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Mapping Non-Prescription Pre-Session Support across Psychedelic Substances

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Abstract

Psychedelic preparation is commonly discussed through screening, psychological readiness, set, setting, therapeutic support, and integration planning. In clinical-adjacent, retreat, ceremonial, and harm-reduction contexts, however, non-prescription pre-session supports are also used or discussed before psychedelic sessions. These practices may involve nutrients, botanicals, amino acids, cannabinoids, terpenes, hydration strategies, sleep-related agents, gastrointestinal supports, or non-ingestive procedures such as PC6 acupoint stimulation and orientation scripts. At present, they are often described as informal advice, product-specific recommendations, or commercial stacks rather than as researchable categories. This article maps non-prescription pre-session support practices across psychedelic substances and organizes them into a research taxonomy based on intended target domain, inclusion rationale, psychedelic context, evidence boundary, and interaction burden. It does not propose supplement stacks, dosing rules, treatment recommendations, medication-discontinuation advice, or clinical protocols. Individual agents are mentioned only as illustrative examples of broader categories and are linked to evidence boundaries. The purpose is to make such practices documentable and comparable for future research while avoiding premature clinical or commercial translation.

Keywords: Interaction burden, Non-prescription practices, Pre-session support, Psychedelic preparation, Research mapping.

1. Introduction

Preparation is widely recognized as important in psychedelic research, therapy-adjacent practice, retreat settings, ceremonial contexts, and harm-reduction work. Established discussions emphasize screening, psychological readiness, set and setting, therapeutic relationship, informed consent, contextual containment, and integration planning [1,2]. These domains are essential, but they do not fully describe non-prescription pre-session practices that appear in real-world psychedelic contexts.

Such practices may include ingestive agents, hydration-related practices, sleep-related agents, gastrointestinal supports, or non-ingestive procedures. They are often described as "support" for nausea vulnerability, somatic tension, pre-session fear, anticipatory anxiety, hydration status, prior-night sleep, autonomic arousal, or bodily readiness. The scientific problem is not that these practices are necessarily effective. The problem is that they are rarely classified in a way that makes them documentable, comparable, and available for systematic study.

Product-centered language obscures the intended target domain, evidence level, substance-specific relevance, and interaction burden. A multi-ingredient product may contain agents aimed at nausea, sleep, autonomic tone, inflammation, anxiety, or hydration, yet the product name alone does not clarify which target is being addressed. Similarly, a practice described as calming may also introduce sedation, serotonergic burden, sympathomimetic burden, gastrointestinal burden, product-safety burden, organ-toxicity burden, or unfamiliar-agent burden.

This article addresses that gap by mapping non-prescription pre-session support categories across psychedelic substances. The aim is not to demonstrate that particular agents work, recommend supplements, formulate dosing schedules, or provide clinical instructions. The narrower aim is to classify pre-session support practices as researchable categories rather than as informal product lists.

The central claim is that the category, not the individual product, should be the primary unit of analysis. For example, gastrointestinal support, autonomic calming support, pre-session fear and anticipatory anxiety modulation, sleep and circadian stabilization, and interaction-burden assessment are categories. Individual agents are mentioned only when they clarify category structure, evidence boundaries, or interaction burden.

2. Scope and Non-Prescriptive Position

This article does not propose supplement stacks, dosing rules, treatment recommendations, medication-discontinuation advice, or clinical protocols. Individual agents are mentioned only as illustrative examples of broader pre-session support categories. The proposed taxonomy is intended for documentation, study design, and risk-sensitive classification.

The substance scope is limited to classic serotonergic psychedelics and closely related tryptamine contexts: psilocybin, LSD, mescaline, vaporized N,N-DMT, 5-MeO-DMT, and ayahuasca or oral DMT with monoamine

oxidase inhibition. These substances were selected because they are commonly discussed within psychedelic preparation, retreat, ceremonial, and harm-reduction contexts and because they differ meaningfully in duration, route, gastrointestinal burden, intensity, and interaction profile. Entactogens and empathogens such as MDMA are not included as primary psychedelic contexts in the substance-specific matrix because their pharmacology, social-use patterns, thermoregulatory risks, and hydration-related adverse-event profile differ substantially from the substances mapped here. However, MDMA-related hyponatremia literature is cited only as a documentation analogy for hydration and electrolyte risk in altered-state settings involving heat, sweating, prolonged activity, vomiting, or overhydration. It is not used to equate MDMA with classic psychedelics or to expand the taxonomy to entactogens.

The article is not a general theory of set and setting, aftercare, integration, acute panic stabilization, or psychedelic transformation. The present focus is limited to non-prescription physiological, psychophysiological, and non-ingestive support categories considered before the acute psychedelic state begins.

3. Defining Pre-Session Support Categories

Pre-session support categories are non-prescription physiological, psychophysiological, or non-ingestive support domains considered before psychedelic sessions to address tolerability-relevant variables such as nausea vulnerability, autonomic arousal, pre-session fear, anticipatory anxiety, hydration status, sleep quality, and somatic readiness.

This definition is deliberately cautious. The term "support" is used descriptively because it reflects how such practices are commonly framed in real-world settings; it does not imply efficacy. "Non-prescription" does not mean risk-free. Botanicals, supplements, cannabinoids, amino acid derivatives, sedatives, stimulants, and multi-ingredient products may alter arousal, perception, cardiovascular state, gastrointestinal function, sleep, liver-safety considerations, or interaction burden. "Pre-session" refers only to practices considered before the acute psychedelic phase, not to emergency management or post-acute integration.

A category-based taxonomy is necessary because the same agent may occupy different roles depending on context. A cannabinoid product may be classified as anticipatory anxiety modulation, sedative/confusional burden, or interaction exposure. Magnesium may be classified as autonomic calming support, while tolerability concerns should be recorded separately when gastrointestinal symptoms occur. Kava may be classified as an anxiety-related botanical example, while also requiring sedative/confusional and product-safety or organ-toxicity burden coding. A sleep-related agent may support prior-night sleep while contributing to residual morning sedation. Classification must therefore record both the intended target and the possible burden.

4. Category Inclusion Criteria

To avoid arbitrary category creation, each category should meet at least one of the following inclusion criteria and preferably more than one.

Table 1. Category inclusion criteria.

Inclusion criterion	Meaning
Real-world use	The category appears in clinical-adjacent, retreat, ceremonial, or harm-reduction discussions
Target-domain plausibility	The category corresponds to a tolerability-relevant variable such as nausea, sleep, arousal, anxiety, hydration, or somatic readiness
Evidence boundary	Available evidence can be classified as direct, indirect, mechanistic, traditional, or caution-dominant
Interaction relevance	The category may alter risk, burden, or interpretability of adverse effects
Documentability	The category can be recorded consistently in future studies or observational reports

These criteria prevent circular reasoning. A category is not included merely because it is considered relevant; it is included because it is used, targets a definable domain, carries an evidence boundary, may introduce interaction burden, or can be documented in future research.

This inclusion structure is important because non-prescription pre-session practices currently occupy an ambiguous position between informal preparation, commercial wellness products, harm-reduction advice, and physiological readiness. Without category-level classification, future studies risk recording only product names while missing the intended target domain and the interaction burden. A taxonomy therefore functions as a pre-empirical tool. It does not settle efficacy questions, but it makes them researchable by defining what should be recorded, compared, and interpreted.

The inclusion criteria also help separate three questions that are often conflated. First, is a practice used or discussed in real-world psychedelic-adjacent contexts? Second, does the practice correspond to a definable target domain, such as nausea, sleep, anxiety, hydration, or somatic arousal? Third, does the practice introduce a burden that should be documented even if its intended target is supportive? A practice can meet the taxonomy's inclusion threshold because it is potentially helpful, potentially burdensome, commonly used, or simply important to document. This distinction is central to the proposed mapping approach.

5. Citation and Evidence Boundary

Because non-prescription pre-session support is often discussed informally, each illustrative agent requires an evidence boundary. The relevant question is not whether an agent has been proven to improve psychedelic outcomes, but whether it has credible evidence for the target domain under which it is classified. For most examples, evidence is indirect, domain-specific, mechanistic, traditional, or caution-based rather than psychedelic-context specific.

Accordingly, no illustrative agent should be presented as a psychedelic-session intervention unless direct psychedelic-context evidence exists. Ginger may be cited under gastrointestinal support because systematic

reviews address nausea and vomiting, but this does not establish psychedelic-specific efficacy [3]. PC6 acupoint stimulation may be cited as a non-ingestive nausea-related example because it has been studied for postoperative nausea and vomiting, but that evidence is not psychedelic-specific [4]. L-theanine may be cited under stress-response or anxiety-modulation categories because human studies address psychological or physiological stress responses, but this does not prove benefit before psychedelic sessions [8,9]. Kava may be cited under anxiety-related target-domain evidence because clinical literature has examined kava extracts for generalized anxiety disorder, but this must be balanced by explicit safety-boundary coding because kava products have also been associated with clinically apparent liver injury [32–34].

The evidence boundary is not a minor qualification; it is the core safeguard of the taxonomy. A target-domain citation does not mean that a substance should be used before a psychedelic session. It means only that a given example can be classified under a domain that has some relevant evidentiary basis outside the psychedelic context. This distinction allows future research to observe and compare real-world practices without presenting them as established interventions. It also prevents commercial or anecdotal claims from being imported into scientific language without qualification.

6. Target-Domain Taxonomy

The first layer of the taxonomy classifies non-prescription pre-session supports by intended target domain. This classification does not imply that the category has proven efficacy in psychedelic contexts.

Table 2. Target-domain taxonomy of non-prescription pre-session support categories.

Category	Intended target domain	Illustrative examples	Evidence boundary
Gastrointestinal support	Nausea vulnerability, gastric discomfort, vomiting risk	Ginger, peppermint, PC6 acupoint stimulation	Indirect nausea/vomiting evidence; not psychedelic-specific
Autonomic calming support	Somatic tension, sympathetic arousal, perceived heart activation	Magnesium, taurine, L-theanine	Indirect stress, arousal, or inhibitory-system evidence
Pre-session fear and anticipatory anxiety modulation	Fear of intensity, cognitive arousal, loss-of-control anxiety, nervous tension	L-theanine, passionflower, lemon balm, kava, CBD-containing products; linalool-related products; orientation scripts	Indirect anxiety/stress evidence; sedative, product-safety, and organ-toxicity concerns coded separately where relevant
Hydration and electrolyte readiness	Fasting, sweating, vomiting risk, long duration	Electrolyte solutions	Physiological readiness category; not anti-panic treatment
Sleep and circadian stabilization	Prior-night sleep, rhythm stability, morning clarity	Melatonin, valerian, glycine	Sleep/circadian evidence; possible residual sedation coded separately
Cofactor support	General metabolic cofactor status	B6/P-5-P	Biochemical cofactor role; not an anxiolytic claim
Neuroimmune/background support	Somatic irritability, inflammatory background load	PEA, quercetin	Exploratory background category; not acute psychedelic-session evidence
Interaction-burden assessment	Serotonergic, sedating, stimulating, MAO-sensitive, product-safety, organ-toxicity, or unfamiliar exposure	Sceletium/kanna, 5-HTP, kratom, caffeine, kava	Burden classification, not support endorsement

The category names are functional rather than product-based. This allows comparison across settings even when different agents or products are used. Two settings may use different products but still engage the same category, such as gastrointestinal support or anticipatory anxiety modulation. Conversely, two products marketed for "calm" may differ substantially if one is mainly sedating, another serotonergic, another cannabinoid-based, and another associated with formulation-specific safety concerns.

Gastrointestinal support should be treated as a target-domain category rather than as a claim that any given agent prevents psychedelic nausea. Ginger has systematic-review evidence in nausea and vomiting contexts, but this evidence is indirect for psychedelic sessions [3]. PC6 acupoint stimulation has been studied for postoperative nausea and vomiting, including in Cochrane-reviewed evidence, but this remains indirect for psychedelic contexts [4]. Peppermint inhalation has been reviewed as a complementary approach for nausea and vomiting in postoperative, chemotherapy, and pregnancy-related contexts; this evidence is also indirect and should be treated cautiously [5].

Pre-session fear and anticipatory anxiety modulation should be treated as a central category. In rapid-onset or high-intensity states such as vaporized N,N-DMT and 5-MeO-DMT, the participant may enter the session with fear of intensity, loss of control, bodily overwhelm, or self-dissolution. Such fear may shape baseline autonomic tone before the psychedelic state begins. This category includes ingestive examples, such as L-theanine, passionflower, lemon balm, kava, cannabidiol-containing products, or linalool-related products, and non-ingestive examples, such as brief orientation scripts, expectation-setting, and facilitator reassurance. Non-ingestive examples are grounded in broader preparation, interpersonal support, and harm-reduction principles rather than agent-specific evidence [1,2]. They should be documented separately because they may address uncertainty without adding pharmacological interaction burden.

Kava may be classified as an illustrative example within pre-session fear and anticipatory anxiety modulation because human clinical literature has examined kava extracts for anxiety-related target domains. A double-blind, randomized, placebo-controlled study investigated kava in generalized anxiety disorder, and the broader clinical

literature has treated kava primarily as an anxiolytic botanical rather than as a psychedelic-context intervention [32]. However, kava differs from milder botanical examples because safety concerns are central to its classification. Products labeled as kava have been associated with clinically apparent liver injury, and reviews emphasize formulation quality, extraction method, plant material, duration of use, co-medications, alcohol co-use, and other risk factors as relevant to hepatotoxicity assessment [33,34]. Therefore, kava should be cross-coded under sedative/confusional burden and product-safety or organ-toxicity burden rather than treated as a routine pre-session support example.

Sleep and circadian stabilization should distinguish rhythm support from sedation. Melatonin is relevant because it is directly involved in sleep-wake and circadian regulation [15,16]. Valerian is relevant only as an illustrative sleep-related botanical with mixed evidence and methodological limitations [17]. Glycine is relevant because small human studies have examined subjective sleep quality and polysomnographic correlates [18]. None of these examples should be converted into psychedelic-session recommendations.

Cofactor support is included only as a general metabolic documentation category. B6/P-5-P is an illustrative example because vitamin B6 functions as a metabolic cofactor in cellular physiology, including amino acid and neurotransmitter-related pathways [19]. This category should not be interpreted as an anxiolytic or acute tolerability intervention.

Hydration and electrolyte readiness is included as a physiological documentation category, particularly in contexts involving vomiting, sweating, fasting, heat exposure, or prolonged duration. It should not be interpreted as an anti-anxiety intervention or as treatment for electrolyte disturbance. Although MDMA is not one of the primary psychedelic contexts in this taxonomy, MDMA-related hyponatremia literature illustrates a broader documentation principle: altered-state settings involving heat, sweating, prolonged activity, vomiting, or overhydration require careful recording of hydration and electrolyte status [30,31]. This analogy is used only to justify documentation of hydration status, not to equate MDMA with the psychedelic substances mapped here.

Neuroimmune/background support is retained only as an exploratory documentation category because some real-world pre-session products include agents framed around pain, inflammation, oxidative stress, or somatic irritability. PEA may be cited only as a background example because systematic reviews address pain-related or inflammatory domains rather than psychedelic-session outcomes [20]. Quercetin may be cited only as a background flavonol example with antioxidant and anti-inflammatory literature, while acknowledging low bioavailability and lack of psychedelic-context evidence [21]. This category should not be interpreted as an acute tolerability intervention.

7. Substance-Specific Category Relevance

The second layer maps category relevance across psychedelic contexts. Substance-specific relevance does not mean that a category is recommended. It means that the category is more relevant to document and study in that context.

Table 3. Substance-specific category relevance.

Psychedelic context	Primary category relevance
Psilocybin	Gastrointestinal support; pre-session fear and anticipatory anxiety modulation; autonomic calming
LSD	Sleep/circadian stabilization; long-duration tolerability; pre-session fear and anticipatory anxiety modulation; autonomic calming; hydration readiness
Mescaline	Gastrointestinal support; autonomic calming; hydration/electrolyte readiness; long-duration tolerability
Vaporized N,N-DMT	Pre-session fear and anticipatory anxiety modulation; autonomic calming; rapid-onset readiness
5-MeO-DMT	Pre-session fear and anticipatory anxiety modulation; clarity-preserving autonomic calming; prior-night sleep stability
Ayahuasca / oral DMT + MAOI	Gastrointestinal support; hydration/electrolyte readiness; pre-session fear modulation; MAO-sensitive interaction-burden assessment

This section does not restate full experience trajectories. It identifies which pre-session support categories are most relevant to document for each psychedelic context. For psilocybin, documentation should emphasize gastrointestinal support, pre-session fear, and autonomic calming. For LSD, documentation should emphasize sleep/circadian stabilization, long-duration tolerability, and hydration readiness. For mescaline, documentation should emphasize gastrointestinal support, hydration/electrolyte readiness, and autonomic body-load categories. For vaporized N,N-DMT and 5-MeO-DMT, documentation should emphasize pre-session fear, rapid-onset readiness, and clarity-preserving autonomic calm. For ayahuasca or oral DMT with monoamine oxidase inhibition, documentation should emphasize gastrointestinal support, hydration/electrolyte readiness, and MAO-sensitive interaction burden.

The matrix is not intended to rank psychedelic substances or to describe their full pharmacological or phenomenological profiles. Its function is narrower: to identify which pre-session categories are most likely to require documentation in a given context. A long-duration substance may make sleep, hydration, and endurance-related reporting more relevant. A rapid-onset substance may make pre-session fear, orientation, and autonomic arousal especially important to record. A monoamine oxidase inhibition context makes interaction-burden assessment more salient. These distinctions support better documentation without converting category relevance into preparation advice.

This table should not be read as a preparation protocol. Its purpose is to guide documentation and research design.

8. Evidence-Level Mapping

The third layer classifies the level of evidence supporting each category. This prevents indirect evidence, mechanistic plausibility, traditional use, or commercial claims from being treated as direct psychedelic-context evidence.

Table 4. Evidence-level mapping.

Evidence level	Meaning
Level A	Direct psychedelic-context evidence
Level B	Human studies exist for the target domain; evidence may remain mixed, indirect, or context-dependent
Level C	Mechanistic plausibility with limited or no human target-domain evidence
Level D	Traditional/common-use rationale
Level E	Caution-dominant category where interaction burden outweighs support plausibility

These evidence levels classify the type of evidence available, not the strength or conclusiveness of clinical efficacy. Level B indicates that human studies exist for the relevant target domain, such as sleep, stress response, anxiety, nausea, or subjective tolerability. It does not imply universally accepted clinical efficacy, guideline-level support, or direct relevance to psychedelic sessions. Human evidence may still be mixed, context-dependent, small-sample, formulation-specific, or methodologically limited. Therefore, a Level B classification should be read as "human target-domain evidence exists," not as "clinically established for pre-session psychedelic use."

Level A requires direct evidence in psychedelic contexts. Level B applies when human studies exist for the intended target domain but not specifically for psychedelic sessions. Ginger, PC6 acupoint stimulation, peppermint, melatonin, glycine, L-theanine, and kava would generally be discussed at this level only for their target domains, not for psychedelic outcomes [3–5,8,9,15,16,18,32]. B6/P-5-P belongs under cofactor support rather than anxiolytic or acute calming claims [19]. Level C indicates mechanistic plausibility with limited direct human evidence for the specific target. Taurine, linalool, and quercetin often fit here when discussed as mechanistic or background examples rather than acute interventions [7,14,21]. Level D refers to traditional, common-use, or informal rationale. Level E applies when the main scientific relevance of a category is caution rather than support plausibility.

A single agent may also occupy different evidence levels depending on the claim being evaluated. For example, a sleep-related compound may have Level B evidence for sleep outcomes, while having no direct evidence for psychedelic-session tolerability. A botanical may have indirect human evidence for anxiety-related outcomes but require Level E caution coding because of sedation, product variability, or organ-safety concerns. This prevents the mistaken inference that evidence for one domain can automatically be transferred to psychedelic preparation.

Most non-prescription pre-session support categories currently fall into Levels B–E rather than Level A. This limitation is central to the rationale for the taxonomy. Before clinical claims can be made, real-world practices must first be named, categorized, documented, and compared.

9. Interaction-Burden Taxonomy

The fourth layer concerns interaction burden. This layer is necessary because non-prescription agents can be perceived as supportive while introducing new risk or interpretive ambiguity.

Table 5. Interaction-burden taxonomy.

Burden category	Description
Serotonergic burden	Agents that may increase serotonergic tone or interact with serotonergic psychedelics
MAO-sensitive burden	Agents relevant in MAOI or harmala contexts
Sedative/confusional burden	Agents that may impair clarity, orientation, recall, balance, or responsiveness
Sympathomimetic burden	Agents that may increase arousal, heart rate, blood pressure, tremor, or panic vulnerability
Gastrointestinal burden	Agents that may provoke nausea, reflux, cramping, diarrhea, or gastric distress
Product-safety / organ-toxicity burden	Agents or products associated with formulation variability, contamination, organ-toxicity concerns, or safety issues requiring separate documentation
Unfamiliar-agent burden	Agents not previously tested by the participant

Serotonergic burden and MAO-sensitive burden should be kept analytically distinct. Serotonergic burden concerns agents that may alter serotonergic tone or combine with serotonergic psychedelics in clinically relevant ways. Sceletium tortuosum / kanna is an example of a non-prescription botanical requiring careful burden classification because mesembrine-type constituents and standardized extracts have been discussed in relation to serotonin reuptake inhibition and PDE4 activity [22,23]. 5-HTP and St. John's wort should be documented under serotonergic-burden assessment rather than framed as support [24,25].

MAO-sensitive burden concerns contexts in which monoamine metabolism is altered, such as ayahuasca, oral DMT with monoamine oxidase inhibition, harmala-containing preparations, or pharmaceutical MAOIs. This is a distinct burden category because monoamine oxidase inhibition changes the relevance of serotonergic, adrenergic, dietary, and medication-related exposures.

Sedative/confusional burden is relevant because excessive sedation, impaired orientation, poor recall, or reduced responsiveness may complicate safety assessment. Valerian, high-sedation cannabinoid/terpene products, kratom, alcohol, benzodiazepines, sedating sleep agents, and kava should be documented here when relevant. Kratom is placed here as a burden example because its principal alkaloids have opioid-receptor activity and may produce stimulant-like or sedative/opioid-like effects depending on context [26,27].

Product-safety or organ-toxicity burden is relevant where a non-prescription agent has known formulation-specific, contamination-related, or organ-safety concerns. Kava is a useful example because it has anxiety-related human evidence, yet products labeled as kava have also been linked to clinically apparent liver injury, including

rare severe cases. This does not make kava categorically equivalent to serotonergic or MAO-sensitive burden; rather, it illustrates why support categories must be cross-coded with safety-burden categories when agent-specific risk is material [33,34].

Sympathomimetic burden is relevant because arousal, tachycardia, tremor, heat, or agitation may be interpreted as danger or may increase physiological strain. Caffeine is included here because it is a central nervous system stimulant and meta-analytic evidence links caffeine intake with increased anxiety risk, particularly at higher intake levels [28]. Unfamiliar-agent burden is relevant because new agents introduced on or near the session day make later adverse effects harder to interpret.

Interaction-burden classification does not require proving that a harmful interaction occurred. It requires documenting plausible burden categories so that future research can detect patterns. This is especially important in observational settings, where adverse outcomes may otherwise be attributed only to the psychedelic substance, the participant's psychology, or the surrounding context. Recording burden categories makes it possible to distinguish the psychedelic context from additional exposures that may influence arousal, sedation, nausea, cognition, hydration, or safety.

10. Documentation Model

A taxonomy becomes useful only if it can be operationalized. The following documentation model records pre-session support practices without recommending them.

Table 6. Documentation model for pre-session support practices.

Field	Purpose
Support category	Category-level reporting
Agent/product used	Exposure documentation
Ingestive or non-ingestive	Distinguishes pharmacological exposure from procedural support
Timing	Prior-night vs same-day use
Prior tolerability	Unfamiliar-agent burden
Intended target domain	Nausea, anxiety, sleep, autonomic tension
Psychedelic context	Psilocybin, LSD, mescaline, DMT, 5-MeO-DMT, ayahuasca
Evidence boundary	Direct, indirect, mechanistic, traditional, or caution-dominant
Observed outcome	Exploratory research signal
Adverse effect	Safety signal
Interaction-burden category	Risk classification

Category-level reporting is the central field. Agent or product name remains necessary for exposure documentation, but it should not replace the category. The distinction between ingestive and non-ingestive support is also important. PC6 acupoint stimulation, orientation scripts, or facilitator expectation-setting do not introduce the same pharmacological burden as orally ingested agents, yet they may target the same domain, such as nausea vulnerability or pre-session fear.

Timing distinguishes prior-night exposure from same-day exposure. This matters because a sleep-related agent taken the evening before a session may have different implications than an anxiolytic or botanical product taken shortly before the acute state begins. Prior-night use may influence sleep continuity, morning clarity, residual sedation, or gastrointestinal tolerance. Same-day use may influence anticipatory anxiety, autonomic tone, nausea, or interpretability of early somatic effects. Without timing data, it becomes difficult to determine whether a reported effect belongs to the psychedelic context, the support practice, or their interaction.

Prior tolerability distinguishes familiar practices from unfamiliar agents introduced shortly before a session. This is a key documentation point because unfamiliar-agent burden can create interpretive confusion. A participant who uses a new botanical, cannabinoid product, supplement, or multi-ingredient formula on the session day introduces a second exposure whose effects may be difficult to distinguish from psychedelic onset, anxiety, nausea, sedation, or cardiovascular sensations. For this reason, prior tolerability should be treated as a core documentation field rather than as a minor background detail.

Observed outcomes should remain exploratory. Examples include nausea, vomiting, anticipatory anxiety, panic, perceived clarity, sedation, dizziness, gastrointestinal distress, cardiovascular discomfort, session completion, or need for additional support. Such observations do not establish causality, but they can generate hypotheses for future studies. The goal is not to infer efficacy from uncontrolled reports, but to create a structured record that allows patterns, burdens, and possible confounders to be examined over time.

11. Research Agenda

The taxonomy supports several research directions. First, survey studies should document which non-prescription pre-session support categories are used in clinical-adjacent, retreat, ceremonial, and informal contexts. These surveys should record categories as well as specific agents, timing, prior tolerability, intended target domain, and perceived burden. Such surveys would provide an initial descriptive map of real-world practice without implying that any practice is beneficial.

Second, observational studies should examine associations between category use and tolerability-related outcomes, including nausea, anticipatory anxiety, bodily distress, sedation, panic, session completion, and adverse events. Candidate outcomes include pre-session anxiety ratings, nausea ratings, session completion, need for additional support, adverse-event reports, and post-session tolerability assessments. These studies should avoid interpreting associations as proof of efficacy, but they can identify which categories merit further controlled study or closer safety monitoring.

Third, substance-specific comparisons should test whether category relevance differs across psilocybin, LSD, mescaline, vaporized N,N-DMT, 5-MeO-DMT, and ayahuasca or oral DMT with monoamine oxidase inhibition. For example, gastrointestinal support may be especially relevant to document in mescaline and ayahuasca contexts, while pre-session fear and rapid-onset readiness may be especially relevant in vaporized N,N-DMT and 5-MeO-

DMT contexts. Such comparisons should be framed as documentation priorities rather than preparation recommendations.

Fourth, adverse-event mapping should examine whether serotonergic, MAO-sensitive, sedative/confusional, sympathomimetic, gastrointestinal, product-safety, organ-toxicity, or unfamiliar-agent burdens appear more often in difficult or medically concerning sessions. This type of research could help distinguish adverse events related primarily to psychedelic intensity from those complicated by additional exposures.

Fifth, future clinical and retreat-related studies should include standardized pre-session support reporting fields. Such reporting would not endorse any agent; it would make pre-session exposure history visible. Even when studies do not test supplements or botanicals, documenting them as background exposures may improve interpretability, reduce confounding, and support better adverse-event analysis.

12. Limitations

This taxonomy does not establish efficacy. No category should be interpreted as proven to improve psychedelic safety, tolerability, or psychological outcome. It does not provide dosing recommendations, clinical protocols, medical clearance criteria, or product evaluations.

Most categories are supported by indirect evidence, mechanistic plausibility, traditional rationale, or caution-based reasoning rather than direct psychedelic-context trials. Product variability is substantial, especially for botanicals, cannabinoids, supplements, and multi-ingredient formulas. Composition, dose, purity, contamination risk, and labeling accuracy may vary. Commercial CBD products are one example of a broader problem: non-prescription products may vary in labeling accuracy, active ingredient content, contamination, and unintended psychoactive constituents [29]. Kava illustrates another dimension of this limitation because formulation, plant material, extraction method, duration of use, co-medications, alcohol co-use, and liver-safety concerns may materially affect its risk profile [33,34].

Individual reactions also vary. A practice intended as calming may cause sedation, dizziness, gastrointestinal discomfort, agitation, or confusion in some individuals. Self-report may underestimate interaction burden because participants may not consider caffeine, nicotine, sleep agents, botanicals, cannabinoids, amino acids, or supplements relevant psychoactive exposures.

The taxonomy also does not determine whether any support category should be used in a given person or setting. It only identifies what should be documented if such practices are present. Screening, contraindication assessment, emergency preparedness, and professional judgment remain separate requirements. The present value of the taxonomy lies in classification and documentation, not in clinical instruction.

13. Conclusion

Non-prescription pre-session support is already part of real-world psychedelic practice, but it remains scientifically underclassified. A category-based taxonomy can shift discussion from informal product lists to researchable domains organized by target domain, psychedelic context, evidence boundary, and interaction burden.

This allows future studies to document and compare pre-session practices without converting them into recommendations. The practical value of such mapping lies not in endorsing specific agents, but in making real-world preparation practices visible, comparable, and available for careful empirical evaluation.

Abbreviations:

CBD: cannabidiol
LSD: lysergic acid diethylamide
MAOI: monoamine oxidase inhibitor
MDMA: 3,4-methylenedioxymethamphetamine
N,N-DMT: N,N-dimethyltryptamine
5-MeO-DMT: 5-methoxy-N,N-dimethyltryptamine
PC6: pericardium 6
P-5-P: pyridoxal-5-phosphate
PEA: palmitoylethanolamide
PDE4: phosphodiesterase-4
5-HTP: 5-hydroxytryptophan

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