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Exploring Psilocybin-Assisted Schema Therapy: A Conceptual Framework for Potential Therapeutic Synergies in Personality Disorders

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Exploring Psilocybin-Assisted Schema Therapy: A Conceptual Framework for Potential Therapeutic Synergies in Personality Disorders

Running Title: Psilocybin-Assisted Schema Therapy

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Abstract

Personality disorders (PDs) are characterized by rigid and maladaptive patterns of self- and interpersonal functioning, leading to high clinical burden and limited treatment outcomes. Schema Therapy (ST), an integrative psychotherapy rooted in cognitive-behavioral principles, conceptualizes PDs in terms of Early Maladaptive Schemas (EMS)—pervasive cognitive–affective structures formed through unmet emotional needs—and schema modes, dynamic states organizing emotion, belief, and behavior. Evidence indicates moderate efficacy of ST, mainly for borderline personality disorder, with limited research on other Cluster B and C PDs. Emerging evidence suggests that psilocybin, a serotonergic psychedelic, can induce enduring personality change, supporting its potential use in treating PDs. Within a predictive coding framework, the REBUS ("Relaxed Beliefs Under Psychedelics") and REBAS ("Revised Beliefs After Psychedelics") models propose that psilocybin relaxes high-level priors, facilitating cognitive flexibility and revision of maladaptive self-beliefs. Conceptual parallels between EMS and high-level priors suggest that psychedelic-induced relaxation of entrenched beliefs may enhance responsiveness to ST's experiential and cognitive interventions. Psilocybin-Assisted Schema Therapy (PAST) is proposed as a model in which psilocybin sessions are followed by integration

combining psychedelic-induced cognitive flexibility with ST techniques, aimed at strengthening adaptive modes and reducing dysfunctional EMS and dysfunctional modes. PAST could be relevant in the future for enhancing outcomes and potentially reducing treatment duration in Cluster B and C PDs, pending empirical validation. Although current literature is insufficient to recommend psilocybinassisted interventions for PDs, this theoretical article bridges computational neuroscience and clinical psychotherapy, outlining a framework for future studies on PAST feasibility, safety, and efficacy.

Keywords: Psilocybin, schema therapy, personality disorder, early maladaptive schemas, predictive coding, psychedelic-assisted therapy.

Introduction

Personality disorders (PDs) are defined by enduring, inflexible, and maladaptive patterns of thought and behavior that typically emerge during adolescence or early adulthood, remain stable over time, and lead to clinically significant distress or impairment.[1,2] Current estimates indicate that the prevalence of PDs in the general population is approximately 6.1%.[3] In clinical settings, prevalence is substantially higher, affecting approximately 25–50% of psychiatric outpatients and around 40% of psychiatric inpatients.[4,5] Both psychotherapeutic and pharmacological interventions have demonstrated limited efficacy in treating PDs. While professional guidelines generally recommend psychotherapy as the first-line treatment, the overall evidence points to modest effect sizes and low remission rates.[6,7] Likewise, there are currently no pharmacological treatments approved for PDs in the United States or Europe. Medications may help alleviate particular symptoms,[8,9] but in more complex cases they often lead to polypharmacy[10], with prescribing practices that substantially exceed what is supported by scientific evidence or clinical guidelines[11]. Given these limitations, there is a clear and urgent need to explore and develop novel therapeutic approaches for the treatment of PDs.

Therapeutic Framework of Schema Therapy for Personality Disorders

Schema Therapy (ST) is a cognitive-behavioral–based psychotherapeutic approach for PDs and chronic, treatment-resistant conditions that integrates attachment- and psychodynamic-informed formulations as well as elements of Gestalt therapy. ST

conceptualizes PDs as arising from Early Maladaptive Schemas (EMS), which are predominantly implicit, pervasive cognitive–affective structures formed in early childhood in response to unmet core emotional needs and adverse developmental environments.[12,13] Once established, EMS operate as rigid interpretative templates, biasing perception, memory, and interpersonal behavior in ways that reinforce maladaptive self- and other-representations. Their persistence is further maintained by dysfunctional coping styles, which prevent the disconfirmation of underlying schema-based beliefs.

In this framework, ST further conceptualizes psychological functioning through the schema mode model, which describes dynamic, moment-to-moment shifts between coherent patterns of emotion, cognition, and behavior that become activated when EMS are triggered.[13,14] Rather than being static traits, schema modes represent activated EMS-driven states that emerge in response to perceived threats or core need frustration, triggered by daily life events. Four functional classes of modes are typically distinguished: child modes, reflecting unfiltered affective vulnerability and unmet needs (e.g., the Vulnerable or Angry Child); maladaptive coping modes, which involve surrendering to, avoiding, or overcompensating for activated EMS (e.g., the Detached Protector or Self-Aggrandizer); Dysfunctional Parent modes, representing punitive or demanding introjects (e.g., the Punitive or Demanding Parent); and adaptive modes, most notably the Healthy Adult, which supports emotion regulation, self-compassion, and goal-directed behavior. Clinically, the relevance of the mode model is particularly evident in PDs, where EMS remain structurally stable and enduring over time, while schema modes fluctuate dynamically in response to triggers and interpersonal contexts; interventions therefore target the active state rather than the abstract schema. Central therapeutic work involves identifying maladaptive coping and dysfunctional parent modes—such as the Detached Protector or Punitive Parent—while accessing and responding to vulnerable child modes, and strengthening the Healthy Adult mode, which supports emotion regulation, limited reparenting, and adaptive interpersonal functioning. Experiential techniques are particularly powerful within this framework because they allow the therapist to directly engage the activated mode in vivo—rather than discussing it abstractly—thereby facilitating corrective emotional experiences that meet unmet needs and reduce the dominance of maladaptive coping and dysfunctional parent modes.

ST for PDs typically unfolds over several phases[13] (Figure 1). In the initial phase, the therapist establishes a strong therapeutic alliance, conducts assessment, and introduces the patient to the model. This is followed, and concurrently supported, by a psychoeducational phase, where EMS, triggers, and coping styles are identified, and patients learn to recognize their schema modes. Upon completion of these two phases, a first structured case conceptualization is developed, systematically organizing individual clinical features according to the EMS and schema mode model. The central phase focuses on modifying maladaptive EMS and reducing the dominance of maladaptive modes through cognitive, experiential, and emotional techniques—such as imagery rescripting, role-playing, and chair work—while strengthening adaptive modes, particularly the Healthy Adult. The final phase involves consolidation, relapse prevention, and gradual termination, ensuring the patient can maintain gains independently. Duration varies with disorder severity, complexity, and setting, ranging from several months for less severe presentations to 18–36 months for complex PDs such as borderline personality disorder (BPD).[15,16] Across all phases, experiential work and the therapeutic relationship—operationalized through limited reparenting—are considered central to promoting lasting change.

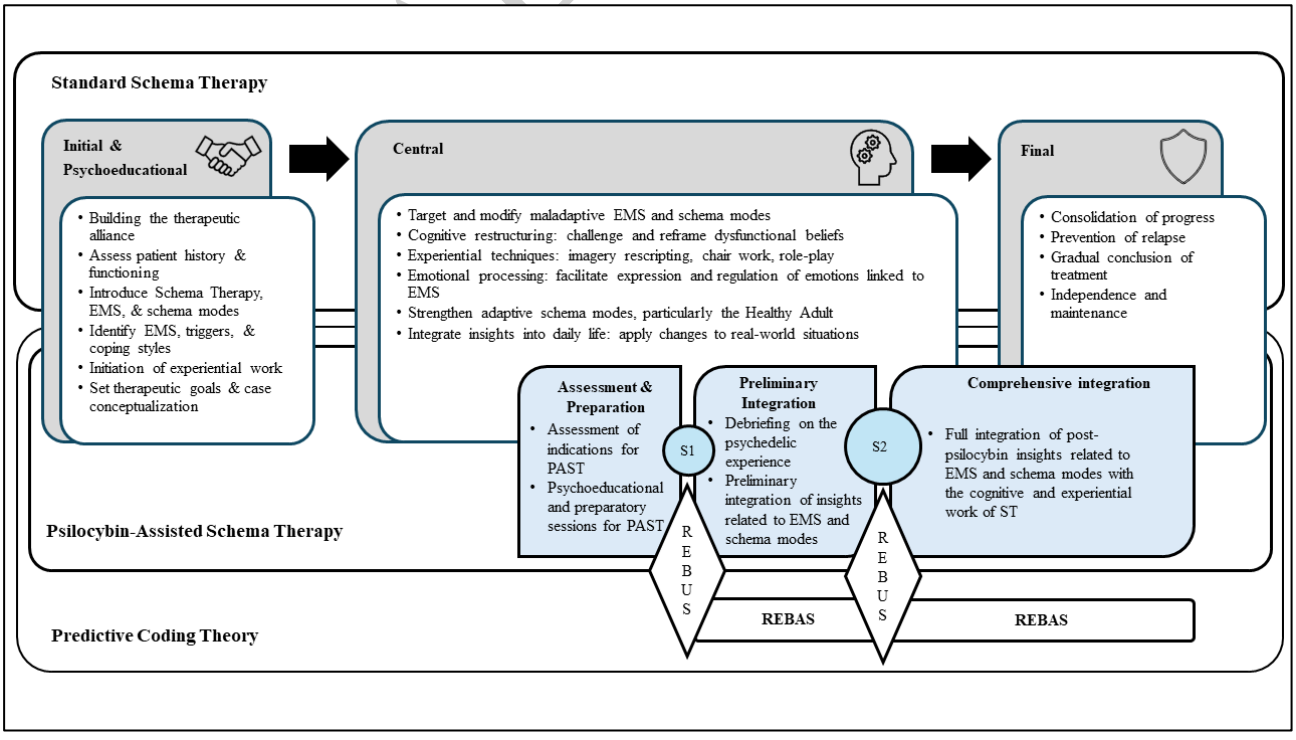

Figure 1 - Schema Therapy phases for PDs showing temporal integration of PAST with REBUS and REBAS mechanisms. EMS = Early Maladaptive Schema; PAST = Psilocybin-Assisted Schema Therapy; PDs = Personality Disorders; REBAS = Revised Beliefs After Psychedelics; REBUS = Relaxed Beliefs Under Psychedelics; ST = Schema Therapy; S1 = Preparatory Low-Dose Psilocybin Session; S2 = Full-Dose Therapeutic Psilocybin Session.

Current evidence – focused primarily on BPD[15,17] but also including other cluster B and cluster C PDs[18] - indicates that ST demonstrates moderate efficacy in reducing BPD symptoms and, to a lesser extent, symptoms of other PDs. ST has also shown a moderate effect in improving quality of life and in reducing EMS in patients with PDs.[19] However, given the still limited number of studies - particularly those examining PDs beyond BPD, including other cluster B and cluster C conditions - further research is needed to confirm these findings.

Psilocybin in Contemporary Clinical Models

Psilocybin is a psychedelic tryptamine found in several hallucinogenic mushroom species, including members of the *Psilocybe*, *Panaeolus*, *Inocybe*, and *Stropharia* genera. In addition to naturally occurring psilocybin, synthetic psilocybin and its active metabolite, psilocin, are also available for research and clinical development. Psilocybin-containing mushrooms have a long history of ritual and ceremonial use;[20] however, given the aims of the present manuscript, this section focuses on contemporary clinical models and their relevance to psychotherapy.

Following oral ingestion, psilocybin is rapidly dephosphorylated into psilocin, which exerts its effects on the central nervous system primarily through partial agonism at multiple serotonin receptors, with 5-HT2A receptor activation considered central to its mechanism of action. When administered orally, subjective effects typically emerge within 10–40 minutes and last approximately 2–6 hours, depending on dosage and individual sensitivity.[21] This relatively time-limited pharmacological profile is often considered advantageous in clinical settings, as it enables full-session monitoring within a single working day while reducing logistical challenges associated with longer-acting psychedelics (e.g., LSD).[22]

Beyond its traditional and recreational use, psilocybin is currently under investigation for its potential clinical role in the treatment of several psychiatric conditions. Indeed, recent trials suggest that psilocybin, typically administered in conjunction with structured psychological support, may produce clinically meaningful

effects in treatment-resistant depression,[23] major depressive disorder,[24,25] anxiety and depression associated with life-threatening illness,[26,27] substance use disorders,[28,29] and obsessive–compulsive disorder.[30]

Contemporary psychedelic-assisted treatment is best understood as a structured clinical process in which psilocybin administration is embedded within clearly defined preparatory, dosing, and integration phases.[23,31,32] Preparation typically involves multiple non-pharmacological sessions aimed at screening, establishing therapeutic rapport, clarifying intentions, reviewing potential risks, and developing a shared framework for navigating the altered state.[31] Dosing sessions are conducted in controlled settings with continuous medical and psychological monitoring, emphasizing safety, containment, and supportive presence rather than directive psychotherapy during the acute drug effects.[31,32] Integration sessions occur in the days and weeks following dosing and focus on meaning-making, emotional processing, and the consolidation of cognitive, behavioral, and relational change.[23,33]

Contemporary models differ in emphasis. “Psychedelic” approaches generally employ one or a few high-dose sessions intended to occasion profound experiential or peak-type states,[34] whereas historical “psycholytic” models utilized repeated lower doses embedded within ongoing psychotherapy to facilitate gradual analytic work.[35.] A currently active debate in the field concerns the nature of the interpersonal interaction accompanying psychedelic administration. Some investigators describe this interaction primarily as “psychological support,” emphasizing that therapeutic effects are understood to arise principally from the pharmacological action of the psychedelic compound, while interpersonal involvement serves mainly to ensure safety and minimize adverse outcomes.[36] Others characterize it as “psychedelic-assisted psychotherapy,” situated within the broader framework of psychedelic-assisted therapy (PAT), arguing that the interpersonal process not only promotes safety but also actively engages therapeutically relevant psychological processes that contribute to treatment efficacy.[32,37] Recent analyses have noted that interpersonal procedures in published trials are often heterogeneous, inconsistently defined, and insufficiently characterized, making it difficult to clearly distinguish between safety-focused support and efficacy-oriented psychotherapy.[38] Clarifying these distinctions is essential for conceptual precision, regulatory transparency, and the accurate interpretation of clinical outcomes.

As of 2025, some jurisdictions have begun to authorize psilocybin for therapeutic use under strict regulatory frameworks, such as Australia[39] and certain U.S. states (e.g., Oregon and Colorado),[40] where licensed centers provide psilocybin-assisted services for adults. However, psilocybin has not yet received approval from the FDA or any European regulatory agency for general clinical use, and its administration remains largely restricted to research settings or tightly regulated programs.

Psilocybin and Personality: Therapeutic Potential and Trait Modulation

Emerging evidence indicates that a single high-dose administration of psilocybin can lead to enduring changes in personality structure.[41] In a seminal double-blind study, MacLean, Johnson, & Griffiths[42] reported that healthy volunteers who received psilocybin showed significant and lasting increases in Openness—encompassing imagination, aesthetic sensitivity, and cognitive flexibility—especially among participants who experienced a mystical-type state during the session. More recent clinical research has expanded these findings. Erritzoe et al.[43] found that patients with treatment-resistant depression exhibited marked reductions in Neuroticism and increases in Extraversion and Openness three months after psilocybin-assisted therapy. These results have been supported by later naturalistic and clinical studies showing similar shifts in personality traits, including decreased neuroticism and increased openness and conscientiousness.[24,44-46] Together, these findings suggest that the acute psychedelic experience—particularly its emotionally and existentially salient components—may facilitate durable modifications in personality, contributing to the long-term therapeutic potential of psilocybin.

More broadly, research suggests that psychedelics may exert adaptive effects on identity, interpersonal functioning, and pathological personality traits. Clinical studies of psychedelic-assisted therapies indicate that adaptive changes tend to emerge primarily in the domains of negative affectivity, disinhibition, and detachment. However, these findings should be interpreted with caution, as they may be better accounted for by treatment-related improvements in co-occurring clinical conditions such as depression, anxiety, or substance use disorders.[47]

In addition, several recent conceptual contributions have proposed that psychedelic-assisted therapies may hold clinical promise for pathological personality

functioning, particularly in conditions characterized by affective dysregulation, interpersonal instability, rigid self-schemas, or trauma-related personality pathology.[48-50] However, the empirical base remains limited. Many hypotheses regarding PD populations rely on studies of trait change in non-PD samples or on early psychedelic research (primarily conducted between the 1950s and 1970s) within heterogeneous, pre-DSM diagnostic frameworks and marked by significant methodological limitations. Thus, conclusions about cluster-specific effects remain preliminary and hypothesis-generating. To date, no randomized controlled trial has investigated the effects of psychedelic-assisted therapies in patients with formally diagnosed PDs. Although recent naturalistic cohort studies have examined psychedelic use in individuals meeting criteria for PD diagnoses, the evidence remains observational and does not support causal conclusions.[51] Notably, an open-label study evaluating psilocybin therapy in individuals with co-occurring major depressive disorder and BPD has been completed (clinicaltrials.gov; NCT05399498). In addition, a more recent study investigating MDMA-assisted therapy in pathological narcissism is listed as active, not recruiting (NCT06565494).

Overall, the limited available evidence and emerging theoretical work suggest that psychedelic-assisted therapies may warrant cautious investigation in individuals with cluster B personality pathology, particularly when prominent emotional dysregulation, trauma-related schemas, and behavioral dyscontrol are present. At the same time, clinical caution is essential, given the heightened possibility of adverse or unintended outcomes in this population. Although research on cluster C conditions remains sparse, there are reasons to hypothesize potential relevance for individuals with obsessive-compulsive personality features. Specifically, psychedelic-induced increases in cognitive flexibility and openness, combined with reductions in negative affectivity, may plausibly counter the rigidity, perfectionism, and overcontrol that characterize obsessive-compulsive personality pathology, particularly when such traits are sustained by rigid maladaptive self-schemas and heightened threat sensitivity. By contrast, individuals with cluster A personality disorders have generally shown minimal or no improvement in the limited available reports, and some data suggest a heightened risk of symptom exacerbation in this group.[47]

Psychedelics, Predictive Processing, and Belief Revision: The REBUS and REBAS Models

Recently, Carhart-Harris & Friston[52] proposed the REBUS ("Relaxed Beliefs Under Psychedelics") model, which posits that psychedelics exert their effects by relaxing the precision weighting of high-level priors – abstract, often implicit, top-down probabilistic beliefs that encode accumulated knowledge about the self, others, and the environment, which constrain perception, emotion regulation, and self-referential cognition. These priors operate at a hierarchical level above immediate sensory input, biasing the interpretation of incoming evidence, and are updated only when prediction errors exceed their precision. When excessively rigid or overweighted, high-level priors could maintain maladaptive beliefs and contribute to psychopathology, including PDs.[53] Grounded in the hierarchical predictive processing framework[54] and the entropic brain hypothesis,[55] REBUS suggests that the increased neuronal entropy induced by psychedelics reduces the rigidity of the high-level priors, thereby enhancing the influence of bottom-up signals originating from both intrinsic neural systems (e.g., limbic networks) and external sensory inputs.

A recent study by Zeifman et al.[56] suggests that psilocybin not only relaxes cognitive rigidity in the short term (i.e., REBUS) but also facilitates the sustained revision of maladaptive beliefs. This study reported the first empirical evidence that the relaxation and revision of negative self-belief confidence mediates psilocybin's positive psychological outcomes in healthy individuals. Particularly strong evidence was seen for a relationship between decreases in negative self-belief confidence and increases in well-being. This preliminary finding has been conceptualized in the REBAS ("Revised Beliefs After Psychedelics") model. Post-acute cognitive restructuring may be crucial for achieving durable therapeutic change, as it supports the integration and consolidation of more adaptive self-related beliefs. According to the REBAS model, the persistence of psilocybin's therapeutic effects therefore depends on the integration processes that unfold after the acute psychedelic phase, highlighting the importance of guided therapy and reflective work. This sequential process—initial relaxation followed by structured revision—may be particularly relevant in conditions characterized by longstanding and rigid personality structures, such as PDs.

Psilocybin-Assisted Schema Therapy (PAST): Potential Mechanisms and Applications

In view of the above, integrating psilocybin into Schema Therapy (ST) protocols for cluster B and C personality disorders may substantially enhance therapeutic effectiveness, potentially leading to meaningful clinical advances in an area that remains in need of improved interventions. We propose the conceptual framework of Psilocybin-Assisted Schema Therapy (PAST), situating it within the broader field of psychedelic-assisted therapy and, more specifically, within psychotherapy-oriented models grounded in ST. Consistent with this perspective, psilocybin is not conceptualized as a stand-alone pharmacologic agent, but as a catalyst embedded within a structured psychotherapeutic process. The present proposal therefore focuses on how psilocybin might interact with and enhance core ST mechanisms that are already central in PD treatment, particularly experiential interventions (imagery rescripting, chair work), schema mode differentiation, and the strengthening of the Healthy Adult. Notably, in recent years, several studies have proposed incorporating psychedelic therapy within cognitive-behavioral interventions that challenge and promote distancing from negative self-beliefs, with the aim of enhancing their efficacy in disorders such as depression and anorexia.[33, 57-59] From a theoretical standpoint, Psilocybin-Assisted Schema Therapy (PAST) can be framed within the conceptual parallels between EMS and high-level priors as conceptualized in predictive coding models. Although originating from different fields of application – high-level priors in computational neuroscience and EMS in clinical psychotherapy – the two constructs exhibit significant conceptual overlap when EMS are understood as excessively rigid high-level priors, representing the clinical phenotype of such rigidity as manifested in persistent personal and interpersonal schemas and the resulting dysfunctional modes. Interestingly, Herzog, Kube, & Fassbinder[53] have recently proposed a predictive processing account of BPD, suggesting that, starting from a genetic predisposition and early adverse environmental factors (e.g., childhood maltreatment), strong negative beliefs about the self and others may develop, accompanied by reduced integration of new information. This mechanism, potentially explaining the characteristic rigidity and persistence of these features in BPD, bears significant parallels with the formation of EMS as conceptualized within the ST framework.

Psilocybin sessions could be introduced during the central phase of therapy, once a solid therapeutic alliance has been established and experiential work—particularly imagery rescripting—has already begun. The primary indication would be for cases in which neither a satisfactory reduction in the pervasiveness of EMS and maladaptive modes nor sufficient strengthening of the Healthy Adult has been achieved. Moreover, psilocybin could also be useful in cases where the therapeutic process has been effective, serving as a means to reinforce and consolidate gains. Given that PAST has not yet been empirically tested, this proposed indication should be understood as a hypothesis-generating research framework rather than a clinical recommendation. In future trials, the timing and indication for a psilocybin session could be operationalized using validated ST assessment instruments, such as changes in EMS severity as measured by the Young Schema Questionnaire (YSQ)[60] and schema mode profiles as assessed by the Schema Mode Inventory (SMI)[61], alongside functional outcomes and measurable process markers (e.g., persistent mode-driven behavioral patterns, limited generalization of gains to daily functioning, or repeated therapy stalemates despite adequate treatment exposure). Such operationalization would allow PAST to be tested within a falsifiable and methodologically transparent framework. In this context, the psilocybin-induced initial relaxation of beliefs (i.e., REBUS) followed by their structured revision (i.e., REBAS), in conjunction with the cognitive and experiential interventions of ST, may facilitate enduring reductions in EMS severity and in the dominance of maladaptive schema modes, alongside strengthening of the Healthy Adult.

Building on this conceptual model, a structured yet provisional therapeutic sequence can be delineated. An initial preparatory session with a low dose of psilocybin could be followed, after 3–4 weeks, by a full-dose therapeutic session.[24,27] The preparatory low-dose psilocybin session serves to familiarize the patient with psychedelic effects, establish therapeutic intentions, assess individual reactivity**,** and reduce uncertainty by allowing a gradual and ethically safer exposure to the acute psychedelic experience. Importantly, in PDs populations, alliance-building should be conceptualized as occurring primarily during non-pharmacologic preparation sessions, where expectations, boundaries, and relational dynamics can be addressed explicitly and without pharmacologically enhanced suggestibility. Psilocybin sessions should be adequately introduced and prepared with preliminary psychoeducational

sessions, during which the PAST model is clearly and comprehensively explained to the patient, and followed by integration sessions to process the experience.[31] Because acute psychedelic states have been associated with transient relaxation of high-level beliefs and increased emotional salience,[52] attachment-related EMS may become temporarily destabilized—more experientially accessible yet less rigidly constraining—particularly in individuals with cluster B features characterized by affective and relational instability.[62] In this context, heightened attachment needs and increased mode lability within the therapeutic relationship warrant explicit attention to informed consent, boundary management, and potential dependency or idealization dynamics within the ST framework. Psychedelic-assisted therapy sessions should be conducted by the primary schema therapist and, ideally, by a co-therapist—both adequately trained in psychedelic-assisted therapy—to ensure appropriate medical oversight, continuous psychological support, ethical safeguards, and competent management of the acute psychedelic experience, in accordance with international recommendations.[63,64] During the post-psilocybin integration sessions, chair work should be reintroduced as early as possible due to its characteristics as an experiential exercise, balanced by a significant cognitive component, alongside other cognitive techniques, followed by imagery rescripting, which should be continued until the conclusion of the treatment.

In light of current evidence indicating a specific efficacy of psilocybin in reducing negative self-beliefs, PAST may be particularly indicated for cluster B and C personality disorders characterized by the predominance of EMS within the domains of disconnection and rejection (e.g., defectiveness/shame, social isolation/alienation), impaired autonomy and performance (e.g., dependence/incompetence, failure) and overvigilance and inhibition (e.g., negativity/pessimism, overcontrol/emotional inhibition, unrelenting standards/hypercriticalness, punitiveness), as these are closely linked to persistent negative self-representations. Based on the same rationale, post-psilocybin experiential exercises (e.g., chair work and imagery rescripting) are expected to be more effective in distancing the strongly self-critical and punitive Dysfunctional Parent modes, while simultaneously promoting the strengthening of the Healthy Adult mode, capable of caring for the vulnerable parts (i.e., Child modes).

Clinical Risks and Iatrogenic Considerations

Given the vulnerability and clinical complexity of individuals with PDs, any proposal to integrate psilocybin into a ST framework must be accompanied by an explicit consideration of potential risks, iatrogenic mechanisms, and common failure modes. These risks are not ancillary: in PD populations, they may represent key determinants of outcome. Accordingly, PAST should be regarded as a hypothesis-generating model whose potential clinical development should occur within controlled research settings or rigorously regulated programs, with appropriate medical oversight, structured preparation and integration, and clinicians trained in both ST and psychedelic-assisted treatment.

Several risk domains may be particularly salient in individuals with cluster B and C personality pathology. First, psilocybin may transiently destabilize self-organization in individuals with insufficiently consolidated Healthy Adult functioning, particularly when maladaptive schemas are strongly embedded in autobiographical memory and self-narrative. In line with predictive processing models,[52] transient relaxation of high-level beliefs may facilitate revision while increasing confusion, suggestibility, and affective lability. Second, the acute psychedelic experience may involve transient alterations in self-experience and perception, including depersonalization, derealization, or dissociative-like phenomena.[31,32] In individuals with trauma-related vulnerability or prominent detachment-based coping, such experiences may warrant particular clinical caution. In Schema Therapy terms, this may manifest as a strengthening of Detached Protector modes or as rapid oscillations between Vulnerable Child and overcompensatory states. Third, as discussed above, psychedelic-assisted interventions may intensify attachment-related processes within the therapeutic relationship, increasing the risk of idealization, dependency, or boundary-testing behaviors related to limited reparenting, particularly in individuals with abandonment or emotional deprivation EMS. Fourth, psilocybin may precipitate intense emotional flooding that temporarily exceeds the patient's regulatory capacity, leading to acute dysphoria, panic, or destabilizing post-session rebound.[31] Finally, given the heightened emotional intensity and plasticity of acute psychedelic states, maladaptive schema modes—such as Impulsive or Angry Child modes, punitive internal dialogues, or grandiose overcompensation—may be transiently amplified or

insufficiently integrated, particularly in the absence of a clear case conceptualization and structured integration.

For these reasons, careful screening and clearly defined safety parameters are essential. Although formal criteria remain to be empirically established, PAST would likely be contraindicated in individuals with current or past psychotic disorders or bipolar I disorder with a history of mania. Other presentations—such as severe dissociative disorders with frequent depersonalization or amnestic episodes, acute or imminent suicide risk, unstable substance use that compromises safety or engagement, or significant medical contraindications—would warrant thorough stabilization and enhanced monitoring rather than automatic exclusion. Additional caution is indicated in cases marked by pronounced impulsivity, severe interpersonal instability, or recurrent crisis-driven service use, particularly in the absence of robust stabilization and a well-established therapeutic alliance. Importantly, adverse outcomes appear to be strongly moderated by set and setting variables. Contemporary clinical trials conducted under structured safety protocols indicate that psilocybin, when administered in controlled settings with appropriate screening, preparation, and integration, demonstrates a favorable safety profile in both non-clinical and selected clinical populations.[31,34]

From a clinical standpoint, risk management strategies would include extended preparation focused on stabilization and grounding; explicit boundary-setting and careful management of attachment dynamics; continuous monitoring during dosing sessions; and structured, mode-focused integration aimed at preventing avoidance-based coping, consolidating Healthy Adult functioning, and supporting autonomous regulation (see Table 1 for a structured overview). Importantly, recent preliminary (preprint) findings suggest that although EMS are highly prevalent among individuals seeking psychedelic-assisted psychotherapy and correlate with baseline depressive symptomatology, baseline EMS severity does not appear to predict the quality of the acute psychedelic experience or overall symptom improvement. These findings imply that EMS may serve primarily as clinically meaningful targets for integration rather than as selection criteria or moderators of treatment response.

Table 1 - Potential Risk Domains, Underlying Mechanisms, and Management Strategies in Psilocybin-Assisted Schema Therapy (PAST)

Risk domain	Schema Therapy framing	REBUS/REBAS Mechanism	Potential Adverse Outcomes	Preventive and Management Strategies	Screening red flags / relative contraindications
Identity destabilization (fragile self-structure)	Weak/unstable Healthy Adult; marked mode shifts	Relaxation of high-level self-related priors; reduced precision of self-model	Confusion, discontinuity of self-narrative; increased suggestibility; post-session affective dysregulation	Extended preparation; clear ST formulation; paced sequencing; Healthy Adult consolidation	Severely limited or absent Healthy Adult functioning; pronounced mode instability; recent major life stressor; prior destabilization after high-intensity experiential treatment
Dissociation / depersonalization / derealization	Detached Protector activation; Child/Overcompensator oscillations	Reduced precision of self- and reality-related high-level priors, increasing bottom-up influence	In-session dissociative-like withdrawal; transient depersonalization-like experiences; avoidance of affective processing; integration difficulties.	Grounding preparation; dissociation management plan; paced exposure; gradual dosing; anti-avoidant integration	Recurrent depersonalization/derealization; diagnosed dissociative disorder; unstable trauma-related dissociation; history of recurrent amnestic episodes.
Attachment intensification within the therapeutic relationship	Abandonment/Emotional Deprivation EMS; Vulnerable Child/Compliant Surrender activation;	Increased relational salience; reduced top-down regulation of attachment priors	Dependency; boundary-testing behaviors related to limited reparenting; idealization–devaluation cycles; crisis-driven service use; diminished autonomous functioning; relational ruptures	Autonomy-focused integration; Healthy Adult consolidation; explicit boundary-setting; relational transparency; monitoring of schema-driven relational patterns; structured follow-up; two-therapist model where	Marked attachment dysregulation; recent relational ruptures in therapy; recurrent dependency patterns; prior boundary violations; persistent high-intensity help-seeking behaviors; recurrent crisis-driven service use; limited social support and external stabilizing resources.

				feasible.	
Emotional flooding beyond regulatory capacity	Vulnerable Child overwhelm; limited Healthy Adult regulation; low distress tolerance	Increased bottom-up prediction error with reduced top-down regulatory precision.	Panic, dysphoria, agitation; post-session rebound dysregulation; avoidance-based coping	Pre-dosing stabilization; distress tolerance training; clear crisis plan; optimized set and setting; continuous monitoring; regulation-focused integration	Acute or imminent suicide risk; recent severe self-harm behavior; marked affective instability with frequent crises; severe insomnia; uncontrolled panic or anxiety.
Maladaptive schema mode amplification	Transient amplification of Impulsive Child, Angry Child, Self-Aggrandizer, or Punitive Parent modes	Maladaptive updating of high-level priors during post-acute plasticity	Behavioral disinhibition; interpersonal conflict; intensified self-criticism; increased shame; maladaptive behaviors justified as authentic self-expression	Mode-focused integration; early post-session chair work; behavioral commitments; clear limit-setting; corrective emotional processing	Marked impulsivity or antisocial traits; active substance misuse; severe punitive self-criticism; elevated risk of aggression.

ST = Schema Therapy; EMS = Early Maladaptive Schemas; REBUS = Relaxed Beliefs Under Psychedelics; REBAS = Revised Beliefs After Psychedelics.

Conclusions

The theoretical framework outlined here integrates contemporary evidence from Schema Therapy and psychedelic-assisted interventions to propose a conceptually grounded model for Psilocybin-Assisted Schema Therapy (PAST) targeting cluster B and C personality disorders. It does not aim to define specific therapeutic protocols, but rather to provide a conceptual foundation and stimulate future clinical research in this emerging field. A key strength lies in integrating process models—such as EMS and high-level priors—with emerging empirical findings on psilocybin, thereby fostering dialogue and conceptual coherence across domains ranging from computational neuroscience to clinical psychotherapy, and providing a coherent rationale for integrating psychotherapies that address cognitive, emotional, and experiential dimensions, such as ST, with psychedelic-assisted interventions. Additionally, the manuscript highlights specific clinical targets (negative self-beliefs, EMS, maladaptive schema modes) and practical considerations for the sequencing of a hypothetical treatment. Importantly, the framework also delineates structured risk domains and corresponding preventive strategies, emphasizing that the same window of plasticity that may enable therapeutic revision can also generate destabilizing trajectories if not adequately managed. Furthermore, validated self-report instruments, such as the YSQ and SMI, are available to quantify changes in EMS and schema modes, which could be highly useful in future studies to assess the effectiveness of PAST. The proposed framework may open new avenues to enhance treatment efficacy for PDs and potentially shorten the often lengthy duration of therapy, thereby improving cost-effectiveness and optimizing resource utilization.

Nonetheless, several limitations should be acknowledged. First, as highlighted by the recent review by Carrithers et al.,[47] a major limitation of current psychedelic-assisted intervention research is the lack of robust and clinically meaningful study designs. Most existing trials rely on small or convenience samples, open-label protocols, and short follow-up periods, which compromise internal validity and increase the likelihood of experimental artifacts (e.g., demand, placebo, expectancy effects). Moreover, personality change is commonly assessed with instruments developed for normative traits and self-report measures, rather than validated tools for maladaptive personality and informant ratings, thus constraining the ability to evaluate enduring and clinically relevant outcomes in populations with personality

pathology. Second, although there are reasons to suggest that psilocybin may have a clinically significant role in the treatment of various types of PDs, particularly those within clusters B and C, the discussion remains largely theoretical, relying on extrapolation from studies of psilocybin in depression, anxiety, and healthy volunteers rather than formal trials in individuals with clinically defined PDs. To date, no trial has directly examined the effects of psychedelic-assisted interventions in this population, although preliminary studies of psilocybin in co-occurring conditions are currently underway. Third, although the conceptual parallels between EMS and high-level priors, as proposed in predictive coding models, are theoretically intriguing, no empirical study has yet validated these potential analogies, nor has any clinical research directly examined the integration of psychedelic-assisted therapy with ST for the treatment of PDs or any other mental health condition. Fourth, no empirical research has yet evaluated the capacity of psilocybin-assisted therapy to therapeutically modify EMS or schema modes. Consequently, evidence on the safety, tolerability, efficacy, and long-term outcomes of PAST in individuals with PDs remains lacking.

Looking ahead, future studies will be needed both to refine the conceptualization of integrating psilocybin with ST and to empirically test its feasibility. On one hand, it is necessary to better delineate the specific indications for individual PDs, which remain too vague, as well as appropriate exclusion criteria; on the other hand, initial mechanistic studies may examine schema-related processes in controlled samples, followed by carefully designed trials in individuals with clinically defined PDs. Such a stepwise approach may help determine whether psychedelic-induced plasticity can be safely and meaningfully integrated within structured Schema Therapy frameworks for personality pathology.

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