MDMA, Internal Family Systems therapy, and the Minnesota model in the resolution of C-PTSD-induced alcohol and diazepam addiction—A retrospective case study

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Abstract

In February 2023, Australia became the first country in the world to allow psychiatrists to prescribe 3,4-methylenedioxymethamphetamine (MDMA) for post-traumatic stress disorder (PTSD). This may have left interested clinicians looking for practical examples of the use of MDMA. In the 1950s and 1960s, psychedelics were successfully utilized in the treatment of alcoholism. This case study, the first of its kind in recent years, illustrates in detail how and why MDMA, combined with Internal Family Systems therapy (IFS), can promote abstinence.

The case features a man in his forties with a long history of addiction to alcohol and diazepam. The addiction appeared as an attempt to avoid emotional pain caused by witnessing severe, chronic domestic violence in early childhood perpetrated by an alcoholic stepfather. While alcohol temporarily suppressed complex post-traumatic stress disorder (C-PTSD)-related anxiety, it also created intolerable shame and a feeling of inadequacy, which in turn resulted in increased use of alcohol. SSRI medications initially helped somewhat but failed to resolve the issues in the long term. C-PTSD presented itself not only as anxiety and depression but also as physical tensions and pains, and their relaxation with various substances caused intense pleasure, leading to addiction. Later, diazepam was prescribed as a substitute for alcohol. While alcohol use was reduced, an addiction to diazepam emerged instead.

There appeared to be a lack of understanding about the causal relationship between adverse childhood experiences (ACEs) and the addiction, as well as the severity of the condition. Eventually, after several failed attempts at quitting and a suicidal period, the patient accepted that he needed more intensive external help, enrolled in a 28-day retreat utilizing the Minnesota abstinence model, felt unprecedented safety and acceptance, gained insight about the ACEs as a cause of his alcoholism, and was able to give up alcohol and diazepam, but the abstinence was fragile and stressful to maintain.

Regardless, 'the most painful issues' caused by witnessing life-threatening domestic violence remained unresolved. A single session combining MDMA and IFS therapy allowed him to safely re-experience these events in an embodied manner. A later IFS session without MDMA complemented the outcome of resolving his C-PTSD and stabilizing his abstinence.

Keywords: domestic violence, alcoholism, PTSD, C-PTSD, addiction, substance dependency, Minnesota model, abstinence model, ayahuasca, LSD, MDMA

Introduction

Substance use disorder treatments may be divided into abstinence and non-abstinence models (Paquette et al., 2022). The latter include harm reduction approaches. The use of benzodiazepines as a substitute for alcohol as a method of alleviating anxiety resulting from an underlying, unresolved complex post-traumatic stress disorder (C-PTSD) could be classified as a harm reduction method.

A more feasible approach would be to resolve the underlying trauma with the intention of reaching abstinence. Classical psychedelics, due to their somatic safety and non-addictive nature, may complement abstinence models. 3,4-methylenedioxymethamphetamine (MDMA) is not a classical psychedelic but an 'empathogen', and a possibility of lethal overdosing exists. Regardless, its properties typically make a treatment with it 'easier' for patients than with classical psychedelics, as well as possibly more feasible to use by therapists with insufficient personal experience with classical psychedelics. Also, MDMA will likely be the first psychedelic therapy to be officially endorsed for PTSD. The present case therefore exemplifies the use of MDMA in the treatment of alcoholism.

While MDMA sessions may spontaneously result in favorable outcomes without a therapy component, the concepts and methods of Internal Family Systems (IFS) therapy have been found compatible with MDMA therapy (Schwartz and Sweezy, 2020). IFS techniques applied in a state of emotional safety induced by MDMA may help in rescuing parts of the personality that have been 'exiled' as too painful. An embodied 'reliving' and a subsequent 'integration'

of these 'exiled' or 'split' memories of adverse experiences may result in resolution of the related symptoms, including addiction and anxiety.

The author's approach was ethnographic, with an intention to collect cases of successful treatment of various mental disorders with different psychedelics. The interviewee was found on an online forum. The details of this case were acquired through two semi-structured, retrospective online interviews conducted in October 2022, with a total duration of three hours. In addition, the patient provided an audio recording of the application of IFS techniques during the latter part of the first MDMA session. An additional follow-up discussion was conducted in December 2022. Medical records were unavailable. The fulfillment of the ICD-11 diagnostic criteria 6B41 for C-PTSD, as well as the fulfillment of diagnostic criteria for anxiety disorders and alcohol-related disorders, can be derived from the clinical features presented in the case description.

Benzodiazepines as a substitute for alcohol

In the 1980s, a standard for medical practice stated that benzodiazepines had become the standard pharmacological treatment for alcohol withdrawal and that the use of other medications in alcohol withdrawal without defensible medical justification could raise potential medical-legal liability (Smith and Wesson, 1985). The withdrawal was intended to be short-term. Regardless, benzodiazepines began to be routinely prescribed long-term as a substitute for alcohol. In most cases, this practice was insufficient to produce satisfactory results, and withdrawal from benzodiazepines was often as difficult as or more difficult than withdrawal from alcohol (Peppin et al., 2021).

The Minnesota abstinence model

The Minnesota model is an abstinence model that originates from the 12-step model of Alcoholics Anonymous (AA), a mutual aid fellowship for individuals with alcoholism (Anderson et al., 1999; McElrath, 1997; Montague and Fairholm, 2019; White and Kurtz, 2008). The Minnesota model is an inpatient/retreat model consisting of a 28-day individualized treatment plan including group and individual psychotherapy, psychoeducation, assignments, family involvement, and fellowship attendance (Montague and Fairholm, 2019).

AA-based models are often classified as 'spiritual' approaches (Feigenbaum, 2013). In this context, 'spiritual' might be best understood as *having to do with (re)gaining personal agency that was lost due to trauma.* Personal agency has recently been recognized as central to the recovery from severe mental illness (Lysaker and Leonhardt, 2012); addictions resulting in interpersonal violence and/or suicidality may qualify as such. With regard to efficacy, Montague and Fairholm concluded that the model enhanced psychological wellbeing in the addicted population (Montague and Fairholm, 2019). It also appeared promising as an effective treatment for anxiety and depression in the absence of addiction.

An alternative definition of 'spiritual' could be 'feeling connected to something that is greater than you are, or actually feeling as being it, feeling as one with it ... one shifts from one's identity' (Solluna, 2018). In this sense, transcending one's everyday consciousness ('default mode network') or conceptual framework, or connecting with one's subconscious memories, resulting in a noticeable alteration of one's self-concept or identity, could be construed as a 'spiritual' experience.

The Internal Family Systems therapy model

Internal Family Systems therapy is a relatively recent therapeutic approach developed by Richard Schwartz (Schwartz, 2021; Schwartz and Sweezy, 2020). It has also been adapted for self-therapy (Earley, 2009). Schwartz was initially a family therapist but found the method ineffective. After listening to his patients talk about conflicting, internal subpersonalities or 'parts', he began applying his family therapy methods to these internal parts. Instead of seeing the mind as monolithic, he began viewing it as multi-part, or as an 'internal family'. However, his initial attempts to force, fight, and control these parts in his patients resulted in failure. Therefore, Schwartz considered the concept of 'willpower' counterproductive.

Eventually, he adopted a method based on acceptance and curiosity about the parts. He noticed that parts could be discussed with, and they 'replied' to questions about their motives. Many parts aimed at protecting the patient from events similar to those that had occurred in the past. He noted that the mindsets of these parts appeared 'frozen in past traumas', i.e. events during which their extreme roles had been needed. Yet even the most destructive parts had protective intentions. If these 'protectors' could be convinced that it was no longer necessary to protect the patient, they could 'step out of their roles'. Subsequently, the patient and therapist could access 'exiled' parts that the protectors had been protecting.

These 'exiles' contained a conceptual framework from the age of the original trauma. Moreover, they acted according to that framework. They also carried a representation of the body state from the age of the trauma. In other words, the exiles carried emotions and beliefs that had become 'attached' to them from one's environment. Schwartz labeled these as 'burdens', and the goal of IFS therapy was to 'unattach' these burdens from parts (this resembled indigenous conceptualizations of trauma as an external 'entity').

Burdens could result from either direct or indirect experience. For example, the sense of worthlessness that came into a child when a parent abused them, or the belief that no one could be trusted were 'personal burdens', corresponding

to 'internal working models' of Bowlby's attachment theory. Another class of burdens were indirectly acquired 'legacy burdens'. These represented transgenerational trauma that could be adopted from the behavioral patterns of one's parents. The existence of legacy burdens could be more difficult to notice.

Schwartz described that typically, a person using substances was considered 'an addict' who had 'an irresistible urge to use drugs'. The urge could be combated with opioid antagonists, with the willpower of the addict, or with recovery programs. However, some recovery programs could further polarize the addictive part, and willpower often failed. Instead, Schwartz proposed that the part that sought drugs should be viewed as protective: it carried the burden of responsibility for keeping the person from severe emotional pain or even suicide. The person was to be helped to get to know that part, to honor it for its noble intention, and eventually negotiate permission to heal or change what the part protected, i.e., an 'exiled' part (often called 'an inner child'). The 'addict' part thus served as a protector and carried a burden of fear and responsibility. As such a protector part was liberated from its associated burden, the part typically transformed into a useful ally, serving a productive purpose.

If a person had been abused as a child, a protector could also adopt the violent energy of their perpetrator and use that energy to protect the person from the abuser. The part subsequently carried the (legacy) burden of the perpetrator's hatred, and a desire to dominate and punish vulnerability. These parts could then violate other, internal parts of the person, or other people.

In addition to parts, every person also possessed a 'Self'. It could not be damaged, it did not have to develop, and it possessed an inherent capacity to heal internal and external relationships. It could be temporarily obscured, but it never disappeared. If protectors could be convinced to 'step aside', eventually the Self would come forward.

Protector parts could also 'blend' with the Self, resulting in the blended parts taking over the person. The reason for blending was that protectors distrusted the Self because it had not been able to protect the person from abuse. Concerning interpersonal relations, one's protectors could only see the protectors of others. Thus, if one was blended with burdened protectors, one could not perceive the Selves of others. Blended parts produced only projections, transferences, and other distortions, resulting in the person feeling lonely and disconnected; the opposite of 'oneness'. The interactions of people with blended protectors often ended up in polarized, constantly escalating 'protector wars', typical in corporations, families, and politics.

In contrast, the Self's view was undistorted. The Self represented perfection (or perhaps 'divinity' or 'sacredness') which only needed to be uncovered and released. It was the seat of consciousness, characterized by qualities such as perspective, presence, patience, playfulness, persistence, curiosity, calm, confidence, compassion, creativity, clarity, courage, and connectedness ('the eight C's'). The Self was the only inner entity that was fully equipped to lead the internal family. The goals of IFS thus included the restoration of trust in the Self, and the subsequent promotion of Self-leadership. Once in Self, one felt less isolated and lonely, was more curious about others, and had more courage to help them.

Parts could be identified by their associated bodily sensations, and by discerning a set of bodily sensations, one could identify and 'unblend' a protector part from the Self. Eventually, if all protectors could be unblended, only the Self would remain, resulting in a state similar to enlightenment.

Yugler discussed the intersection of IFS and psychedelics, calling IFS 'a non-pathologizing form of psychotherapy' (Yugler, 2021). He also connected some indigenous, psychiatric, psychedelic, and IFS concepts. For example, the indigenous concept of a 'spirit' could, in some contexts, refer to an IFS part. Similarly, the concept of 'entity' in the psychedelic context referred to a part. Yugler mentioned that IFS could be used for 'navigating' psychedelic experiences. Additionally, Dutcher has discussed the limitations of IFS with regard to dissociative identity disorder (DID) (Dutcher, 2022).

Trauma Release Exercises

The present case also involved the use of Trauma Release Exercises (TRE), a method featuring self-induced therapeutic musculoskeletal tremors that release trauma- or anxiety-induced muscle tension (Begin et al., 2022; Berceli, 2015; Berceli et al., 2014). While academic research on the method remains scarce, due to its ease of adoption and perceived efficacy, the method has gained relatively widespread popular adoption. A small nine-week initial trial (n=9) on multiple sclerosis patients indicated improvements in most measured indicators, including an almost 50% decrease in fatigue (Lynning et al., 2021). Anecdotally, the method might occasionally resolve a trauma, but more commonly, it only transiently alleviates symptoms, leaving the underlying conflict unresolved, and requiring the method to be applied repeatedly. Its advantages include ease of adoption, feasibility for self-treatment, perceived efficacy in alleviating symptoms, and being cost-free.

Psychedelics for alcohol use disorders

The treatment of addictions, including alcoholism, with psychedelics is not a new idea. In fact, it was widely utilized in the 1950s and 1960s, until misguided politics originating from the US resulted in the international prohibition of psychedelics, against expert advice. Assuming that the primary mechanism of action of psychedelics is the resolution

of underlying complex traumas, which cause symptoms, and that the avoidance of symptoms maintains addictive behaviors, outcomes appear consistent for classical psychedelics, as expected.

With regard to the conception of psychedelics/entheogens as 'spiritual' or 'sacred', Roberts noted that the world may be 'transitioning from an era of word-based religion to an era of experience-based religion' (Roberts, 2014). Borrowing from Stolaroff (Stolaroff, 2012), Roberts suggested a protocol that included: initially working with patients in individual sessions, then moving them to a group; starting with a less challenging entheogen such as MDMA; and starting with a low dose and working up to stronger ones.

Utilizing the concept of sacredness, better treatment efficacy could be achieved through personal, embodied experiences of 'sacressness' or 'divinity', instead of attempts to understand issues intellectually. These experiences of divinity would not need to be related to an externalized 'God', but to an experience of divinity of the Self, i.e., the divinity of the patients themselves. Such experiences would then result in these patients conceptualizing themselves as valued instead of failed and inadequate, which, in turn, would resolve depression and anxiety.

LSD

LSD was widely utilized for the treatment of alcoholism in the 1950s and 1960s (Abramson, 1966). Lattin described that the co-founder of AA, Bill Wilson, was 'a firm believer in the ability of LSD to free some hardcore alcoholics from their addiction' (Lattin, 2020; Yaden et al., 2021). In Wilson's view, 'some diehard alcoholics' required 'a spiritual awakening to overcome their addiction'. Wilson said LSD sparked 'a great broadening, deepening, and heightening of consciousness'. Wilson had experienced a spontaneous or plant medicine induced spiritual experience in 1934. His first LSD experience in 1956 was similar. He and his AA friends had taken LSD 'frequently and with much benefit'. Lattin himself had used psilocybin, MDMA, ketamine, ayahuasca, and 5-MeO-DMT successfully for his addiction, while some others were said to have experienced unspecified issues.

In 2012, Krebs and Johansen performed a meta-analysis of randomized controlled trials of a single 200–800 µg dose of LSD for alcoholism (Krebs and Johansen, 2012). Six eligible trials including 536 participants indicated a beneficial effect of LSD on alcohol misuse (OR 2.0; 95% CI 1.4–2.8; $p<0.001$; $I_2=0\%$).

Concerning the treatment of C-PTSD with LSD, in the last two decades, it has been utilized, for example, in Switzerland, its birthplace. Psychotherapist Friederike Meckel Fischer organized group psychotherapy sessions with MDMA, LSD, and 2C-B (Meckel Fischer, 2015; Sessa and Meckel Fischer, 2015). More recently, Oehen and Gasser also treated C-PTSD patients with MDMA and LSD (Oehen and Gasser, 2022). The safety of LSD has been discussed in another article by the author (Turkia, 2022). Yaden et al. went into great detail about the potential synergies between classical psychedelics and 12-step programs (Yaden et al., 2021).

Ayahuasca

In indigenous and neoshamanic contexts, ayahuasca, a botanical decoction originating from the Amazonian rainforest, has been routinely used in the treatment of addictions (Talin and Sanabria, 2017). A systematic review by Calleja-Conde et al. pointed to significant benefits in both animal and human studies (Calleja-Conde et al., 2022). Reviews by Frecska et al. and James et al. discussed additional aspects (Frecska et al., 2016; James et al., 2022). A substance use disorder treatment program described by Berlowitz et al. (n=36) pointed to significant decreases in addiction severity to various substances, including alcohol (Berlowitz et al., 2019). Rush et al. presented a study protocol (Rush et al., 2021). Loizaga-Velder and Verres interviewed thirteen therapists who applied ayahuasca professionally in the treatment of addictions (Loizaga-Velder and Verres, 2014). A recent online cross-sectional study (n=8629) by Perkins et al. found that consumption of ayahuasca in naturalistic settings was associated with lower self-reported current consumption of alcohol and other drugs for those with and without prior substance use disorders, with such effects present after adjusting for religious or social group effects (Perkins et al., 2021).

MDMA

MDMA has been described as an 'empathogen', meaning 'generating a state of empathy'; an 'entheogen', meaning 'awakening the God within'; and an 'entactogen', meaning 'touching the self within' (Shulgin, 2020). In the IFS context, the third characterization would appear to be the most fitting: a general reduction of fear would allow for the 'stepping aside' of protectors, and subsequently a more direct access to the Self.

With regard to the effects of MDMA, Holland noted that 'unlike alcohol or anti-anxiety drugs, there is no clouding of consciousness or sedation, and unlike cocaine or methamphetamine, there is no agitation or paranoia. Its effects are more easily controlled and predictable than those of LSD or psilocybin. The chemical effects of MDMA more closely resemble an immediately acting antidepressant such as fluoxetine, but the euphoria and calm are more profound' (Holland, 2001). Holland et al. also provided detailed interviews of therapists who had utilized MDMA in psychotherapy.

Passie chronicled the early use of MDMA in psychotherapy between 1977–1985 (Passie, 2018). A predecessor of MDMA was the mescaline derivative methylenedioxy-amphetamine (MDA), which 'became the drug of choice of some underground psychotherapists from the mid-1960s on'. However, due to a degree of toxicity, MDA was later replaced with MDMA.

In the late 1970s and 1980s, psychotherapist Leo Zeff, who had initially worked with LSD, later trained more than 150 MDMA therapists and administered MDMA to about 4000 people. Later, the Association for the Responsible Use of Psychedelic Agents (ARUPA) was formed. Its members included Zeff, pharmacologist-chemist David E. Nichols, psychologist Rick Doblin (the founder of MAPS), Joseph Jackson Downing (a gestalt therapist treating alcoholics with LSD), psychiatrist Stanislav Grof (LSD therapist and the inventor of the Holotropic Breathwork method), psychiatrist and psychotherapist Oscar Janiger (also treated alcoholics with LSD), psychiatrist Richard Ingrasci (Ingrasci, 1985), chemist Alexander Shulgin (the inventor of 2C-B, which could be combined with MDMA; Shulgin and Shulgin (1991, 1997)), engineer-researcher Myron Stolaroff (Stolaroff, 2012), associate professor of psychiatry Rick Strassman, psychologist-psychotherapist-researcher Ralph Metzner (Leary et al., 1964), and psychiatrist George Greer. Another main character in the field was Chilean psychiatrist Claudio Naranjo. Yet another psychiatrist and an associate professor at Stanford University, Joseph J. Downing, treated alcoholics with LSD in the 1960s and adopted MDMA in the 1980s.

Another early MDMA therapist, Ann Shulgin, wrote about Zeff, describing that he began by giving MDMA to therapists because 'no therapist had any business giving a consciousness-altering drug to any other person unless the therapist personally knew its effects' (Shulgin, 2020). MDMA became a favorite tool of psychotherapists 'because it could be given safely to people who were too emotionally fragile to benefit from classical psychedelics'.

According to Shulgin, a verbal, face-to-face contract between the therapist and patient was a necessary condition for MDMA therapy (Shulgin, 2020). It was essential that the contract was face-to-face instead of written. The contract consisted of four rules: 1. all sexual feelings were allowable and could be discussed but could not be acted out physically; 2. feelings of hostility and anger were allowable and could be discussed but could not be acted out physically except in a mutually agreed manner, for example by pounding a pillow; 3. a decision to commit suicide in a symbolic manner during the session was not allowed, i.e., if the patient would 'see the friendly death door and know, that by stepping through it, she would be done with this life, she was not to do so during that session'; 4. the patient needed to promise to abide by these rules without exception and without reservations.

Shulgin noted that the critical period was the falling-off of the drug effects, that is, the last 1–2 hours of the 4–6-hour session. In this phase, the fears, 'defenses', or structures that had been lifted by the euphoric effect gradually tried to reintroduce themselves, and in order to obtain a lasting benefit from the session, the patient needed to fight them off. The session was to be ended only when the patient decided that she was too tired to work further.

Shulgin emphasized that a therapist who had not undergone a journey to her own 'dark side' or 'shadow' could not and was not allowed to guide a client on such a journey: such a therapist lacked authority and believability to calm a client struggling with intense, deep fears (Shulgin, 2020). Shulgin also gave another rule: a therapist needed to feel 'something very close to love for the person she was guiding'. There needed to be real caring 'at the gut level', not only intellectual concern for the client's welfare. Shulgin added that such real caring could not be forced, and that the therapist was required to have sufficient insight and honesty in order to be aware of her own true feelings. Hostility, apprehension, or indifference were absolute contraindications to therapeutic work.

In general, Shulgin's insights and suggestions mirrored the principles of IFS. For example, she referred to the concept of an 'overseer' or 'higher self' of the patient, which was the actual healing force: 'a part that was a self-healer'; the therapist only 'helped to activate it'.

The MDMA sessions described in this case study broadly followed the outlines given by Shulgin (as well as the outlines recommended by the Multidisciplinary Association for Psychedelic Studies (Henriques and Abreu, 2020; Mithoefer et al., 2017)). The duration of the session was 5–6 hours. The dose was 130 mg, with a 'booster' dose of 70 mg two hours after the first dose.

Recent SSRI exposure may reduce response to MDMA-assisted psychotherapy (Feduccia et al., 2020; Price et al., 2022). In the present case, SSRIs had been discontinued almost two years before the MDMA session. SSRI administration had been chronic, but the dose was moderate (over a decade of escitalopram with a daily dose of 10 mg). Response to MDMA appeared non-attenuated.

Sarparast et al. recently provided a systematic review of interactions between psychiatric medications and MDMA or psilocybin (Sarparast et al., 2022). A clinical trial by Mitchell et al. found that MDMA-assisted therapy was highly efficacious in individuals with severe PTSD, and that the treatment was safe and well-tolerated even in those with comorbidities (Mitchell et al., 2021). They concluded that the method represented a potential breakthrough treatment. Another recent clinical trial by Brewerton et al. found that MDMA-assisted therapy significantly reduced eating disorder symptoms in adults with severe PTSD (Brewerton et al., 2022). In addition to delivering substantial clinical benefit, the method was found to be very cost-effective (Marseille et al., 2022). Kaspian discussed the feasibility of MDMA for self-treatment (Kaspian, 2016, 2020). Passie provided a short review of Phil Wolfson's work with patients in psychotic crisis and their families (Passie, 2018). McCarthy discussed MDMA and the role of theology in the 'psychedelic renaissance' (McCarthy, 2022). A 2019 documentary film, 'Trip of Compassion', featured MDMA therapy sessions carried out at the Beer Yaakov Mental Health Center in Israel (Karni, 2019).

Case description

A man in his early forties described his first four years of childhood as 'good', but had only one memory of these years for a long time. At the age of five, his parents divorced. All his other memories concerned the period after that. His 'self-consciousness' emerged during this time. His stepfather was an 'untreated alcohol addict' who was physically violent and mentally unstable. Between the age of five and fifteen, the boy felt unsafe, as well as insecure about himself. He avoided conflicts with the stepfather, and tried to 'protect' his mother. His role was that of a protector, and he needed to stay 'on watch' all the time.

When the stepfather had been drinking, he became unpredictable and extremely violent toward the mother. Regardless, the boy had succeeded at school and been 'so nice' that his mother had wondered about it. He had good social skills, was popular at school, and had played football since the age of six. The football club was a supportive factor that enabled him to develop as a person, to become a 'team player', to play 'for the team', and to take care of people in his social circles. He had friends, he was talented, learning was easy for him, and his memory was good, especially his 'body memory' (Riva, 2018). Externally, his life appeared good.

However, 'deeper, darker patterns of thought' were present already in his early childhood. His father was a teacher, a school principal, and a 'pragmatic atheist' who believed in mathematical models, physics, and rationality. At the age of four, his father took him to a planetarium. He felt he got 'too much information': things he could not understand. He heard about space, the sun's expansion into a red giant, and the end of the world. For a few weeks, he felt intense fear about the world coming to an end. He 'became conscious of such issues too early', without the capability to understand them. This caused anxiety and fears.

A more severe, 'persistent atmosphere of danger' emerged after the divorce, due to the arrival of the stepfather. The stepfather did not exactly hit the boy, but could drag him around by pulling his hair, or push him. These reactions resulted from stating one's own opinion, or from disagreeing. This created a feeling of injustice. If the boy tried to defend himself, the stepfather punished him physically to 'put him in his place'.

In the meantime, the mother had another child with the stepfather. At the age of fifteen, the boy wondered how his mother had endured the relationship with the stepfather for ten years. Through sports, the boy gained physical strength and a feeling of empowerment. He told the mother that the next time the stepfather hurt her, he would defend her and, if necessary, kill the stepfather. For this purpose, he had acquired a heavy steel bar, which he kept in his room.

Soon after, the mother announced that she would leave the stepfather, and she moved out with both children. He described the stepfather as 'narcissistic' but said that the connection had been cut quite soon, without excessive problems.

At the age of fifteen, the boy found a girlfriend who was one year younger. Her family was 'supportive and loving', with three daughters, and the girlfriend's parents 'kind of adopted' him as a member of their family. He was happy with the girlfriend, living a 'normal life'; he gained 'space for his own feelings'. In retrospect, he felt grateful toward her family.

During secondary school, around the age of seventeen, feelings of anxiety and panic emerged. Once, he could not breath, and the girlfriend's father drove him home. Once during a class, he panicked and was taken to a school nurse, and to a health clinic. The ECG was normal. The feeling of being cared for calmed him down, allowing him to survive the school and eventually graduate from it, but with less stellar grades than before.

The military service felt easier for him: everything was well structured, and he did not need to worry about anything by himself. The team spirit was good; he felt safe and loved in the group. He enjoyed the physical training. Life was 'clearly structured'. Only situations in which he had to stand guard or perform something under stress caused bouts of anxiety. An 'introspection mode' caused severe symptoms of anxiety.

After the military service, he got an apartment with his girlfriend. The relationship was satisfying. He was in excellent physical shape and took a job in which he could utilize it. The job was relatively simple and well structured. Soon he got an offer for a better job.

Between the ages of 20 and 24, he noticed that for him, due to the intense feeling of safety and relaxation it produced, occasional drinking gave an unusually strong satisfaction. Alcohol kept fears at bay, and under its influence, he could 'be himself: a world-loving person', without the anxiety that 'persisted in the background'.

Between the ages of 25 and 30, he noticed that such ideation intensified. He only drank on weekends and was functional at work, but he drank all weekend instead of just Friday and Saturday, the doses grew constantly larger, and he could not tolerate the hangovers because of 'too intense mental suffering'.

At the age of 26, he visited a doctor who, after three visits, said that 'after a difficult childhood, his brain was in a difficult state, and medication would help'. The doctor prescribed him 10 mg of escitalopram and 0.25 mg of alprazolam (later 0.5 mg). After a few weeks, this medication decreased the anxiety, but he described the effect as 'transient'.

His girlfriend suffered about his issues, and their relationship ended after 14 years. He got a 'dream job' in another city and moved there. The new job and the new environment gave him 'some extra kick', and he also started a new relationship. His relationship with alcohol, however, caused problems in the new relationship.

At the age of 30, he realized he was drinking too much but could not stop drinking. It affected his work performance during the week. He could not recall what had happened during his drinking periods, and cheated his girlfriend a few times. One of these events resulted in the conception of a child outside his relationship. This caused a 'massive crisis' with his girlfriend. He realized how much of an effect alcohol had on his life, and completely stopped using it.

The relationship crisis was solved, they got married, and had a child together three years later. While he did not drink, he was prescribed 5 mg of diazepam for anxiety and 'maintenance of abstinence'. He began using it almost daily. On some days, he used 10-15 mg, on other days, nothing. Without diazepam, he could not function at work. Summer holidays were 'easier'. He was also prescribed codeine/acetaminophen compound analgesics and muscle relaxants for physical pains. He described all these as 'very addictive', producing feelings of 'safety and peace, relaxation, and intense pleasure'. In retrospect, he considered that his 'addiction disease' had effectively started during this time, as a result of diazepam use.

The prescriptions were intended as temporary, but he found them 'difficult to end'. He mentioned that his body had possibly 'invented pains' in order for him to get a new prescription. Back pain was included in the symptoms. He did not intentionally mix the medication with alcohol, but he frequently took them while suffering from a hangover; in practice, the use was frequently mixed. Yet, he only used prescribed medication, and did not attempt to buy it from the street.

At the age of 40, he 'crashed': he could not control his drinking, and failed at his job. For the most part, he blamed the workplace for his issues. He could not sleep, and his use of prescription medicines increased. Soon after, he and the management agreed on a severance package, and he left the job.

His intention was to find 'his own path for healing and get himself into shape'. He noted that medicine had not helped, and looked into science more generally, investigating the physiology of sleep, pharmacology, addiction theory, body therapies, and yoga. Regardless, his suffering did not end there: he was constantly 'balancing' his diazepam use, and after a few months, his drinking became uncontrollable once more. He realized that he had lost control of his life, and felt intolerable shame for his inadequacy as a husband and father. Possibly as an excuse to escape the intolerable situation, he again cheated on his wife while drunk, and eventually filed for a divorce.

At the age of 41, although his drinking was uncontrollable, he began a relationship with the new woman. Her mother had died of alcoholism 20 years earlier, and she therefore recognized his situation as similar. Twice, he ended up in an emergency room as a result of drinking, and stayed at a hospital for 3–5 days each time. Twice he had to call an ambulance due to a panic attack, and he stayed at the emergency department overnight. Outwardly, he appeared as 'an outgoing, average middle-class father in his 40s', and his addiction was not taken too seriously.

Soon after, on a work trip, he drank so much that he could not complete his tasks, nor leave the hotel. After five days of drinking, he called his mother, who traveled six hours to fetch him from a hotel room and to enroll him in a hospital. Only at this point did his mother realize the seriousness of the situation. At this point, he was suicidal, and a psychiatric evaluation was performed. However, as his mother was accompanying him, he was discharged from the hospital.

Due to his suicidality, the hospital notified child welfare authorities, who in turn notified his ex-wife. She, in turn, enlisted a neighbor who had a background in Alcoholics Anonymous. The neighbor visited him and told him about the possibility of attending AA group meetings.

His first two-hour meeting 'opened a new way of thinking'. An older gentleman had noted that the substances were not the actual issue: instead, the pain 'originated from the depths of the soul', i.e., from past experiences. According to the man, if one flushed with alcohol pain originating from something that had happened the same day, one might have been slightly in trouble, but if one tried to flush pain originating far away in the past, one was in deep trouble.

The man described that this was 'the first time' he thought about his situation 'in a wider perspective', the issue being 'the immense intolerability of being me'. Because of 'an enormous feeling of safety and acceptance, unlike anything I had experienced before when I had been weak and revealed it', he was able to adopt this new perspective.

He attended two more sessions before taking a trip that he had booked earlier. The sessions had empowered him, and he felt that he could travel while retaining his abstinence. However, already at the airport, he had been too fearful to board the airplane without drinking. From that moment on, 'the disease took over'. He ended up again at a detoxification center, and subsequently as an inpatient at a substance abuse rehabilitation facility, confused.

At this point, he realized that he needed to admit that he had a problem, a disease, and that he needed help. In the rehabilitation center, he ended the escitalopram medication that he had been using for 13–14 years, although there had been breaks of a few months and once of six months. While the medication had initially helped, in the end the response had been nonexistent despite increases in dosing. He speculated that this might have been due to withdrawal symptoms exceeding the therapeutic effect.

He had been taking alprazolam for nearly five years and diazepam for nine years. He said that his 'actual dependency' had been towards diazepam, not alcohol. As an alleviator of anxiety and fear, 'diazepam had replaced alcohol'. He did not crave alcohol, and he could attend business events without drinking; therefore, he had not considered himself an alcoholic.

After the rehabilitation period, he visited AA once a week, focusing on following the 12-step program and building daily routines: sleeping, breathing, yoga, training, and bodywork. It 'felt like hell' but he 'survived'. He learned to 'direct the anxiety' and gained 'occasional moments of control'. Relying on emotional support from the AA group, he 'stayed on the path', following an exact daily routine for ten months, and took on a new job.

When the COVID-19 pandemic arrived, his new workplace was practically shut down, AA meetings were cancelled, daycare centers closed, and babysitters were unavailable. The 'emotional load'—feelings of inadequacy and shame—grew too large, and he relapsed into drinking. His new employer proved unexpectedly supportive, but there were simply no customers, and he could not reach his own goals in order to feel that he was 'worth his pay'. Eventually, he changed to another job less affected by the pandemic. His new boss was an ex-alcoholic, and he felt 'seen', safe, and performed well.

Yet, he got 'a single arrogant idea': since he had been abstinent for a year, he could surely take one drink on a work trip without relapsing. After the first glass, he knew he had 'no intention or capability whatsoever to stop drinking', so the 'disease took over immediately', and he drank continuously for nine days. This led to immense suffering and shame about his drinking, and eventually to suicidality. He retreated to a hotel room without anyone knowing where he was, with the idea of drinking himself to death.

Meanwhile his family was on high alert, he 'had visions, dreams'. In his dream, his daughter appeared, pleading with him to return home. This dream 'gave his life a meaning': even if he had nothing else, his daughter loved him. He still had his fatherhood; it was 'the light to walk toward'.

He took a taxi to a rehabilitation center and fought through the initial detoxification period. His employer paid for a longer inpatient rehabilitation period. He was motivated to try anything to feel better. He had realized that he had 'drifted very far from what he had been born to be', could 'no longer recognize himself', and wanted to 'find a way to reconnect with himself'.

After the rehabilitation, a few days after New Year's Eve, he enrolled directly into a 28-day Minnesota inpatient treatment period. He was 43 years old, and had quit taking prescription pharmaceuticals approximately 1.5 years before. At the door, he pleaded: 'Help me'. The treatment 'restored his faith in the possibility of feeling happy, feeling that life is meaningful, feeling love and caring, and knowing how to laugh'. These had been hidden for a very long time; he had hidden behind a wall, shut himself down completely. He felt 'mentally at home' at the clinic. There was a community. He could 'just be, without caring about anything outside'. Everyone knew that he was there, they did not need to worry, and he himself was safe, felt safe. In retrospect, he said that it had been 'absolutely necessary' that he got into this treatment, no matter how. Perhaps, without the pandemic, he would have missed it. During treatment, he began to 'more firmly walk the right path' and connect with himself. Inside, there was a defenseless little boy who had developed all kinds of methods for protection, and demanded consolation for the pain that still resided in him.

Since this period, his 'path from the dark into the light was quite firm'. He attended AA meetings daily. For the whole winter of 2021, he did cross-country skiing, and for the rest of the year, he cooked, attended meetings, and led meetings, living with his new partner. This 'enormously consoled the small child inside him'.

Regardless, some issues remained too painful to face. His experience of himself remained 'fragmented'. He recalled one memory from early childhood: he had looked at a mirror, recognized that the image represented himself, and felt shocked because he had felt uncertain about who he was. This memory was, to him, a 'fragment'. Thereafter, his identity remained unclear, which posed a challenge for him.

Of the more recent experiences, the most difficult concerned his pain over his mother being beaten up. Several times, as the mother had been lying unconscious on the floor without moving, he had thought that the mother had died. At other times, she had been vomiting because of a concussion, and he had been shouting in an attempt to make the stepfather stop beating her. Nothing had helped; the abuse had continued. They had been at a cottage in the countryside, which they could not leave without the stepfather, and where no help was available. He had not been afraid of getting beaten up himself, but he had worried for the mother.

By chance, he found a therapist who provided IFS and MDMA therapy. By the time of the interview, he had attended two therapy sessions. The first session was with MDMA, combined with IFS therapy during the session. Unexpectedly, a week before the prearranged MDMA session, the stepfather passed away. The theme of the session was the stepfather's violence towards the patient's mother. The patient met a child part related to this age. The events were relived, and the history of cruelties was eventually emotionally accepted. He overcame his hatred and gently bid the stepfather farewell. Subsequently, the patient also recalled a few good moments with the stepfather, concluding that he had not been only a monster but had also possessed a few positive qualities. The patient felt

'exceedingly grateful' about this experience. The session had produced 'such a large effect', that he felt that there was no need to hurry with the second one, because he needed to process the material that had come up.

Three months later, a second session without MDMA was arranged. The patient wanted to 'challenge himself', that is, to show that he could progress without MDMA. IFS activated a one-hour TRE-like trembling that felt 'enormous'. Three 'waves' of trembling washed over him. Painful issues 'spontaneously emerged from the subconscious', and he was 'detoxed from dogmatic thinking'. The theme of this session was a moment in his early childhood (three or four years old) during which he had become conscious of his own mortality. He had worried that if his breathing stopped, he would die; this was the early root of his anxiety.

With regard to the contributions of the utilized methods, his attendance in AA and the Minnesota retreat contributed to his understanding that he was an addict, with a strong tendency to get addicted to anything that alleviated his C-PTSD-induced anxiety. The interpersonal acceptance and support provided by these treatments also directly alleviated his symptoms, and increased his readiness to accept external help.

Regardless, he remained unable to face 'the most painful memories'. The contribution of the single session combining MDMA and IFS was the resolution of the most severe traumas. This session resolved amnesia and fragmentation related to the memories of domestic violence. Afterwards, he also discussed these events with his mother, gaining an understanding that his mother was no longer under duress because of the violence. He understood that the stepfather's father had also been a violent alcoholic; this resolved the rest of his anger and bitterness towards the stepfather. The need for revenge dissolved, and he ceased to dream of killing the stepfather. He also realized that his own father had also possessed a number of issues leading to the divorce, although these issues were less severe than those of the stepfather's.

An analysis of the IFS session

After an unguided, introspective part of the MDMA session, a 45-minute IFS therapy session was arranged. An audio recording of the IFS session was available. In the beginning of this session, the patient described feeling a 'burning sensation of discomfort and hopelessness that was unallowable'. This feeling was about longing for his father. Missing the father had 'felt wrong', something that he 'should not have felt'.

When the family, with the stepfather, traveled to a summer cottage by car, the ever-increasing physical distance to his real father felt sad. There was no way to contact his father, and he missed him silently. He also described a later event during which he was forced to separate from his girlfriend due to him taking a job in another city. The longing for connection with the girlfriend resembled the longing for connection with the father. During his later relationships, this longing presented itself as jealousy.

The therapist pointed to the part missing the father, asking for its age. The part was five or six years old. The therapist then asked the patient (his Self) to 'be present' for this child part. The child part felt physical discomfort. When asked what the child part would need, the patient answered: 'Father, love, intimacy'. The feeling of longing for the father raised guilt about hurting the mother's feelings.

The therapist pointed out that the feelings of the child were more important than those of the mother's; this felt 'contradictory, confusing' to the patient. The patient was instructed to give the child what he would have needed; the answer was 'being held'. The therapist asked the patient to introduce the adult Self to the child part, including his real age, and his current life situation.

When asked how the child part reacted to this, the child part felt happy about 'connecting to an adult who understood him'. When asked what the child part wanted to do in the presence of this newfound adult connection, the patient responded that simply being able to feel the longing was 'important'. The therapist responded that the child part was allowed to miss the father and that being able to share one's dreams and needs was fundamentally important in order for a person to stay healthy.

The therapist asked whether this child part still carried physical, emotional, or 'spiritual' residual tensions in its body, and instructed the patient to 'collect all these into a pile' in front of him. The patient commented that he 'no longer needed to feel unsafe'. The therapist asked the patient to imagine a bonfire in which all these sensations of unsafety burned and disappeared, and were 'replaced by a healing luminosity'. The therapist stated that the child part could access all the qualities, information, methods, tools, and technologies that it needed to sustain this new consciousness. The patient was instructed to thank the child part and give it a present, which symbolized the new cooperative relationship between the part and the adult Self. The patient chose a candle as this symbol, commenting that it symbolized 'hope and light'.

The therapist appeared to have concluded that there were two child parts related to the car trip. The second part was asked whether it wanted to join the Self and the first child part in their newfound communality. The patient could not immediately recall the situation, then described that the second part 'no longer felt that bad'. The therapist commented that this part would likely reintegrate by itself but nonetheless instructed the patient to ask the part's age, introduce both his adult Self and the first child part to the second part, and ask what the second part would

need. The second part wanted to have 'a friend' so that it would not need to stay on the backseat of the car alone. The part 'felt ill' and vomited on occasion. The therapist asked the adult Self to 'sit with' the child part. The child part was 'reading a comic book'. With the Self as a friend, the child part wanted to chat and tell jokes. The therapist asked the child part to tell a joke. The part did, and its mood became more positive.

The therapist asked whether this child part still carried something that had served it so far but was no longer necessary and should be released. The part no longer needed to carry the feelings of longing and loneliness. These were again released to the earth and to the healing light. The therapist stated that the second child part was now privileged to have access to all the amusing material that existed. It now also had a new friend who enjoyed any discussions and jokes. The part could summon any superpower it wanted and update itself whenever it wanted. It was free to choose any location in the patient's body and reside there. The part again got a present and was thanked for its protective role and cooperation. The patient was instructed to take a deep breath to gain a somatic feeling of bodily expansion.

The patient was then instructed to ask [the 'protectors'] whether it would be allowable to access the teenager part who had been separated from the first girlfriend. This part felt 'inconsolable, desolate', and was crying. The needs of the part were 'consolation and trust' and its age was fifteen. The therapist instructed the patient to inform the part of the patient's actual age. The patient was instructed to tell the teenage part that the adult Self could offer 'life experience that could provide trust'. The patient described feelings of loneliness, adding that the fifteen-year old part was also 'slightly drunk'. By lowering his defenses, alcohol had enabled him to feel the longing for love. The patient remembered more details about the situation. The girlfriend had provided the teenager 'the only safety' that he possessed at the time, and having been forced to separate from her had resulted in desolation. Alcohol had eased this feeling of desolation.

The patient mentioned that he could now approach the feeling of desolation with gentleness. The teenager part wanted to be held in safety; a mental image of this was provided. The therapist asked how the teenager would feel if this safe holding were continuously available as 'a superpower'. The patient said that he 'needed to save the teenager', as well as the five-year-old missing love. He had always wanted to sleep next to his mother but had not been allowed to do so; he was instructed to imagine this.

The patient wished for faith in the strength of the relationship with the girlfriend. The therapist asked whether there was something that the teenager, now holding the superpower of safety, could give up. The patient wanted to give up 'the difficult, horrible, excruciating energy'. It was released into nature. The patient was asked to breathe into the space in his body left empty by the feeling that had been released. He felt lighter, could see colors in a more intense way, and felt the longing of the small child in a safe way, instead of feeling it as 'poison'. The patient was again instructed that he could access all the information needed to update the part, including 'patience, calmness, curiosity, playfulness, and creativity'. He would never again miss anything; instead, he would reside in a beautiful state of creation.

When asked what was still missing, the teenager part wanted to get a kiss from his girlfriend. The patient imagined this event, commented that it 'worked well', and imagined holding the girlfriend. The part was asked to maintain this feeling of being embraced while missing nothing at all, and to 'save' this feeling in some location in his body. The part was asked to continuously keep itself updated and continue integrating in the body, deepening the feelings of bodily extension, relaxation, and being safe and 'blessed'. The therapist stated that these updated parts could also update the patient's other parts as needed. The IFS session was ended when all parts responded that they no longer missed something.

Discussion

Likely due to the effect of the MDMA calming down the protectors, the need to negotiate with the protectors was minimal. Most of the work in the session involved updating the exiled child and teenager parts. The effect of the therapy was likely largely based on the believability of the patient's mental images based on the therapist's suggestions given while the patient's 'defenses' were still lowered by MDMA. A key part of the session appeared to have been a recall of a situation at the age of fifteen in which alcohol had been associated with the regulation of feelings of safety. Assumedly, this use of alcohol at the age of fifteen was the initiation period of alcohol addiction. Thus, the 'root of the problem' was addressed in the MDMA and IFS session, resulting in the stabilization of the patient's abstinence.

A traumatizing event, by being overwhelming and uncontrollable, eliminates the sense of personal agency, i.e., the feeling or expectation of having control over one's state (i.e., control over the satisfaction of one's basic needs, especially physical safety). Rebuilding this sense of agency is required for the resolution of such a trauma. In a naturalistic setting, revenge, or killing the aggressor, is a primitive method for regaining agency (in the case of sexual trauma, raping someone else may serve as such a method). In the therapeutic context, optimally, both parties should be healed by processing the experiences in a peaceful manner, without further physical aggression taking place.

When describing his experience, the patient said that the MDMA session had been the first time that he had been able to think about his experiences of domestic violence 'in a wider perspective'. He had been able to adopt a new perspective because of 'an enormous feeling of safety and acceptance, unlike anything I had experienced during the previous times when I had been weak and had revealed it'. Thus, the healing was due to having been 'weak', 'seen' and 'accepted', all three simultaneously.

Alternatively, using IFS terminology, it could be said that the process involved an unblending of protector parts from the Self, resulting in an uncovering of the inherent qualities of the Self, and the promotion of Self-leadership. The 'addict' protector part was liberated from its burdens (fears). This rendered unnecessary both the alleviation of emotional pain by substance use, and the planning of violent revenge.

A good outcome was achieved with only one MDMA session because the patient had already practiced many of the available somatic methods, such as TRE, yoga, and breathwork. Also, the role of Minnesota treatment and learning to accept external help appeared essential, although the patient speculated that had he received MDMA therapy a decade or so earlier, it would likely have resolved his issues on its own.

On the adoption of psychedelic therapy

With regard to the adoption of psychedelic therapy, Shulgin noted that the likely reason for non-adoption so far has been 'an intense unconscious fear of the hidden depths of the human psyche ... nurtured in a thousand ways by family and culture, and too often by institutional religion'. She noted that it was 'up to us to find out how to turn this around'. As a sign of hope, she commented that a change in attitude seemed already to have begun, and that 'this kind of spiritual journey, this kind of understanding and transformation of the dark side of the soul' was required for the survival of the human species.

Schwartz wrote that the currently prevailing mindsets had resulted in massive inequality and polarization, and the solution was to adopt a new view of human nature that would 'release the collaboration and caring that lives in our hearts' (Schwartz, 2021). He emphasized the need for leadership that would reduce fear-based reactive behaviors and foster confidence in the inherent goodness and ingenuity of humanity. The obstacle was the current mindset, which promoted 'the darkness in humanity'. He proposed IFS as a paradigm that would allow for the necessary changes.

Another method worth mentioning is Allione's adaptation of a Buddhist Chöd method (Allione, 2008, 2014, 2020). This method also involves 'parts' and 'unblending', does not require the use of psychedelics, and is applicable for self-treatment. The method has also been described as 'cutting through the ego'; in this interpretation, 'ego states' might roughly equal blended protector parts (see also (Dutcher, 2022)).

With regard to the training of therapists, it has been noted that a therapist can only bring a patient to the level of clarity that the therapist herself has reached. With regard to Shulgin's four rules (Shulgin, 2020), it can be seen that a therapist or a public health official lacking any or sufficient personal experience of psychedelics could not have produced the third rule, nor understand the rationale behind the ruleset. On the other hand, we can question the universal validity of Shulgin's ruleset, and assume that the rule against symbolic suicide was set because she had not passed that 'gate' herself. Another therapist who had passed this 'gate' considered it a part of a symbolic death-rebirth process, and considered the rule unnecessary or counterproductive.

Indigenous psychedelic guides often stress the importance of following a strict ruleset. However, when asked what the actual rules are, it appears that they are personal. The role of such rules would thus seem to be to keep the therapist within their personal area of expertise. In general, it is likely that the more experienced a therapist, the fewer restrictions are necessary (e.g., with respect to the treatment of borderline conditions or psychotic disorders). Conversely, therapists who have not fully processed their own past experiences would likely be triggered by the patients' issues and would constantly need to fight against this triggering, consuming their energy, possibly eventually ending up (re)traumatized or burned out after working with difficult patients. By becoming triggered, they would also fail to properly 'hold the space' (provide safety) for their patients, resulting in inferior outcomes and/or re-traumatization of the patients.

Reaching sufficient 'evidence-based' self-confidence may require a few hundred personal sessions with varied dosing in varied situations. Regardless, even some psychedelic guides with such experience appear to carry an unfeasible amount of residual personal trauma. In these cases, reaching the 'next level' of therapeutic efficacy would assumedly require experiencing a fully non-dual state, i.e., a state where all boundaries, including all distinctions between 'desirability' and 'undesirability', or 'good' and 'bad', are fully dissolved, the observing self is fully absent, and all residual somatic tensions are fully relaxed, including all tensions on a sub-limbic level. While such states may be occasionally, tangentially, and transiently reached with high doses of classical psychedelics such as LSD and ayahuasca, it may be that these substances are, after all, in many cases insufficient for the purpose of consistently and fully experiencing such states, and therefore too slow to produce results in difficult cases, as well as too weak as tools to consistently produce therapists with the rock-solid confidence needed to tackle the likely most challenging issues, for example the treatment of violent, psychotic prisoners. Eventually, a therapist should likely reach a state of complete acceptance based on the energy of Self, with an attitude of neither trying nor needing to change anything or heal anyone. This, admittedly paradoxical-sounding position for a therapist, would nonetheless likely be the

requirement for ultimate therapeutic efficacy. Therefore, the final frontiers of psychedelic therapy may currently remain unexplored for most people.

Conclusions

On a societal level, alcohol may have been utilized as one of the main instruments for suppressing issues that should have been faced and resolved instead. Alcohol and psychedelics likely represent opposite approaches: alcohol suppresses, while classical psychedelics reveal. Entactogens such as MDMA might provide 'the Middle Way'—a more gradual, softer journey into our collective traumatic past.

The many incidental consequences of the prevalent alcohol abuse include child abuse and neglect, and domestic violence. This case study described how MDMA, a more 'beginner-level' instrument for therapeutic work, resolved severe, complex post-traumatic stress disorder in one session, although preliminary work had been completed in advance. The Internal Family Systems (IFS) framework, a relatively recent development in the field of psychotherapy, complemented MDMA in producing the desired outcome.

With these tools, the perpetuation of transgenerational trauma was stopped. These affordable methods, already widely and successfully utilized in the mid-1900s, deserve to be swiftly and widely re-adopted. Sufficiently deep personal experience with classical psychedelics and/or MDMA is required for the therapists, and the processes for acquiring this experience should be initiated already.

Abbreviations: The following abbreviations are used in this manuscript:

2C-B	4-bromo-2,5-dimethoxyphenethylamine
5-MeO-DMT	5-methoxy-N,N-dimethyltryptamine
ACE	adverse childhood experience
C-PTSD	complex post-traumatic stress disorder
DMT	N,N-dimethyltryptamine
LSD	lysergic acid diethylamide
MAPS	Multidisciplinary Association for Psychedelic Studies
MDMA	3,4-methylenedioxymethamphetamine
TRE	Trauma Release Exercises

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References

Abramson, H., 1966. LSD in psychotherapy and alcoholism. American Journal of Psychotherapy 20, 415–438. URL: https://doi.org/10.1176/appi.psychotherapy.1966.20.3.415, doi:10.1176/appi.psychotherapy.1966.20.3.415.

Allione, T., 2008. Feeding Your Demons: Ancient Wisdom for Resolving Inner Conflict. Little, Brown and Company.

Allione, T., 2014. 'Feeding your demons' with Lama Tsultrim Allione. URL: https://youtu.be/aEbJ_maF_fo?t=1331.

Allione, T., 2020. How to feed your demons. URL: https://web.archive.org/web/20220926051504/https://www.lionsroar.com/how-to-practice-feeding-your-demons/.

Anderson, D.J., McGovern, J.P., Dupont, R.L., 1999. The origins of the Minnesota model of addiction treatment—a first person account. Journal of Addictive Diseases 18, 107–114. URL: https://doi.org/10.1300/j069v18n01_10, doi:10.1300/j069v18n01_10.

Begin, J., Bertolucci, L., Blostein, D., Minasny, B., 2022. Characterizing a common class of spontaneous movements. International Journal of Therapeutic Massage & Bodywork: Research, Education, & Practice 15, 4–17. URL: https://doi.org/10.3822/ijtmb.v15i3.719, doi:10.3822/ijtmb.v15i3.719.

Berceli, D., 2015. Shake It Off Naturally: Reduce Stress, Anxiety, and Tension with TRE. CreateSpace, United States.

Berceli, D., Salmon, M., Bonifas, R., Ndefo, N., 2014. Effects of self-induced unclassified therapeutic tremors on quality of life among non-professional caregivers: a pilot study. Global Advances in Health and Medicine 3, 45–48. URL: https://doi.org/10.7453/gahmj.2014.032, doi:10.7453/gahmj.2014.032.

Berlowitz, I., Walt, H., Ghasarian, C., Mendive, F., Martin-Soelch, C., 2019. Short-term treatment effects of a substance use disorder therapy involving traditional Amazonian medicine. Journal of Psychoactive Drugs 51, 323–334. URL: https://doi.org/10.1080/02791072.2019.1607956, doi:10.1080/02791072.2019.1607956.

Brewerton, T.D., Wang, J.B., Lafrance, A., Pamplin, C., Mithoefer, M., Yazar-Klosinki, B., Emerson, A., Doblin, R., 2022. MDMA-assisted therapy significantly reduces eating disorder symptoms in a randomized placebo-controlled trial of adults with severe PTSD. Journal of Psychiatric Research 149, 128–135. URL: https://doi.org/10.1016/j.jpsychires.2022.03.008, doi:10.1016/j.jpsychires.2022.03.008.

Calleja-Conde, J., Morales-García, J.A., Echeverry-Alzate, V., Bühler, K.M., Giné, E., López-Moreno, J.A., 2022. Classic psychedelics and alcohol use disorders: a systematic review of human and animal studies. Addiction Biology 27. URL: https://doi.org/10.1111/adb.13229, doi:10.1111/adb.13229.

Dutcher, T., 2022. IFS as DID therapy? A personal analysis. URL: https://www.dis-sos.com/ifs-for-did/. https://archive.ph/yCwMI.

Earley, J., 2009. Self-Therapy: A Step-By-Step Guide to Creating Wholeness and Healing Your Inner Child Using IFS, A New, Cutting-Edge Psychotherapy. Pattern System Books, Larkspur, CA. URL: https://web.archive.org/web/20230105025450/http://internalfamilysystems.ir/wp-content/uploads/books/SelfTherapyV1.pdf.

Feduccia, A.A., Jerome, L., Mithoefer, M.C., Holland, J., 2020. Discontinuation of medications classified as reuptake inhibitors affects treatment response of MDMA-assisted psychotherapy. Psychopharmacology 238, 581–588. URL: https://doi.org/10.1007/s00213-020-05710-w, doi:10.1007/s00213-020-05710-w.

Feigenbaum, J.C., 2013. A historical review of perceptions of key aspects of spirituality and religion within Alcoholics Anonymous. Journal of Addictions Nursing 24, 229–236. URL: https://doi.org/10.1097/jan.0000000000000004, doi:10.1097/jan.0000000000000004.

Frecska, E., Bokor, P., Winkelman, M., 2016. The therapeutic potentials of ayahuasca: possible effects against various diseases of civilization. Frontiers in Pharmacology 7, 35. URL: https://doi.org/10.3389/fphar.2016.00035, doi:10.3389/fphar.2016.00035.

Henriques, A., Abreu, C., 2020. MDMA Assisted Therapy – with Michael Mithoefer. URL: https://web.archive.org/web/20220407034439/https://internalfamilysystems.pt/multimedia/webinars/mdma-assisted-therapy-michael-mithoefer.

Holland, J. (Ed.), 2001. Ecstasy: The Complete Guide: A Comprehensive Look at the Risks and Benefits of MDMA. Park Street Press, Rochester, VT.

Ingrasci, R., 1985. Testimony for MDMA hearing. URL: https://web.archive.org/web/20220815144725/https://maps.org/research-archive/dea-mdma/pdf/0011.PDF.

James, E., Keppler, J., Robertshaw, T.L., Sessa, B., 2022. N,N-dimethyltryptamine and Amazonian ayahuasca plant medicine. Human Psychopharmacology: Clinical and Experimental 37. URL: https://doi.org/10.1002/hup.2835, doi:10.1002/hup.2835.

Karni, G., 2019. Trip of Compassion. URL: https://vimeo.com/ondemand/tripofcompassion.

Kaspian, P., 2016. MDMA self-therapy has almost totally cured me of the trauma from childhood sexual abuse and other violence. Reddit. URL: https://web.archive.org/web/20220405093231/https://www.reddit.com/r/mdmatherapy/comments/4p9t31/mdma_selftherapy_has_almost_totally_cured_me_of/.

Kaspian, P., 2020. MDMA Solo. Psychedelic University Press. URL: https://web.archive.org/web/20220404075634/https://castaliafoundation.com/kali/MDMA-solo.pdf.

Krebs, T.S., Johansen, P.Ø., 2012. Lysergic acid diethylamide (LSD) for alcoholism: meta-analysis of randomized controlled trials. Journal of Psychopharmacology 26, 994–1002. URL: https://doi.org/10.1177/0269881112439253, doi:10.1177/0269881112439253.

Lattin, D., 2020. Bill Wilson, LSD and the secret psychedelic history of Alcoholics Anonymous. URL: https://web.archive.org/web/20221023100218/https://www.lucid.news/bill-wilson-lsd-and-the-secret-psychedelic-history-of-alcoholics-anonymous/.

Leary, T., Metzner, R., Alpert, R., 1964. The Psychedelic Experience: A Manual Based on the Tibetan Book of the Dead. URL: https://web.archive.org/web/20180705020413/http://www.lycaeum.org:80/books/books/psychedelic_experience/tibetan.html.

Loizaga-Velder, A., Verres, R., 2014. Therapeutic effects of ritual ayahuasca use in the treatment of substance dependence—qualitative results. Journal of Psychoactive Drugs 46, 63–72. URL: https://doi.org/10.1080/02791072.2013.873157, doi:10.1080/02791072.2013.873157.

Lynning, M., Svane, C., Westergaard, K., Bergien, S., Gunnersen, S., Skovgaard, L., 2021. Tension and trauma releasing exercises for people with multiple sclerosis – an exploratory pilot study. Journal of Traditional and Complementary Medicine 11, 383–389. URL: https://doi.org/10.1016/j.jtcme.2021.02.003, doi:10.1016/j.jtcme.2021.02.003.

Lysaker, P.H., Leonhardt, B.L., 2012. Agency: its nature and role in recovery from severe mental illness. World Psychiatry 11, 165–166. URL: https://doi.org/10.1002/j.2051-5545.2012.tb00121.x, doi:10.1002/j.2051-5545.2012.tb00121.x.

Marseille, E., Mitchell, J.M., Kahn, J.G., 2022. Updated cost-effectiveness of MDMA-assisted therapy for the treatment of posttraumatic stress disorder in the United States: findings from a phase 3 trial. PLOS ONE 17, e0263252. URL: https://doi.org/10.1371/journal.pone.0263252, doi:10.1371/journal.pone.0263252.

McCarthy, B., 2022. Christianity and psychedelic medicine: a pastoral approach. Christian Bioethics: Non-Ecumenical Studies in Medical Morality URL: https://doi.org/10.1093/cb/cbac008, doi:10.1093/cb/cbac008.

McElrath, D., 1997. The Minnesota Model. Journal of Psychoactive Drugs 29, 141–144. URL: https://doi.org/10.1080/02791072.1997.10400180, doi:10.1080/02791072.1997.10400180.

Meckel Fischer, F., 2015. Therapy with Substance: Psycholytic Psychotherapy in the Twenty First Century. Muswell Hill Press, London.

Mitchell, J.M., Bogenschutz, M., Lilienstein, A., Harrison, C., Kleiman, S., Parker-Guilbert, K., G., M.O., Garas, W., Paleos, C., Gorman, I., Nicholas, C., Mithoefer, M., Carlin, S., Poulter, B., Mithoefer, A., Quevedo, S., Wells, G., Klaire, S.S., van der Kolk, B., Tzarfaty, K., Amiaz, R., Worthy, R., Shannon, S., Woolley, J.D., Marta, C., Gelfand, Y., Hapke, E., Amar, S., Wallach, Y., Brown, R., Hamilton, S., Wang, J.B., Coker, A., Matthews, R., de Boer, A., Yazar-Klosinski, B., Emerson, A., Doblin, R., 2021. MDMA-assisted therapy for severe PTSD: a randomized, double-blind, placebo-controlled phase 3 study. Nature Medicine 27, 1025–1033. URL: https://doi.org/10.1038/s41591-021-01336-3, doi:10.1038/s41591-021-01336-3.

Mithoefer, M.C., Mithoefer, A., Jerome, L., Ruse, J., Doblin, R., Gibson, E., Ot'alora, M., Sola, E., 2017. A Manual for MDMA-Assisted Psychotherapy in the Treatment of Posttraumatic Stress Disorder. Version 8.1: 22 May 2017. URL: https://web.archive.org/web/20181002155634/https://s3-us-west-1.amazonaws.com/mapscontent/research-archive/mdma/TreatmentManual_MDMAAssistedPsychotherapyVersion+8.1_22+Aug2017.pdf.

Montague, H., Fairholm, I., 2019. The Minnesota model: a clinical assessment of Its effectiveness in treating anxiety and depression compared to addiction. International Journal of Mental Health and Addiction 18, 1422–1436. URL: https://doi.org/10.1007/s11469-019-00168-0, doi:10.1007/s11469-019-00168-0.

Oehen, P., Gasser, P., 2022. Using a MDMA- and LSD-group therapy model in clinical practice in Switzerland and highlighting the treatment of trauma-related disorders. Frontiers in Psychiatry 13. URL: https://doi.org/10.3389/fpsyt.2022.863552, doi:10.3389/fpsyt.2022.863552.

Paquette, C.E., Daughters, S.B., Witkiewitz, K., 2022. Expanding the continuum of substance use disorder treatment: nonabstinence approaches. Clinical Psychology Review 91, 102110. URL: https://doi.org/10.1016/j.cpr.2021.102110, doi:10.1016/j.cpr.2021.102110.

Passie, T., 2018. The early use of MDMA ('ecstasy') in psychotherapy (1977–1985). Drug Science, Policy and Law 4, 205032451876744. URL: https://doi.org/10.1177/2050324518767442, doi:10.1177/2050324518767442.

Peppin, J.F., Pergolizzi, J.V., Raffa, R.B., Wright, S.L. (Eds.), 2021. The Benzodiazepines Crisis: The Ramifications of an Over-Used Drug Class. Oxford University Press, New York, NY.

Perkins, D., Opaleye, E.S., Simonova, H., Bouso, J.C., Tófoli, L.F., GalvÃo-Coelho, N.L., Schubert, V., Sarris, J., 2021. Associations between ayahuasca consumption in naturalistic settings and current alcohol and drug use: results of a large international cross-sectional survey. Drug and Alcohol Review 41, 265–274. URL: https://doi.org/10.1111/dar.13348, doi:10.1111/dar.13348.

Price, C.M., Feduccia, A.A., DeBonis, K., 2022. Effects of selective serotonin reuptake inhibitor use on 3,4-methylenedioxymethamphetamine–assisted therapy for posttraumatic stress disorder. Journal of Clinical Psychopharmacology 42, 464–469. URL: https://doi.org/10.1097/jcp.0000000000001595, doi:10.1097/jcp.0000000000001595.

Riva, G., 2018. The neuroscience of body memory: from the self through the space to the others. Cortex 104, 241–260. URL: https://doi.org/10.1016/j.cortex.2017.07.013, doi:10.1016/j.cortex.2017.07.013.

Roberts, T.B., 2014. From the 500-year blizzard of words to personal sacred experiences—the new religious era, in: Ellens, J.H. (Ed.), Seeking the Sacred with Psychoactive Substances: Chemical Paths to Spirituality and to God. Praeger, Santa Barbara. Psychology, religion, and spirituality.

Rush, B., Marcus, O., García, S., Loizaga-Velder, A., Loewinger, G., Spitalier, A., Mendive, F., 2021. Protocol for outcome evaluation of ayahuasca-assisted addiction treatment: the case of Takiwasi Center. Frontiers in Pharmacology 12. URL: https://doi.org/10.3389/fphar.2021.659644, doi:10.3389/fphar.2021.659644.

Sarparast, A., Thomas, K., Malcolm, B., Stauffer, C.S., 2022. Drug-drug interactions between psychiatric medications and MDMA or psilocybin: a systematic review. Psychopharmacology 239, 1945–1976. URL: https://doi.org/10.1007/s00213-022-06083-y, doi:10.1007/s00213-022-06083-y.

Schwartz, R.C., 2021. No Bad Parts: Healing Trauma & Restoring Wholeness with the Internal Family Systems model. Sounds True, Boulder, Colorado.

Schwartz, R.C., Sweezy, M., 2020. Internal Family Systems Therapy. 2 ed., Guilford Press, New York.

Sessa, B., Meckel Fischer, F., 2015. Underground MDMA-, LSD- and 2-CB-assisted individual and group psychotherapy in Zürich: outcomes, implications and commentary. Drug Science, Policy and Law 2, 2050324515578080. URL: https://doi.org/10.1177/2050324515578080, doi:10.1177/2050324515578080.

Shulgin, A., 2020. The new psychotherapy: MDMA and the shadow, in: Roberts, T.B. (Ed.), Psychedelics and Spirituality: The Sacred Use of LSD, Psilocybin, and MDMA for Human Transformation. Park Street Press, Rochester, Vermont.

Shulgin, A.T., Shulgin, A., 1991. PiHKAL: A Chemical Love Story. URL: https://www.erowid.org/library/books_online/pihkal/pihkal.shtml.

Shulgin, A.T., Shulgin, A., 1997. TiHKAL: The Continuation. URL: https://www.erowid.org/library/books_online/tihkal/tihkal.shtml.

Smith, D.E., Wesson, D.R., 1985. The Benzodiazepines: Current Standards for Medical Practice. Springer Netherlands, Dordrecht. OCLC: 840305757.

Solluna, S., 2018. Full body orgasm as a spiritual path. URL: https://open.spotify.com/episode/5Z5UDNCWaRm1L9g0BSUPtS.

Stolaroff, M., 2012. A protocol for a sacramental service, in: Roberts, T.B. (Ed.), Spiritual Growth with Entheogens: Psychoactive Sacramentals and Human Transformation. Park Street Press, Rochester, VT.

Talin, P., Sanabria, E., 2017. Ayahuasca's entwined efficacy: an ethnographic study of ritual healing from 'addiction'. International Journal of Drug Policy 44, 23–30. URL: https://doi.org/10.1016/j.drugpo.2017.02.017, doi:10.1016/j.drugpo.2017.02.017.

Turkia, M., 2022. Self-treatment of psychosis and complex post-traumatic stress disorder with LSD and DMT—A retrospective case study. Psychiatry Research Case Reports 1, 100029. URL: https://doi.org/10.1016/j.psycr.2022.100029, doi:10.1016/j.psycr.2022.100029.

White, W.L., Kurtz, E., 2008. Twelve defining moments in the history of Alcoholics Anonymous, in: Recent Developments in Alcoholism. Springer New York, pp. 37–57. URL: https://doi.org/10.1007/978-0-387-77725-2_3, doi:10.1007/978-0-387-77725-2_3.

Yaden, D.B., Berghella, A.P., Regier, P.S., Garcia-Romeu, A., Johnson, M.W., Hendricks, P.S., 2021. Classic psychedelics in the treatment of substance use disorder: potential synergies with twelve-step programs. International Journal of Drug Policy 98, 103380. URL: https://doi.org/10.1016/j.drugpo.2021.103380, doi:10.1016/j.drugpo.2021.103380.

Yugler, S., 2021. Working with Internal Family Systems (IFS) therapy and psychedelics: everything you need to know. URL: https://web.archive.org/web/20210407152231/https://psychedelicstoday.com/2021/04/07/internal-family-systems-ifs-therapy-and-psychedelics-explainer/.