

Psychedelic-assisted therapy: a survey on the clinical methods of Swiss physicians

Kristian Beichmann*^{ID}, Polina Catzeflis*^{ID}, Helena D. Aicher^{ID}, Federico Seragnoli^{ID}, Abigail Calder^{ID}, Adam Amrani and Gregor Hasler^{ID}

Ther Adv Psychopharmacol

2026, Vol. 16: 1–24

DOI: 10.1177/
20451253261448745

© The Author(s), 2026.
Article reuse guidelines:
sagepub.com/journals-
permissions

Abstract

Background: The Swiss Federal Office of Public Health provides case-by-case exemptions allowing physicians to provide psychedelic-assisted therapy (PAT) using psilocybin, lysergic acid diethylamide (LSD), or 3,4-methylenedioxy-*N*-methamphetamine (MDMA).

Objectives: The study provided an overview of PAT as currently provided in Switzerland under the regulatory framework of the Federal Office of Public Health (FOPH).

Design: Swiss PAT practices were examined using an anonymous survey of physicians providing PAT. Questions included physicians' backgrounds, training, therapeutic orientation, treatment protocols, patient characteristics, and perceived benefits.

Methods: Participants were recruited from PAT professional associations and the research team network. Forty-one physicians providing PAT under FOPH exemptions contributed to the survey.

Results: Respondents used PAT primarily for depression, anxiety, post-traumatic stress disorder (PTSD), and chronic pain. Most physicians practiced in private practices, private outpatient clinics or shared practices (82%), with a minority in hospitals (18%). The most reported labels when providing PAT were body-oriented (61%), psychodynamic (59%), and eclectic (54%) approaches. Respondents provided PAT using psilocybin (85%), MDMA (71%), and LSD (65.9%). Choice of first substance was linked to diagnosis, with physicians preferring psilocybin for depression (54%) and substance use disorder (46%) and MDMA for PTSD (86%) and anxiety disorders (54%). A total of 90% reported always playing music during psychedelic sessions. Loss of orientation in time and space, feeling too cold, anxiety, and nausea were the most frequent adverse effects of PAT. 95% had emergency medication available, on average used during 2.4% of sessions. Challenges included legal constraints, high patient expectations, and financial barriers. Group therapy was common, with 9% reporting providing only group sessions, 42% providing both individual and group settings, and 47% providing only individual sessions. Only 9% reported never using co-sitters.

Conclusion: This study offers valuable insights into the methods and experiences of physicians providing PAT in a legal clinical context, giving insight into the considerable variety of clinical methods. Cultural and regulatory differences may limit generalizability.

Keywords: clinical practice, group therapy, LSD, MDMA, naturalistic use, psilocybin, psychedelic therapy, psycholytic therapy, Switzerland

Received: 3 December 2025; revised manuscript accepted: 12 April 2026.

Introduction

In recent years, interest in psychedelic-assisted therapy (PAT) has grown substantially, accompanied by a steady increase in clinical studies investigating its therapeutic potential in psychiatry¹ as

well as neurological and somatic conditions.^{2–4} Several countries have implemented government-regulated access pathways, compassionate use programs, or partial medical integration for psychedelic substances, including Canada,⁵ Australia,⁶ select

Correspondence to:

Gregor Hasler
Molecular Psychiatry
Laboratory, Faculty of
Science and Medicine,
University of Fribourg,
Villars-sur-Glâne,
Switzerland

Fribourg Mental Health
Network, Chemin du
Cardinal-Journet 3,
Villars-sur-Glâne 1752,
Switzerland

Lake Lucerne Institute,
Fribourg, Switzerland
gregor.hasler@unifr.ch

Kristian Beichmann
Polina Catzeflis
Adam Amrani
Molecular Psychiatry
Laboratory, Faculty of
Science and Medicine,
University of Fribourg,
Villars-sur-Glâne,
Switzerland

Helena D. Aicher
Clinical Research Center
for Substance-Assisted
Therapy, Department of
Psychiatry, Division of
Medicine, University of
Basel, Basel, Switzerland
Swiss Medical Association
for Psychedelic Therapy
(SÄPT), Bern, Switzerland

Federico Seragnoli
Psychiatry Department,
Geneva University
Hospitals, Geneva,
Switzerland

Institute of Psychology,
University of Lausanne,
Lausanne, Switzerland

Abigail Calder
Molecular Psychiatry
Lab, Faculty of Science
and Medicine, University
of Fribourg, Villars-sur-
Glâne, Switzerland

Fribourg Mental Health
Network, Villars-sur-
Glâne, Switzerland

*The authors contributed
equally to this work and
share first authorship

U.S. states,^{7,8} and Israel.⁹ However, many clinical trials lack detailed reporting of therapeutic methods,^{10,11} and legal restrictions in most jurisdictions continue to limit the feasibility of naturalistic or practice-based research on PAT.¹² Furthermore, the challenges associated with translating structured trial protocols into real-world clinical settings remain underexplored.¹³ In this context, Switzerland presents a unique case, offering a legally sanctioned framework for PAT within medical practice, thus enabling the investigation of PAT as it is applied in real-world clinical care.

In Switzerland, the use of the psychedelic substances lysergic acid diethylamide (LSD) and psilocybin, as well as the empathogen 3,4-methylenedioxy-*N*-methamphetamine (MDMA), is allowed under the limited medical use law¹⁴ for the treatment of diseases deemed as treatment-resistant and incurable.^{15–21} The exemption was first administered by the Swiss Federal Office of Public Health (FOPH) between 1988 and 1993 and reintroduced in 2014.²² Swiss physicians in clinics and private practices may apply for time-restricted, case-by-case licenses to treat their patients with these substances. This makes Switzerland a unique case in the global landscape of PAT. However, little is known globally about the PAT practices in Switzerland, which is partially due to the lack of formal study, with most literature focusing instead on general descriptions of the practice¹⁵ and treatment recommendations.²³ One doctoral thesis by Ernst Benz²⁴ previously attempted to summarize the concrete techniques of PAT being practiced by physicians in Switzerland, but it has yet to be updated.

The Swiss situation is of particular interest because real-world clinical practice is less standardized than research studies and involves a more diverse patient population. Studying PAT outside of controlled trials therefore offers valuable insights into the practical realities and challenges of using psychedelics in real-world clinical settings. Switzerland's experience with PAT may provide an important addition to data gleaned from the controlled conditions of clinical research under tight regulations. Understanding the nuances of how psychedelics are used in real-world practice could help bridge the gap between experimental research and clinical application.

The current project used an online survey to gather detailed information on the current practice of PAT in Switzerland, including practitioner

backgrounds, patient characteristics, and concrete therapeutic techniques and settings, as well as processes, opinions and challenges deemed important by the respondents. The results of this study aim to provide a perspective on the realities of PAT in clinical practice, providing insights into how these therapies could potentially be implemented on a broader scale. These findings may be valuable for clinicians, researchers, and policy-makers involved in the development of psychedelic therapies and training programs, both in Switzerland and internationally.

Methods

The anonymous online survey was conducted via REDCap (<https://project-redcap.org/>) from February 2024 to November 2024. Recruitment was conducted via advertisements during events of the Swiss Psycholytic Medical Society (“Schweizerische Ärztegesellschaft für Psycholytische Therapie,” SÄPT) (<https://saept.ch/>), as well as through direct email contact with registered medical professionals of the SÄPT. Additional participants were identified through the authors' professional networks, including registered members of the two French-speaking PAT professional associations: the Swiss Professional Association–Psychedelics in Therapy (“Association professionnelle Suisse - Psychédéliques en Thérapie” (ASPT), <https://www.aspt-association.ch/>) and Swiss Society of Psychedelics in Medicine (“Société Suisse de Médecine Psychédélique” (SSPM), <https://swisspsychedelic.ch/>), as well as the Italian-speaking Alaya Foundation (“Fondazione Alaya,” <https://fondazionealaya.ch/>). Advertisements were distributed in French and German and included descriptions of the aim of the study and an anonymous link to participate.

The survey took around 60–90 min to complete. Participants were included if they were physicians who had ever treated a patient with PAT under the Swiss limited medical use law. Physicians who had no direct clinical experience administering PAT, or whose involvement was limited to research, supervision, or training without direct patient treatment, or if PAT was practiced outside the Swiss limited medical use legal framework, were excluded.

It was possible to fill out the survey in English, German, or French language. Participants received written information about the study

prior to accessing the anonymous online survey. Participants received no compensation.

The Strengthening the Reporting of Observational Studies in Epidemiology statement for cross-sectional studies was consulted when preparing this manuscript (Supplemental Material).²⁵

Measures

The full survey, along with all results and open-text answers, is available in the Supplemental Material. The survey included multiple-choice questions, open-text questions, rankings, Likert scales, and continuous scales. The questions were chosen by the research team, in part drawing inspiration from the work of Benz.²⁴ The topics covered by the survey are summarized in Table 1.

The survey section on individual processes was based largely on previous literature describing patient experiences, but also theorized models of therapeutic mechanisms,^{26–32} as well as drawn from the authors' own experience with providing PAT.³³ Group processes described in the survey were based on the 11 group therapy factors of Yalom.^{34,35} All sections of the survey were developed specifically for this study and are original. No external questionnaires, scales, or guidelines were used beyond what has been described, and the survey instruments have not been formally validated. Before distribution, two student volunteers tested the survey, to check for programming errors. No formal pilot testing was performed on the target population.

Additionally, significant consideration was given to selecting a term that accurately represents the broad and diverse category of therapies in which the use of psychedelic substances is integral to treatment. For this project, we adopted the term PAT, which was motivated by the need to avoid terminology that might inadvertently favor or exclude specific therapies that might not fall within the label of therapeutic interventions, as discussions on the therapeutic mechanisms of PAT are ongoing^{36,37} While the FOPH does not provide specific terminology of this therapeutic approach, other labels (e.g., psycholytic therapy) have historically been associated with use of psychedelics in therapy²⁹ and variations in preferred terminology across Switzerland's linguistic regions further complicated the choice. By selecting PAT, we aimed to provide a neutral, inclusive term that minimizes potential biases and an

explanatory note regarding the terminology was included at the beginning of the survey.

Data analysis

Statistical analyses and all graphics were conducted in R (version 4.3.1; R Core team, Vienna, Austria)³⁸ and the RStudio environment (version 2024.09.1+394, Posit Software, Boston, MA, USA).³⁹ All analyses were descriptive. Qualitative data was used for illustrative examples.

Results

PAT-relevant training, theoretical orientation, and personal experience with psychedelics

A total of 41 individuals began the survey, out of which 21 answered the entire survey and 20 respondents did not complete the survey. The demographic data of the participants is displayed in Table 2. A total of 32 participants (78.0%) responded in German, 7 (17.1%) in French, and 2 (4.88%) in English. Almost all participants (39 out of 41) reported providing both PAT and conventional psychotherapy, with an average of 20.08 years of experience. Three participants had ceased practicing conventional psychotherapy, having stopped between 4 and 5 years prior to the interview.

Regarding the languages in which PAT was provided, most physicians use German ($n=35$) and English ($n=29$), followed by French ($n=9$) and Italian ($n=3$). Participants commonly began practicing PAT through interactions with colleagues ($n=33$, 80.49%) and personal experiences with psychedelics ($n=31$, 75.61%). Other influential factors included literature on psychedelics ($n=26$, 63.41%) and exposure to the field during medical training ($n=18$, 43.9%).

In terms of the professional context of PAT, most participants indicated working in the private sector ($n=26$, 63.41%), with fewer working in the public sector ($n=13$, 31.71%) or across both sectors ($n=2$, 4.87%). More specifically, the majority practiced in private offices ($n=27$, 65.85%) and outpatient clinics ($n=16$, 39%). Fewer physicians worked in hospitals ($n=9$, 21.95%) or shared practices ($n=7$, 17.1%).

Figure 1 shows the types of training that respondents reported having undergone before beginning to practice PAT. Respondents were presented with a list of items. The most commonly reported

Table 1. Categories and topics of the survey.

Category	Topics
Participant information	Number of participants
	Age, gender, language
	Years of experience in conventional psychotherapy and PAT
PAT-relevant training and self-experience	Professional work context (public or private sector)
	Preparation techniques for PAT
	Theoretical frameworks for conventional psychotherapy and PAT
Characteristics of PAT patients	Number of personal psychedelic experiences
	Number of patients treated
	Age and gender
Indications for PAT	Referral sources
	Primary diagnoses
	Previous experience with psychedelics
Contraindications for PAT	Psychiatric diagnoses
	Somatic diagnoses
	Other psychological problems
Substances	Psychiatric diagnoses
	Other factors
	Types of substances and dosages
PAT framework	Choice of substance according to diagnosis
	Other determining factors for substance choice
	Number and frequency of substance sessions per patient
Predictors of successful therapy outcome	Number of preparation and integration sessions
	Topics within preparation and integration sessions
Adverse effects	General factors
	Patient characteristics
Set, settings, therapeutic techniques	Types and frequency of adverse effects during PAT
	Strategies to alleviate adverse effects
	Types of mindsets promoted before PAT
	Group or individual settings
	Number of co-therapists
	Room preparation

(Continued)

Table 1. (Continued)

Category	Topics
	Patient positions during PAT
	Usage of music
	Usage of body contact in conventional psychotherapy and PAT
	Rules on consent for body contact
Therapeutic processes	Frequency of observed therapeutic processes in individual and group sessions
Personal opinions	Necessity of self-experience with psychedelics for PAT therapists
	Advantages of PAT
	Challenges in PAT
	Free comment

PAT, psychedelic-assisted therapy.

Table 2. Demographic information of participants.

Characteristics	N	%
Total participants	41	100.0
Age of participants (years)		
Mean	—	52.42
Range	—	33–86
Gender		
Male	34	82.9
Female	7	17.1
Experience in conventional psychotherapy		
Still practicing	39	95.1
Retired	3	7.3
Average years of experience	20.08	—

Percentages may not sum to 100% within categories due to multiple responses.

training included techniques for inducing altered states of consciousness ($n=26$, 63.41%), including meditation, holotropic breathwork, and hypnosis; co-sitting with a supervisor during psychedelic sessions ($n=22$, 53.66%); and specific

training programs in PAT ($n=21$, 51.22%), with respondents indicating having attended training with SÄPT, the MIND Foundation and the Psychiatric Research Institute of Prague.

Participants were asked to indicate their theoretical framework(s) when providing conventional psychotherapy and PAT, and if they considered their approach when providing PAT to be fundamentally different from that when providing conventional psychotherapy. In total, 11 out of 41 respondents (26.8%) indicated that their approach when providing PAT was fundamentally different from their approach when providing conventional psychotherapy. Figure 2 shows that for conventional psychotherapy, the majority of respondents endorsed psychoanalytic/psychodynamic ($n=18$, 43.90%), body-oriented ($n=17$, 41.46%), and cognitive behavioral approaches ($n=13$, 31.70%). For PAT, the three most prominent approaches were body-oriented ($n=25$, 60.95%), psychoanalytic/psychodynamic ($n=24$, 58.54%), and eclectic ($n=22$, 53.66%).

Regarding personal experience with psychedelics, 35 respondents (85.37%) reported having had previous personal experience, one respondent (2.44%) stated they did not, and five respondents (12.2%) preferred not to disclose this information. The frequency of previous psychedelic experiences is shown in Figure 3.

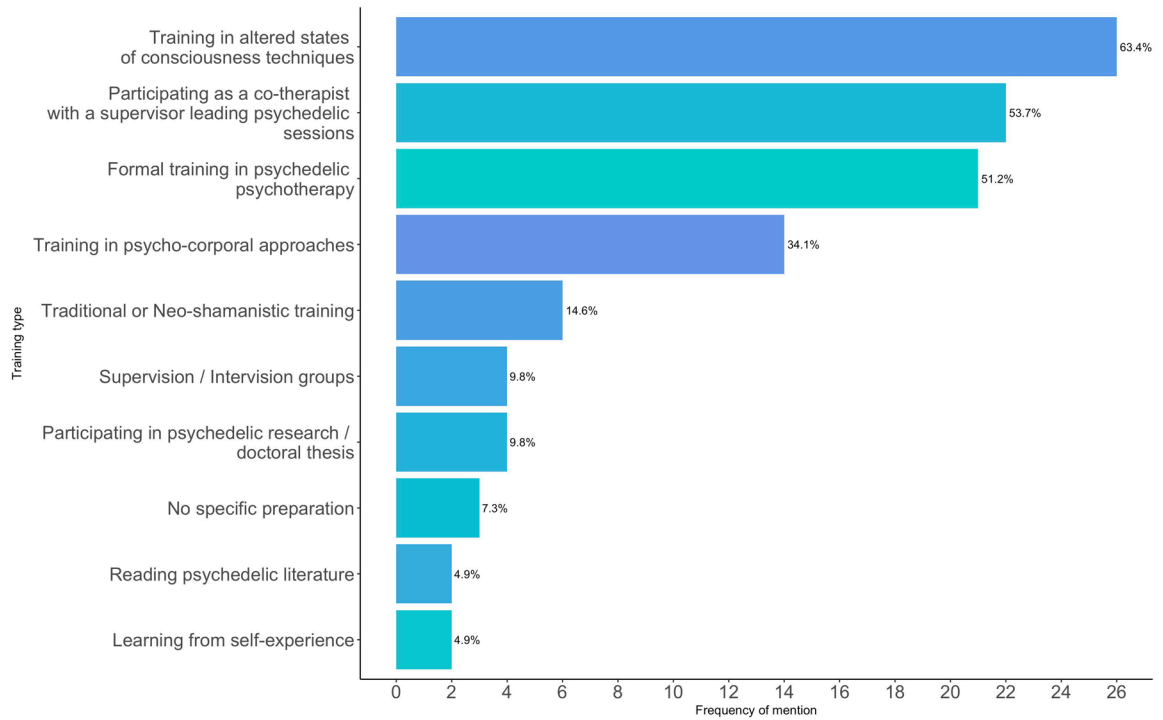


Figure 1. Preparation techniques for PAT practice ($N=41$). PAT, psychedelic-assisted therapy.

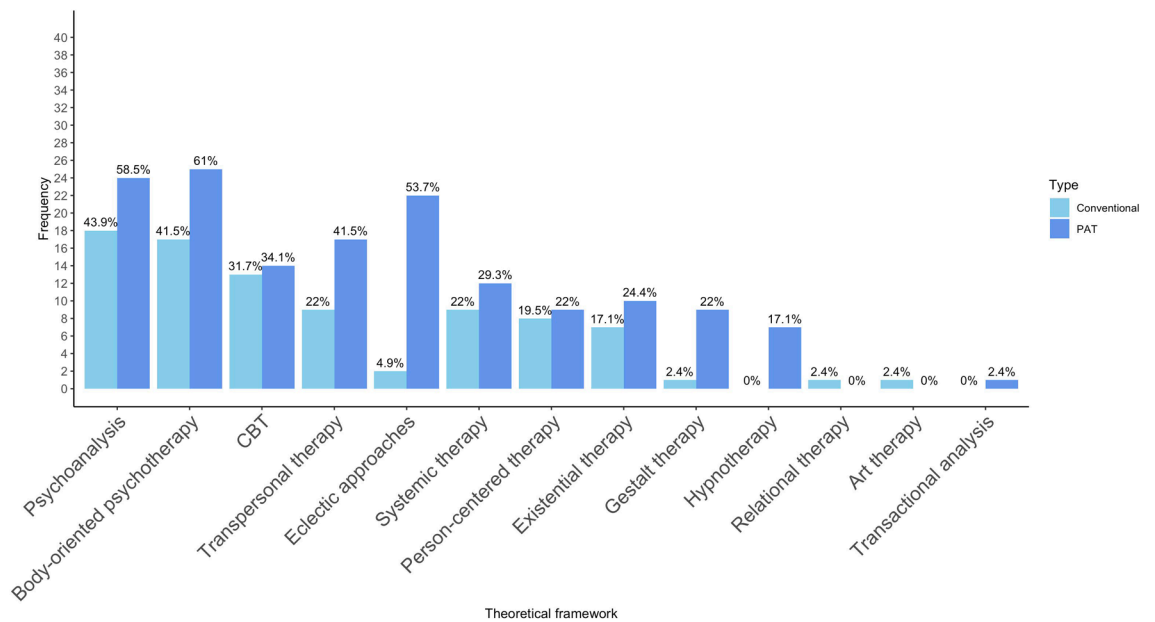


Figure 2. Comparison of theoretical frameworks between conventional psychotherapy and PAT ($N=41$). PAT, psychedelic-assisted therapy.

Most respondents ($n=20$, 95.24%) revealed having regularly taken part in intersession centered on their work with PAT, while 18 of 21 reported discussing their work in PAT regularly with a supervisor.

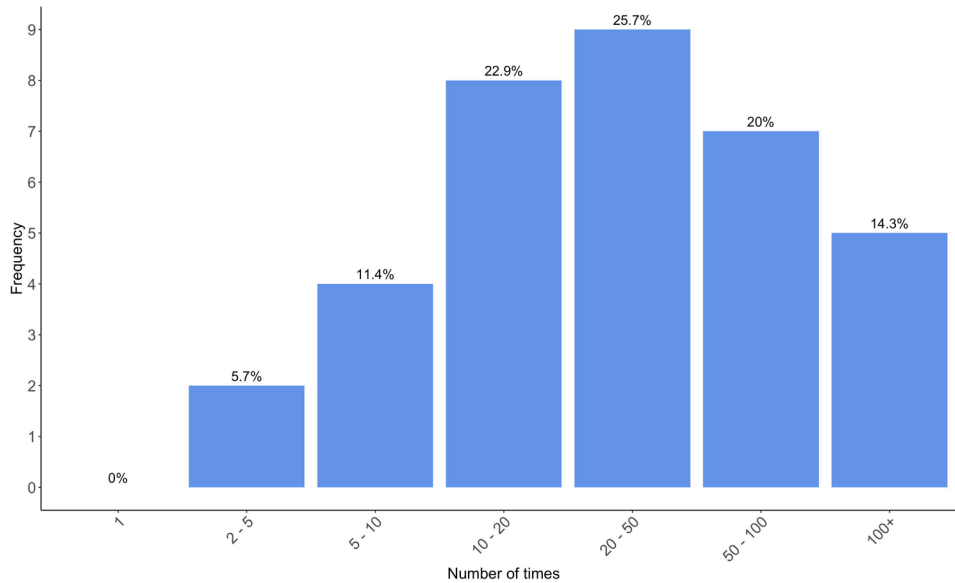


Figure 3. Number of previous personal experiences with psychedelic reported by respondents ($N=41$).

Characteristics of PAT patients

The number, age, and gender of patients treated with PAT is displayed in Table 3.

Regarding referral sources, an average of 49.4% of patients were the respondent's own regular patients (range 0%–100%). Patients specifically seeking PAT through self-referral accounted for 43.3% (range 0%–100%). Referrals from other psychiatrists or psychologists constituted 28.5% (range 0%–100%), while referrals from general practitioners made up 9.11% (range 0%–68%).

The respondents were asked to rank the frequency of the primary diagnoses of their PAT patients. The following list represents the mean ranking order:

1. Depression
2. Anxiety disorder
3. Complex post-traumatic stress disorder (cPTSD)
4. Post-traumatic stress disorder (PTSD)
5. Somatic issues
6. Substance use disorder
7. Obsessive-compulsive disorder (OCD)
8. Personality disorders
9. Eating disorders
10. Attention deficit hyperactivity disorder (ADHD) & end-of-life distress
11. Bipolar disorder

Table 3. Demographic information on PAT patients, as reported by the respondents.

Category	<i>n</i>
Patients treated in lifetime	
Total	1048
Mean	26.9
Min.	1
Max.	90
Patients treated per year	
Mean	9.55
Min.	1
Max.	30
Age of patients	
Mean	44.6 years
Min.	18 years
Max.	86 years
Gender of patients	
Female	57.6%
PAT, psychedelic-assisted therapy.	

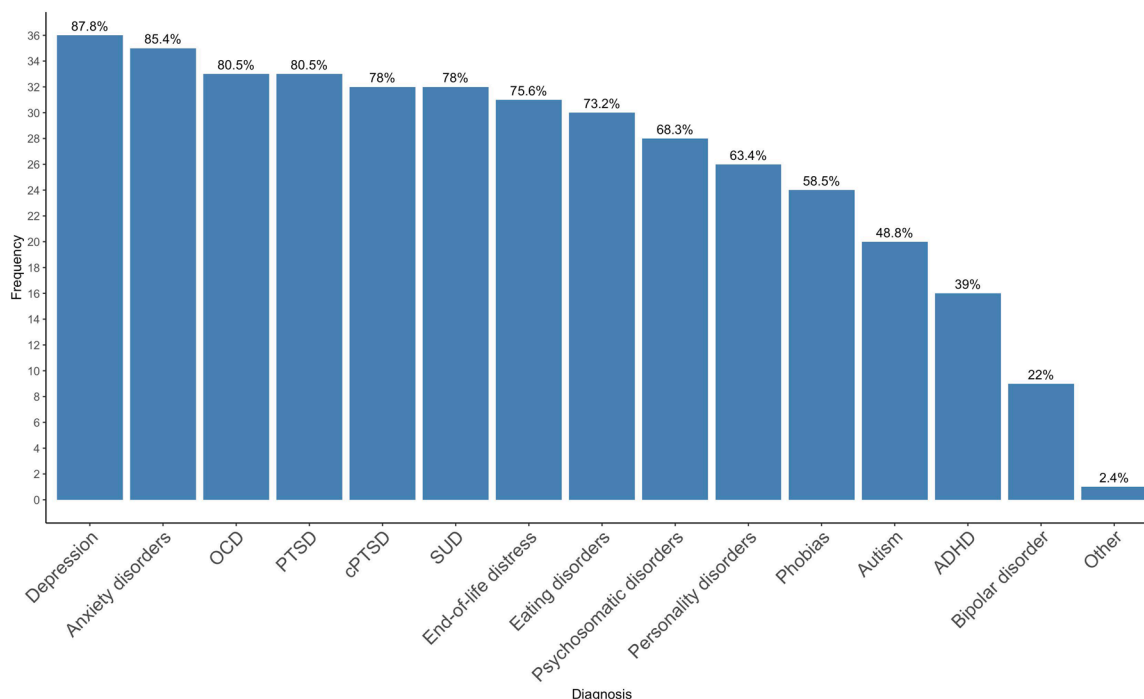


Figure 4. Psychiatric diagnoses endorsed as indications for PAT, according to respondents ($N=41$). PAT, psychedelic-assisted therapy.

In total, the ranking shows a moderate agreement among respondents (Kendall's $W=0.41$, $p < .001$).

Finally, respondents were asked to estimate, on a scale of 0%–100%, the proportion of their patients with previous experience with psychedelics prior to PAT treatment, as well as the context of such experiences. For patients with previous psychedelic use, recreational use was the most reported reason, accounting for an average of 67.3% (range 0%–100%). Personal development followed at 31.2% (range 0%–100%) and use in therapeutic settings accounted for 11.2% (range 0%–100%). Performance enhancement was less common, averaging 4.58% (range 0%–30%), while other reasons made up 8.81% (range 0%–70%).

Indications and contraindications for PAT

Respondents were presented with a list of various psychiatric diagnoses as potential indications for PAT (Figure 4). The most cited diagnoses were depression ($n=36$, 87.8%), anxiety disorders ($n=35$, 85.4%), PTSD ($n=33$, 80.5%), and OCD ($n=33$, 80.5%). Other frequently reported diagnoses included complex PTSD ($n=32$, 78%) and substance use disorders ($n=32$, 78%). End-of-life distress ($n=31$, 75.6%), eating disorders

($n=30$, 73.2%), and psychosomatic disorders ($n=28$, 68.3%) were also common indications. Personality disorders ($n=26$, 63.4%) and phobias ($n=24$, 58.5%) were noted, while autism ($n=20$, 48.8%) and ADHD ($n=16$, 39%) were less common. Bipolar disorder was reported by nine respondents (22%), and one respondent mentioned “other” conditions (2.4%).

When asked about somatic indicators for PAT, respondents most commonly identified chronic pain ($n=29$, 70.7%) and cluster headaches ($n=28$, 68.3%) as key conditions. Parkinson's disease was mentioned by 12 respondents (29.3%), while five mentioned other somatic conditions (12.2%), among them cancer, Scheuermann's disease and chronic fatigue syndrome/myalgic encephalomyelitis occurring following or being associated with an Epstein-Barr virus infection, and ulcerative colitis, Crohn's disease, and migraine. Furthermore, respondents were asked to indicate what other psychological problems respond well to PAT from a predefined list with several possible answers. Figure 5 displays the results.

Over 60% of all respondents mentioned that PAT can be effective for unresolved trauma ($n=32$,

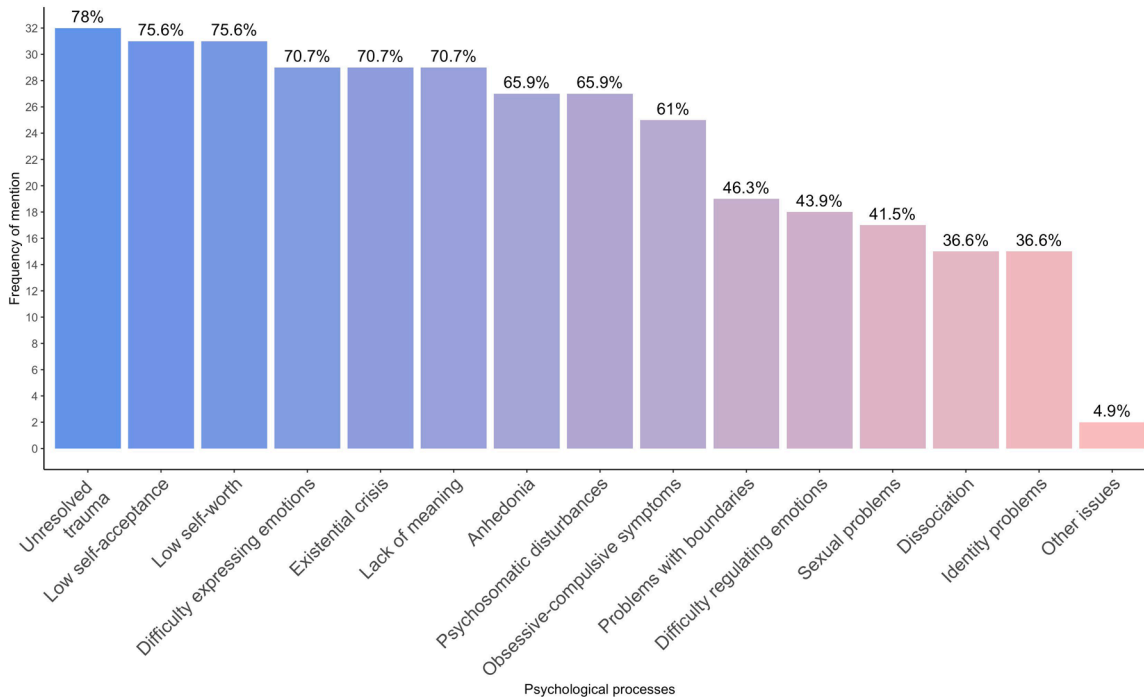


Figure 5. Psychological processes or characteristics as indicators for PAT ($N=41$). PAT, psychedelic-assisted therapy.

78%), low self-acceptance ($n=31$, 75.6%), low self-worth ($n=31$, 75.6%), difficulty expressing emotions ($n=30$, 70.7%), existential crisis ($n=30$, 70.7%), lack of meaning ($n=30$, 70.7%), anhedonia ($n=28$, 65.9%), psychosomatic disturbances ($n=28$, 65.9%), and obsessive-compulsive symptoms ($n=26$, 61%). Other, less frequently mentioned issues were problems with boundaries ($n=18$, 46.3%), difficulty regulating emotions ($n=17$, 43.9%), sexual problems ($n=16$, 41.5%), dissociation ($n=14$, 36.6%), and identity problems ($n=14$, 36.6%).

Regarding contraindications for PAT, Table 4 summarizes how often each factor or diagnosis was mentioned. The answers given for the category “other” are listed in the Supplemental Material.

Most respondents reported diagnoses related to psychosis as a contraindication, with the greatest number of respondents ($n=27$, 65.9%) naming schizophrenia. A total of 61% of respondents ($n=25$) reported unreliable therapeutic relationship as a contraindication for PAT as well, and 56.1% of respondents ($n=23$) also considered somatic states, such as severe problems with the heart, liver or pregnancy, as a contraindication. A total of 51.2% of respondents ($n=21$) stated that unrealistic expectations, for example,

seeking a “quick fix,” could be contraindications as well, and 26.8% ($n=11$) viewed a difficult life situation (e.g., an unstable living situation) as a contraindication.

The framework and structure of PAT

The survey included questions about the number of substance sessions per patient, as well as preparation and integration sessions. It also asked about body contact practices during substance sessions.

Respondents indicated that on average, patients were provided with 5.1 substance sessions, ranging from 1 to 20 sessions per patient, within the total length of the therapy. The majority of respondents reported providing substance sessions 3 months apart from each other, on average ($n=12$, 48%). Other answers ranged between 1 week apart ($n=2$, 8%), 3 weeks apart ($n=6$, 24%), 4 months apart ($n=4$, 16%) and 6 months apart ($n=1$, 4%).

Almost all respondents (19 out of 21) indicated providing specific preparation sessions in order to prepare the patient for the session with the substance, with most holding between two and five sessions ($n=16$, 84.21%). Common themes

Table 4. Summary of contraindications mentioned by respondents.

Categories	Contraindications	Frequency of mention (% of respondents)	Count per category
Diagnoses related to psychosis	Schizophrenia	27 (65.9)	94
	Psychotic background (personal or first-grade relative)	24 (58.5)	58.5
	Bipolar disorder	23 (56.1)	56.1
	Psychotic disorders	20 (48.8)	48.8
Therapeutic relationship	Unreliable	25 (61.0)	57
	Unstable	20 (48.8)	48.8
	Dependent	12 (29.3)	29.3
Physical health	Somatic states (e.g., problems with liver, heart, pregnancy)	23 (56.1)	40
	Age	15 (36.6)	36.6
	Psychosomatic disorders	2 (4.88)	4.88
Personality / attitudes	Unrealistic expectations	21 (51.2)	47
	Borderline personality	15 (36.6)	36.6
	Personality traits	7 (17.1)	17.1
	Other personality disorders	4 (9.76)	9.76
Other diagnosis-related factors	Severity of symptoms	12 (29.3)	23
	Substance use disorder	5 (12.2)	12.2
	Other diagnoses	4 (9.76)	9.76
	Unipolar depression	3 (7.32)	7.32
Social	Life situation (e.g., unstable living situation)	11 (26.8)	30
	Social situation (e.g., severely limited social circle)	9 (22.0)	22.0
	Educational background	5 (12.2)	12.2
	Cultural background	5 (12.2)	12.2
Other		6 (14.6)	6

in these sessions included strengthening the therapeutic relationship ($n = 20$, 95.24%), psychoeducation ($n = 19$, 90.48%), and fostering a fitting mindset ($n = 16$, 84.21%).

Concerning integration sessions, all respondents ($n = 21$) indicated providing sessions dedicated to processing the experience following a session with

psychedelics, with varying amounts of time after the psychedelic session (1–90 days). On average, respondents provided 2.9 sessions (range 1–6). Some provided integration only in individual settings ($n = 9$, 42.85%) while others did so in group or individual settings ($n = 11$, 52.38%). One respondent indicated only providing integration in groups.

The most commonly mentioned integration method was psychotherapeutic conversation ($n=16$, 84.21%). Other methods included writing and drawing ($n=7$, 33.33%), body practices (e.g., dance) ($n=5$, 23.81%), music ($n=4$, 19.05%) and meditation ($n=3$, 14.29%). Respondents were asked to explain the goals of integration sessions, and we include some illustrative answers below:

Stabilizing and fostering the metacognitive process. Identifying and anchoring the long-term catalytic effect of the experience

Making the extraordinary experience suitable for everyday life. Moving from experiencing to action

Highlight and emphasize the changes implemented by the patient in their daily life, detect long-term undesirable effects (ontological shock), and support the change.

Set, settings, and therapeutic techniques in PAT

The majority of respondents ($n=15$, 71.4%) reported always promoting a specific mindset or intention before the substance session, while 19% ($n=4$) did so in certain cases and two (9.5%) indicated that they never did so. When prompted to elaborate on these mindsets or intentions, respondents provided many different answers. Some examples include:

Mindful attention, openness to the process, being involved in the process

Openness, readiness for anything, no specific expectations, trust in the process and the substance.

The majority of respondents ($n=10$, 47.6%) stated that they provided PAT to individuals only, while some ($n=9$, 42.9%) offered both group and individual sessions and two (9.5%) provided PAT only in groups. Respondents reported that the groups they led varied in size (mean=6 people, range 2–14). Those who provided both kinds of settings were asked to elaborate on their reasoning for choosing one or the other. Among the open text answers given are:

Severity, but always discussed with patients; sometimes financial situation also plays a role

Individual setting for very severe cases, group incompetency, high degree of anxiety, avoidance and fear of closeness.

Co-therapists were common, with only two respondents stating that they never included co-therapists. All others indicated including co-therapists either always ($n=13$, 68.42%) or in certain cases ($n=6$, 31.58%). Most respondents reported having co-therapists holding degrees in psychology ($n=19$, 46.3%), medicine ($n=14$, 34.1%), or nursing ($n=9$, 22%), and others in other professions (e.g., pedagogy, complementary therapy, social work; $n=6$, 14.6%). All respondents took co-therapist gender into account when conducting PAT, either in certain cases ($n=4$, 44.4%) or always ($n=5$, 55.5%).

Figure 6 shows the number of co-therapists usually chosen for individual and group PAT. In the individual setting, most respondents indicated conducting sessions alone with the patient ($n=11$, 57.9%), or with one other co-therapist ($n=8$, 42.1%). In the group setting, most respondents conducted PAT in pairs ($n=6$, 54.7%), while others did so alone ($n=2$, 18.2%) or with three therapists ($n=2$, 18.2%). One respondent reported a total of four therapists in the room (9.1%).

Regarding location, most respondents reported holding individual PAT sessions at their practice or clinic ($n=17$, 89.47%). In contrast, for group PAT substance sessions, only about half of the respondents use their practice or clinic ($n=4$, 45.45%), while the other half preferred renting alternative locations that offer suitable infrastructure and access to nature ($n=6$, 54.55%).

Concerning the specific preparation of the room, all but one ($n=20$) respondent indicated preparing the room in a special way before a psychedelic session. Common ways of preparing the setting for psychedelic sessions included playing music from a speaker ($n=19$, 95%), providing food and drink ($n=17$, 85%), ensuring silence ($n=17$, 85%), tuning down the lights ($n=16$, 80%), and providing flowers ($n=15$, 75%). Additionally, creating darkness ($n=5$, 25%), creating a sense of holiness ($n=5$, 25%), and setting up an “altar” ($n=4$, 20%) were also noted as preparations by some respondents.

Over half of the respondents stated that patients usually lie on a mattress ($n=15$, 71.43%) or a bed ($n=10$, 47.62%), while some also had their patients sit on the ground ($n=6$, 28.57%) or sofas ($n=5$, 23.81%). The majority of respondents occasionally took their patients outside

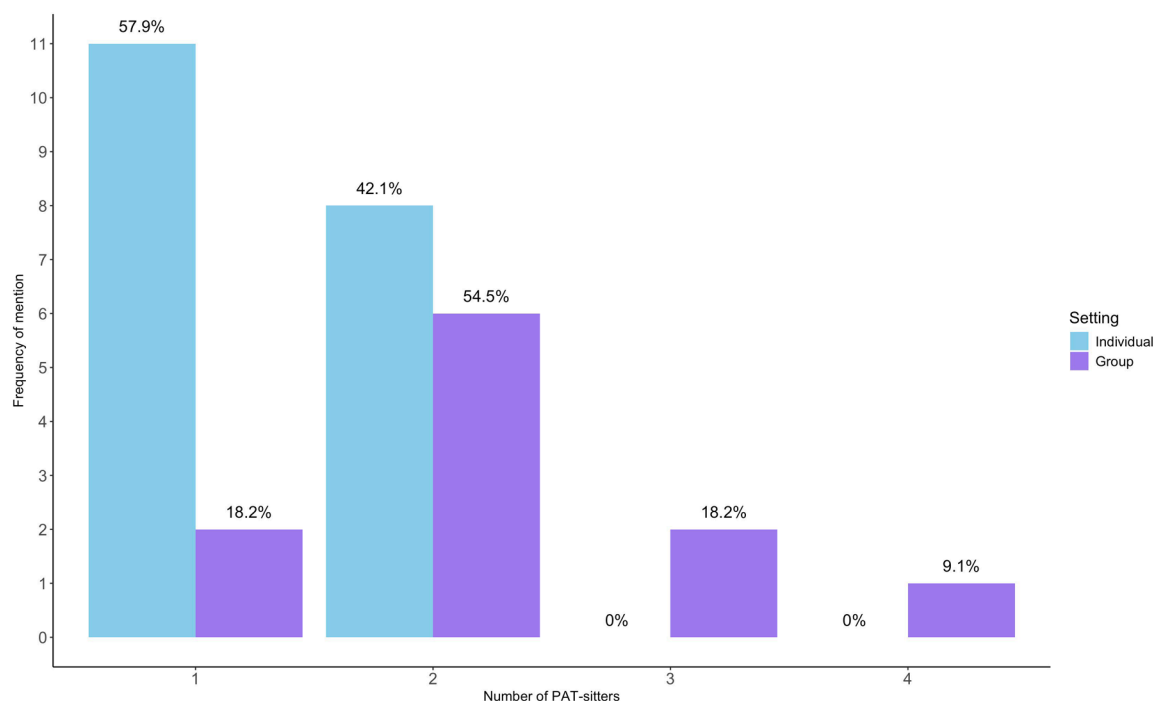


Figure 6. Number of co-therapists or sitters in individual and group PAT settings ($N=21$). PAT, psychedelic-assisted therapy.

(in nature, e.g., garden) during the PAT session ($n = 13$, 61.9%).

Regarding music, most respondents (19 out of 21, 90.5%) always play music during psychedelic sessions, with two respondents (9.5%) doing so only in certain cases. On average, patients were encouraged to spend 60.48% of the session in silent introspection (range 8%–100%). Additionally, 15 respondents (71.43%) encouraged wearing eyeshades during the introspection phase, while six (28.57%) did not. Music selection varied between preselected playlists and intuitive choosing of music pieces, either with or without the patient's involvement. Respondents also indicated using moments of silence when they deemed it necessary to deepen the personal process without distractions.

In substance sessions, 84% of respondents (18 out of 25) agreed that physical touch is an important tool in PAT. Another 8% ($n=2$) were neutral, and 8% ($n=2$) disagreed.

Respondents also indicated how often they use physical touch during sessions, using a four-point Likert scale from “Yes, always” to “No, never.” The frequency of physical touch in PAT

compared to conventional psychotherapy is presented in Figure 7.

When practicing conventional psychotherapy, most respondents reported implementing physical touch “not usually” ($n=10$, 40%) or “sometimes” ($n=9$, 36%). Number for PAT was higher, with most respondents using it “sometimes” ($n=15$, 60%) or “always” ($n=7$, 28%). The most frequent kind of body contact used by the respondents was holding a patient's hand ($n=23$, 92%), putting their hand on a patient's shoulder ($n=21$, 84%), mediated body contact (e.g., using blankets or pillows; $n=16$, 64%), and holding a patient's head ($n=13$, 52%).

Respondents indicated several reasons for using body contact in psychedelic sessions, with 96% ($n=24$) mentioning support during difficult experiences, and 92% ($n=23$) helping patients feel safe. Others cited facilitating catharsis (68%, $n=17$) or insight (28%, $n=7$).

Respondents also identified several situations in which bodily contact may not be appropriate. These included patient requests not to be touched ($n=24$, 96%), concerns about sexual feelings ($n=22$, 88%), a history of sexual abuse ($n=20$, 80%), and the

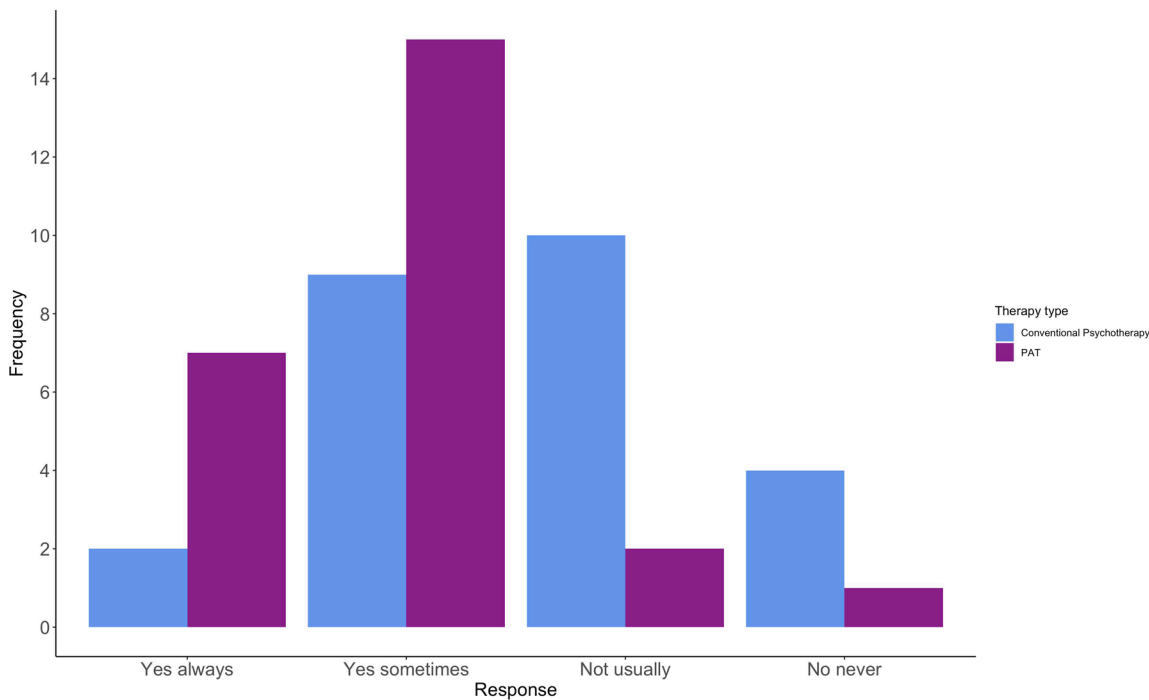


Figure 7. Reported use of body contact in conventional psychotherapy and PAT ($N=25$). PAT, psychedelic-assisted therapy.

Table 5. Range of dosages of psychedelic substances used in PAT.

Substance	Average dose	Smallest dose	Largest dose	SD
LSD	125 μ g	20 μ g	600 μ g	25.33 μ g
Psilocybin	22.04 mg	2.5 mg	60 mg	5.39 mg
MDMA	116 mg	25 mg	300 mg	11.74 mg

LSD, lysergic acid diethylamide; MDMA, 3,4-methylenedioxy-*N*-methamphetamine; PAT, psychedelic-assisted therapy.

physician's own insecurity about boundaries ($n=20$, 80%). Other factors included a patient's history with violence ($n=19$, 76%) and the detection of sexual feelings within oneself as a physician ($n=19$, 76%). Fewer respondents noted concerns about being alone with the patient ($n=13$, 52%) or opposite-sex interactions ($n=5$, 20%).

Additionally, most respondents ($n=24$, 96%) reported discussing consent to body contact before the psychedelic session. Some indicated also addressing it during the session ($n=14$, 56%) or ensuring written consent beforehand ($n=7$, 28%). Most ($n=20$, 88%) also stated that they ensure consent is obtained again before any intervention, and 40% ($n=10$) reported only touching patients capable of consenting in the moment

during the session. Others emphasized only implementing touch in PAT when touch was previously introduced during conventional therapy ($n=5$, 20%) or only touching if invited ($n=3$, 12%). Areas excluded from touch were most often stated to be private/sexual body parts. Further answers regarding the use of touch are available in the Supplemental Material.

Substances, dosages, and polypharmacy. The substances used by respondents in PAT included psilocybin ($n=35$, 85.4%), MDMA ($n=29$, 70.7%), and LSD ($n=27$, 65.9%; Table 5).

Respondents considered a variety of factors when choosing which psychedelic substance to use. Presented with a closed list, the three most

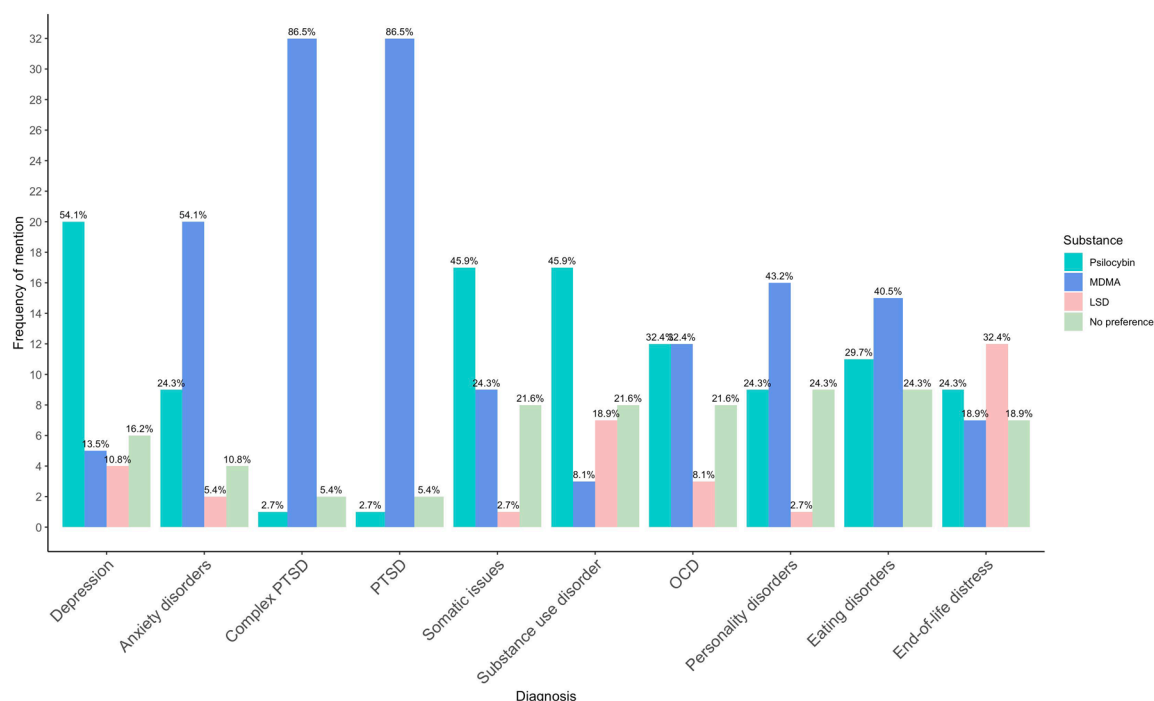


Figure 8. Choice of first psychedelic substance according to diagnosis ($N=37$).

commonly cited criteria for choosing substance and dosage were diagnosis ($n=19$, 90.5%), patient preference ($n=16$, 76.2%), and current themes or processes ($n=15$, 71.4%). Figure 8 shows respondents' preferred substances for PAT according to diagnosis.

Psilocybin was most commonly preferred for treating depression ($n=20$, 54.1%), somatic issues (e.g., chronic pain; $n=18$, 45.9%), and substance use disorder ($n=18$, 45.9%), while MDMA was primarily used for cPTSD and PTSD (both $n=32$, 86.5%), and also frequently for anxiety disorders ($n=20$, 54.1%), personality disorders ($n=17$, 43.2%), and eating disorders ($n=15$, 40.5%). Both psilocybin and MDMA were equally favored for OCD (both $n=12$, 32.4%). LSD was most often chosen for end-of-life distress ($n=12$, 32.4%). Notably, several respondents reported having no preferred substance for certain conditions, particularly personality disorders and eating disorders.

Therapeutic processes in individual and group PAT

For those practicing PAT in individual settings, respondents were asked to state the therapeutic processes they viewed to be at play most frequently

during the substance session on a five-point Likert scale ranging from “never” to “always” (Figure 9).

The most frequently endorsed processes included confrontation with personal issues, enabling life review and integration, reflection on the psychedelic experience, promoting connectedness with self and world, and developing new perspectives. When asked to name which therapeutic processes the respondents considered to be the most important for PAT out of this list, the three most-endorsed items were “promoting connectedness with the self and the world” ($n=12$, 57.14%), “life review and integration” ($n=6$, 28.57%) and “processing traumatic experiences” ($n=6$, 28.57%).

Concerning therapeutic processes in PAT group therapy, respondents were asked to rate the 11 group therapy factors of Refs. 35 on the same Likert scale (Figure 10). The therapeutic processes observed most often were the “instillation of hope” in oneself and the therapy, “interpersonal learning” from other group members, and the experience of “group cohesion” and the establishment of a social microcosm. Understanding “existential factors,” experiencing “catharsis,” and “learning by imitation” were also sometimes observed.

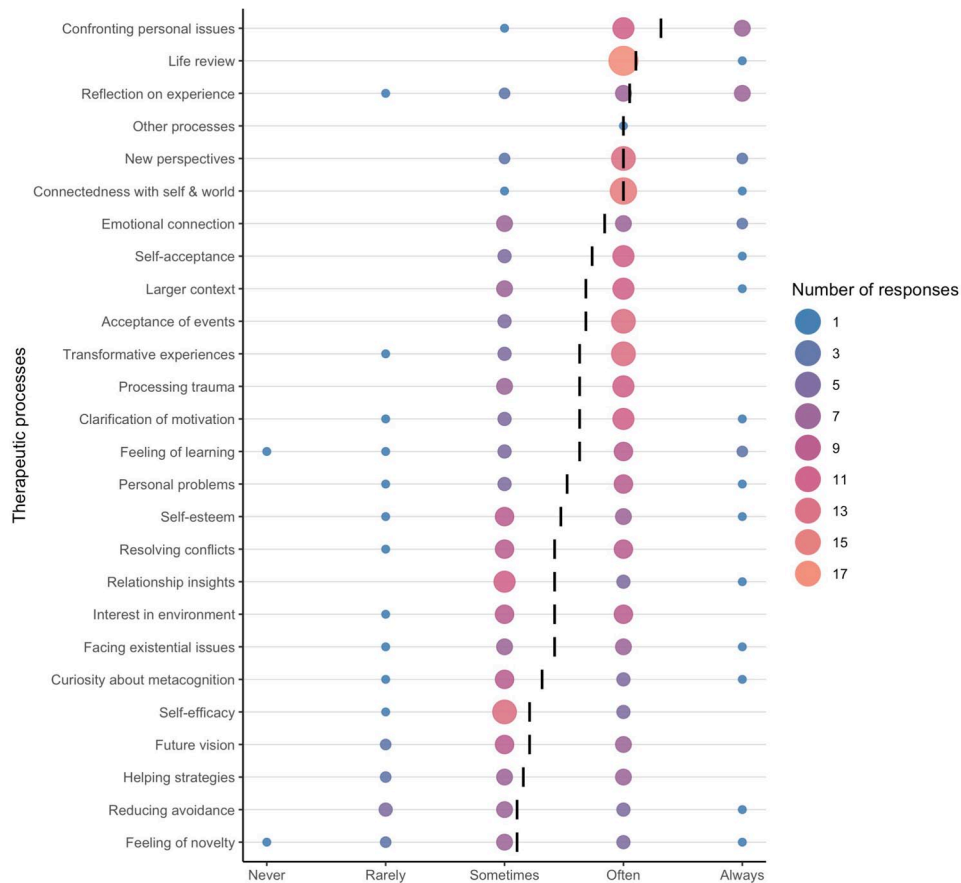


Figure 9. Therapeutic processes observed during individual PAT substance sessions ($N=19$). Data arranged by mean (black vertical lines). PAT, psychedelic-assisted therapy.

The three most important factors in group PAT, according to respondents, were “interpersonal learning” from other group members ($n=12$, 57.14%), “lowering the feeling of being alone in one’s pain” ($n=8$, 38.1%), and “corrective recapitulation of the primary family group behavioral pattern” ($n=7$, 33.3%).

Predictors of successful therapy outcome

Respondents most frequently identified a strong therapeutic relationship as the key predictor of successful outcomes in PAT, with 20 respondents (95.24%) citing it. This was followed by favorable patient characteristics ($n=14$, 66.66%), the facilitation of deep psychological insight ($n=13$, 61.91%), and the occurrence of a profound psychedelic or mystical experience ($n=11$, 52.38%). Other factors played comparatively smaller roles, including diagnosis specifics ($n=4$, 19.05%), diagnosis severity ($n=2$, 9.52%), the presence of

few or no comorbidities ($n=2$, 9.52%), and a short delay between symptom onset and treatment initiation ($n=1$, 4.77%).

Regarding specific patient characteristics predicting successful outcomes, respondents selected multiple options from a predefined list. The most frequently cited traits included high commitment to therapy ($n=10$, 47.62%), high self-awareness ($n=9$, 42.86%), certain personality traits ($n=8$, 38.1%), and an internal attribution of success ($n=8$, 38.1%). Less commonly mentioned were philosophical outlook or worldview ($n=4$, 19.05%) and level of education ($n=3$, 14.29%), while external attribution of success and other characteristics were not cited ($n=0$).

When asked to describe favorable patient characteristics and resources predictive of success in PAT, respondents most often mentioned a willingness for transformative change ($n=36$, 87.8%)

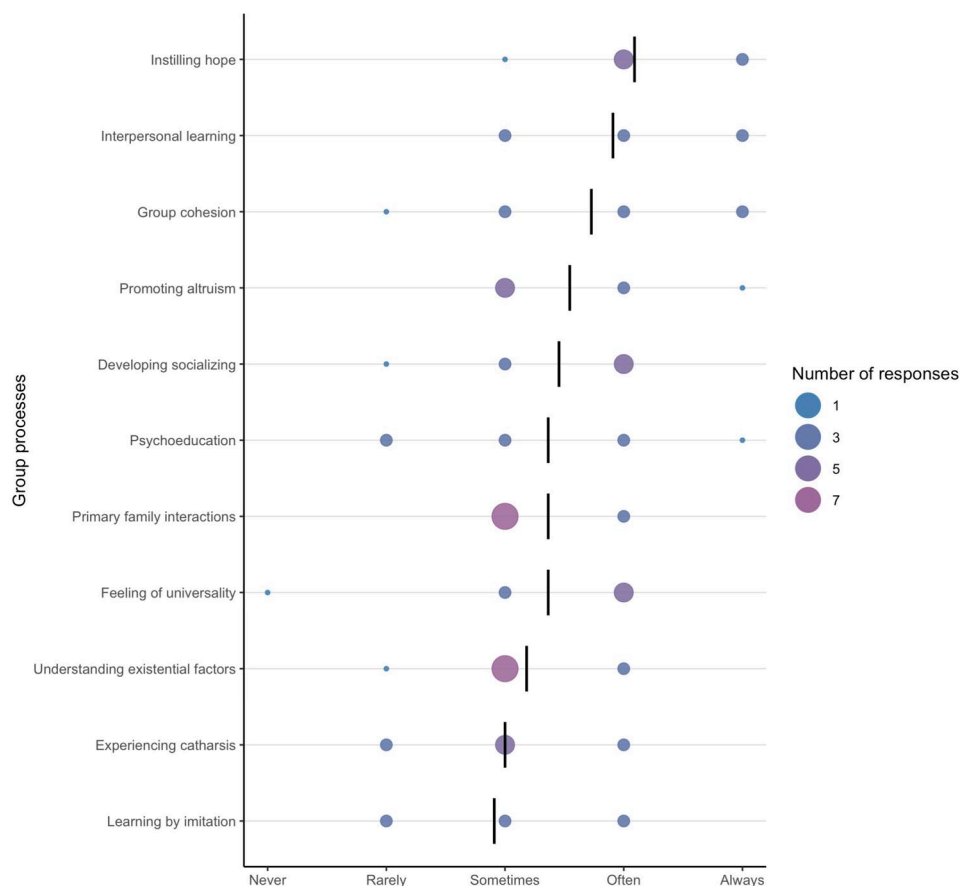


Figure 10. Therapeutic processes observed during PAT group substance sessions ($N = 11$). Data arranged by mean (black vertical lines). PAT, psychedelic-assisted therapy.

and a strong therapeutic bond ($n = 35$, 85.4%). Other important factors included high motivation ($n = 29$, 70.7%), high compliance ($n = 21$, 51.2%), and attachment style ($n = 15$, 36.6%), with 10 respondents specifying secure attachment and four citing insecure attachment. Additionally, high emotional regulation was noted by 14 respondents (34.1%), and four respondents (9.8%) mentioned other relevant conditions.

Mitigating adverse effects

Adverse effects observed during psychedelic sessions were defined as unwanted and negatively perceived experiences, as opposed to “challenging experiences,” which could retrospectively be interpreted positively from a therapeutic perspective. Respondents were asked to subjectively rate how often they observed different adverse effects during PAT on a six-point Likert scale ranging from “never” to “always.”

The most frequent adverse effects (defined as sometimes or often observed) included loss of orientation in time and space, feeling too cold, anxiety, and nausea (Figure 11). In contrast, rarely observed negatively perceived side-effects included delirium, suicidality, self-harm, and loss of eyesight.

When asked about their efforts to alleviate adverse effects, all except one respondent indicated having emergency medication available during a session. Twenty indicated having benzodiazepines available (95.24%), 17 had antipsychotics (80.95%), and 5 had “other” rescue medication (23.81%), with 3 specifying ketanserin and 1 mentioning beta blockers. On average, respondents indicated having used emergency medication in 2.43% of sessions. Anxiety/panic was indicated as the most common reason for giving medication. Further reasons and substances are mentioned in the Supplemental Material.

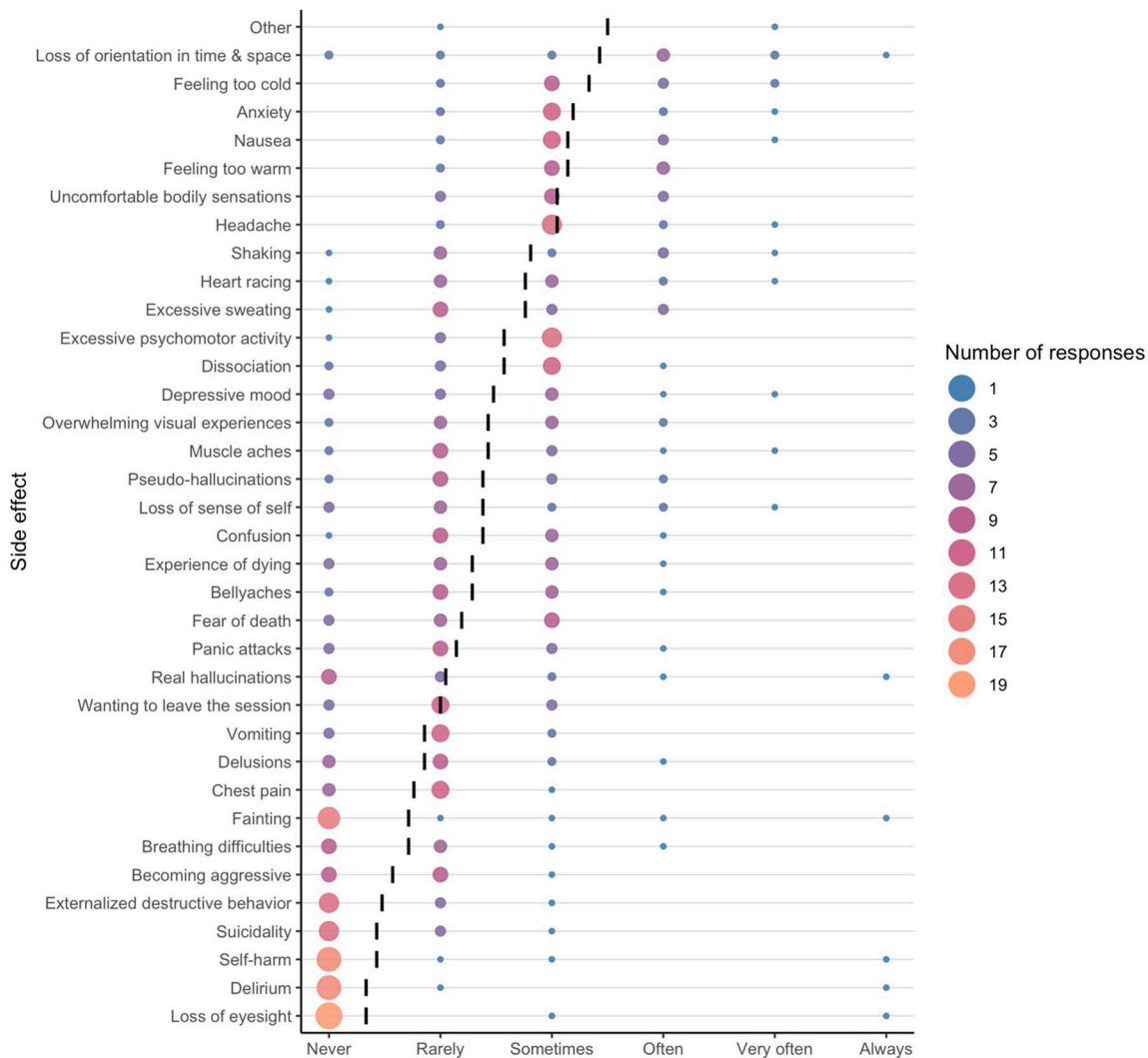


Figure 11. Distribution of the frequency of observed adverse effects during PAT ($N=36$). Data arranged by mean (black vertical lines). PAT, psychedelic-assisted therapy.

Opinions on personal experience with psychedelics, advantages and challenges of PAT

When asked whether physicians should have their own psychedelic experiences, 37 respondents (90.24%) answered “Yes,” and 4 respondents (9.76%) answered “No.” When prompted to explain the reasoning behind their answers, respondents provided a variety of motives:

To understand how these states feel, what effect they have on the psyche and its deeper layers; to see the risks, potential, but also limitations (in order to better manage false hopes in patients). To understand that one or a few substance sessions—even the best ones—are not enough to bring about or sustain a successful and lasting development.

I do not think it is necessary. Everybody's experience is different. We have to listen to the patient's experience to work with it in psychotherapy as with other experiences. We never experience everything our patients experience.

Both quotations are from respondents who have had their own psychedelic experience.

When asked about the advantages of PAT, respondents cited the intensification of general psychotherapy factors ($n=19$, 90.48%), facilitated access to the unconscious ($n=17$, 80.95%), confrontation with existential questions ($n=16$, 76.19%), and the opportunity for more engaging therapeutic work ($n=13$, 61.9%). Additionally, overcoming treatment resistance ($n=12$, 57.14%), facilitating

regression ($n=11$, 52.38%), being preferred by some patients ($n=4$, 19.04%), and shorter therapy duration ($n=2$, 9.52%) were also mentioned.

Regarding challenges in providing PAT, respondents mentioned costs and insurance issues ($n=19$, 90.48%), legal restrictions on access to PAT ($n=18$, 85.71%), lack of training opportunities ($n=14$, 66.6%), high patient expectations ($n=14$, 66.6%), and inadequate payment for physicians ($n=14$, 66.6%). Additional concerns such as physician exhaustion ($n=12$, 57.14%), the duration of therapy ($n=9$, 42.86%), unpredictability ($n=9$, 42.86%), media-driven public attention ($n=9$, 42.86%), and stigma within the medical system ($n=7$, 33.3%) were also common. Fewer respondents indicated challenges such as risks of increasing symptom severity ($n=5$, 23.81%), challenging therapy experiences ($n=5$, 23.81%), lack of scientific data ($n=3$, 14.28%), lack of treatment guidelines ($n=1$, 4.76%), and risks of side effects ($n=1$, 4.76%). Open text answers on this topic are found in the Supplemental Materials.

Discussion

The objective of this anonymous online survey was to provide a detailed overview of the current status of PAT in Switzerland, as delivered by physicians participating in the limited medical use program. The project drew inspiration from a doctoral thesis by Ernst Benz,²⁴ who created a similar survey on the state of PAT in Switzerland during the first period of limited medical use program under the auspices of the Federal Office of Public Health (FOPH).

The outcomes of this survey give insight into the considerable variety of personal clinical methods and opinions within PAT as it is being provided in Switzerland today. PAT is viewed as a transdiagnostic tool and is provided in a non-standardized way with psilocybin, MDMA, and LSD. Individual factors influencing substance and dosage choice are diagnosis, patient preference, and current themes or processes of the patient. Psilocybin is preferred for depression, somatic issues, and substance use disorder, while MDMA is favored for cPTSD, PTSD, anxiety disorders, personality disorders, and eating disorders. LSD is primarily used for end-of-life distress. Somatic diagnoses as indications for PAT mainly include chronic pain and cluster headaches, which are in line with current research.^{40,41} The range of reported dosages

varied greatly, and although the average doses reported here fall within commonly accepted therapeutic ranges.⁴²

PAT practice in Switzerland is generally well tolerated, as is also documented in other clinical trials.⁴³ Adverse effects include the loss of orientation in time and space, feeling too cold, anxiety, and nausea, and rare adverse effects include delirium, suicidality, self-harm, and loss of eyesight. Patients typically receive an average of 5.1 substance sessions, spaced on average 3 months apart between each session. This number is considerably higher than in most clinical trials, which typically include two substance sessions.⁴⁴⁻⁴⁶ Reasons for this discrepancy are that the Swiss limited medical use law¹⁴ allows only for the treatment of diseases deemed as treatment-resistant and incurable, which is a considerably different population group than in most research settings, and the fact that many practitioners see this treatment as embedded within a psychiatric/psychotherapeutic framework. However, some argue that the choice of fewer substance sessions in research, often due to practicability, sometimes comes with patients feeling underserved with the short treatment and thus seeking further psychedelic access elsewhere.⁴⁷

In addition, most physicians provide multiple preparation sessions, focusing on strengthening the therapeutic relationship, psychoeducation, and fostering a suitable mindset. All physicians provide integration sessions, using methods including psychotherapy, writing, and body practices. The goal is to stabilize, process, and integrate the psychedelic experience of the patient.

Considering the setting, around half of the Swiss physicians only provide substance sessions in individual settings, whilst the other half is flexible on providing PAT in groups or individual settings. This contrasts greatly with the clinical trial landscape, which typically studies individual settings. Group PAT was more common in the research of the 20th century and many point to the benefits of group settings in PAT.^{34,48} Most respondents included co-therapists, typically with backgrounds in psychology, medicine, or nursing. Individual sessions often occurred in private practices or clinics, while group sessions were held in clinics or rented locations with nature access.

The therapeutic process most often observed in individual PAT sessions is the confrontation with personal issues of the patient, while the

therapeutic process deemed as the most important in PAT is summarized to be the promotion of connectedness with the self and the world. In group PAT, the most observed therapeutic process is the instillation of hope, whereas interpersonal learning is mentioned to be the most important factor by most respondents. Similar psychological mechanisms of action have been hypothesized and summarized elsewhere.^{34,49}

The most common PAT training methods include the preparation with other techniques for altered states of consciousness, personal experience with psychedelics, and specific PAT training programs. The vast majority of respondents hold the opinion that personal experience with psychedelics as part of PAT training helps to better understand the effects and risks, though a minority disagrees, stating that listening to the patient's experience is enough. This contributes to the ongoing discussion around the reasons why PAT therapists should or should not have personal experiences with psychedelics prior to proving PAT.^{50–53}

Theoretical approaches seem to shift between conventional psychotherapy and PAT, with body-oriented, psychoanalytic/psychodynamic, and eclectic being most common for PAT. This stands in contrast to research studies, where a CBT-based approach is most frequently used.⁵⁴ Most of the respondents also agree that body contact is a valuable tool in PAT. Body contact is frequently employed and its consent is almost always discussed beforehand, as it is also advised by others.⁵⁵ The main advantages of touch interventions during PAT, as stated by the respondents, include intensifying therapeutic factors, facilitating access to the unconscious, addressing existential questions, and overcoming treatment resistance, thereby adding to existing literature on the advantages of supportive touch in PAT.^{56–58}

The most frequently reported contraindication for PAT was family history of psychosis, or personal history of psychosis, corresponding with current Swiss PAT treatment recommendations.⁵⁹ While contraindicating psychosis in PAT is a prominent viewpoint in the psychedelic research community,⁶⁰ as it is often linked to an increased probability of a psychedelic-induced psychosis post-treatment, some have begun to research this potential connection in recent times,⁶¹ highlighting the need for more nuanced risk stratification within psychosis-spectrum populations. Other contraindications include an

unreliable therapeutic relationship, which is less directly supported by quantitative outcome data but strongly grounded in broader psychotherapy research. As outlined by Villiger,⁶² the therapeutic alliance is widely regarded as a central mechanism of change across psychotherapeutic modalities and is plausibly amplified in psychedelic-assisted contexts, where heightened emotional openness and suggestibility may increase both therapeutic potential and vulnerability. Unlike clinical research studies, where patients usually meet the study therapists only at the start, Swiss PAT patients typically have an established therapeutic relationship beforehand, which is also reflected in the Swiss training of PAT therapists.⁶³

All in all, the findings of our survey describe a richness of varying clinical methods and experiences in the practice of PAT in Switzerland. It is our hope that this report can serve as a basis for further discussions about the clinical methods of PAT.

Generalizability

An important mention considering the outcomes of this study is the particularity of the medical system in Switzerland and its limited medical use program. In it, close collaboration and exchange of information within and between federal agencies and the professional PAT organizations play a vital role, including regular regional super-/interventions and transparency about the therapeutic processes to federal agencies. Since 2014 until the end of 2024, the FOPH has granted over 1795 cases for PAT⁶³ and introduced a consistent quality control, as the number of physicians and patients are rapidly increasing.²¹ In addition, the SÄPT provided a comprehensive 3 year training program the first time in 2018,⁶³ which included multiple personal experience sessions in dyad and group formats for the therapists as part of a research program (NCT05570708).

Within our survey, most of the PAT patients had previous experience with psychedelics, which differs markedly from clinical research studies,^{44,64} and could have affected the safety management and the therapeutic process. The respondents also stated that the main challenges in providing PAT in Switzerland include costs and insurance issues, legal restrictions, lack of training, high patient expectations, and inadequate physician payment.

Due to the legal regime surrounding PAT, a majority of the treatment is financed by patients, providing important economic barriers to treatment access, as indicated by respondents. Self-pay care tends to be utilized more by those with greater financial resources, which may influence motivation and persistence in treatment.^{65,66} The patients treated by our respondents may not be representative of the broader population. Economic factors could partly explain the patterns of treatment adherence and engagement described by respondents. However, while economic factors likely contribute to patient self-selection and may influence treatment engagement, the professional practice settings of respondents closely mirror those of psychiatrists in Switzerland overall,⁶⁷⁻⁶⁹ suggesting that PAT is being delivered within typical ambulatory psychiatric contexts rather than in a marginal or exceptional sector.

Considering these factors, the findings of the current survey should be viewed as exemplary, as the applicability and generalizability of the Swiss PAT methods are highly limited, since other countries function under different political structures and health care systems.

Limitations

All data were obtained through self-reported surveys, with most items relying on retrospective recall. Such data are inherently subjective and susceptible to multiple forms of practitioner bias, including recall bias and social desirability bias. In particular, practitioners may unintentionally underreport adverse events, deviations from best practices, or safety-related interventions. Consequently, reported clinical conduct may differ from actual practice, and the findings should be interpreted accordingly.

Methodological limitations of this survey include a low completion rate, with a dropout rate of approximately 50%. While the scope of the study necessitated a certain level of detail, it is important to acknowledge that the meticulous and in-depth nature of many questions serves as both a key strength and a limitation. The survey instruments were not validated and no formal pilot testing was conducted. This may limit the generalizability and reliability of the findings.

Additionally, the number of patients treated with PAT varied greatly among respondents, with some having experience with over 100 clinical cases, and others having treated only two or three

patients in total. This heterogeneity might have left some respondents with a limited amount of experience on which to base their answers, for example, in questions related to the relative frequency of diagnoses and patients' previous use of psychedelics before undergoing PAT.

Finally, all substances used by physicians working within the confines of the limited medical use scheme of the FOPH are provided by pharmacists from the University of Basel. As a result, the dosages may not be directly comparable to those used in RCTs, where other pharmaceutical formulations may be used, with the exception of trials using the same supplier.

Conclusion

This study provides a comprehensive survey of PAT clinical methods among Swiss physicians under the limited medical use of banned narcotics administered by the Federal Office of Public Health since 1989. Our findings highlight the considerable diversity in theoretical orientations, clinical approaches, substances and dosages, patient populations, settings and therapeutic techniques, which are applied in an individualized and participatory manner. These findings provide a foundation for understanding the real-world clinical methods of PAT. As psychedelic therapies continue to gain attention globally, Switzerland's unique regulatory model offers valuable insights into both the opportunities and challenges of integrating these treatments into healthcare, ensuring safe, effective, and ethical implementation in diverse therapeutic settings.

Declarations

Ethics approval and consent to participate

Following exchanges with the Institutional Review Board of the University of Fribourg, it was determined that ethical approval was waived, as it involves only anonymous, non-sensitive data, with participant contact information handled with confidentiality. Written informed consent was obtained from all participants prior to participation. Participants were required to endorse a statement confirming that they had received no compensation and that they voluntarily consented to participate before accessing the survey.

Consent for publication

Not applicable.

Author contributions

Kristian Beichmann: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Project administration; Writing – original draft; Writing – review & editing.

Polina Catzeflis: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Writing – original draft; Writing – review & editing.

Helena D. Aicher: Data curation; Methodology; Writing – original draft; Writing – review & editing.

Federico Seragnoli: Methodology; Writing – review & editing.

Abigail Calder: Conceptualization; Methodology; Writing – review & editing.

Adam Amrani: Conceptualization; Writing – review & editing.

Gregor Hasler: Conceptualization; Project administration; Supervision; Writing – review & editing.

Acknowledgements

We would like to thank Peter Gasser, who helped us find the doctoral thesis of Ernst Benz, which served as an important inspiration for this research project. Furthermore, we would like to thank the SÄPT and ASPT for their help in reaching physicians working with PAT and distributing the survey. We would also like to thank Chloé Battisti for reviewing the French translation of the survey.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Competing interests

The authors declare that there is no conflict of interest.

Availability of data and materials

The datasets generated during and/or analyzed during the current study are available from the corresponding author* on request.

ORCID iDs

Kristian Beichmann  <https://orcid.org/0009-0000-0039-1302>

Polina Catzeflis  <https://orcid.org/0000-0003-3594-7790>

Helena D. Aicher  <https://orcid.org/0000-0001-5915-7086>

Federico Seragnoli  <https://orcid.org/0000-0001-9261-770X>

Abigail Calder  <https://orcid.org/0000-0001-9528-404X>

Gregor Hasler  <https://orcid.org/0000-0002-8311-0138>

Supplemental material

Supplemental material for this article is available online.

References

1. Siegel AN, Meshkat S, Benitah K, et al. Registered clinical studies investigating psychedelic drugs for psychiatric disorders. *J Psychiatr Res* 2021; 139: 71–81.
2. Seragnoli F, Martignoni G, Martignoni E, et al. Psychedelic-assisted therapy for palliative care within a home treatment setting: a case report. *Clin Case Rep* 2024; 12(9): e9305.
3. Fleury V, Tomkova E, Catalano Chiuvé S, et al. Psilocybin-assisted psychotherapy for Parkinson's disease without depression: a case-report. *J Parkinsons Dis* 2025; 15(2): 440–444.
4. Gasser P, Liechti ME and Holze F. Treatment of neuropathic pain with repeated low-dose MDMA: a case report. *Front Psychiatry* 2025; 16: 1513022.
5. Chandimal NA. Regulatory amendments authorize requests for psychedelic restricted drugs: cassels, <https://cassels.com/insights/regulatory-amendments-authorize-requests-for-psychedelic-restricted-drugs/#:~:text=As%20of%20January%205%2C%202022%2C,3> (2022, accessed 15 March 2025).
6. Lu D. Australian psychiatrists can now prescribe MDMA | psilocybin: who can access them and how do they work?. *The Guardian*. <https://www.theguardian.com/australia-news/2023/jul/01/australian-psychiatrists-can-now-prescribe-mdma-and-psilocybin-who-can-access-them-and-how-do-they-work#:~:text=From%20July%201%20psychiatrists%20in,announced%20the%20change%20in%20February>. .
7. Kenney A. What to know about Colorado's psychedelic law. *CPR News*, <https://www.cpr.org/2023/06/21/colorado-psychedelic-law-for-psilocybin-mushrooms/> (2023, accessed 27 February 2025).

8. Carboni LP. New Mexico Becomes Third State in the U.S. to Legalize Access to Psilocybin: Foley & Lardner LLP, <https://www.foley.com/insights/publications/2025/04/new-mexico-becomes-third-state-us-legalize-access-psilocybin/> (2025, accessed 20 April 2025).
9. Ginsberg NL. Israel embraces research on MDMA-assisted therapy for PTSD. Multidisciplinary Association for Psychedelic Studies (MAPS), <https://maps.org/2020/02/26/press-release-israel-embraces-research-on-mdma-assisted-psychotherapy-for-ptsd/#:~:text=On%20February%203%2C%202019%2C%20Israel,Tel%20Hashomer> (2020, accessed 27 February 2025).
10. Brennan W, Kelman AR and Belser AB. A systematic review of reporting practices in psychedelic clinical trials: psychological support, therapy, and psychosocial interventions. *Psychodelic Med* 2023; 1(4): 218–229.
11. Aday JS, Horton D, Fernandes-Osterhold G, et al. Psychedelic-assisted psychotherapy: where is the psychotherapy research? *Psychopharmacology (Berl)* 2024; 241(8): 1517–1526.
12. Pilecki B, Luoma JB, Bathje GJ, et al. Ethical and legal issues in psychedelic harm reduction and integration therapy. *Harm Reduction J* 2021; 18(1): 40.
13. Williams ML, Korevaar D, Harvey R, et al. Translating psychedelic therapies from clinical trials to community clinics: building bridges and addressing potential challenges ahead. *Front Psychiatry* 2021; 12: 737738.
14. Gesundheit Bd. Limited medical use of banned narcotics 2025, <https://www.bag.admin.ch/bag/en/home/gesetze-und-bewilligungen/gesuche-bewilligungen/ausnahmebewilligungen-bewilligungen-betmg/ausnahmebewilligungen-verbotene-betaeubungsmittel/ausnahmebewilligungen-beschaenkte-medizinische-anwendung.html> (2025, accessed 07.02.2025).
15. Aicher HD, Schmid Y and Gasser P. Psychedelika-assistierte Psychotherapie. *Die Psychotherapie* 2024; 69(2): 98–106.
16. Gasser P. Research update: psychedelic group therapy in Switzerland. *MAPS Bulletin* 2017; 27(1): 28–29.
17. Gasser P. Psychedelic group therapy. In: Barrett FS and Preller KH (ed). *Disruptive psychopharmacology. Current topics in behavioral neurosciences*. Cham: Springer, 2022, pp. 23–34.
18. Gasser P, Kirchner K and Passie T. LSD-assisted psychotherapy for anxiety associated with a life-threatening disease: a qualitative study of acute and sustained subjective effects. *J Psychopharmacol* 2015; 29(1): 57–68.
19. Schmid Y, Gasser P, Oehen P, et al. Acute subjective effects in LSD- and MDMA-assisted psychotherapy. *J Psychopharmacol* 2021; 35(4): 362–374.
20. Seragnoli F, Thorens G, Penzenstadler L, et al. Psychothérapie assistée par psychédéliques (PAP): le modèle genevois. *Annales Médico-psychologiques, revue psychiatrique* 2024; 182(9): 806–813.
21. Liechti ME, Gasser P, Aicher HD, et al. Implementing psychedelic-assisted therapy: history and characteristics of the Swiss limited medical use program. *Neurosci Appl* 2025; 4: 105525.
22. Calder A and Hasler G. Extrapharmacological safety topics in psychedelic-assisted psychotherapy. *JAMA Psychiatry* 2023; 80(8): 761–762.
23. Aicher HD, Duffour C, Liechti ME, et al. Treatment recommendations Psychedelic-assisted therapy (PAT): PAT, Psychedelic-Assisted Therapy IG https://swisspsychedelic.ch/wp-content/uploads/2024/09/Treatment_recommendations_PAT.pdf (2024, accessed 15 February 2025).
24. Benz E. Halluzinogen-unterstützte Psychotherapie. Erhebung bei der Schweizerischen Ärztesgesellschaft für Psycholytische Therapie. [Doctoral]. Psychiatrische Universitätsklinik Zürich (Burghölzli), 1989.
25. von Elm E, Altman DG, Egger M, et al. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: guidelines for reporting observational studies. *Lancet* 2007; 370(9596): 1453–1457.
26. Agin-Liebes G, Ekman E, Anderson B, et al. Participant reports of mindfulness, posttraumatic growth, and social connectedness in psilocybin-assisted group therapy: an interpretive phenomenological analysis. *J Humanistic Psychol* 2021; 0(0): 1–28.
27. Passie T. *Healing with entactogens: Therapist and patient perspectives on MDMA-assisted group psychotherapy*. Santa Cruz, CA: Multidisciplinary Association for Psychedelic Studies (MAPS), 2012.
28. Passie T and Dürst T. Heilungsprozesse im veränderten Bewusstsein: Elemente psycholytischer Therapieerfahrung aus der Sicht von Patienten. In: Jungarberle H, Gasser P, Weinhold J, et al. (eds). *Therapie mit*

- psychoaktiven Substanzen Praxis und Kritik der Psychotherapie mit LSD, Psilocybin und MDMA.* Bern: Verlag Hans Huber, 2008, pp. 165–194.
29. Passie T, Guss J and Krähenmann R. Lower-dose psycholytic therapy—a neglected approach. *Front Psychiatry* 2022; 13: 1020505.
 30. Stauffer CS, Anderson BT, Ortigo KM, et al. Psilocybin-assisted group therapy and attachment: observed reduction in attachment anxiety and influences of attachment insecurity on the psilocybin experience. *ACS Pharmacol Transl Sci* 2021; 4(2): 526–532.
 31. Brekxema JJ, Niemeijer AR, Krediet E, et al. Psychedelic treatments for psychiatric disorders: a systematic review and thematic synthesis of patient experiences in qualitative studies. *CNS Drugs* 2020; 34(9): 925–946.
 32. Hasler G. Toward the “helioscope” hypothesis of psychedelic therapy. *Eur Neuropsychopharmacol* 2022; 57: 118–119.
 33. Seragnoli F, Picard F, Thorens G, et al. Metacognitive feelings of epistemic gain are central to the understanding of psychedelic-induced mystical-type experiences. *Cogn Ther Res* 2025; 49: 873–901.
 34. Ponomarenko P, Seragnoli F, Calder A, et al. Can psychedelics enhance group psychotherapy? a discussion on the therapeutic factors. *J Psychopharmacol* 2023; 37(7): 660–678.
 35. Yalom ID. *Theory and practice of group psychotherapy*. 5th ed. New York, NY, USA: Basic Books, 1995.
 36. Goodwin GM, Malievskaia E, Fonzo GA, et al. Must psilocybin always “assist psychotherapy”? *Am J Psychiatry* 2024; 181(1): 20–25.
 37. Zamaria JA, Fernandes-Osterhold G, Shedler J, et al. Psychedelics assisting therapy, or therapy assisting psychedelics? the importance of psychotherapy in psychedelic-assisted therapy. *Front Psychol* 2025; 16: 1505894.
 38. Team RC. R: a language and environment for statistical computing (Version 4.3.1). Computing RfS, 2023.
 39. Team R. RStudio: integrated development environment for R (Version 2024.09.1+394). Posit Software P, 2024.
 40. Schindler EA, Sewell RA, Gottschalk CH, et al. Psilocybin pulse regimen reduces cluster headache attack frequency in the blinded extension phase of a randomized controlled trial. *J Neurolog Sci* 2024; 460: 122993.
 41. Rusanen SS, De S, Schindler EAD, et al. Self-reported efficacy of treatments in cluster headache: a systematic review of survey studies. *Current Pain Headache Rep* 2022; 26(8): 623–637.
 42. Liechti ME and Holze F. Dosing psychedelics and MDMA. In: Barrett FS and Preller KH (eds) *Disruptive psychopharmacology. Current topics in behavioral neurosciences*, vol. 56. Cham, Switzerland: Springer, 2021, pp. 3–21.
 43. Hinkle JT, Graziosi M, Nayak SM, et al. Adverse events in studies of classic psychedelics: a systematic review and meta-analysis. *JAMA Psychiatry* 2024; 81(12): 1225–1235.
 44. Carhart-Harris R, Giribaldi B, Watts R, et al. Trial of psilocybin versus escitalopram for depression. *New England J Med* 2021; 384(15): 1402–1411.
 45. Müller F, Zaczek H, Becker AM, et al. Efficacy and safety of low- versus high-dose-LSD-assisted therapy in patients with major depression: a randomized trial. *Med* 2025; 6(9): 100725.
 46. Kvam T-M, Goksøyr IW, Rog J, et al. MDMA-assisted therapy as a treatment for major depressive disorder: proof of principle study. *Br J Psychiatry* 2025; 227(5): 1–7.
 47. Jacobs E, Murphy-Beiner A, Rouiller I, et al. When the trial ends: the case for post-trial provisions in clinical psychedelic research. *Neuroethics* 2024; 17(1): 3.
 48. Trope A, Anderson BT, Hooker AR, et al. Psychedelic-assisted group therapy: a systematic review. *J Psychoactive Drugs* 2019; 51(2): 174–188.
 49. van Elk M and Yaden DB. Pharmacological, neural, and psychological mechanisms underlying psychedelics: a critical review. *Neurosci Biobehavioral Rev* 2022; 140: 104793.
 50. Nielson EM and Guss J. The influence of therapists’ first-hand experience with psychedelics on psychedelic-assisted psychotherapy research and therapist training. *J Psychedelic Studies* 2018; 2(2): 64–73.
 51. Earleywine M and Gomez SG. Is personal experience essential for effective psychedelic therapists?: the challenges of small, accumulating therapist effects. *Psychedelic Med* 2024; 2(3): 138–145.
 52. Aday JS, Skiles Z, Eaton N, et al. Personal psychedelic use is common among a sample of psychedelic therapists: implications for research and practice. *Psychedelic Med* 2023; 1(1): 27–37.
 53. Villiger D. Personal psychedelic experience of psychedelic therapists during training: should

- it be required, optional, or prohibited? *Int Rev Psychiatry* 2024; 36(8): 869–878.
54. Yaden DB, Earp D, Graziosi M, et al. Psychedelics and psychotherapy: cognitive-behavioral approaches as default. *Front Psychol* 2022; 13: 873279.
55. Lee A, Rosenbaum D and Buchman DZ. Informed consent to psychedelic-assisted psychotherapy: ethical considerations. *Canadian J Psychiatry* 2024; 69(5): 309–313.
56. Luoma J, Allen LR, Gold V, et al. Getting in touch with touch: the importance of studying touch in MDMA-assisted therapy and the development of a new self-report measure. *Psychedelic Med* 2024; 2(1): 25–32.
57. Bender DA, Nayak SM, Siegel JS, et al. The role of touch in psychedelic therapy: perspectives from a survey of practitioners in research settings. *Am J Psychotherapy* 2025; 78(4): 224–230.
58. Salomons J. Integrating psychedelic experiences through touch. *J Transformative Touch* 2022; 2(1): 2.
59. Aicher HD and Gasser P. Treatment recommendations for psychedelic-assisted therapy. *Swiss Archives Neurol Psychiatry Psychotherapy* 2024; 175: 1488043038.
60. Frecska E. Therapeutic guidelines: dangers and contra-indications in therapeutic applications of hallucinogens. *Psychedelic Med* 2007; 1: 69–96.
61. Sabé M, Sulstarova A, Glangetas A, et al. Reconsidering evidence for psychedelic-induced psychosis: an overview of reviews, a systematic review, and meta-analysis of human studies. *Mol Psychiatry* 2024; 29: 3139–3171.
62. Villiger D. Patient–therapist relationship in psychedelic-assisted therapy: implications for future real-world settings. *General Hospital Psychiatry* 2025; 96: 54–59.
63. Aicher H, Müller F and Gasser P. Further education in psychedelic-assisted therapy–experiences from Switzerland. *BMC Med Education* 2025; 25(1): 1–10.
64. Goodwin GM, Aaronson ST, Alvarez O, et al. Single-dose psilocybin for a treatment-resistant episode of major depression. *New England J Med* 2022; 387(18): 1637–1648.
65. Gao YN and Olfson M. High out-of-pocket cost burden of mental health care for adult outpatients in the United States. *Psychiatr Serv* 2025; 76(2): 200–203.
66. Filc D, Davidovitch N, Novack L, et al. Does socioeconomic status influence utilization of health care services in a single-payer universal health care system?: Nadav Davidovitch. *Eur J Public Health* 2014; 24(Suppl_2): cku151-050.
67. Association FSM. Statistique médicale de la FMH, <https://www.fmh.ch/fr/themes/statistique-medicale/statistique-medicale-fmh.cfm> (2025, accessed 2 February 2025).
68. Association FSM. Médecins dans le secteur ambulatoire par discipline principale et par canton; 2024, <https://www.fmh.ch/files/pdf32/3.-medecins-dans-le-secteur-ambulatoire-par-discipline-principale-et-par-canton.pdf> (2025, accessed 2 February 2025).
69. Association FSM. Médecins par discipline principale et par canton; 2024, <https://www.fmh.ch/files/pdf32/2.-medecins-en-exercice-par-discipline-principale-et-par-canton.pdf> (2025, accessed 2 February 2025).