

Presence at the Threshold

The person of the therapist in psychedelic and inner experiential work

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The person who meets us there

Some of my clients describe deep experiential sessions as “psychedelic without the hallucinations.” Something previously discussed becomes emotionally present. A conviction that seemed inseparable from identity loosens. Grief arrives with tenderness rather than humiliation. The person may feel more connected to themselves and, sometimes, more able to meet another person without the old expectation deciding everything in advance.

I am interested in what makes such an opening possible. Medicine may contribute substantially. A therapeutic model can help us recognize and accompany what is unfolding. Yet the person who brings that model into the room also brings a relationship with fear, uncertainty, shame, love, and their own wish to help. Those relationships enter the work, whether we have examined them or not.

The proposition I want to develop is that the therapist's personal and relational capacities deserve a primary place in how we understand successful depth work. I mean a clinical priority: the quality of accompaniment through which an intervention becomes an encounter with this particular person. Participant accounts substantiate its importance; they do not establish that therapist characteristics explain more outcome variation than medicine, method, patient capacities, or circumstances. We should not turn a compelling clinical argument into a ranking the available data cannot support.

My concern is what follows when we take that argument seriously. We must ask more of ourselves than knowing how to invite someone inward. Can we remain available when they are frightened, disappointed in us, or unconvinced by our understanding? Can they discover something we did not anticipate? The threshold belongs to them. Our preparation includes learning how to stand beside it without making it ours.

What research asks us to take seriously

The importance of the person of the therapist is more than a clinical intuition. Wampold and colleagues' 1997 meta-analysis found roughly equivalent average outcomes among the bona fide psychotherapies they examined.[1] This challenges the expectation that allegiance to a particular model will explain therapeutic success. It does not mean every treatment is equally suited to every difficulty, or tell us by itself what produces change. It leaves us with a question that matters in the consulting room: what becomes possible across methods when treatment is offered well?

Wampold's later synthesis gives the relationship a more specific place. Drawing primarily on meta-analyses, it examines alliance, empathy, expectations, and therapist differences. The alliance includes an emotional bond and collaboration on goals and tasks; it is more than liking one another. The review reports an alliance-outcome correlation of approximately .27 across nearly 200 studies involving more than 14,000 patients.[2] This is a meaningful association, not proof that presence is the largest cause of improvement. It gives us reason to attend closely to how treatment becomes a shared undertaking.

Swan and Heesacker's University of Florida study approaches the question from the prospective patient's side. Among 329 adults, participants preferred a description of therapy emphasizing relational common factors over one emphasizing specific evidence-based ingredients.[3] This measures preferences, not outcomes, and the descriptions offered shape what can be inferred. Still, it reminds us that people may approach treatment asking whether they can trust the person who offers it, before they ask which theory that person follows.

For experiential and psychedelic work, these findings provide a broader foundation rather than a direct test. My clinical inference is that depth asks us to make that collaboration available precisely when ordinary confidence falters: when someone needs to slow down, disagrees with us, or cannot yet receive our care. To understand what this looks like from inside the encounter, we need to listen to the people being accompanied.

What people remember about being accompanied

The most useful accounts for this question describe what care felt like. In Iwakabe, Edlin, and Thoma's study of an AEDP client's experience, the participant described profound empathy, affirmation, and connection with Diana Fosha. Her face, voice, bodily responsiveness, and experiential guidance mattered. Receiving her empathy was itself consequential; he could approach emotional experience he had previously feared. This was an exceptionally successful case selected for study, not a portrait of an average session.[4]

In Barone and colleagues' interviews following MDMA-assisted therapy for life-threatening illness, participants emphasized the therapists' dedication, skill, emotional support, and the dependable treatment setting. One considered connection with the

people at least as important as the medicine. Participants also credited MDMA with making trust and emotional safety more available.[5] Their accounts describe interacting contributions, not a contest in which relationship defeats pharmacology.

Beaissant and colleagues' psilocybin participants valued a professional, accepting, kind environment and encouragement to communicate without pressure.[6] In Brett and colleagues' interviews, concentrated attention and identity-affirming care could feel reparative to people accustomed to being othered. One described being "held in a cocoon of safety." [7] These accounts suggest that the quality of attention can change how treatment is received before we have explained why.

There are differences of setting and expectation across these sources. A retrospective interview, a selected clinical case, and a group-treatment account cannot be combined into a universal patient voice. Nevertheless, a recognizable relational pattern recurs: acceptance that reduces shame, dependable attention, and guidance responsive enough to leave room for the person's own experience. I take that convergence as a reason to examine the therapist's contribution more closely, not as proof that every powerful experience has the same cause.

Presence has to become something the patient can receive

Warmth is an intention until someone experiences it as care. A soft voice may soothe one person and feel patronizing to another. Enthusiasm may communicate delight or become an expectation to improve. The same intervention can offer company or repeat the experience of someone with authority deciding what should happen inside us.

Lipton's account of therapeutic presence in AEDP helps make this distinction practical. Presence involves attention to our own embodied experience, attunement to the patient, willingness to be affected, and reflection on what happens between us.[8] It asks for participation rather than a convincing performance of kindness. Our care needs to remain capable of being corrected by the person receiving it. The alliance research makes that correction consequential: agreement about the work must be discovered with the patient, rather than inferred from their willingness to follow us.[2]

Snyder's clinical account in *Leaning Into Love* is valuable because she notices her own detachment. Intellectual conversation has become a place where therapist and patient can remain together without fully encountering each other. Her recognition changes her participation, and the work opens toward more tenderness and connection.[9] The relevant capacity includes returning from absence. We need not be continuously attuned to be useful; we need to become interested when we are not.

That interest can feel exposing. It requires hearing that our reassurance has landed as dismissal, or that we have missed the sadness behind a clear account. A therapist who can bear that recognition without defending an intention offers something different from a therapist who needs to be experienced as helpful. For me, humility becomes clinically

substantial at precisely this point: the patient's account is allowed to change what I do next.

Protection softens when it is no longer being opposed

Defenses are ways of preserving a workable relationship with experience. Explaining may protect against grief. Competence may guard against the shame of needing someone. Anger can hold a boundary that has repeatedly been ignored. Understanding these responses does not make every consequence benign, but it changes the manner in which we approach them.

Schwartz's IFS offers a language for this respect. Managers anticipate difficulty, Firefighters seek urgent relief, and Exiles carry vulnerable experience; Self describes a different quality of relationship with those parts.[10,11] The therapist's curiosity matters because protection is not simply an obstruction to the supposedly real work. It tells us something about what has been dangerous and what may still be dangerous now.

Calof's account of hypnotherapy, discussed alongside his work with Simons in *The Couple Who Became Each Other*, offers a complementary orientation. He describes facilitating the person's own resources and reconsidering earlier experience with capacities acquired since.[12] The therapist accompanies an inner process without owning it. This is relevant to portrayals, parts work, and psychedelic imagery, even though the approaches are not interchangeable.

Our own protection can complicate the meeting. The part of us that cannot bear helplessness may insist on movement. The part that needs to be trusted may hear caution as resistance. Personal work can help us recognize these investments before they become instructions. I want us to approach a defense with enough respect that it need not intensify merely to retain a place in the conversation.

This is one way of understanding what happens when a person feels firmly and empathically held. They may have less need to monitor, explain, please, or defend against the relationship itself. Feeling has more room because some of the work of facing it is shared. Trust does not abolish protection; it can make alternatives possible.[13]

The body needs more than an invitation to go deeper

Parts have a bodily life. A frightened or controlling response may arrive with muscular readiness, narrowed attention, and an urge to act. Another person becomes busy, distracted, or eager to leave. Stillness may mean bracing and intense alertness, or distance, heaviness, and reduced contact. The therapist needs the patient's help to understand which experience is occurring.

Sympathetic activity contributes to mobilization; parasympathetic pathways participate in cardiac regulation, recovery, and some immobilization responses. These systems interact. Freezing can combine mobilization with inhibition and should not automatically be

equated with shutdown.[14] A psychological part is not an autonomic structure. Nervous-system activation can intensify its urgency without explaining its whole meaning.

Fight, flight, freeze, and fawn are useful shorthand when they sharpen curiosity. Fawn describes appeasing or self-abandoning attempts to preserve safety through another person's approval, not a discrete autonomic circuit. An agreeable patient may be afraid of disappointing us. A guide who interprets that agreement as readiness can mistake accommodation for consent.

The window of tolerance helps us ask whether someone can remain sufficiently present to feel, notice, choose, and stay in contact. Strong emotion can be workable; quietness can conceal disconnection. Sensorimotor approaches bring attention to small increments, pacing, and resources that support that capacity.[15] We should not make calmness the entrance requirement for feeling, nor assume that intensity demonstrates useful processing.

The therapist becomes one resource through rhythm, responsiveness, predictable boundaries, and a willingness to pause. Other resources belong increasingly to the client: orienting outward, moving, recognizing an early signal, recalling a trusted presence, or asking to stop. An inward focus, eye contact, or breathing invitation may help or feel intrusive. We ask and observe.

Our own window matters too. When we become urgent, disappointed, or afraid, the patient may begin managing us. Consultation and personal work help us recover the capacity to distinguish a workable opening from disorganization. The aim is enough regulation for experience to become bearable and meaningful, with growing participation from the person whose life continues beyond the session.

Medicine may loosen a certainty without deciding what replaces it

The default mode network participates in internally oriented activity, including self-reference and autobiographical reflection.[16,17] Psychedelic findings involving changes in network activity, coupling, and broader organization help us understand why familiar experience can become less familiar.[18,19] They do not locate a Manager in a network or explain what a particular defense means.

Carhart-Harris and Friston's REBUS account proposes that classic psychedelics can relax the governing confidence of high-level prior beliefs.[20] Clinically, this invites a conversation about convictions such as needing others is dangerous. When that conviction becomes less inevitable, previously discounted care may register. Less certainty can also bring confusion and greater openness to suggestion. The therapist's responsibility includes leaving room for the person's own meaning to form.

Huxley's first-person mescaline account in *The Doors of Perception*, with its reducing-valve metaphor, offers a philosophical way of considering what habitual

consciousness excludes.[21] It is not a neural explanation. Its usefulness here is to remind us that loosening a familiar organization of experience does not tell us how to accompany the unfamiliar one.

Participant accounts give the question human form. Malone and colleagues describe psilocybin experiences involving changed relationships with the body, mortality, and belonging.[22] Gasser and colleagues' LSD interviews include increased emotional access and shifts from painful feeling toward relief or wider perspective.[23] Van der Kolk and colleagues' work on MDMA and self-experience similarly draws attention to capacities beyond symptom scores.[24]

These routes have different pharmacology and demands. Their clinical convergence is a possibility of changed relationship with experience, not an identity of mechanisms. The therapist can help an opening become something the person can explore rather than an explanation they are expected to accept.

AEDP gives accompaniment a detailed clinical form

Fosha's work asks whether a person is alone with what is happening and whether the offered relationship can actually be received. AEDP portrayals bring emotionally significant encounters into present experience, within an actively engaged dyad.[25] That makes the therapist's participation part of the work rather than merely a preliminary condition for it.

Fosha and Thoma's metatherapeutic processing attends to the experience of beneficial change.[26] Someone feels understood and then becomes sad, embarrassed, or suspicious. A helpful moment has touched the history of what was missing. If we stay interested, the person may discover both the new care and their difficulty receiving it. Integration can begin within that hesitation.

I find this an especially useful frame for psychedelic work. Its detailed attention to affect, relationship, and the reception of help can support a person before, during, and after a medicine session. The AEDP Institute's psychedelic committee and Fosha, Green, and Gleiser's ketamine seminar reflect this developing clinical conversation.[27,28] They do not establish comparative superiority.

AEDP can also become a demand if we need a transformation or a completed emotional process. Our commitment to the model should make us more responsive to what is happening, not more persuasive about what ought to happen. A patient may need to remain with an ordinary concern, turn outward, or leave something unfinished. The therapist's ability to bear that choice is part of the frame's usefulness.

IFS is most helpful when the map makes room for the meeting

IFS can help a therapist recognize the concern within a harsh response and the competing needs within apparent resistance. Its influence in MAPS-associated MDMA work is documented in the writings of Schwartz and Sweezy, Mithoefer, and a firsthand training account.[29,30,31] That establishes a connection, not that most therapists in every cohort were formally trained in IFS.

The most revealing client material comes from Sarrassat and Hill's four-person study of IFS in psychedelic integration. Participants valued respectful pacing, consent, and relational strength. One found terminology obstructive and asked, "Can we just drop the language and stay with the part?" The therapist could hear the request, and contact improved.[32] Here, flexibility was part of what made the method useful.

Keiser's first-person IFS account describes active support as she approached vulnerable imagery and developed a compassionate relationship with a younger self.[33] It illustrates a therapist helping care become an internal capacity, rather than simply reassuring from outside. Its practice-website setting and single-person perspective limit generalization.

The risk of hegemony appears when a patient's experience must justify itself to the model. Refusal becomes another protector, uncertainty becomes avoidance, or a powerful image becomes proof of the guide's worldview. The question in my essay [Meet Me Before You Move Me](#) remains relevant: has the person been encountered before being directed? A useful map should help us listen when their experience refuses its categories.

Our own inner work becomes visible in how we respond

Phelps's framework for psychedelic therapist training includes empathic presence, trust enhancement, self-awareness, ethical integrity, and knowledge of drug effects.[34] These are professional capacities, not personality ornaments. They become consequential in how we respond to distress, dependency, idealization, difference, and the limits of our understanding.

A small qualitative study of beginning therapists learning IFS suggests that the model helped them recognize internal processes and personal agendas relevant to their clinical relationships.[35] That is a useful opening for thinking about self-work. It does not prove that therapists with a particular history of inner exploration produce better outcomes.

The question I want to ask is more demanding than whether we have had profound experiences. What has our work made us able to bear? Can we remain open to anger without rushing reconciliation? Can we hear that someone needs us without becoming indispensable? Can we tolerate not knowing without retreating into a map? Personal psychedelic work may contribute, as may sustained experiential therapy, contemplative practice, supervision, and honest relationships. None confers competence by itself.

Richards asks guides to be “authentic and well-grounded within themselves.”[36] Groundedness includes being moved without making the patient care for our response. It includes recognizing when our excitement about healing has become pressure. A person should not have to produce a revelation to reassure us that we are good at our work.

Schore's account of implicit communication gives this discipline another language. Face, voice, gesture, rhythm, and affect regulation communicate before a complete explanation exists.[37] A therapist can offer an elegant formulation while missing a tentative glance or a withdrawal after our enthusiasm. The opportunity may be to slow down and ask how we have just affected the person. This is not a division into thinking left brains and feeling right brains; it is attention to dimensions of the encounter that intellect alone can overlook.

Our own healing may make those moments more accessible because less of our attention is occupied with protecting ourselves. That is my clinical hypothesis, not a finding established by these comparisons. We remain wounded and capable of mistakes. What matters is whether we can recognize our participation, seek help, and return with responsibility rather than an explanation that exempts us.

Mentorship and humility belong beside depth

Fadiman's *The Psychedelic Explorer's Guide* places preparation and the life around a journey within the work.[38] This widens our attention beyond the striking session. What support exists beforehand? Who helps the person afterward? What happens when daily relationships do not change as quickly as the inner experience?

The mentorship history associated with Stolaroff's conversations with Leo Zeff in *The Secret Chief Revealed* raises a related question for the guide: who helps us recognize what we cannot see alone?[39] Historical practitioners can enlarge our questions without becoming authorities beyond scrutiny. Admiration needs room for examination, especially when a teacher's personal influence is powerful.

Warmth and charisma do not guarantee safety. Dependable boundaries, revisable consent, appropriate medical coordination, and accountability must accompany presence. Emotional holding does not imply physical touch. Guides need to recognize destabilization and obtain help rather than spiritualize an unsafe process. Humility includes the willingness to interrupt, disappoint, or acknowledge that another kind of care is needed.

Cultural and social differences also enter the encounter. Our wish to understand can conceal assumptions about identity, family, spirituality, or what freedom should look like. Self-work needs to include our relationship with power and the ways we may feel least inclined to receive correction. A patient should not have to resemble us, admire our mentors, or share our worldview to receive our fullest attention.

An expanded state and an expanded capacity to live

James's *The Varieties of Religious Experience* takes unusual consciousness seriously while asking about its fruits in a life. He also distinguishes an experience's felt authority from any obligation on others to accept its revelation.[40] These are valuable disciplines for a therapist who has been deeply changed by their own inner work. Our conviction should not become someone else's destination.

Richards's *Sacred Knowledge* and Yaden and Newberg's *The Varieties of Spiritual Experience* give spiritual meaning a serious place in the conversation.[36,41] We can listen to wonder without taking possession of its explanation. A sense of unity, a loved person's imagined presence, or ordinary relief at no longer feeling alone may each matter. Depth need not arrive in a grand vocabulary.

The shared therapeutic destination I am proposing is greater capacity to live with oneself and others. Grief can be accompanied rather than endured alone; anger can become an intelligible signal rather than catastrophe; care can reach someone who has learned to discount it. Nonmedicine experiential work can support these kinds of changes without reproducing the perceptual effects or timetable of a psychedelic session. Neither route guarantees them.

We do not need to uncover a hidden scene to work with an implicit expectation that needing someone is dangerous. Imagery and portrayals can revise a relationship with experience without establishing new historical facts. What matters afterward includes whether a person can receive help, speak more honestly, respect a limit, acknowledge an impact, and remain connected when difference returns.

The therapist's relational capacities deserve a primary place because they shape how every other contribution is offered and received. They are neither sufficient by themselves nor independent of the patient's resources and circumstances. I want us to take responsibility for developing them with the seriousness we bring to learning a method. The person who accompanies another into depth must remain willing to be a person in their own continuing work.

References and selected readings

1. Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. N. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." *Psychological Bulletin*, 122(3), 203-215. Meta-analysis.
2. Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14(3), 270-277. Research synthesis.
3. Swan, L. K., & Heesacker, M. (2013). Evidence of a pronounced preference for therapy guided by common factors. *Journal of Clinical Psychology*, 69(9), 869-879. Preference study.
4. Iwakabe, S., Edlin, J., & Thoma, N. (2022; online 2021). A phenomenological case study of accelerated experiential dynamic psychotherapy: The experience of change in the initial session from a client perspective. *Journal of Psychotherapy Integration*, 32, 363-376. Article.

5. Barone, W., Mitsunaga-Whitten, M., Blaustein, L. O., Perl, P., Swank, M., & Swift, T. C. (2022). Facing death, returning to life: A qualitative analysis of MDMA-assisted therapy for anxiety associated with life-threatening illness. Original study.
6. Beaussant, Y., Tarbi, E., Nigam, K., et al. (2024). Acceptability of psilocybin-assisted group therapy in patients with cancer and major depressive disorder: Qualitative analysis. *Cancer*, 130, 1147-1157. Original study.
7. Brett, J., et al. (2025, online publication). A qualitative analysis of participant expectations and experiences of psilocybin-assisted psychotherapy for methamphetamine use disorder. *Addiction*. Original study.
8. Lipton, B. *The being is the doing: The foundational place of therapeutic presence in AEDP*. Clinical essay and transcript.
9. Snyder, M. *Leaning into love: The radical shift*. Clinical essay and transcript.
10. Schwartz, R. C. *Evolution of the Internal Family Systems model*. Author essay.
11. IFS Institute. *The Internal Family Systems model outline*. Model description.
12. Calof, D. L., with Simons, R. (1996). *The couple who became each other*. Bantam. See Calof's Fresh Air interview, originally 1997, rebroadcast 1998.
13. Lipton, B., & Fosha, D. (2011). Attachment as a transformative process in AEDP: Operationalizing the intersection of attachment theory and affective neuroscience. *Journal of Psychotherapy Integration*, 21, 253-279. Author manuscript.
14. Kozłowska, K., Walker, P., McLean, L., & Carrive, P. (2015). Fear and the defense cascade: Clinical implications and management. Clinical synthesis.
15. Sensorimotor Psychotherapy Institute. *SP for Complex Trauma and Dissociation*, developed by Janina Fisher. Training description.
16. Raichle, M. E., et al. (2001). A default mode of brain function. *PNAS*, 98, 676-682. Article.
17. Gusnard, D. A., et al. (2001). Medial prefrontal cortex and self-referential mental activity: Relation to a default mode of brain function. *PNAS*, 98, 4259-4264. Article.
18. Carhart-Harris, R. L., et al. (2012). Neural correlates of the psychedelic state as determined by fMRI studies with psilocybin. *PNAS*, 109, 2138-2143. Article.
19. Siegel, J. S., et al. (2024). Psilocybin desynchronizes the human brain. *Nature*, 632, 131-138. Article.
20. Carhart-Harris, R. L., & Friston, K. J. (2019). REBUS and the anarchic brain: Toward a unified model of the brain action of psychedelics. *Pharmacological Reviews*, 71, 316-344. Theoretical article.
21. Huxley, A. (1954). *The doors of perception*. Chatto & Windus. Publisher description and limited preview of later edition.
22. Malone, T. C., et al. (2018). Individual experiences in four cancer patients following psilocybin-assisted psychotherapy. *Frontiers in Pharmacology*, 9, 256. Original accounts.
23. Gasser, P., Kirchner, K., & Passie, T. (2015). LSD-assisted psychotherapy for anxiety associated with a life-threatening disease: A qualitative study of acute and sustained subjective effects. *Journal of Psychopharmacology*, 29, 57-68. Author-hosted paper.
24. van der Kolk, B. A., et al. (2024). Effects of MDMA-assisted therapy for PTSD on self-experience. *PLOS ONE*, 19, e0295926. Article.

25. Fosha, D. *AEDP portrayals: The dyadic experiential processing of trauma to a corrective emotional experience*. Training description.
26. Fosha, D., & Thoma, N. (2020). Metatherapeutic processing supports the emergence of flourishing in psychotherapy. *Psychotherapy*, 57, 323-339. Article.
27. AEDP Institute. *AEDP and psychedelic-assisted psychotherapy*. Committee statement.
28. Fosha, D., Green, M., & Gleiser, K. (2026). Ketamine-assisted AEDP seminar. Public seminar description.
29. Schwartz, R. C., & Sweezy, M. (2019). *Internal Family Systems therapy* (2nd ed.). Guilford. Institute excerpt on MDMA/PTSD.
30. Mithoefer, M. (2013). MDMA-assisted psychotherapy: How different is it from other psychotherapy? *MAPS Bulletin*.
31. Jackson, C. (2016). Integrity, mentorship, and self-care. Firsthand MAPS training account.
32. Sarrassat, S., & Hill, S. (2026). How does the internal family systems model of psychotherapy support clients in the integration of their psychedelic experiences? An interpretative phenomenological analysis of clients' testimonies. *Journal of Psychedelic Studies*, 10, 271-285. Original study.
33. Keiser, K. (2021). Therapy for therapists: One therapist's experience with IFS. First-person account.
34. Phelps, J. (2017). Developing guidelines and competencies for the training of psychedelic therapists. *Journal of Humanistic Psychology*, 57, 450-487. Article.
35. Mojta, C., Falconier, M. K., & Huebner, A. J. (2014; online 2013). Fostering self-awareness in novice therapists using Internal Family Systems therapy. *The American Journal of Family Therapy*, 42(1). Original qualitative study.
36. Richards, W. A. (2015). *Sacred knowledge: Psychedelics and religious experiences*. Columbia University Press. Publisher. See Richards (2023), *The role of the therapist in psychedelic therapy*.
37. Schore, A. N. (2022). Right brain-to-right brain psychotherapy: Recent scientific and clinical advances. *Annals of General Psychiatry*, 21, 46. Theoretical review.
38. Fadiman, J. (2011). *The psychedelic explorer's guide: Safe, therapeutic, and sacred journeys*. Park Street Press. Publisher excerpt.
39. Stolaroff, M. (2004/2022). *The secret chief revealed: Conversations with Leo Zeff, pioneer in the underground psychedelic therapy movement*. Publisher's historical account.
40. James, W. (1902). *The varieties of religious experience*. Longmans, Green. Original text.
41. Yaden, D. B., & Newberg, A. B. (2022). *The varieties of spiritual experience: 21st century research and perspectives*. Oxford University Press. Publisher abstract and contents.

Note on sources

This is a clinical and theoretical synthesis informed by participant accounts, clinical transcripts, neuroscience, historical writing, and philosophy. Those sources have different evidential roles. Neither vivid experience nor an interview establishes a treatment mechanism or a ranking of causal contributions. Historical books are not contemporary practice standards. The essay concerns professional reflection, not a protocol for administering medicine or undertaking trauma work alone.