance and symbolic therapies with nondual therapies: the modalities do not work in the same way, affecting the roles of practitioners and clients alike, and indeed some marked differences appeared in the results contrasting nondual practitioners from the rest.

Additionally, the transpersonal modalities examined were not restricted to the many standard confines of conventional psychotherapy, such as therapist disclosure, length of session time, setting, insurance restrictions, and distinct technique guidelines, which biased the data in unknown ways or made comparisons across modalities or with conventional psychotherapy challenging. The sample was delimited to private practitioners who
conduct sessions without agency/organizational restrictions, such as client population, modalities used, time constraints, formal assessments, and client finances. This may skew toward participants who have similar experience in private practice as well as the type of client they attract. For example, according to the Centers for Disease Control and Prevention (2022), nearly one-quarter of American adults who received mental health counseling services were Caucasian, female and living in cities. Therefore, the demographic similarities of therapist and client may have influenced the data. To address this inherent bias, international participants were recruited, but the sample was still mostly American.

Finally, thematic analysis, or any qualitative method, has inherent limitations. The data were verbal statements made by the sample about their experience of the way clients contribute to therapy sessions. Because participants had varying levels of certification, licensure, and education, they did not share a consistent language. Participants had fostered their own spiritual, transpersonal, and healing practices and thus answered according to their experience and pre-formed interpretation of the purpose of the study, and/or in ways they thought might impress the interviewer. This was minimized, to the extent possible, by not providing detailed descriptions of the study. Decoding participant meaning was constrained by the first researcher’s own experience, knowledge, and interpretation of the participants’ words (Braun & Clarke, 2006). A rigorous attempt was made to limit bias through acknowledgement and transparency, including bracketing and self-awareness practices, such as journaling, centering before interviews, meditating before coding, and keeping field notes. The researcher applied an eclectic epistemological position that underpinned the results (Holloway & Todres, 2003), supported by an inductive approach to the analysis.

The research question was delimiting because it assumed that what emerges between a client and a therapist in session is cocreated. The design also assumed that the client’s contribution could be subjectively experienced, identified, and articulated by therapists, and that therapists, without clients’ input, could accurately judge what clients contribute to psychotherapy. Additionally, it assumed that client contributions are a necessary factor in the healing process and worthy of exploration. The design would have been more robust with the addition of a client sample for triangulation. A study that included conventional therapists talking about the clients’ role would have provided a more comprehensive comparison, given the dearth of literature on the topic in general.

**Coming to Transpersonal Psychotherapy**

The sample believed clients sought to include spirituality in the therapeutic experience, had a prior knowledge of and interest in the transpersonal, and had been dissatisfied with conventional therapy modalities because they were therapy-savvy, having participated in traditional psychotherapy for years, often exhausting mainstream modalities without relief. Previous studies have suggested that the client’s existing beliefs, perceptions, and assumptions about the therapeutic process influence treatment, engagement, consistency, and dropout rate (Barret, et al., 2008). Thus, a client’s negative experience with conventional therapy may have provided the expectation and motivation for greater engagement with new, alternative modalities to address their therapy goals. This increased engagement may have contributed to the client’s relating to a transpersonal therapist differently and to certain dynamics in the client role, such as wanting to be more self-directed.

Similarly, therapists were drawn to transpersonal modalities owing to their own experiences, which directly influenced their approach to practicing and attracting the type of client they wanted to work with. Clients who seek out therapists who use transpersonal modalities likely have a preconceived expectation that the therapist will better understand their transpersonal experiences. From a methodological standpoint, such pre-existing notions may introduce bias favorable to transpersonal psychotherapy because both client and therapist find meaning in transpersonal experiences. However, from a therapeutic standpoint, such commonalities may strengthen therapeutic rapport-building. Since the majority reported that their clients presented with common problems (e.g., American Psychological Association, 2021; National Center for Post-Traumatic Stress Disorder, 2022)
rather than unusual issues that might be outside the realm of conventional therapies, the clients seem to be seeking relief for common problems they felt could not be successfully treated with conventional therapy. The question regarding the efficacy of conventional psychotherapy is longstanding. A popular saying in the field asserts that one-third of clients get better, one-third stay the same, and one-third get worse. A study by Dragioti and colleagues (2017) indicated that not only is the effectiveness of conventional psychotherapy commonly exaggerated but also only a tiny fraction of the meta-analyses (7%) they assessed provided convincing evidence that psychotherapy was effective. Barnes and colleagues (2013) examined the most common reasons clients are dissatisfied with conventional talk therapies: 74% of participants withdrew from therapy because they continued to struggle in and between sessions.

Another factor pertaining to conventional therapy and client satisfaction appears in the psychedelic-assisted psychotherapy research. Clients who participated in psychedelic-assisted clinical trials (e.g., Bouso, et al., 2008; Carhart-Harris, et al., 2012; Garcia-Romeu, & Richards, 2018) met criteria including diagnosis, length of time or persistence of symptoms without relief, and unsuccessful therapeutic interventions thought to render such individuals treatment-resistant (Schenberg, 2018). Psychedelics, then, can present, augment, or substitute for conventional interventions and offer symptom relief when previous treatments have failed (Bouso, et al., 2008). Results from several studies imply that psychedelic-assisted psychotherapy can be more effectual and faster than conventional interventions, even for clients with chronic, persistent symptoms (Garcia-Romeu, & Richards, 2018; Greenway, et al., 2020; Wheeler, & Dyer, 2020).

It is possible that a client sharing a transpersonal experience with a transpersonal therapist would feel greater validation and connection to the therapist (Bordin, 1979, 1980, 1994) based on session content produced by transpersonal modalities. Cortright (1997) asserted that transpersonal therapists process content that addresses existential/spiritual dimensions normally given short shrift in conventional therapy. The deliberate inclusion of such content processed in session may provide additional support. Further, therapists’ acknowledgment of what may be happening beyond presenting problems, pathological diagnosis, and prognosis may prevent the client from feeling marginalized or misunderstood (Boorstein, 1986, 1996; Brown, 2020; Wells, 2000). The recognition of such client experiences helps create the non-judgmental environment that affords the client the freedom to report anomalous, transpersonal experiences without fear of pathologizing (McCormick, 2000). The same cannot be said for conventional psychotherapy, where particular transpersonal experiences are commonly diagnosed as pathological and could not be understood or processed appropriately without the support of transpersonal theory (Blackstone, 2006, 2007; Bugental, 1978; Hart, 1997; Hart & Puhakka, 2000). This study is congruent in finding that transpersonal therapists believe their clients gain therapeutic benefit by having a space that encourages transpersonal and spiritual experiences.

The Client Role in Transpersonal Psychotherapy

Many studies (e.g., Geller et al., 2013; Sackett & Lawson, 2015; Spencer et al., 2019) imply that the therapeutic process is client-led yet still place much of the therapeutic responsibility on the practitioner. In conventional psychotherapy, clients tend to defer to therapists as the therapist is perceived to be the authority (Rennie, 1990; Timulak & Creaner, 2010; Timulak & Keogh, 2017).

It is conventionally accepted that client resistance is an integral part of therapeutic work (e.g., Beutler et al. 2011) that ultimately adversely affects the process. However, contemporary views of client resistance concentrate on its protective role as a safeguard of emotional security for the client (e.g., Frankel & Levitt 2006; Miller 2003; Mouqué, 2005). As shown here, clients seeking transpersonal psychotherapy differ from those seeking conventional therapy because they are less defensive. Therefore, even though they suffer from common complaints, they may be more functional and less egoically driven. They are receptive to exploring spirituality, altered states, unconscious
personal dynamics, and anomalous experiences, including transcendence (even loss) of self and to consider alternate ideas, qualities identified in the literature (Boorstein, 2000; Cortright, 1997; Hartelius et al., 2013). The transpersonal client is emotionally ready to drop preconceived notions and delve deeper into the unconscious, using altered states for stronger confrontation and possible relief from suffering (Lemercier & Terhune, 2018; Prendergast, 2003). This study upheld Watson and Wiseman’s (2021) assertion that transpersonal clients were interested, curious, and ready to experience such material regardless of the painful dynamics that might surface.

The findings suggested that the client role characteristics and behaviors are unavoidably more developed than those of conventional therapy clients by the very demands of the transpersonal modality, which requires immense levels of openness, trust, and risk-taking, especially in trance-induced and drug-induced states compared to talk therapies. The transpersonal client was described as not only open and willing but longing to examine the psychic drivers of their suffering rather than to fall back on defense mechanisms (Wellings, 2000). Further, a conventional approach accepts suffering as an innate aspect of being human (Vaughan, 2013), whereas a goal of transpersonal psychotherapy is to reach the heart of suffering and release it.

Since a primary component of transpersonal therapy is a more expansive continuum of psychological health and well-being than conventional models, it affords clients the opportunity of working at deeper levels (Boorstein, 1997; Fenner, 2003; Johnson, 2017; Prendergast, 2003; Rodrigues & Friedman, 2015). The majority of participants noted their clients’ ability to know their own values, thoughts, feelings, behaviors, strengths, and weaknesses, a level of self-awareness further cultivated in therapy. While this emphasis on self-awareness was shared across orientations, for nondual therapists self-awareness is interpreted in a unique way: Self-knowledge is understood to be the dissolution of the separate self in identification with All That Is, which makes possible a direct knowledge of reality (Fenner, 2003; Johnson, 2017). It stands to reason that nondual therapists would identify self-awareness as a significant client quality.

Although there is no way of measuring an individual’s authenticity, capacity for vulnerability and honesty in psychotherapy, these client characteristics tend to be valued by the therapists in this study as well as in the literature (Coleman, 2017; Cortright, 1997; Lee, 2019; Neri, 2008; Yalom, 1957). Moreover, although the demands on clients seem higher than in conventional therapy, those demands differed considerably by modality. For example, the majority whose primary modality is psychedelic-assisted talked more about clients having to demonstrate greater ego strength and psychological maturity prior to entering the drug-induced altered state. During a psychedelic experience the client must be prepared to be saturated by flooding auditory and visual hallucinations, transient alterations to perception, and distorted representations of body, time, and space (Nour, et al., 2016). Other modalities, such as hypnosis, dreamwork, and past-life regression therapy, in contrast, present subconscious material cloaked in metaphor, archetype, and symbol to be processed at a slower rate governed by the client’s defense mechanisms.

In transpersonal psychotherapy, the client is viewed as having the capacity for self-healing (Roberts & Winkelman, 2013). A key component of the therapist’s role is to empower the client to draw out inner strengths and allow that natural, healing process to unfold while the client decides which issues to explore or therapeutic goals to set. The content of transpersonal therapy is decided solely by the client (Garcia-Romeu & Richards, 2018; Mithoefer et al., 2013; Roberts & Winkelman, 2013). The findings support these theoretical articles. Since the sample had had their own transpersonal transformative self-learning processes, they felt equipped to recognize, understand, and facilitate the client’s transformative experiences, including having their own transpersonal development furthered merely by supporting the client (Rodriguez & Friedman, 2013; Siegel, 2019).

The Therapeutic Alliance and Therapist Role in Transpersonal Psychotherapy

A significant body of research asserts that the therapeutic alliance is paramount in psychotherapy in general and transpersonal psychology in
particular (e.g., Ackerman & Hilsenroth, 2003; Ardito & Rabellino, 2011; Braga, 2017; Cheng & Lo, 2016; Geller & Porges; 2014; Grof, 2012; Horvath, 2001; Horvath & Luborsky, 1993; Prendergast, 2003; Stargell; 2017; Walsh & Vaughan, 1980). The findings that the client-therapist relationship is non-hierarchical and that the therapist’s role is that of supporter and teammate align with research on transpersonal psychotherapy (Phelon, 2001, 2004; Richards et al., 2015; Schneider, 2015; Wellings & McCormick, 2000). Nondual therapist Blackstone (2006) asserted that the encounter between client and therapist is transpersonal, in which a co-created, transsubjective field emerges. If the therapist’s and client’s consciousness are unified or shared, such communication would transcend the clinical limitations and boundaries in conventional modalities. Almost all the nondual therapists stressed the equality of the therapeutic relationship, congruent with the literature (e.g., Spira, 2017; Siegel, 2017). The transpersonal therapist understands that by merely engaging in the relationship both therapist and client share in the process of transformation (Cardenà et al., 2017; Daniels, 2005; Walsh & Vaughan, 1980, 1993). In the present study, therapists’ appropriate self-disclosure was a feature of their therapeutic engagement. In their meta-analysis, Hill, et al. (2018), suggested that therapist self-disclosure enhanced the therapeutic relationship and was associated with improved client mental health, openness, and beneficial outcomes. Moreover, almost all of the psychedelic-assisted participants reported that the therapists’ appropriate self-disclosure was embedded in their role as supporter and was a common pre-journey practice (e.g., Carhart-Harris et al., 2016; Coleman, 2017; Grof, 1980; Watts & Luoma, 2020).

Participants emphasized the therapists’ holding space, a metaphorical term for the transpersonal, inter-subjective environment that exists in the therapeutic setting. According to Phelon (2004), many transpersonal techniques require the therapist to maintain the position of witness, actively listening rather than interpreting the client’s experience. Although participants perceived the therapists’ necessarily establishing safety and trust as part of their function, both factors reflect an additional demand on the client, who is taking a much higher risk when engaging in trance-inducing modalities than in conventional therapy. This is especially true in psychedelic-assisted modalities, when the client may become highly disoriented and therefore dependent on the therapist’s competency and integrity to manage their physical as well as psychological safety.

The results are congruent with literature indicating that psycho-spiritual practices, such as meditation, yoga, and bodywork, may positively contribute to personal growth for both client and therapist (Johnson & Grand, 1998; Johnson, 2013, 2018; Siegel, 2013). The majority said clients should mentally, physically, and spiritually prepare for sessions, congruent with authorities who say that meditation helps clients increase personal and transpersonal awareness, diminish boundaries between the client and the therapist, and readies clients for nonordinary exploration (Cortright, 1997; Johnson, 2000; Leary, 2010). However, induced trance therapists thought client preparation may have a negative effect, and some literature agrees that less preparation might allow clients to remain wide open and decrease session anxiety (Weiss, 2010; Woolger; 1987, 1993).

Ramifications for Future Research

A meaningful follow-up would be to interview clients of the transpersonal practitioners regarding their experience and expectations of the therapist role. Evidence suggests therapists have much to gain by attending to clients’ dreams (Deslauriers, 2013; Hartmann, 2000, 2007a, 2007b; Hill & Goates; 2004; Hill & Knox, 2010), pre- and peri-natal and past-life impressions (Bahrami & Haidari, 2021; Hunter & Eimer, 2012; Kokoszka, 1988; Rank, 1999; Wade, 1998, 2022), childhood and/or current trauma (Christensen, et al., 2009; Cardenà, et al., 2000; Watkins & Watkins, 1997), and that subconscious work is valuable and effective (Hartman & Zimberoff, 2003, 2013; Spitzer, 2001). Expanding the skillset of conventional therapists to include transpersonal modalities could reduce some client dissatisfaction with conventional methods and enable deeper, more transformational work from a positive rather than a disease-based perspective.

Transpersonal psychotherapy has the possibility of extending its reach into more
mainstream psychotherapy by conducting further research on modalities considered more conventional but involving altered states, such as Eye Movement Desensitization and Reprocessing Therapy (EMDR), mindfulness, and the like (e.g., Grof, 2003, 2014; Krystal, 2003; Siegel, 2017). Comparing client satisfaction and therapeutic outcomes between conventional and transpersonal modalities could assess therapeutic efficacy, including matching modality to presenting issue and client readiness. These findings also imply that the client-led, non-hierarchical dynamics of the transpersonal TA might mitigate some problems with conventional therapy, provided a certain level of client readiness. It may be advantageous to embrace the expanded expectations of both therapist and client regarding establishing goals and content for processing, fostering client empowerment and self-efficacy and therapist competency.

Finally, an interesting result was the response similarities between nondual therapists and psychedelic-assisted therapists, suggesting that they share a similar approach as it pertains to client/therapist roles, attitudes, and behaviors, and the dynamics of the therapeutic alliance, which may be important to pursue with a larger, more specific sample.

**Conclusion**

This study expands the transpersonal literature on psychotherapy, especially the work of Boorstein (2000) and Cortright (1997). Although existing studies attempted to capture who the transpersonal client is, such a profile has not yet been fully established (Grof, 1967; Seigel, 2019; Vaughan, 1979; Yalom, 2002). These findings describe the transpersonal client’s characteristics, traits, attitudes, and behaviors as experienced by transpersonal practitioners and begin to distinguish that client from conventional therapy clients in terms of goals and readiness. The findings point to the dynamics of the transpersonal psychotherapeutic process and how they affect the roles of client and therapist, placing more demands on both. The information suggests that transpersonal psychotherapy may be adjunctive or complementary to conventional therapy, with developmental overtones for both client and therapist: conventional psychotherapy may be needed to address foundational client ego needs to strengthen the psyche to the point where transpersonal psychotherapy is possible without defensiveness; and conventional therapists may need development to relinquish the “expert” role for a more collaborative, egalitarian one that allows the client to lead, and perhaps also need to have and own their own transpersonal transformative experiences. Transpersonal psychotherapy may not be suited for all clients, and conventional therapy may only work for some clients up to a point. Transpersonal modalities could be integrated into conventional therapy as an expansion of therapeutic exploration based on client need, readiness, ego strength, psychological maturity, as well as therapist readiness, psychological maturity, and openness to trans-egoic dynamics. This study points to the unique contribution of transpersonal psychotherapy, transpersonal psychotherapists, transpersonal modalities, and the clients willing and ready to engage them.

**References**


The Client Role in Transpersonal Psychotherapy


Wade, J. (2018). After awakening, the laundry: Is nonduality a spiritual experience?. International Journal of Transpersonal Studies 31


Appendix A: Interview Questions

Please know all information you provide will remain confidential. Please note that you are not required to answer any of the questions and feel free to stop at any time. Are you ready to proceed?

First, I need to ask you a few basic demographic questions for purposes of data analysis:

- What is your sex?
- What is your race or ethnicity?
- What is the highest level of education you have completed?
- Where is your practice located?

1. What led you to identify as a transpersonal practitioner or use transpersonal modalities in your therapy practice?
2. Which transpersonal modalities do you use most often or routinely with clients?
3. What do you see as the role of the client in a transpersonal practice like yours? How is that different or the same as the role of the client in conventional therapy?
4. What types of clients seek transpersonal therapy, such as the kind you practice, compared to conventional therapy? What personal qualities do they have? What kinds of problems do they present? How would you assess their psychological functioning compared to that of people seeking conventional psychotherapy? How have the kinds of clients you see changed over time as your practice has evolved or the modalities you use have changed?
5. Who decides which issues to focus on? the goals of treatment? How does this happen?
6. What do you consider to be the most important traits for a client to have to be successful in therapy, and why? What qualities do they need to have to benefit from a particular modality? What would signal to you that a client is not appropriate for your type of therapy practice or would not benefit from a particular modality?
7. How would you describe the therapeutic relationship you try to establish with clients?

8. What is your role, and what do you do? What is the client’s role, and what do they do?
9. How do you think the client contributes to the co-creation of the therapeutic alliance? How does a transpersonal therapeutic alliance differ from a conventional one, if it does?
10. Please describe your role in the therapy process. What are you doing or trying to create?
11. Please describe a real client experience that illustrates what you feel a client is bringing to the therapy process.
12. In what ways do you think a client can prepare to engage in the kind of therapy you practice? For the transpersonal modalities you bring into the therapy session.

13. Is there anything else you would like to add?

Thank you so much for your time and energy. It has been very informative. I really appreciate you taking the time to be interviewed and for speaking with clarity about your experience with clients in your practice. Thank you.

About the Authors

Phyllis Alongi, PhD, LPC, ACS, is a clinician in private practice who has numerous years of experience working with children, adolescents, and adults incorporating a variety of transpersonal modalities. She is a clinical consultant who provides mental and behavioral health education to local and national organizations, as well as conference presentations. In addition to becoming an Accredited Clinical Supervisor, she teaches at Monmouth University, Graduate School of Professional Counseling.

Jenny Wade, PhD, is a professor at the California Institute of Integral Studies, San Francisco, a researcher, organization and leadership development consultant, and developmental psychologist specializing the structuring of consciousness in normal and non-ordinary states and related transformative processes. The Millennium Middle School in San Francisco based their curriculum on her developmental theory, and she designed an advanced leadership program for His Serene Highness Prince Alfred of Leichtenstein and the

About the Journal

The *International Journal of Transpersonal Studies* is a Scopus listed peer-reviewed academic journal, and the largest and most accessible scholarly periodical in the transpersonal field. IJTS has been in print since 1981, is published by Floraglades Foundation, sponsored in part by Attention Strategies Institute, and serves as the official publication of the International Transpersonal Association. The journal is available online at www.transpersonalstudies.org, and in print through www.lulu.com (search for IJTS).