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Psychedelic-Assisted Psychotherapy: Therapeutic Relationship, Suggestibility, and Set and Setting

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Narrative Clinical Review

Abstract—Psychedelic-assisted psychotherapy is not a single treatment. It joins a psychoactive compound, a selected participant, preparatory and follow-up encounters, an interpersonal relationship, and a deliberately arranged setting. This narrative clinical review examines evidence available through 30 November 2022, with particular attention to therapeutic alliance, suggestibility, expectancy, consent, and set and setting. Early controlled trials of psilocybin- and 3,4-methylenedioxymethamphetamine-assisted interventions reported clinically important signals in several narrowly defined populations. They did not establish a transferable class effect, the independent contribution of psychotherapy, or effectiveness in routine practice. Functional unblinding, high expectancy, small selected samples, intensive support, and uncertain durability limit inference. The same conditions that may facilitate emotional learning also intensify power. During an altered state, a therapist's language, touch, metaphysical assumptions, and responses to apparent memory can shape meaning when the patient's capacity to evaluate influence is changed. Ethical practice therefore requires enhanced consent before exposure, compound-specific medical and psychiatric screening, explicit boundaries, culturally responsive preparation, non-directive support, adverse-event monitoring, and integration that neither certifies revelation nor dismisses it. The therapeutic relationship should be studied as a possible active ingredient and a possible source of harm. Until comparative process research matures, clinicians should distinguish evidence from interpretation, protect uncertainty, and avoid presenting an investigational package as a pharmacological shortcut or a universally transformative psychotherapy.

Index Terms—psychedelic-assisted psychotherapy, psilocybin, MDMA, therapeutic alliance, suggestibility, set and setting, informed consent, integration

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I. INTRODUCTION

The label psychedelic-assisted psychotherapy covers different compounds, diagnoses, therapeutic models, staffing, session structures, and legal contexts. Psilocybin, LSD, and MDMA do not share identical pharmacology or phenomenology; MDMA is often classed as an empathogen, not a classic psychedelic. Evidence for one package cannot be transferred to another drug, population, or psychotherapy.

By late 2022, randomized trials had reported promising signals in depression, cancer-related distress, PTSD, and alcohol use disorder, while professional guidance still described these agents as investigational (Reiff et al., 2020; American Psychiatric Association, 2022). Public claims that psychedelics heal obscure necessary questions: what was administered, to whom, by whom, under which safeguards, and against what comparator?

The psychotherapy component matters precisely because drug effects do not occur in an interpersonal vacuum. Expectations are formed during recruitment and preparation; attention is guided by instructions, music, eye shades, and therapist responses; an intense experience is later narrated with another person. Set and setting are therefore not decorative additions around a pharmacological core. They are plausible moderators of acute experience and outcome, although their separate causal contributions have rarely been tested rigorously (Hartogsohn, 2016; Haijen et al., 2018).

This review takes neither enthusiasm nor prohibition as a substitute for clinical reasoning. It examines the therapeutic relationship as both resource and risk, especially when suggestibility and felt certainty may be heightened. It does not provide dosing instructions, endorse unlicensed administration, or treat naturalistic use as equivalent to supervised research. No patient material or disguised clinical vignette is used. The practical purpose is to identify what responsible communication would require if an altered state is deliberately joined to psychotherapy.

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II. SCOPE AND REVIEW METHOD

This bounded narrative clinical review covers sources publicly available by 30 November 2022. Searches combined psychedelic-assisted psychotherapy and relevant compounds with alliance, expectancy, masking, suggestibility, set and setting, preparation, integration, consent, touch, ethics, training, and equity. Priority went to guidance, controlled studies, systematic reviews, process analyses, qualitative research, and safety guidance.

The review does not combine effects statistically. Trials were read as studies of compound-specific treatment packages rather than interchangeable tests of a psychedelic class. The term psychotherapy is used only when structured psychological treatment was actually part of the protocol; psychological support, monitoring, and integration are not assumed to constitute a validated psychotherapy. MDMA studies are included because the clinical and public discourse commonly groups them with psychedelic-assisted care, but their findings are not used as evidence for classic serotonergic psychedelics.

Trial outcomes are evidence about the studied package and sample; claims about alliance, meaning, or mechanism remain hypotheses unless tested. Ethical recommendations draw on professional documents and analysis, not efficacy alone. Qualitative reports identify possible processes and harms without proving causation; naturalistic surveys remain limited by self-selection, recall, and uncertain substance identity.

A relevant earlier JPPC article was read in full because it examines questions as therapeutic communications that can redirect attention and meaning (Haverkampf, 2017). Here it supports only the general proposition that therapist language is an intervention, not any claim about psychedelic safety or efficacy. No author-developed Communication-Focused Therapy protocol is proposed. The review's no-patient-material stance avoids the false vividness of a composite case, which would be particularly problematic in a field where dramatic narratives already influence expectation.

III. THE TREATMENT IS A COMPOUND-CONTEXT PACKAGE

The relevant clinical unit is the package: selection, preparation, compound, setting, support, post-session contact, integration, and follow-up. Each element may affect safety and outcome; removing one changes the intervention, while keeping a room and script constant does not make compounds equivalent. Evidence claims should specify substance, indication, therapeutic model, and setting.

Research protocols often devote many hours to one or two administration sessions. Preparation sets expectations and contingencies; trained facilitators monitor the acute period; follow-up assesses adverse events, orientation, and meaning. These resources are part of the tested exposure and belong in any account of cost, scalability, and transfer to ordinary services.

Psychological support can be ethically indispensable without having been shown to be the unique mechanism of symptom change. Some protocols emphasize non-directive presence, others incorporate cognitive-behavioral, acceptance-based, motivational, psychodynamic, or trauma-focused elements. Brennan and Belser's review of contemporary models illustrates substantial variation and offers one integrative framework, while also disclosing commercial relationships relevant to appraisal (Brennan & Belser, 2022). A named model is a clinical proposal until its distinct effects are compared.

This distinction protects psychotherapy from two opposite reductions. The first treats the therapist as a pleasant safety accessory to a curative molecule. The second attributes drug-related change to a preferred psychological theory without testing it. Both overlook interaction. A compound may change affect, perception, self-experience, and learning conditions; a relationship may guide attention and interpretation within those conditions. The research question is not which side owns the outcome, but how their contributions and interactions can be estimated.

IV. EARLY EFFICACY SIGNALS AND THEIR BOUNDARIES

Controlled studies available by the cutoff provided reasons for careful further research. Psilocybin-assisted interventions were associated with reduced depression in selected samples, including a wait-list controlled trial and a comparison with escitalopram in which the prespecified primary depression outcome did not show a significant between-group difference (Davis et al., 2021; Carhart-Harris et al., 2021). A larger trial of single-dose psilocybin with psychological support in treatment-resistant depression found benefit at one dose level but also adverse events and no license to infer a generic psychotherapy effect (Goodwin et al., 2022).

Other indications used different packages. Psilocybin trials reported sustained reductions in anxiety and depression among patients with life-threatening cancer and reduced heavy drinking when combined with psychotherapy for alcohol use disorder (Griffiths et al., 2016; Bogenschutz et al., 2022). A phase 3 trial of MDMA-assisted therapy for severe PTSD reported substantial improvement under intensive protocol conditions (Mitchell et al., 2021). These results concern particular eligibility criteria, therapists, comparators, outcome windows, and compounds.

Trial magnitude must be read beside design. Unmistakable effects invite functional unblinding; recruitment favors willingness for an intense intervention; media attention and investigator allegiance raise expectancy. Samples often

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exclude psychosis risk, medical instability, and routine-care complexity, while therapist contact is extensive. Internal validity does not settle effectiveness, transportability, or active ingredients.

Longer follow-up is encouraging in some cohorts but cannot fully repair an uncontrolled design or attrition. Follow-up reports described durable improvement among participants who remained in selected psilocybin studies, while later stages lacked untreated controls and some participants reported additional psychedelic use (Carhart-Harris et al., 2018; Gukasyan et al., 2022). Durability, relapse pathways, repeat exposure, comparative effectiveness, and rare harms require larger, independent, longer studies.

Table 1. What selected trials established—and what they left open by 30 November 2022

Studied package	Evidence signal	Inference boundary
Psilocybin-assisted intervention for major depression	Rapid symptom improvement in selected controlled samples	Small or selected samples; expectancy and masking; model-specific support; durability
Psilocybin versus escitalopram with psychological support	Improvement in both groups; several secondary signals favored psilocybin	Prespecified primary outcome was not significantly different; secondary outcomes need caution
Single-dose psilocybin with psychological support for treatment-resistant depression	Dose-specific short-term benefit in a larger randomized trial	Adverse events, selected eligibility, short primary window, psychotherapy contribution unresolved
Psilocybin-assisted psychotherapy for alcohol use disorder	Fewer heavy drinking days than active placebo package	Specialist protocol; expectancy; generalizability and longer comparative follow-up
MDMA-assisted therapy for severe PTSD	Large symptom and functional signals in a phase 3 protocol	MDMA is pharmacologically distinct; intensive staffing; masking and dissemination questions

V. SET AND SETTING AS CLINICAL VARIABLES

Set usually refers to the person's expectations, intentions, mood, history, and readiness; setting includes physical, interpersonal, institutional, and cultural context. The distinction is convenient rather than clean. A research centre's reputation alters expectation, a therapist's explanation becomes part of mind-set, and a room communicates what kind of experience is anticipated. Hartogsohn's historical analysis shows that the language has repeatedly carried scientific, therapeutic, and cultural assumptions rather than naming two simple controls (Hartogsohn, 2016).

Prospective naturalistic data associate clear intention and positive pre-experience state with aspects of acute experience, while baseline traits and acute qualities also relate to later well-being (Haijen et al., 2018). Such findings support careful attention to context but do not prove that any prescribed ambience improves clinical outcomes. People choose their settings; expectations, dose, prior experience, and social conditions covary. The evidence justifies measurement and transparent reporting more strongly than it justifies a standardized aesthetic.

The physical environment can reduce avoidable distress: privacy, comfortable temperature, accessible toilets, unobstructed monitoring, predictable sound, and freedom from unnecessary traffic matter. Music, artwork, eye shades, and ritualized language can also guide emotion and interpretation. They are therefore interventions, not neutral background. A playlist may feel containing to one person and culturally alien, sentimental, religious, or controlling to another. Preference should be discussed before the person's evaluative freedom is altered.

Setting extends beyond the room: recruitment, advertised claims, conflict disclosure, genuine withdrawal, and follow-up shape the encounter. A luxurious environment cannot compensate for weak emergency systems or coercive consent. The aim is a range of tolerable experiences, not manufactured mysticism or performance of a preferred narrative.

VI. EXPECTANCY, MASKING, AND THE CULTURE OF PROMISE

Expectancy can shape attention, engagement, interpretation, and reporting. Transformative advertising may amplify hope before consent, while conspicuous acute effects let participants and therapists infer assignment. A placebo-controlled label therefore does not establish psychologically comparable groups.

A systematic examination of psychedelic trials found that expectancy and masking success were often not adequately measured or reported and argued that effect estimates may be inflated (Muthukumaraswamy et al., 2021). Active placebos, independent raters, expectancy measurement, assessment of treatment guesses, and balanced information can improve inference, although none abolishes the problem. Investigators should publish these data, including therapist guesses, rather than treating a recognizable subjective effect as an inconvenient footnote.

Clinical communication should neither cool hope performatively nor recruit belief. Descriptions such as reset, breakthrough, inner healer, or years of therapy in one day may function as suggestions even when offered as metaphors. Preparation should present multiple possible trajectories: relief, no meaningful benefit, transient improvement, confusion, difficult affect, or worsening. The patient's desire for a particular experience can be acknowledged without making that experience a treatment target or a test of openness.

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The broader culture matters. News coverage, celebrity testimony, commercial clinics, advocacy, prohibition history, and spiritual communities supply scripts before a participant meets a therapist. These influences cannot be excluded, but they can be elicited. Ask what the person has heard, what they expect the drug to reveal, what disappointment would mean, and whether they feel pressure to report transformation. Such questions improve consent and give later outcome assessment a more honest baseline.

VII. SUGGESTIBILITY, MEANING, AND EPISTEMIC CARE

A small placebo-controlled study found that LSD increased scores on one measure of suggestibility in healthy volunteers (Carhart-Harris et al., 2015). This does not establish that every psychedelic, dose, patient, or therapeutic statement becomes more influential. It does establish a credible reason for restraint. Altered salience, emotion, self-boundaries, and confidence can make a therapist's ordinary words unusually consequential, especially when the therapist is already invested with medical and symbolic authority.

The risk is not confined to explicit directives. Questions select attention and propose categories. Facial reactions reward some accounts; silence can be understood as confirmation; repeated invitations to surrender or go deeper can define resistance. Earlier JPPC work describes questions as communications that can redirect information and meaning (Haverkampf, 2017). In an altered state this general clinical fact warrants heightened caution, not a special communication theory or a claim that questioning has a proven psychedelic mechanism.

Psychedelic experiences can carry a noetic quality: ideas may feel discovered rather than imagined. Survey and trial data suggest that metaphysical beliefs can shift after psychedelic exposure (Timmermann et al., 2021). Whether a new belief is welcome, accurate, durable, or disruptive is a separate question. Therapists should not certify claims about God, recovered memory, cosmic identity, childhood abuse, or another person's motives. Nor should they ridicule spiritual meaning. Epistemic care holds felt significance and factual uncertainty at the same time.

Timmermann, Watts, and Dupuis propose a gentle approach to mediating insights because feelings of truth may be both therapeutically useful and hazardous (Timmermann et al., 2022). In practice, the therapist can ask how an experience affects life, relationships, and values; what alternative meanings are possible; and what evidence would be needed before acting on a factual claim. Decisions with irreversible consequences deserve time after acute effects have resolved. Integration should enlarge reflection rather than convert intensity into certainty.

VIII. THE THERAPEUTIC RELATIONSHIP: INGREDIENT AND RISK

Trust allows a participant to enter an uncertain experience while knowing that another person will remain attentive. That is a clinical achievement, not simply friendliness. Preparation should show how the therapist responds to disagreement, fear, shame, and requests to stop. A participant who believes that cooperation is required to receive the treatment may report alliance while withholding doubt. The relevant relationship can tolerate a refusal, a correction, and an experience that does not fit the programme's theory.

A process analysis in psilocybin-assisted therapy for depression found associations among therapeutic alliance, rapport, acute experience, and later depressive symptoms (Murphy et al., 2022). The analysis supports studying alliance as more than background, but it does not prove a simple causal chain. Baseline severity, participant characteristics, expectancy, and shared-method measurement may contribute. A strong alliance may facilitate benefit, reflect early hope, or both. It can also make influence harder to recognize.

Qualitative accounts describe themes of connection, emotional encounter, avoidance, and changed perspective after psilocybin-supported treatment (Belser et al., 2017; Breeksema et al., 2020; Watts et al., 2017). These reports convey what symptom scales miss, yet they come from small, selected cohorts embedded in particular teams. Their language should inform questions, not become a template participants are expected to reproduce. Silence, terror, anger, flatness, or an ordinary experience also require respectful space.

Transference, idealization, gratitude, dependency, erotic feeling, and fear may intensify around a therapist who witnessed a vulnerable altered state. The clinician must anticipate rather than exploit this asymmetry. Post-session contact, availability, gifts, social media, dual relationships, and endings need explicit policies. Supervision should examine the therapist's wish to be healer, guide, initiate, rescuer, or expert witness to revelation. Charisma is not competence, and participant devotion is not an outcome measure.

IX. PREPARATION AS CONSENT AND COLLABORATION

Preparation is sometimes described as teaching the participant to trust, let go, and be open. Those instructions may help some people, but they can also imply that fear or refusal represents failure. A collaborative preparation explains likely perceptual and emotional effects, bodily monitoring, the planned role of staff, how to communicate needs, what cannot be guaranteed, and what happens if the participant wants less interaction. It invites preferences without promising that they will remain unchanged during the session.

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Enhanced consent is warranted because acute experiences can be difficult to imagine and may affect values, identity, or metaphysical belief. Smith and Sisti argue that ordinary medication-style disclosure may be insufficient for psilocybin because people could experience consequential changes they did not anticipate (Smith & Sisti, 2021). Consent should cover the possibility of profound meaning as well as panic, shame, disorientation, disappointment, symptom worsening, and an unwanted shift in worldview.

Preparation also establishes language. Ask which forms of address, reassurance, music, silence, proximity, and nonsexual touch are acceptable, and which are not. Identify a simple way to signal stop or space. Discuss whether the participant wants spiritual language avoided, welcomed only when they introduce it, or approached within a particular tradition. These preferences guide care but do not authorize the therapist to lead belief. Consent to one form of support is not blanket consent to escalation.

Practical planning includes transport, accompaniment after discharge, medication review by an appropriate prescriber, emergency contacts, delayed decision-making, and follow-up. The participant should understand the legal and regulatory status of the intervention and the limits of confidentiality in a research or clinical setting. Payment, withdrawal, data use, recordings, and access after the protocol ends deserve plain language. Preparation has succeeded when the person can disagree knowledgeably, not when enthusiasm has been secured.

Table 2. Preparation topics that protect agency before altered consciousness

Topic	What must be discussed	Communication safeguard
Evidence and alternatives	Compound- and indication-specific evidence, uncertainty, nonresponse, standard care	Use absolute clarity; avoid breakthrough guarantees and class-wide claims
Acute experience	Possible fear, perceptual change, bodily effects, altered self and time, difficult material	Describe a range; do not prescribe the correct experience
Support and boundaries	Staff roles, observation, language, proximity, touch, privacy, recordings	Obtain granular preferences while sober; provide a stop signal
Meaning and memory	Intense conviction, spiritual content, apparent memories, delayed interpretation	Distinguish felt significance from factual verification
Aftercare	Transport, supervision, emergency contact, follow-up, integration, deterioration	Name who is responsible, when, and how help is reached

X. THE ADMINISTRATION SESSION: SUPPORT WITHOUT CAPTURE

During administration, the therapist or monitor holds simultaneous tasks: observe medical and psychological safety, preserve a stable frame, respond to need, and avoid capturing the person's experience. Support can be quiet and specific: orientation to place and time, permission to adjust posture or music, reminders that effects change, and confirmation that the person is not alone. Interpretation is usually postponable. The more striking the content, the stronger the reason to resist an immediate explanatory triumph.

Distress is not automatically therapeutic exposure, resistance, or impending breakthrough. It may reflect expected acute anxiety, trauma activation, interpersonal threat, physical illness, an unwanted environmental cue, or an adverse reaction. The first response is assessment. Check communication, behavior, vital signs as the protocol requires, environmental triggers, and the person's request. Reassurance should not become pressure to continue. Safety guidelines emphasize screening, preparation, a supportive environment, trained monitors, and follow-up for persistent effects (Johnson et al., 2008).

Non-directiveness is an ethical orientation rather than literal passivity. A silent therapist can still communicate judgment, abandonment, or fascination. A directive may be needed for immediate safety. The aim is the least influential response compatible with care, followed by later review. Staff should document significant interventions, changes to music or positioning, touch, restraint or emergency medication if ever required, and any departure from protocol. This enables supervision and prevents intuition from becoming unreviewable authority.

Session length and altered cognition create ordinary human needs that glamorous accounts omit: hydration according to protocol, toileting, nausea, temperature, fatigue, modesty, and privacy. Procedures must protect dignity when mobility and judgment are affected. The participant should not be left to negotiate boundaries at peak intensity. Staffing and relief plans must prevent monitor exhaustion. A calm room is only as safe as the team's capacity to recognize deterioration and escalate care.

Clinical box: a low-suggestion response to intense material

- Orient first: establish immediate safety, bodily state, location, and the person's request.
- Reflect experience without certifying its explanation: 'This feels vivid and important right now.'
- Do not name a memory, diagnosis, spiritual truth, or relationship meaning for the participant.
- Use only the previously agreed form of proximity or touch, unless immediate safety requires otherwise.
- Record consequential content and revisit it after recovery with alternatives and uncertainty intact.

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XI. CONSENT, TOUCH, SEXUAL BOUNDARIES, AND POWER

Altered consciousness does not create a therapeutic exception to ordinary boundaries. It makes their protection more demanding. A person may seek closeness, become frightened by distance, comply automatically, or later remember an interaction differently. Consent for touch must therefore be specific, discussed while sober, revocable, and limited to defined forms and circumstances. Agreement to supportive hand-holding does not authorize embracing, bodywork, lying beside the participant, or any sexualized contact.

The therapist remains responsible for noticing that apparent assent during intoxication may not represent free authorization. If a participant requests unplanned touch, the safest response is generally to use agreed alternatives and defer renegotiation until capacity is restored, except where immediate physical safety requires action. Teams should use observable protocols, document contact, and provide a route for reporting concern outside the treatment relationship. Two-person staffing alone does not guarantee safety if norms discourage challenge.

Published ethical analyses warn that psychedelic work combines vulnerability, authority, touch, intense attachment, and potentially blurred spiritual roles (Pilecki et al., 2021; American Psychiatric Association, 2022). Sexual contact is prohibited, not transformed into healing by a facilitator's theory. Romantic or commercial recruitment from former participants, secrecy, retaliatory discharge, and claims that discomfort proves resistance are warning signs. Organizations need independent complaints processes, safeguarding training, and consequences that do not depend on participant charisma or therapist status.

Consent also concerns personality, values, and relationships. A participant may later reinterpret a marriage, religion, occupation, or identity through the experience. The therapist should neither accelerate life-changing decisions nor preserve the previous life at any cost. Encourage time, ordinary consultation, and assessment of mood, sleep, impulsivity, and coercion. Respect for autonomy includes protection from the clinician's preferred future. Smith and Sisti's enhanced-consent argument is especially pertinent where change itself may be experienced as both benefit and loss (Smith & Sisti, 2021).

XII. INTEGRATION WITHOUT APPROPRIATING THE EXPERIENCE

Integration is widely used and inconsistently defined. A concept analysis found that the term covers varied practices directed toward making sense of experience and translating it into life across psychological, behavioral, relational, spiritual, bodily, and other domains (Bathje et al., 2022). The breadth is clinically useful and evidentially dangerous: almost any follow-up can be called integration, while the added value, optimal timing, dose, provider, and possible harms remain insufficiently tested.

The first integration task is often prosaic: sleep, hydration, medication continuity, orientation, support, and adverse-event assessment. Ask about anxiety, depressed or elevated mood, suicidal thought, perceptual disturbance, confusion, substance use, interpersonal conflict, and the capacity to work or care for others. A compelling narrative should not conceal deterioration. Conversely, an experience that felt empty or frightening should not be reframed automatically as hidden success. Nonresponse deserves care without therapeutic blame.

Meaning-making can proceed through description before interpretation. What was sensed, remembered, feared, desired, or understood? Which parts feel certain, and which remain unclear? How does the account change across days? Patient narratives after psilocybin have emphasized reconnection and renewed engagement, and acceptance-based models propose translating such processes into flexible action (Watts et al., 2017; Watts & Luoma, 2020). These are useful possibilities, not mandatory stages or proof that a particular metaphysics is curative.

Integration should end in proportionate choices. A small conversation, return to routine, grief practice, relapse-prevention step, or decision to wait may be more responsible than dramatic reinvention. Factual claims about recovered events require independent caution; major financial, relational, medical, or legal decisions should not be made merely because they feel revealed. A therapist can help test coherence and consequence while preserving authorship. The experience belongs to the participant; the clinician does not become its priest, translator, or owner.

Table 3. An integration sequence that separates experience, interpretation, and action

Phase	Clinical questions	Guardrail
Stabilize	Sleep, body, medication, orientation, support, risk, adverse effects	Do not privilege narrative depth over safety and function
Describe	What was perceived, felt, remembered, and communicated?	Record uncertainty; avoid completing the story for the person
Interpret	What meanings are possible? What fits prior values and context?	A felt revelation is not external verification
Test	What alternatives, evidence, and consequences should be considered?	Delay irreversible decisions; seek ordinary sources of knowledge
Translate	What small, observable, values-consistent step is warranted?	Action is optional and revisable; no transformation is required

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XIII. SCREENING, ADVERSE EVENTS, AND CONTINUITY OF CARE

Research safety partly reflects exclusion, which narrows generalizability. Protocols have screened psychosis and bipolar vulnerability, cardiovascular disease, pregnancy, interacting medication, unstable substance use, and suicidality, with compound-specific variation (Johnson et al., 2008; Reiff et al., 2020). Qualified professionals must conduct screening; a generic wellness intake is inadequate.

Medication questions differ by compound and protocol. Stopping antidepressants or other medicines may cause withdrawal, relapse, or destabilization. This review offers no discontinuation schedule: changes require an accountable prescriber, rationale, monitoring, and a contingency for deterioration. Trial eligibility rules are not routine-care algorithms.

Acute risks include panic, confusion, agitation, impaired judgment, nausea, cardiovascular change, and unsafe behavior; later concerns include insomnia, mood elevation, psychosis, suicidality, relational disruption, or persistent perceptual symptoms. Carefully screened studies suggest serious lasting events are uncommon, but small samples and short follow-up cannot estimate rare harm. Ascertainment must be active and transparent.

Continuity is a safety intervention. Participants need named urgent contacts, coordination with ordinary clinicians, and a plan for nonresponse or deterioration after study contact ends. Long-term reviews report possible benefit amid heterogeneous measures, selected samples, and limited controlled follow-up (Aday et al., 2020). Services should track function, subsequent treatment, repeat exposure, and harm.

Clinicians will meet patients considering or using psychedelics outside trials. A nonjudgmental history can reduce harm without endorsing use: clarify the presumed substance, timing, context, co-use, events, and persisting symptoms. Identity and dose may be uncertain; immediate medical or psychiatric risk precedes integration.

Harm-reduction and integration therapy may support people without supplying prohibited substances, but law and professional boundaries vary (Pilecki et al., 2021). Clinicians must know applicable licensure, documentation, insurance, and duty-of-care rules. Curiosity does not authorize sourcing, dosing, combination, or evasion advice; the contract should define scope.

Benefit can be acknowledged while reviewing sleep, mood, risk, adherence, relationships, and function. Apparent memory or metaphysical certainty deserves respectful caution; persistent distress requires psychiatric and medical differential assessment. Integration must not delay indicated treatment, and conventional care should not be withdrawn as punishment.

Clinicians can maintain empathic care without claiming expertise or sharing enthusiasm. Consultation and referral should remain available. If use continues despite risk, any discussion of emergency recognition, sober support, or dangerous circumstances must stay within legal and professional scope. The aim is safety and communication, not covert psychedelic treatment.

XIV. TRAINING, FIDELITY, CULTURE, AND ACCESS

Personal psychedelic experience is not therapist competence. Proposed domains include knowledge, skill, self-awareness, and ethics (Phelps, 2017); teams also need expertise in the disorder, differential and suicide assessment, medical escalation, trauma, culture, boundaries, documentation, and the relevant protocol. Conviction may deepen empathy or create blind spots; it is not a credential.

Training should expose influence through observed practice, supervision, fidelity review, and examination of adverse moments. Supervision must address suggestion, spiritual assumptions, touch, rescue, idealization, countertransference, and deviations, independently of recruitment. Brennan and Belser offer an organized model, but disclosed industry relationships remain relevant to appraisal (Brennan & Belser, 2022).

Culture shapes healing, ritual, privacy, touch, family involvement, and legitimate knowledge. Borrowing Indigenous aesthetics without Indigenous governance, or treating Western mystical scales as universal, can reproduce extraction. The field's white-centred participation, practice, and history are structural concerns (Thrul & Garcia-Romeu, 2021); changing décor does not redistribute authority.

Intensive therapist time, rooms, screening, and follow-up are costly. Removing safety elements for scale changes the intervention; private billing may concentrate access among affluent patients. Services should report recruitment, exclusion, retention, and aftercare, and involve affected communities in design rather than only diversify promotional images.

Research must treat context as measurable. Protocols should describe preparation, therapist behavior, staffing, music, touch, crisis procedures, integration, supervision, and deviations. Existing therapy models and varied integration practices show why drug replication alone cannot replicate treatment (Brennan & Belser, 2022; Bathje et al., 2022).

Dismantling and comparative designs are difficult but possible. Studies might compare structured therapeutic models, levels of preparation, integration formats, or therapist behaviors while preserving minimum safety. They should measure alliance at multiple times, expectancy before allocation, treatment guesses, participant preference, suggestive communication, and perceived coercion.

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Independent raters and qualitative interviews can complement symptom measures. The aim is not to subtract humane support but to learn which elements help, for whom, and at what cost.

Harms research requires independent routes of disclosure. Standard adverse-event checklists may miss boundary violations, unwanted belief change, dependency, financial exploitation, shame about nonresponse, or delayed relational disruption. Participants should be contacted after the research relationship has ended and allowed to report outside the treatment team. Data should include excluded and withdrawn participants where consent permits. Commercial sponsors, therapist training organizations, and investigators should publish financial and intellectual conflicts.

Representative samples and community partnership are scientific necessities. Recruitment should address racial and socioeconomic exclusion, disability access, language, prior trauma with institutions, and cultural interpretations of altered states. Outcomes should include function, quality of life, service use, medication changes, relationships, and participant-defined benefit or harm. Comparative effectiveness against credible established care matters more for practice than repeated demonstrations against weak controls. The central question is whether the full package improves lives safely under conditions services can actually sustain.

XV. LIMITATIONS

This narrative review was limited to literature available by 30 November 2022 and is not a systematic review or meta-analysis. A rapidly expanding field creates unusual publication and allegiance pressures. Several cited authors developed treatment models, worked in prominent research groups, or reported industry relationships. Inclusion does not validate a model or eliminate conflict. The review emphasizes communication and ethics and cannot cover pharmacology, neurobiology, regulation, or every compound in equivalent depth.

The evidence base was heterogeneous. Diagnoses, compounds, doses, comparators, psychological support, therapist training, outcome windows, and adverse-event procedures differed. Small samples, selective eligibility, functional unblinding, high expectancy, media attention, and intensive contact limit generalization. Qualitative studies richly describe experience but usually involve small subsets and cannot establish mechanism. Naturalistic studies face selection, recall, uncertain substance, and setting confounds. An association between alliance or acute experience and outcome may reflect common causes rather than mediation.

Safety conclusions are especially constrained. Rare or delayed harms require denominators and follow-up larger than most trials provided. Research screening and monitoring reduce risk but exclude many patients who may seek future care. Absence of an observed event is not proof of absence. Conversely, harms in unsupervised or exploitative settings cannot be assigned automatically to a regulated clinical package. Compound, context, practitioner behavior, and participant vulnerability should be separated wherever evidence permits.

Recommendations about consent, touch, epistemic care, and boundaries are principled clinical safeguards, not trial-proven techniques for improving efficacy. The relevant JPPC cross-citation concerns therapeutic communication and contributes no psychedelic outcome evidence. No patient data, case material, or invented quotation is included. The article's interpretations should be revised as independent comparative trials, regulation, adverse-event surveillance, and patient-led accounts develop.

XVI. CONCLUSION

Psychedelic-assisted psychotherapy is best understood as a relational treatment package under investigation, not a molecule plus ambience and not a universal school of therapy. Early trials justify disciplined interest. They do not establish a class-wide cure, the independent effect of psychotherapy, or routine-care safety. Compound, indication, selection, preparation, setting, relationship, integration, and follow-up must remain visible in every claim.

The therapeutic relationship may support trust, emotional engagement, and later change. It also concentrates influence when perception, suggestibility, dependency, and felt certainty may be altered. Enhanced consent, explicit touch and sexual boundaries, non-directive support, compound-specific screening, cultural humility, independent safeguarding, and continuity of care are therefore central clinical requirements rather than administrative additions.

Good practice protects the patient's authorship without abandoning them to an intense experience. It can welcome meaning without certifying revelation, inquire without installing memory, and encourage action without demanding transformation. The most credible future research will measure the relationship and setting, report expectancy and masking, seek harms actively, compare realistic alternatives, and follow diverse participants long enough to learn not only whether symptoms change, but what kind of life and care follow.

XVII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). Where CFT is discussed, it is presented as a formulation perspective and not as a substitute for established assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

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Patient material—No identifiable patient material is presented. Any brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

XVIII. REFERENCES

Aday, J. S., Mitzkovitz, C. M., Bloesch, E. K., Davoli, C. C., & Davis, A. K. (2020). Long-term effects of psychedelic drugs: A systematic review. Neuroscience & Biobehavioral Reviews, 113, 179-189. https://doi.org/10.1016/j.neubiorev.2020.03.017

American Psychiatric Association. (2022). Ethical and practical implications of psychedelics in psychiatry: A resource document. https://www.psychiatry.org/psychiatrists/search-directories-databases/resource-documents/2022/ethical-and-practical-implications-of-psychedelics

Bathje, G. J., Majeski, E., & Kudowor, M. (2022). Psychedelic integration: An analysis of the concept and its practice. Frontiers in Psychology, 13, 824077. https://doi.org/10.3389/fpsyg.2022.824077

Belser, A. B., Agin-Liebes, G., Swift, T. C., Terrana, S., Devenot, N., Friedman, H. L., Guss, J., Bossis, A., & Ross, S. (2017). Patient experiences of psilocybin-assisted psychotherapy: An interpretative phenomenological analysis. Journal of Humanistic Psychology, 57(4), 354-388. https://doi.org/10.1177/0022167817706884

Bogenschutz, M. P., Ross, S., Bhatt, S., Baron, T., Forcehimes, A. A., Laska, E., Mennenga, S. E., O'Donnell, K., Owens, L. T., Podrebarac, S., Rotrosen, J., Tonigan, J. S., & Worth, L. (2022). Percentage of heavy drinking days following psilocybin-assisted psychotherapy vs placebo in the treatment of adult patients with alcohol use disorder: A randomized clinical trial. JAMA Psychiatry, 79(10), 953-962. https://doi.org/10.1001/jamapsychiatry.2022.2096

Breeksema, J. J., Niemeijer, A. R., Krediet, E., Vermetten, E., & Schoevers, R. A. (2020). Psychedelic treatments for psychiatric disorders: A systematic review and thematic synthesis of patient experiences in qualitative studies. CNS Drugs, 34(9), 925-946. https://doi.org/10.1007/s40263-020-00748-y

Brennan, W., & Belser, A. B. (2022). Models of psychedelic-assisted psychotherapy: A contemporary assessment and an introduction to EMBARK, a transdiagnostic, trans-drug model. Frontiers in Psychology, 13, 866018. https://doi.org/10.3389/fpsyg.2022.866018

Carhart-Harris, R. L., Bolstridge, M., Day, C. M. J., Rucker, J., Watts, R., Erritzoe, D. E., Kaelen, M., Giribaldi, B., Bloomfield, M., Pilling, S., Rickard, J. A., Forbes, B., Feilding, A., Taylor, D., Curran, H. V., & Nutt, D. J. (2018). Psilocybin with psychological support for treatment-resistant depression: Six-month follow-up. Psychopharmacology, 235(2), 399-408. https://doi.org/10.1007/s00213-017-4771-x

Carhart-Harris, R. L., Giribaldi, B., Watts, R., Baker-Jones, M., Murphy-Beiner, A., Murphy, R., Martell, J., Blemings, A., Erritzoe, D., & Nutt, D. J. (2021). Trial of psilocybin versus escitalopram for depression. New England Journal of Medicine, 384(15), 1402-1411. https://doi.org/10.1056/NEJMoa2032994

Carhart-Harris, R. L., Kaelen, M., Whalley, M. G., Bolstridge, M., Feilding, A., & Nutt, D. J. (2015). LSD enhances suggestibility in healthy volunteers. Psychopharmacology, 232(4), 785-794. https://doi.org/10.1007/s00213-014-3714-z

Davis, A. K., Barrett, F. S., May, D. G., Cosimano, M. P., Sepeda, N. D., Johnson, M. W., Finan, P. H., & Griffiths, R. R. (2021). Effects of psilocybin-assisted therapy on major depressive disorder: A randomized clinical trial. JAMA Psychiatry, 78(5), 481-489. https://doi.org/10.1001/jamapsychiatry.2020.3285

Goodwin, G. M., Aaronson, S. T., Alvarez, O., Arden, P. C., Baker, A., Bennett, J. C., Bird, C., Blom, R. E., Brennan, C., Brusch, D., Burke, L., Campbell-Coker, K., Carhart-Harris, R., Cattell, J., Daniel, A., DeBattista, C., Dunlop, B. W., Eisen, K., Feifel, D., Forbes, M., Haumann, H. M., Hellerstein, D. J., Hoppe, A. I., Husain, M. I., Jelen, L. A., Kamphuis, J., Kawasaki, J., Kelly, J. R., Key, R. E., Kishon, R., Knatz Peck, S., Knight, G., Koolen, M. H. B., Lean, M., Licht, R. W., Maples-Keller, J. L., Mars, J., Marwood, L., McElhiney, M. C., Miller, T. L., Mirow, A., Mistry, S., Mletzko-Crowe, T., Modlin, L. N., Nielsen, R. E., Nielson, E. M., Offerhaus, S. R., O'Keane, V., Páleníček, T., Printz, D., Rademaker, M. C., van Reemst, A., Reinholdt, F., Repantis, D., Rucker, J., Rudow, S., Ruffell, S., Rush, A. J., Schoevers, R. A., Seynaeve, M., Shao, S., Soares, J. C., Somers, M., Stansfield, S. C., Sterling, D., Strockis, A., Tsai, J., Visser, L., Wahba, M., Williams, S., Young, A. H., Ywema, P., Zisook, S., & Malievskaia, E. (2022). Single-dose psilocybin for a treatment-resistant episode of major depression. New England Journal of Medicine, 387(18), 1637-1648. https://doi.org/10.1056/NEJMoa2206443

Griffiths, R. R., Johnson, M. W., Carducci, M. A., Umbricht, A., Richards, W. A., Richards, B. D., Cosimano, M. P., & Klinedinst, M. A. (2016). Psilocybin produces substantial and sustained decreases in depression and anxiety in patients with life-threatening cancer: A randomized double-blind trial. Journal of Psychopharmacology, 30(12), 1181-1197. https://doi.org/10.1177/0269881116675513

Gukasyan, N., Davis, A. K., Barrett, F. S., Cosimano, M. P., Sepeda, N. D., Johnson, M. W., & Griffiths, R. R. (2022). Efficacy and safety of psilocybin-assisted treatment for major depressive disorder: Prospective 12-month follow-up. Journal of Psychopharmacology, 36(2), 151-158. https://doi.org/10.1177/02698811211073759

Haijen, E. C. H. M., Kaelen, M., Roseman, L., Timmermann, C., Kettner, H., Russ, S., Nutt, D., Daws, R. E., Hampshire, A. D. G., Lorenz, R., & Carhart-Harris, R. L. (2018). Predicting responses to psychedelics: A prospective study. Frontiers in Pharmacology, 9, 897. https://doi.org/10.3389/fphar.2018.00897

Hartogsohn, I. (2016). Set and setting, psychedelics and the placebo response: An extra-pharmacological perspective on psychopharmacology. Journal of Psychopharmacology, 30(12), 1259-1267. https://doi.org/10.1177/0269881116677852

Haverkampf, C. J. (2017). Questions in therapy. J Psychiatry Psychotherapy Communication, 6(1), 80-81.

Johnson, M. W., Richards, W. A., & Griffiths, R. R. (2008). Human hallucinogen research: Guidelines for safety. Journal of Psychopharmacology, 22(6), 603-620. https://doi.org/10.1177/0269881108093587

Mitchell, J. M., Bogenschutz, M., Lilienstein, A., Harrison, C., Kleiman, S., Parker-Guilbert, K., Ot'alora G., M., Garas, W., Paleos, C., Gorman, I., Nicholas, C., Mithoefer, M., Carlin, S.,

Haverkampf, C. J. (2022). Psychedelic-Assisted Psychotherapy: Therapeutic Relationship, Suggestibility, and Set and Setting. J Psychiatry Psychotherapy Communication, 2022 Dec 31;11(4):111-120

Poulter, B., Mithoefer, A., Quevedo, S., Wells, G., Klaire, S. S., van der Kolk, B., Tzarfaty, K., Amiaz, R., Worthy, R., Shannon, S., Woolley, J. D., Marta, C., Gelfand, Y., Hapke, E., Amar, S., Wallach, Y., Brown, R., Hamilton, S., Wang, J. B., Coker, A., Matthews, R., de Boer, A., Yazar-Klosinski, B., Emerson, A., & Doblin, R. (2021). MDMA-assisted therapy for severe PTSD: A randomized, double-blind, placebo-controlled phase 3 study. Nature Medicine, 27(6), 1025-1033. https://doi.org/10.1038/s41591-021-01336-3

Murphy, R., Kettner, H., Zeifman, R., Giribaldi, B., Kartner, L., Martell, J., Read, T., Murphy-Beiner, A., Baker-Jones, M., Nutt, D., Erritzoe, D., Watts, R., & Carhart-Harris, R. (2022). Therapeutic alliance and rapport modulate responses to psilocybin assisted therapy for depression. Frontiers in Pharmacology, 12, 788155. https://doi.org/10.3389/fphar.2021.788155

Muthukumaraswamy, S. D., Forsyth, A., & Lumley, T. (2021). Blinding and expectancy confounds in psychedelic randomized controlled trials. Expert Review of Clinical Pharmacology, 14(9), 1133-1152. https://doi.org/10.1080/17512433.2021.1933434

Phelps, J. (2017). Developing guidelines and competencies for the training of psychedelic therapists. Journal of Humanistic Psychology, 57(5), 450-487. https://doi.org/10.1177/0022167817711304

Pilecki, B., Luoma, J. B., Bathje, G. J., Rhea, J., & Fraguada Narloch, V. (2021). Ethical and legal issues in psychedelic harm reduction and integration therapy. Harm Reduction Journal, 18, 40. https://doi.org/10.1186/s12954-021-00489-1

Reiff, C. M., Richman, E. E., Nemeroff, C. B., Carpenter, L. L., Widge, A. S., Rodriguez, C. I., Kalin, N. H., & McDonald, W. M. (2020). Psychedelics and psychedelic-assisted psychotherapy. American Journal of Psychiatry, 177(5), 391-410. https://doi.org/10.1176/appi.ajp.2019.19010035

Smith, W. R., & Sisti, D. (2021). Ethics and ego dissolution: The case of psilocybin. Journal of Medical Ethics, 47(12), 807-814. https://doi.org/10.1136/medethics-2020-106070

Thrul, J., & Garcia-Romeu, A. (2021). Whitewashing psychedelics: Racial equity in the emerging field of psychedelic-assisted mental health research and treatment. Drugs: Education, Prevention and Policy, 28(3), 211-214. https://doi.org/10.1080/09687637.2021.1897331

Timmermann, C., Kettner, H., Letheby, C., Roseman, L., Rosas, F. E., & Carhart-Harris, R. L. (2021). Psychedelics alter metaphysical beliefs. Scientific Reports, 11, 22166. https://doi.org/10.1038/s41598-021-01209-2

Timmermann, C., Watts, R., & Dupuis, D. (2022). Towards psychedelic apprenticeship: Developing a gentle touch for the mediation and validation of psychedelic-induced insights and revelations. Transcultural Psychiatry, 59(5), 691-704. https://doi.org/10.1177/13634615221082796

Watts, R., Day, C., Krzanowski, J., Nutt, D., & Carhart-Harris, R. (2017). Patients' accounts of increased connectedness and acceptance after psilocybin for treatment-resistant depression. Journal of Humanistic Psychology, 57(5), 520-564. https://doi.org/10.1177/0022167817709585

Watts, R., & Luoma, J. B. (2020). The use of the psychological flexibility model to support psychedelic assisted therapy. Journal of Contextual Behavioral Science, 15, 92-102. https://doi.org/10.1016/j.jcbs.2019.12.004