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The Experience-Trajectory Framework: Substance-Specific Risk Stratification for Psychedelic Preparation and Aftercare beyond Set and Setting

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ABSTRACT

Set, setting, preparation, and integration are widely recognized as important dimensions of psychedelic experiences. However, these concepts often remain too general to specify how preparation, containment, and aftercare should differ across substances, routes of administration, acute duration, residual effects, bodily condition, and interaction exposure. This article proposes the Experience-Trajectory Framework for psychedelic preparation and aftercare. The framework focuses on psilocybin, lysergic acid diethylamide (LSD), mescaline, vaporized N,N-dimethyltryptamine (N,N-DMT), vaporized 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT), and ayahuasca or oral N,N-dimethyltryptamine (DMT) combined with monoamine oxidase inhibition. Its central claim is that preparation and aftercare should be stratified by two primary variables: the Experience-Trajectory Profile of the psychedelic state and the participant's Baseline Risk State before exposure. Experience-Trajectory Profile refers to onset, peak phase, acute duration, residual effects, recovery window, and the earliest appropriate timing for interpretation or integration. Baseline Risk State refers to the participant's acute physiological and pharmacological condition, including sleep, hydration, cardiovascular stability, gastrointestinal status, glucose stability, psychological stability, and interaction load. This article is a conceptual framework paper, not a clinical protocol or medication-discontinuation guide. It provides a stratification model that links substance-specific experience trajectories with baseline physiological and interaction states to derive containment intensity, aftercare timing, and post-acute meaning-regulation needs. By distinguishing compressed, medium-duration, long-duration, and monoamine oxidase (MAO)-mediated experience profiles, the framework clarifies why different psychedelic contexts require different screening, containment, stabilization, and follow-up procedures. It is intended as a research-oriented framework for conceptual clarification, safety documentation, retreat-safety evaluation, and future empirical refinement. The framework also offers a basis for future comparative research on preparation standards, retreat safety practices, and post-acute stabilization across different psychedelic contexts.

Keywords: psychedelics, experience trajectory, baseline risk state, interaction load, aftercare

INTRODUCTION

Set and setting remain foundational concepts in psychedelic research and practice. Set refers to the participant's psychological condition, expectations, intentions, and vulnerabilities, whereas setting refers

to the physical, social, relational, and symbolic environment in which the experience occurs. These concepts are necessary, but they are not precise enough to determine what kind of preparation and aftercare are required for different psychedelic substances, routes, durations, and physiological starting conditions [13,18].

A person taking oral psilocybin in a clinical session, a person undergoing ayahuasca in a ceremonial context, a person using vaporized N,N-dimethyltryptamine (N,N-DMT), and a person receiving vaporized 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT) do not face the same experiential, somatic, or interpretive demands. Psilocybin generally requires several hours of supportive presence and same-day or next-day emotional processing. Lysergic acid diethylamide (LSD) and mescaline require a longer endurance window and stronger protection of sleep and recovery time. Vaporized DMT and 5-MeO-DMT produce compressed experiences in which the acute pharmacological phase may be brief while the interpretive and emotional after-effect may outlast the acute state. Ayahuasca adds a distinct pharmacological layer because oral N,N-dimethyltryptamine (DMT) activity depends on monoamine oxidase inhibition. Psilocybin administration literature describes onset around 20–40 minutes, peak subjective effects around 60–90 minutes, and active duration around 4–6 hours; LSD pharmacokinetic and dose-response studies describe effects lasting many hours; mescaline controlled data show dose-dependent subjective duration from 6.4 to 14 hours; and inhaled 5-MeO-DMT is described as beginning within seconds and lasting up to about 20 minutes in reviewed human studies [5,12,14,15,16].

Existing models of preparation and integration are valuable. Psychedelic Harm Reduction and Integration has been proposed as a transtheoretical clinical approach for individuals who are using or considering psychedelics, and psychedelic integration has been analyzed as a broad concept involving meaning-making, emotional processing, behavioral change, spiritual interpretation, and relational support [2,8]. However, such models often remain too broad to specify how preparation and aftercare should change when the route, duration, bodily load, interaction profile, or recovery window changes.

This article proposes Experience-Trajectory Risk Stratification as a more precise framework. The central claim is that psychedelic preparation and aftercare should be stratified by two primary variables: Experience-Trajectory Profile and Baseline Risk State. Experience-Trajectory Profile describes the course of the psychedelic experience from onset and peak intensity to acute duration, residual effects, recovery window, and appropriate timing for interpretation or integration. Baseline Risk State describes the participant's acute physiological and pharmacological condition before the experience, including sleep, hydration, gastrointestinal stability, cardiovascular stability, glucose regulation, psychological stability, and interaction load.

This article is a conceptual framework paper rather than a systematic review or clinical guideline. It does not propose dosing rules, medication discontinuation schedules, or universal safety criteria. It synthesizes findings from psychedelic pharmacology, integration literature, drug-interaction research, retreat-safety studies, and human hallucinogen safety guidelines to propose a risk architecture that can be tested and refined in research design, clinical screening, retreat-safety evaluation, and post-acute care [8,10,13,17,18]. Human hallucinogen research guidelines emphasize screening, preparation, interpersonal support, and safeguards for managing psychological risk in controlled studies; the present framework extends this logic by specifying trajectory-based and somatic variables that should shape preparation and aftercare [13].

The contribution is not the general claim that preparation and integration matter. It is the proposal that the course, route, and physiological starting condition of a psychedelic experience determine the required form of containment and aftercare more precisely than general set-and-setting language alone.

EXISTING RESEARCH AND THE PRECISE GAP

Four research streams are especially relevant. First, clinical safety literature has emphasized screening, preparation, monitoring, and supportive environments in human psychedelic research. Johnson, Richards, and Griffiths' safety guidelines remain a major reference point because they analyze psychological risks and safeguards in human hallucinogen studies [13]. Second, Psychedelic Harm Reduction and Integration (PHRI) and integration literature provide clinical and conceptual models for working with psychedelic experiences before and after the acute session [2,8]. Third, drug-interaction research has begun to identify how psychedelics may interact with other medications and substances [10]. Fourth, retreat-safety research shows that real-world settings vary widely in screening, medication policies, emergency readiness, and polysubstance-risk management. A recent study of 49 publicly advertised retreat organizations found substantial variability in safety practices; many organizations collected medical histories and required or recommended pharmaceutical-drug cessation before attendance, but medication washout, emergency procedures, and polysubstance-risk practices varied [17].

These streams provide necessary building blocks, but they leave a specific gap. Current literature contains models of integration, safety, drug interactions, and retreat practice, but it does not yet offer a compact framework that links substance-specific experience trajectories to baseline physiological and interaction states in order to determine the required form of containment and aftercare.

This gap matters because the operational demands of psychedelic preparation differ across profiles. A compressed high-intensity experience requires immediate reorientation and delayed interpretation. A long-duration psychedelic state requires endurance planning, sleep protection, and next-day recovery. A gastrointestinal/monoamine oxidase (MAO)-mediated ceremony requires different screening and aftercare than vaporized DMT. A participant with high interaction load requires different decision thresholds than a participant with low baseline risk.

Without trajectory-based stratification, preparation models risk treating a 20-minute compressed tryptamine state, a 12-hour lysergamide state, and an MAO-mediated ceremonial experience as variations of the same preparation problem. The gap is not the absence of safety concepts, but the absence of a stratification logic connecting substance trajectory, baseline state, and aftercare demand.

The missing element is therefore not another general statement that preparation or integration is important. The missing element is a stratification model. Such a model should answer three concrete questions: What is the course of the experience? What is the participant's baseline physiological and pharmacological condition? What type of containment and aftercare follows from that combined profile?

EXPERIENCE-TRAJECTORY PROFILES ACROSS PSYCHEDELICS

The first axis of the framework is the **Experience-Trajectory Profile**. This refers to the relationship between onset, peak phase, acute duration, residual effects, recovery window, and the earliest appropriate timing for interpretation or integration. These values are approximate and should not be read as fixed pharmacokinetic constants. They vary by dose, route, preparation, metabolism, tolerance, body weight, study design, and context. Their purpose is not to define standardized dosing expectations, but to identify trajectory-related risk patterns relevant to preparation and aftercare.

Table 1. Experience-Trajectory Profiles Across Psychedelics

Substance	Route	Approximate onset	Peak / main phase	Acute duration	Main aftercare implication
Psilocybin	Oral	~20–40 min	~60–90 min	~4–6 h	Same-day or next-day emotional processing
LSD	Oral	~30–90 min	Several hours	~8–12 h	Sleep protection, delayed decisions, next-day recovery
Mescaline	Oral / cactus	~30–90 min	~2 h plasma peak; effects continue longer	Dose-dependent ~6.4–14 h in controlled data	Endurance, nausea, autonomic load, sleep recovery
N,N-DMT	Vaporized / inhaled	Seconds to minutes	Very rapid	Short-lived; often minutes, route-dependent	Reorientation before interpretation
5-MeO-DMT	Vaporized / inhaled	Seconds to minutes	Within minutes	Commonly ~10–30 min; route-dependent	Stabilization after self-dissolution
Ayahuasca / oral DMT + monoamine oxidase inhibitor (MAOI)	Oral + MAO inhibition	~30–60 min	Often ~1.5–2 h	Commonly several hours	GI recovery, MAO context, ritual meaning regulation

Psilocybin provides the clearest example of a medium-duration profile. Practical administration literature describes oral psilocybin as having an onset of approximately 20–40 minutes, peak subjective effects at roughly 60–90 minutes, and an active duration of about 4–6 hours [16]. Experimental pooled data also show acute, subacute, and long-term subjective effects after psilocybin in controlled human studies [21]. This profile implies that support is needed for several hours and that initial processing may begin later the same day or the following day, once basic physiological and emotional stabilization has occurred.

LSD represents a long-duration profile. Controlled pharmacokinetic and pharmacodynamic work reports effects lasting many hours, and dose-response work shows dose-dependent subjective duration across different LSD doses [5,12]. For aftercare, this matters because the experience may continue into the participant's normal sleep period. Sleep disruption, sensory openness, cognitive stimulation, and emotional intensity may persist beyond the formal session.

Mescaline is especially important for this framework because it combines long duration with bodily load. A controlled human study found dose-dependent subjective effects across 100–800 mg, maximal plasma

concentrations after approximately 2 hours, an elimination half-life of approximately 3.5 hours, and subjective duration increasing from 6.4 to 14 hours with dose. The same study reported increases in systolic and diastolic blood pressure, dose-dependent heart-rate increase, and frequent nausea and emesis at the highest dose [14]. Mescaline therefore illustrates why duration, gastrointestinal burden, and autonomic load should be integrated into preparation and aftercare rather than treated as secondary details.

Vaporized N,N-DMT represents a compressed profile. DMT is not orally active by itself because it is rapidly metabolized by monoamine oxidase; it becomes orally active when combined with MAO inhibition, as in ayahuasca [1,20]. Inhaled or vaporized routes bypass the oral first-pass limitation and produce rapid, short-lived effects [1]. For preparation, the key issue is rapidity and intensity of onset. For aftercare, the key issue is that the pharmacological episode may be brief while psychological processing outlasts the acute effect.

Vaporized 5-MeO-DMT is also compressed, but it should not be collapsed into N,N-DMT. Although both are short-acting tryptamines when inhaled, their phenomenological and safety profiles differ. 5-MeO-DMT is often associated with profound self-dissolution and nondual-type experiences rather than the strongly visual profile often associated with N,N-DMT [15]. A systematic review of clinical trials describes inhaled 5-MeO-DMT as producing effects within seconds that may last up to about 20 minutes, while other routes may last longer; the same review reports no serious adverse events in included human studies while emphasizing the need for larger controlled studies and follow-up [15]. Its short duration does not imply low aftercare need; the compressed peak can generate disproportionate interpretive weight.

Ayahuasca differs from vaporized DMT because oral DMT activity depends on MAO inhibition. Ayahuasca preparations typically contain DMT together with β-carboline compounds such as harmine, harmaline, and tetrahydroharmine, which inhibit MAO-A and enable oral DMT activity [19,20]. Human pharmacology research on ayahuasca found subjective effects peaking between 1.5 and 2 hours after oral administration [19]. Ayahuasca therefore carries a trajectory that is not only longer than vaporized DMT, but also pharmacologically distinct because MAO inhibition changes interaction and dietary relevance.

Experience trajectory is thus not a decorative pharmacological detail. It defines the functional demands placed on the setting, while Baseline Risk State defines the participant's capacity to meet those demands. This distinction avoids a circular argument: the trajectory itself does not determine risk by itself; it specifies the demands that must be matched by containment and aftercare.

BASELINE RISK STATE BEFORE THE EXPERIENCE

The second axis of the framework is the Baseline Risk State. This refers to the participant's acute physiological and pharmacological condition before the psychedelic experience. It combines two domains that are often treated separately: the current body state and the interaction load shaping that state.

Baseline Risk State is not the same as general health status. A person may be medically stable in ordinary life yet acutely unprepared because of sleep deprivation, dehydration, diarrhea, stimulant rebound, hypoglycemia, active infection, or an unstable medication/substance profile. Conversely, a person with a chronic condition may be comparatively stable if sleep, hydration, medication status, and vital signs are well controlled. The framework therefore emphasizes current baseline state rather than abstract health identity.

Physiological Baseline

The physiological baseline includes sleep and recovery, hydration and electrolytes, cardiovascular stability, metabolic stability, gastrointestinal stability, acute illness, and physical exhaustion. Sleep and

recovery matter because sleep loss can reduce emotional tolerance and increase threat sensitivity. Hydration and electrolyte status matter because diarrhea, vomiting, sweating, poor intake, or diuretic exposure can increase dizziness, tremor, orthostatic symptoms, and perceived bodily danger. Cardiovascular baseline includes resting heart rate, blood pressure, palpitations, and orthostatic stability. Metabolic baseline includes fasting stress, hypoglycemia risk, and diabetes-related medication effects. Gastrointestinal baseline includes nausea, reflux, diarrhea, vomiting, delayed gastric emptying, and abdominal discomfort. Acute illness includes fever, infection, inflammatory flare, severe pain, or systemic fatigue.

These are not merely medical details. Under psychedelics, bodily signals can become psychologically amplified. A racing heart can be interpreted as danger. Nausea can become fear of poisoning. Dizziness can become fear of collapse. Tremor can become fear of losing control. This is particularly relevant for compressed high-intensity experiences, where autonomic and perceptual changes can arise within seconds or minutes.

The key point is that physiological baseline affects both safety and interpretation. A participant may be psychologically willing but physiologically unprepared.

Interaction Load

Interaction Load refers to substances, medications, supplements, or everyday exposures that alter the participant's baseline state before a psychedelic experience. It does not imply that every listed substance directly interacts pharmacokinetically with every psychedelic. Rather, it captures cumulative changes in arousal, autonomic tone, sedation, perception, affective stability, metabolic reserve, gastrointestinal function, or cardiovascular reserve.

For precision, interaction load can be reduced to five heuristic risk mechanisms. These categories are not established diagnostic or pharmacological taxonomies. Their purpose is to organize how exposures may alter baseline arousal, sedation, autonomic tone, metabolic reserve, perception, or interpretive stability.

Serotonergic load includes antidepressants, MAO inhibitors, 3,4-methylenedioxymethamphetamine (MDMA), tramadol, and serotonergic supplements. The concern is not that every serotonergic exposure automatically produces serotonin toxicity. The evidence is more complex and substance-specific. A systematic review of drug–drug interactions involving classic psychedelics found that human interaction evidence remains heterogeneous and incomplete [10]. This supports a stratified approach: serotonergic load should be treated as a risk domain requiring assessment, not as a universal rule.

Autonomic or arousal load includes stimulants and sympathomimetic agents such as amphetamines, cocaine, methamphetamine, ephedrine-like agents, yohimbine, high-caffeine pre-workouts, and heavy nicotine exposure. The central mechanism is not necessarily pharmacokinetic interaction with the psychedelic, but amplification of heart rate, blood pressure, tremor, agitation, panic, hyperthermia, or paranoid interpretation. This category is clinically relevant because stimulant toxicity literature describes tachycardia, hypertension, agitation, psychosis, and seizures among clinically important effects of amphetamine toxicity, and because many participants may not report caffeine, nicotine, pre-workout products, or "fat burners" as psychoactive exposures [23].

Sedative or confusional load includes alcohol, benzodiazepines, Z-drugs, opioids, gamma-hydroxybutyrate (GHB), sedating antihistamines, kratom, kava, and dissociatives such as ketamine. The risk mechanism is impaired orientation, reduced communication, increased vomiting or aspiration risk, poor recall, reduced ability to follow support, and difficulty distinguishing psychological distress from

medical deterioration. Combination sedative exposure is clinically relevant because opioids, benzodiazepines, and alcohol can contribute to sedation and severe respiratory depression, especially when combined with other depressants [9].

Cannabinoid-related affective or perceptual load may involve anxiety, paranoia, derealization, cognitive looping, sedation, or perceptual instability in susceptible individuals. Cannabis-anxiety reviews report both anxiogenic and anxiolytic effects, and habitual cannabis use has been associated with anxiety disorders, although causality remains complex [3]. This category should not be treated as uniformly harmful; rather, it identifies a variable that may alter affective and perceptual baseline before a psychedelic experience.

Physiological reserve load includes agents or conditions that alter hydration, glucose regulation, gastric function, immune status, blood pressure, heart rate, or systemic reserve. Examples include glucagon-like peptide-1/glucose-dependent insulinotropic polypeptide (GLP-1/GIP) medications, insulin, sodium-glucose cotransporter 2 (SGLT2) inhibitors, diuretics, blood-pressure medications, thyroid hormones, testosterone replacement therapy, corticosteroids, immunosuppressants, and acute infection. These are not classic psychedelic interaction agents, but they may alter the body's capacity to tolerate intense emotional, autonomic, or gastrointestinal states. GLP-1 receptor agonist literature identifies nausea, vomiting, diarrhea, constipation, dyspepsia, and delayed gastric emptying as clinically relevant gastrointestinal adverse effects; these effects matter here not as direct psychedelic interactions, but as changes in baseline physiological reserve [6,7].

This mechanism-based approach avoids an unmanageable medication list. It also avoids the false claim that every medication directly interacts with every psychedelic. The relevant question is more concrete: what does this exposure do to the participant's baseline risk state?

MAO-Specific Risk

MAO-specific risk is best treated as a special case because it changes the relevance of both DMT and certain co-exposures. Without MAO inhibition, oral DMT is rapidly degraded and is not meaningfully orally active. With MAO inhibition, oral DMT becomes psychoactive. This is the pharmacological basis of ayahuasca and pharmahuasca [19,20].

MAO inhibition also changes the significance of tyramine and monoaminergic co-exposures. Clinical dietary guidance for MAOIs identifies aged, fermented, overripe, or spoiled foods as the main high-tyramine categories, and tyramine exposure can contribute to dangerous blood pressure elevations under MAO inhibition [22]. Ayahuasca should not be treated as identical to irreversible pharmaceutical MAOIs. Harmala alkaloids are reversible MAO-A inhibitors, and their dietary risk profile may differ from older irreversible MAOIs [20,22]. The framework therefore does not assume that ayahuasca carries the same dietary risk as all pharmaceutical MAOIs. Rather, it treats MAO-related dietary and co-exposure factors as a screening domain because MAO inhibition changes the relevance of tyramine, serotonergic load, and autonomic load.

Psychological Baseline

The psychological baseline includes panic vulnerability, psychotic symptoms, mania, suicidality, severe insomnia, acute crisis, unrealistic expectations, group pressure, and absence of aftercare. This category should not simply repeat "set." It should identify conditions in which the participant's current psychological state may be too unstable for exposure, or may require a higher level of containment.

This is consistent with human research safety guidelines that emphasize careful selection, preparation, interpersonal support, and safeguards against psychological risk [13]. It is also consistent with survey data showing that challenging psilocybin experiences can be psychologically intense and, in some cases, have enduring negative consequences, even though many individuals also report later benefit [4].

Not every crisis requires opening. Some states first require stabilization. Psychedelics may intensify unresolved material, but they may also destabilize a participant whose baseline is already fragile. Psychological distress, desire for change, and readiness are not identical. The framework therefore distinguishes motivation from capacity.

Minimal Baseline Stratification

The framework does not require clinical thresholds in order to be operational. It can begin with a low/moderate/high concern structure that identifies whether a session can proceed as planned, requires stabilization, requires clinical review, or should be postponed.

Table 2. Minimal Baseline Stratification

Domain	Low concern	Moderate concern	High concern
Sleep/recovery	Rested, normal recovery	Partial sleep loss, mild fatigue	Severe sleep deprivation, exhaustion, stimulant rebound
Hydration/GI	Stable intake, no active gastrointestinal (GI) symptoms	Mild nausea, mild diarrhea, reduced intake	Active vomiting, dehydration, severe diarrhea, orthostatic symptoms
Cardiometabolic baseline	Stable blood pressure, pulse, glucose	Mild instability or unclear medication effect	Uncontrolled blood pressure, hypoglycemia risk, marked palpitations
Interaction load	None or low exposure	Unclear supplements, cannabis, caffeine, mild sedatives	MAOI/lithium concern, strong stimulant load, serotonergic or sedative load
Psychological baseline	Stable, prepared, supported	Anxious, stressed, uncertain expectations	Mania, psychosis, suicidality, acute panic, severe insomnia

This table is not a clinical decision rule. It is a structured documentation tool. It makes explicit which risk domains should be considered before a psychedelic experience and prevents preparation from being reduced to intention-setting alone.

CONTAINMENT REQUIREMENTS BY RISK PROFILE

Containment should not be described only as “therapeutic,” “ritual,” or “non-clinical.” Those categories matter, but the more precise question is: what kind of containment is required by this risk profile?

Table 3. Containment Requirements by Risk Profile

Risk pattern	Required containment focus
Compressed high-intensity profile	Immediate reorientation, bodily safety, delayed interpretation
Long-duration stimulation profile	Endurance, sleep planning, sensory-load reduction, next-day recovery
GI/MAO-mediated profile	Hydration, vomiting/diarrhea risk awareness, MAO/co-exposure screening
High interaction-load profile	Clinical review, postponement threshold, emergency planning
Psychological instability profile	Stabilization before exposure, crisis assessment, stronger support threshold

Compressed high-intensity experiences, such as vaporized N,N-DMT and 5-MeO-DMT, require rapid and non-intrusive reorientation after an intense peak. The immediate containment task is not interpretive depth but stabilization: orientation, bodily safety, emotional settling, and avoidance of premature metaphysical conclusions.

Long-duration profiles, such as LSD and mescaline, require endurance-based containment. The support structure must account for many hours of altered perception, possible sleep disruption, sensory overload, and fatigue. For these substances, aftercare planning should begin before the session because recovery extends beyond the acute psychological peak.

GI/MAO-mediated profiles, such as ayahuasca, require attention to vomiting, diarrhea, hydration, dietary and co-exposure considerations, and ritual interpretation. The containment system must distinguish culturally meaningful purging from medical warning signs. Persistent vomiting, severe dehydration, chest pain, seizure, hyperthermia, severe confusion, or suspected serotonin toxicity should not be absorbed into symbolic interpretation.

High interaction-load profiles require a different form of containment: pre-acute review and possible postponement. A participant exposed to serotonergic, autonomic, sedative, cannabinoid-related, or physiological-reserve load may not need more encouragement; they may need clinical evaluation or delay.

Psychological instability profiles require stabilization before exposure. Severe insomnia, mania, psychosis, suicidality, or acute panic may require ordinary psychological or medical care before psychedelic exposure is considered. A setting that is emotionally intense but lacks escalation capacity may be unsuitable for such states.

This profile-based framing also clarifies the role of ritual and non-clinical contexts. Ritual settings may provide symbolic containment, but retreat-safety research indicates wide variability in medical screening, medication policies, emergency procedures, and polysubstance-risk management [17]. Therefore, the relevant question is not whether a context is “clinical” or “ritual,” but whether the context can meet the containment requirements generated by the participant’s experience-trajectory and baseline risk profile.

POST-ACUTE MEANING REGULATION

Aftercare should begin with stabilization, not interpretation. The post-acute period is often treated as an integration window, but not all post-acute states are ready for integration. Some require sleep, food, hydration, quiet, and recovery before meaning-making is reliable.

Stabilization Before Integration

Aftercare begins with restoration of baseline conditions: sleep, hydration, food, rest, avoidance of new psychoactive substances, no immediate major life decisions, calm environment, social support, and monitoring for warning signs. These are not trivial details. Sleep loss, dehydration, overstimulation, or emotional exhaustion can distort interpretation.

Integration begins later. It involves meaning-making, reflective evaluation, behavioral translation, therapeutic or ritual discussion, and gradual incorporation into daily life [2,8]. The error is to treat physiological exhaustion as revelation or post-acute intensity as immediate truth. Stabilization is therefore not separate from integration; it is the condition that makes integration proportionate.

Duration-Based Aftercare

The Experience-Trajectory Profile determines the aftercare window. For compressed experiences such as vaporized N,N-DMT and 5-MeO-DMT, the first aftercare task is reorientation. The participant may appear outwardly recovered within minutes, but the existential and emotional density may remain active. Immediate interpretation should therefore be delayed until basic orientation and bodily settling are restored.

For medium-duration experiences such as psilocybin, the aftercare window often begins the same day and continues into the next day. Emotional openness, tenderness, fatigue, and confusion may remain relevant. Support should first document orientation, sleep readiness, hydration, affective stability, and absence of acute warning signs before initiating interpretive processing.

For long-duration experiences such as LSD and mescaline, aftercare must account for sleep disruption and prolonged sensory or cognitive stimulation. Interpretation immediately after a long session may be shaped by fatigue. Major decisions should be delayed until sleep and ordinary bodily rhythm return.

For MAO- or ritual-mediated experiences such as ayahuasca, aftercare must include bodily recovery, hydration, gastrointestinal stabilization, group dynamics, ritual interpretation, and awareness of the authority structure surrounding meaning. The post-acute period is not only psychological; it is somatic, social, and interpretive.

Meaning Inflation and Integrative Maturity

A powerful psychedelic experience may support durable change, but intensity alone does not guarantee maturity, truth, or transformation. This article uses meaning inflation as a proposed conceptual construct to describe a post-acute interpretive risk in which subjective intensity is prematurely treated as evidence of final truth, identity transformation, or immediate life direction.

Meaning inflation is not a diagnosis. It does not pathologize spiritual interpretation, symbolic meaning, or existential insight. It identifies a timing problem: interpretation may precede stabilization. Subjective intensity may be translated too rapidly into certainty, identity, or action. This risk is conceptually related to adverse psychological reactions, derealization, manic-like elevation, challenging experiences, and integration difficulties, but it is not reducible to any single diagnostic category. Classic psychedelics are generally well tolerated in research settings according to recent systematic review evidence, but serious and medically significant adverse events do occur; this supports improved pharmacovigilance and better differentiation of post-acute effects [11].

Meaning inflation therefore requires empirical validation and is proposed here as a heuristic for post-acute research rather than as an established clinical entity. Meaning regulation does not mean suppressing meaning. It means delaying final conclusions until the participant has slept, stabilized, reflected, and tested the experience against life over time. In this sense, integration is not the immediate adoption of the most

intense interpretation. It is the gradual translation of experience into proportionate understanding and action.

Integrative maturity describes the capacity to hold an intense experience without prematurely absolutizing it, and to translate it into life gradually, reflectively, and proportionately. Future empirical work would need to test whether this construct predicts adverse post-acute outcomes, premature decision-making, or destabilizing integration patterns.

OPERATIONAL IMPLICATIONS FOR RESEARCH AND SCREENING

The Experience-Trajectory Framework can be operationalized without becoming a clinical protocol. Its function is to organize what should be documented, assessed, or stratified before, during, and after a psychedelic session.

In research settings, participants should not only be classified by diagnosis, dose, and substance, but also by the expected trajectory of the experience. Session planning should distinguish compressed high-intensity experiences, medium-duration experiences, long-duration experiences, and MAO-mediated experiences. Each category implies different requirements for session length, monitoring period, sleep protection, post-acute follow-up, and timing of integration measures.

In screening, the framework suggests that baseline risk should be documented across a limited number of domains rather than through an open-ended list of possible contraindications. These domains include recent sleep, hydration or fluid loss, gastrointestinal stability, blood pressure and heart-rate concerns, metabolic risk, acute illness, psychological instability, and interaction load. Interaction load should be recorded mechanistically rather than only by medication name: serotonergic load, autonomic/arousal load, sedative/confusional load, cannabinoid-related affective/perceptual load, and physiological-reserve load.

In retreat or ceremonial settings, the framework can serve as a safety-audit tool. It asks whether the setting can meet the demands generated by the participant's experience trajectory and baseline risk state. A long-duration experience requires different planning than a compressed one; an MAO-mediated ceremony requires different screening than vaporized DMT; a participant with high interaction load requires a different decision threshold than a participant with low baseline risk. Retreat-safety research already shows that organizations vary in medical-history collection, medication policies, emergency procedures, and polysubstance-risk management; the proposed framework offers a structured way to compare these practices without reducing all contexts to a single clinical model [17].

For outcome research, the framework also suggests that aftercare should not be measured as a single generic variable. Post-acute follow-up should distinguish physiological stabilization, emotional processing, meaning-making, behavioral implementation, and adverse post-acute effects such as insomnia, anxiety, derealization, mood destabilization, or premature certainty. This would make it possible to study not only whether integration occurred, but whether integration began after adequate stabilization.

EXPERIENCE-TRAJECTORY RISK MATRIX AND CONCLUSION

The Experience-Trajectory Risk Matrix synthesizes the framework into seven variables.

Table 4. Experience-Trajectory Risk Matrix

Variable	Guiding question	Assessment implication
Substance / route	What is being used and how?	Route-specific risk profile

Variable	Guiding question	Assessment implication
Experience-Trajectory Profile	What are onset, peak, duration, residual effects, and recovery needs?	Containment duration and aftercare window
Physiological baseline	Is the body stable?	Proceed, stabilize, clinically review, or postpone
Interaction load	What exposures shape baseline state?	Low, moderate, or high interaction load
MAO-specific risk	Is MAO inhibition present?	Tyramine and co-exposure relevance
Psychological baseline	Is the person stable enough?	Support level or exclusion/postponement threshold
Meaning regulation	When should interpretation begin?	Immediate grounding, delayed integration, or clinical follow-up

This matrix is not a clinical rule. It is a conceptual device for organizing risk domains and identifying conditions that require further assessment, postponement, medical review, or emergency care. Its purpose is not to replace clinical judgment, ritual responsibility, or participant autonomy, but to make implicit risk architecture explicit.

The central contribution of this article is the proposal of Experience-Trajectory Risk Stratification: a framework that links the unfolding course of psychedelic substances with the participant's acute physiological and interaction state in order to determine the required level of containment and post-acute stabilization.

Set and setting remain foundational concepts, but they are not sufficiently specific to guide preparation and aftercare across substances with very different onset, peak, duration, residual effects, and somatic demands. An Experience-Trajectory Framework offers a more precise structure. It distinguishes compressed, medium-duration, long-duration, and MAO-mediated experiences. It distinguishes motivation from baseline readiness. It distinguishes interaction load from direct drug interaction. It distinguishes stabilization from integration. And it distinguishes meaningful interpretation from premature meaning inflation.

The result is not a preparation manual, but a risk architecture. Future work can refine this model through empirical study, operational screening tools, retreat-safety protocols, and clinical trial design. The practical implication is clear: psychedelic preparation and aftercare should be stratified by Experience-Trajectory Profile and Baseline Risk State rather than treated as generic extensions of set and setting.

LIMITATIONS

This article has several limitations. First, it is a conceptual framework paper and not a systematic review, meta-analysis, clinical guideline, or treatment protocol. The proposed Experience-Trajectory Framework synthesizes existing findings to organize risk domains, but it does not establish validated clinical thresholds for proceeding, postponing, or excluding participants.

Second, the trajectory ranges presented for psilocybin, LSD, mescaline, N,N-DMT, 5-MeO-DMT, and ayahuasca are approximate. Onset, peak intensity, duration, residual effects, and recovery needs vary by dose, route, preparation, individual metabolism, tolerance, body weight, psychological state, and context.

The framework therefore uses these ranges as orientation points rather than fixed pharmacokinetic constants.

Third, the category of Baseline Risk State is intentionally broad. It includes physiological condition, psychological stability, and interaction load, but the relative weight of each domain remains to be empirically tested. The low/moderate/high concern structure proposed in this article is a documentation aid, not a validated risk score.

Fourth, the interaction-load categories are heuristic mechanisms rather than established diagnostic or pharmacological classes. They are intended to organize how serotonergic, autonomic, sedative, cannabinoid-related, and physiological-reserve exposures may alter baseline state. Future research should test whether these categories predict adverse acute or post-acute outcomes.

Fifth, the concept of meaning inflation is proposed as a research heuristic, not as a clinical diagnosis. It requires empirical validation, especially regarding whether premature certainty, identity change, or major life decisions after intense psychedelic experiences are associated with destabilizing post-acute outcomes.

Finally, the framework is not intended to replace clinical judgment, emergency procedures, culturally grounded ritual knowledge, or individualized assessment. Its purpose is to make risk domains more explicit and to support research design, screening documentation, retreat-safety evaluation, and future empirical refinement.

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