






AKADÉMIAI KIADÓ

# Subjective ibogaine experiences across intersecting social-ecological dimensions

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## ORIGINAL RESEARCH PAPER



### ABSTRACT

*Background and aims:* Ibogaine, an alkaloid extracted from the root of the *Tabernanthe Iboga* shrub, holds promise in treating addictive disorders. Individuals receiving ibogaine treatment report decreased withdrawal symptoms, cravings, and addiction severity. These changes are often attributed to ibogaine's psychedelic properties: subjectively meaningful, dream-like experiences. Research demonstrates that ibogaine experiences impact multiple social-ecological dimensions and influence addiction and recovery trajectories. No studies have explored the multidimensional experiences of individuals seeking ibogaine treatment for addictions. The current study examines acute and enduring ibogaine experiences at individual, interpersonal, and behavioral health systems levels. *Methods:* Fifteen individuals (5 female, 10 male) who received ibogaine treatment at a medical clinic in Ensenada, Mexico completed semi-structured interviews asking about individual, interpersonal, and behavioral health system experiences post-ibogaine within 12 months of ibogaine treatment (*Mdn* = 169 days). Transcripts were coded and analyzed using a Consensual Qualitative Research approach. *Results:* Many participants reported seeking ibogaine treatment after exhausting other addiction services. Outcomes reported following treatment included alleviated cravings and withdrawal symptoms. Participants indicated that ibogaine experiences prompted insight into their addictions and contributed to their recovery. Self-support and disclosing ibogaine experiences to professional and non-professional supporters were important to participants' recovery post-ibogaine. *Conclusions:* Intersecting experiences across social-ecological levels had an enduring impact on participants' addiction recovery after ibogaine treatment. Despite negative experiences with behavioral health systems prior to receiving ibogaine treatment, most participants sought the support of mental health professionals post-ibogaine. Findings are informative for mental health professionals and clients interested in ibogaine treatment.

### KEYWORDS

ibogaine, psychedelic, psychedelic-assisted therapy, addiction, recovery, substance use

The prevalence of addiction has reached epidemic proportions (U.S. Department of Health and Human Services, 2021), affecting individuals of all ages, races, and socioeconomic backgrounds. Despite various treatment approaches, relapse rates remain alarmingly high, underscoring the need for alternative solutions. Ibogaine, an extract from a West African root, has gained significant attention in recent years for its potential to disrupt the patterns of addiction. Ibogaine's pharmacological properties and ability to induce transformative, introspective experiences are unique among addiction treatment approaches.

Whether ibogaine plays a role in reversing the addiction epidemic, any successful approach to treating addictions must consider the impact of addiction across intersecting social-ecological dimensions. Previous studies demonstrate the value of a social-ecological model in conceptualizing individual, interpersonal, and system-level factors that influence addiction and recovery trajectories (Matto, 2004; Weinberg, 2000). Diverse experiences of addiction across social-ecological dimensions relate to help-seeking (Dschaak & Juntunen, 2018), consequences (Sussman & Sussman, 2011), and outcomes (Karriker-Jaffe, Witbrodt,

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Mericle, Polcin, & Kaskutas, 2020). Therefore, attention to multiple social-ecological dimensions on processes in addiction research is vital.

At the individual level, addiction decreases cognitive functioning and is associated with increased psychiatric comorbidities. Interpersonally, addiction can contribute to problems in building and maintaining personal and professional relationships (National Institute on Drug Abuse, 2020). Systemically, societal stigma, or negative attitudes and beliefs toward people experiencing addiction, contribute to discrimination and unequal opportunities in employment, housing, and health care (Santos da Silveira, Andrade de Tostes, Wan, Ronzani, & Corrigan, 2018). While it is impossible for any single treatment to address all these factors, optimally delivered addiction treatments are conscious of how they influence the client or patient and their meaningful relationships, particularly within a system of care that is fundamentally inequitable and often discriminatory.

Stigma has been researched extensively as a factor contributing to inequities in the accessibility and quality of addiction treatment (Anstice, Strike, & Brands, 2009; Henderson, Stacey, & Dohan, 2008; Weiss, McCoy, Kluger, & Finkelstein, 2004). Those seeking ibogaine treatment may face additional stigma. Rieckmann, Daley, Fuller, Thomas, and McCarty (2007) found that addiction counselors tend to hold negative attitudes toward patients seeking ibogaine treatment, such as thinking interest in ibogaine treatment represents treatment non-compliance or drug-seeking behavior.

In the last decade, societal focus on the prevalence of addiction has increased along with efforts to expand the availability of addiction treatment services and initiatives to address addiction-related stigma. Despite these growing efforts, illicit drug use and overdose deaths have been steadily increasing in the United States (National Center for Health Statistics, 2021; National Institute on Drug Abuse, 2021). Although many addiction treatment options are available, dropout rates remain high. A recent meta-analysis found that the average dropout rate across in-person psychosocial substance use disorder treatments was 30% (Lappan, Brown, & Hendricks, 2020). Dropout rates for treatments with Medication for Opioid Use Disorder (MOUD) are even higher—55% in the first year and greater than 85% after three years (Manhapra, Agbese, Leslie, & Rosenheck, 2018). Additionally, MOUD dropout rates are disproportionately higher among low-income and minoritized populations (Guerrero et al., 2013).

It is incumbent on addiction researchers to thoroughly investigate all potentially effective interventions to address the devastating public health burden of overdoses, high treatment dropout rates, and the immeasurable suffering endured by individuals experiencing addiction and their loved ones. Ibogaine, an alkaloid extracted from the root of the *Tabernanthe Iboga* shrub, is one such promising intervention. *Iboga* has been consumed as a sacrament in the Mbiri and Bwiti traditions of Gabon and Cameroon for centuries (Rodger, 2018). Since the Western discovery of its anti-addictive properties in 1962, ibogaine has been the

subject of research across many disciplines (e.g., chemistry, pharmacology, neurology, psychology, and anthropology) (Alper, 2001; Alper & Lotsof, 2007; Beal & de Rienzo, 1997; Hevesi, 2010).

Decades of research demonstrates that ibogaine reduces opioid, cocaine, alcohol, and nicotine self-administration in animal models (Alper & Lotsof, 2007; Baumann, Pablo, Ali, Rothman, & Mash, 2001; Cappendijk & Dzoljic, 1993; Dworkin, Gleeson, Meloni, Koves, & Martin, 1995; Dzoljic, Kaplan, & Dzoljic, 1988; Glick et al., 1994, 2000; Rezvani, Overstreet, & Leef, 1995). Additionally, observational studies have shown that ibogaine induces rapid and large reductions in opioid withdrawal symptoms and cravings in humans (Alper, Lotsof, Frenken, Luciano, & Bastiaans, 1999; Brown & Alper, 2018; Davis, Barsuglia, Windham-Herman, Lynch, & Polanco, 2017; Noller, Frampton, & Yazar-Klosinski, 2018; Sheppard, 1994) and can be safely administered in medical settings (Alper, 2001; Alper, Stajić, & Gill, 2012; Mash et al., 1998; Ona et al., 2021).

Building on promising preliminary findings that demonstrate ibogaine's pharmacological effects in reducing withdrawals and cravings, two active clinical trials are investigating ibogaine's maximum tolerable dose and efficacy (NCT05029401), and ibogaine's safety profile in methadone detoxification (NCT04003948). Furthermore, recent research examining insightful visions experienced during ibogaine treatment suggests that the personalized content of these visions may directly contribute to positive treatment outcomes and sustained psychological benefits (Brown, Noller, & Denenberg, 2019; Davis et al., 2017). Such insightful experiences commonly occur during ibogaine's *oneiric* phase—8–12 h of dream-like visions characterized by an absence of psychotic symptoms and the retention of primary process thinking (e.g., dreams, fantasies, and magical thinking) (Alper, 2001; Naranjo, 1969).

Research suggests that meaningful experiences that occur during the altered state of consciousness induced by ibogaine may represent a distinct component of its healing capacity, separate from its well-studied pharmacological actions in reducing withdrawal symptoms and cravings (Brown et al., 2019; Camlin et al., 2018; Davis, Renn, Windham-Herman, Polanco, & Barsuglia, 2018). Using ibogaine combined with cognitive behavioral therapy to treat individuals dependent on stimulants, Schenberg et al. (2017) identified themes among participants' therapeutic visionary experiences associated with sustained psychological benefits (e.g., improvements in social support, psychosocial functioning, and increased self-efficacy). Visionary experiences during ibogaine treatment, including revisiting memories and imagining future scenarios in life, offered some patients insights into the role they would like to play in society, a business they would like to start, or how they would like to go back to school to attain their goals in life (Schenberg et al., 2017).

Qualitative research on ibogaine has largely focused on experiences during and immediately after treatment. These studies have been critical in advancing research into the healing capacities of ibogaine, but they largely neglect intersecting interpersonal and systemic social-ecological



factors that influence addiction and recovery trajectories. For example, studies may focus on personally meaningful ibogaine visions and experiences but fail to consider how meaning-making associated with these experiences continues to develop and evolve after ibogaine treatment. Scant attention is paid to the relations between post-ibogaine meaning-making, addiction-related stigma, and ongoing interpersonal and professional support. Studies only attending to meaning-making shortly after participants' experiences with ibogaine may be inadvertently contributing to ibogaine's *miracle cure* mythos.

No studies have investigated themes in the impact of ibogaine treatment on the long-term addiction recovery process across intersecting social-ecological dimensions. The present study is the first to highlight the intersecting individual, interpersonal, and behavioral health system experiences of people who used ibogaine to treat their addictions. Our investigation into participants' descriptions of their experiences during ibogaine treatment and utilization of formal and informal recovery supports post-ibogaine could benefit individuals considering or preparing to seek ibogaine treatment themselves, as well as behavioral health providers supporting ibogaine treatment-seeking individuals.

## MATERIALS AND METHODS

### Participants and procedures

This study was approved by the institutional review board of University at Albany, State University of New York. Individuals were eligible for this study if they: (a) were over the age of 18, (b) sought ibogaine treatment for addiction independently (i.e., without incentive or coercion) in the last 12 months, and (c) spoke English. The PI contacted the ibogaine clinic located in Mexico via phone. The ibogaine clinic, independent of the present study, routinely asks individuals if they are interested in participating in research about ibogaine. A list of individuals who responded affirmatively was provided to the PI ( $n = 48$ ). The PI contacted these 48 individuals via phone up to three times to assess interest in participating in the study. The name of the ibogaine clinic is purposefully omitted to protect participants' privacy.

Nineteen respondents expressed interest in participating in this study during phone conversations with the PI and were emailed a link to an online form to provide informed consent and demographics. Fifteen phone interviews were conducted and transcribed. Purposeful sampling was used to obtain a diverse sample in terms of demographics and types of addiction. Female and non-White participants were first asked to complete an audio-recorded 60-min semi-structured phone interview with the primary investigator, followed by participants with non-opioid addictions. The remaining participants were randomly selected. The time between treatment and phone interviews ranged from 42 to 361 days ( $Mdn = 140.5$ ,  $SD = 120.7$ ).

Two of the fifteen transcribed phone interviews were not initially included in cross-analysis and were used to check

for the stability of findings. Data from all 15 participants are included in the present study. Participants (5 female, 10 male) were mostly White and Multiracial or Multiethnic and had a mean age of 34 (range 24–56). The most common addictions were to opioids (e.g., morphine, fentanyl), alcohol, and kratom (a plant native to Southeast Asia with opioid and stimulant-like properties). One participant sought ibogaine treatment for polysubstance addiction and compensatory behaviors related to eating disorders (i.e., purging and excessive exercise). Detailed demographics are displayed in Table 1.

### Data analysis

We used a Consensual Qualitative Research (CQR; Hill, 2012) approach for this study. Following CQR guidelines, multiple researchers with diverse backgrounds and experiences coded data for emergent themes by identifying core ideas contained in the raw data. Foundational to CQR are meetings where teams of researchers argue for consensus on all coding and cross-analysis decisions. Decisions by unforced consensus result in “interpretations that are deeper, richer, and more thorough, precise, and realistic than ones generated by a single individual” (Schielke, Fishman, Osatuke, & Stiles, 2009, p. 559).

CQR emphasizes taking multiple perspectives into account to understand complex phenomena and minimize researcher bias. Consequently, a demographically diverse team with unique perspectives was assembled. The research team was composed of three doctoral students in counseling psychology, two master's students in mental health counseling, one undergraduate student in psychology, and a psychologist with 17 years of training and experience in addiction research. Four members of the research team had no prior experience with psychedelic substances, three team members identified as being in recovery from addiction, and one team member had previously used ibogaine.

The PI and the psychologist collaboratively developed the semi-structured qualitative interview protocol (Table 2).

Table 1. Sample demographic characteristics

Characteristic	<i>n</i>	%
Gender		
Female	5	33
Male	10	66
Race and Ethnicity		
White	10	66
Multiracial or Multiethnic	2	13
Middle Eastern or North African	1	7
Hispanic or Latino	1	7
Asian	1	7
Type of addiction		
Opioid	9	60
Polysubstance (included opioids)	3	20
Ketamine	1	7
Nicotine, caffeine, and alcohol	1	7
Nicotine, caffeine, and disordered eating	1	7

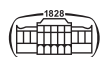


Table 2. Interview protocol

Start-list domains	Interview question(s)
Mental Health Treatment History	Tell me about your mental health treatment history
Addiction Treatment History	Tell me about your addiction treatment history
The Road to Treatment	Prior to ibogaine treatment, what facilitated your decision to use ibogaine? What were the barriers to using ibogaine?
Subjective Meaning Derived from Ibogaine	What were some of the most meaningful experiences you had during ibogaine treatment? What meaning do you derive from your experience with ibogaine? How does this relate to your addiction recovery?
Help or Harm from Ibogaine	How did ibogaine help you? Harm you?
Post-ibogaine Support	What have you done to support your recovery since ibogaine treatment? What would you say is the role ibogaine treatment has played in your life? Who or what were your primary supports after using ibogaine? Why these? What were the most supportive things they said or did? How could they have supported you better?
Transparency about Ibogaine Experiences	Is there anything you chose not to share with your supporters? What and why? Is there anything you chose not to share with a mental health professional about your experience? What and why?
View of Treatment and Professionals	Tell me about your mental treatment history Tell me about your addiction treatment history Did you consider seeking the support of a mental health professional before or after ibogaine treatment? Why or why not?
Other	Describe your experiences with mental health treatments or professionals Is there anything else about your experience that feels important for you to share with me today?

The PI developed and delivered two three-hour CQR training sessions which focused on (a) CQR methodology, coding, and cross-analysis; (b) the roles and obligations for rotating team members, and (c) the procedures for coding. The training also emphasized the use of iterative coding procedures to maximize the representativeness of emergent themes. For example, research team members qualified all codes within the raw data and generated alternate explanations or interpretations of the data to discuss at meetings.

The PI was a member of one rotating coding team and one rotating cross-analysis team. The psychologist audited the coding and cross-analysis but was otherwise not directly involved in either process. Mutual respect, equal involvement, and shared power are considered critical to trustworthy and credible qualitative research (Hill, Thompson, & Williams, 1997). Thus, to minimize the influence of power dynamics, the training included consensus meetings where team members were encouraged to challenge the perspectives of senior team members.

Reflexivity is important in any research endeavor. Thus, all research team members continuously recorded personal experiences, beliefs, biases, and expectations that arose during coding and cross-analysis in shared journals. These were then discussed at each consensus meeting. Most common among researcher biases were beliefs that ibogaine's sustained healing effects most likely depend on the continued professional and non-professional support they seek post-ibogaine and that ibogaine's *oneiric* effects may help people experiencing addiction process traumatic experiences underlying their addictions.

Coding was conducted using NVivo (version 12) and involved identifying, constructing, and reaching consensus on core ideas in the raw data and assigning each core idea to a domain. A start list of domains based on the interview structure was used (Table 2). Coding and cross-analysis were conducted using rotating teams, which allow for many unique perspectives on the data while ensuring consistency across all team members and are considered appropriate when working with large datasets (Hill, 2012). In the first phase of coding, six of the initial twelve transcripts were coded by three rotating pairs of researchers. Each researcher coded their transcript independently before arguing to consensus on their and their partner's coding. All coders collectively addressed unresolved discrepancies in pairs of researchers' understanding of the raw data—reviewing the raw data and arguing for consensus. The entire coding team reached consensus on all domains and core ideas before the external audit of the initial six coded transcripts was conducted by the psychologist. The coding team repeated this process for the remaining six interviews.

Cross-analysis is used in CQR to identify categories and subcategories within individual domains and assign frequency labels to categories and subcategories. During cross-analysis, two researchers and the PI worked in rotating pairs to identify emergent categories and subcategories within each domain, one at a time, for all twelve coded and audited transcripts. The psychologist audited the cross-analysis, which resulted in minor changes to category and subcategory titles. At this point, the whole research team agreed on a significant structural change to the domains to better



reflect the raw data: *Treatment History* was subsumed under *Engagement with Treatment Professionals and Services*. Data within this new combined domain was re-analyzed for emergent categories and subcategories using the cross-analysis procedures described above.

We tested the stability of findings from the first twelve transcripts by randomly selecting three additional uncoded transcripts, which were coded and cross-analyzed using the same procedures. No novel domains, categories, or subcategories emerged. All 15 interviews are included in the final analysis. Frequency labels are used to characterize the prevalence of the categories and subcategories across the entire sample: *General* (14 or 15 participants), *Typical* (8–13 participants), and *Variant* (3–7 participants). All participants were asked via e-mail to review coded transcripts and cross-analyses, a process called member-checking (Hill, 2012). Five participants responded, and all comments supported the domains, categories, and subcategories identified by the research team.

## RESULTS

The seven domains represent factors that characterize participants' ibogaine treatment and addiction recovery experiences across different social-ecological dimensions. These domains reflect the structure of the interview questions (i.e., questions about individual, interpersonal, and behavioral health system experiences) and the start-list of domains used in the initial coding. Results are organized accordingly—Table 3 displays all domains, categories, and subcategories distilled from the raw data. Categories and subcategories represent specific elements common among participants' experiences using ibogaine to support their addiction recovery. Illustrative quotations from participants are provided. Participant identifiers indicate the latency between their ibogaine treatment and their interview in days (e.g. P(5-312) indicates that participant 5 completed their phone interview 312 days after completing ibogaine treatment).

### Individual experiences

#### *Facilitators and barriers to ibogaine treatment*

##### *Facilitators of using ibogaine*

*Exhausted options.* After exhausting available treatment options, desperation motivated most participants to undergo ibogaine treatment. One participant sought ibogaine after consulting doctors and counselors for tools and resources to quit methadone: “there was really nothing [the doctors] could do, but I knew there had to be a different, a better way off of [methadone]” P(5-312). Half of the participants in this subcategory described grave circumstances or feelings of hopelessness after exhausting options, regarding ibogaine treatment as their final attempt at overcoming addiction ( $n = 4$ ).

*Independent research.* Discovering anecdotal and scientific evidence of ibogaine's efficacy through independent research facilitated most participants' decision to use ibogaine. One participant in early recovery from opioids stated:

“What really drove me to do Ibogaine was the success rate with people who are specifically addicted to opiates” P(4-323). More than half of participants conducted years of in-depth research on the healing potential of ibogaine or other psychedelics before undergoing ibogaine treatment ( $n = 8$ ).

*Familial financial assistance.* Receiving financial support from family members was uncommon. Among those for whom financial assistance from family facilitated ibogaine treatment ( $n = 3$ ), only one participant did not substantially contribute to the cost of travel and treatment. Most participants saved and then paid for ibogaine treatment themselves ( $n = 12$ ).

##### *Barriers to ibogaine treatment*

*Cost of ibogaine treatment.* Most participants sought ibogaine treatment for active addictions, and several shared how the cost of sustaining an addiction made saving for treatment a substantial barrier: “It was really the finances, saving enough money to do it. I have taken [opioids] because I've needed to, needed to go to work, needed to function. I started hating the drugs, but you can't go without it” P(12-42). When cost was a barrier, it was accompanied by frustration and angst: “it's a really agonizing decision because you don't really know if it's going to work, and you have to pay a lot” P(9-70).

*Time associated with ibogaine treatment.* The 7–14 days away from work and other responsibilities required to receive ibogaine treatment was a less common barrier. One participant considered the time needed for continued care post-ibogaine to be an integral part of ibogaine treatment, but also a barrier: “another barrier was allowing myself enough time for aftercare and really being able to allow myself time to sit with the experience” P(1-93). Adjusting their workload to allow for continued care post-ibogaine was challenging for this participant to plan.

##### *Ibogaine experiences*

*Meaningful experiences.* All participants in the study described personally meaningful ibogaine experiences. Participants commonly referenced specific visions and recounted the meaning-making processes they engaged in during the months following ibogaine treatment ( $n = 11$ ). Participants who either did not experience or could not recall visions during treatment nonetheless described meaningful treatment experiences ( $n = 4$ ).

*Insight into addiction.* Participants described gaining insights into their addiction during ibogaine's oneiric phase. Insights came in two forms: detailed and personalized visionary experiences ( $n = 6$ ), and introspective thought ( $n = 3$ ). The positive impact of insightful experiences was described by participants who had recently completed ibogaine and those who completed treatment nearly a year before their interview. For example, 347 days after completing treatment, one participant recounted in detail an insightful vision: “my uncle, he was an alcoholic and he was found dead in the streets, in some bushes. When I saw that black ghost when the bushes opened up, it was my uncle, right away I knew, that's my uncle, that's who was talking to me,



Table 3. Emergent domains and categories

Domain and category	<i>n</i>	Frequency	Quote
<b>Facilitators and Barriers to Ibogaine Treatment</b>			<i>P(1-93)</i> "The fact that other modalities didn't really work"
<b>Facilitators of Using Ibogaine</b>	15	<b>General</b>	<i>P(2-79)</i> "I was just desperate at that point. Any alternative that could possibly work I was interested in"
Exhausted Options	8	Typical	<i>P(10-111)</i> "I just didn't think [inpatient rehab] would help and I wanted to try something different."
Independent Research	8	Typical	
Familial Financial Assistance	3	Variant	
<b>Barriers to Ibogaine Treatment</b>	13	<b>Typical</b>	<i>P(9-70)</i> "It's a really agonizing decision because you don't really know if it's going to work the way you've been told it could, and it's a really big financial investment."
Cost of Ibogaine Treatment	7	Variant	
Time Associated with Ibogaine Treatment	3	Variant	
<b>Ibogaine Experiences</b>			<i>P(15-169)</i> "You face your addiction and you kind of convince yourself that you don't have to be an addict anymore... having deep thoughts about [addiction], facing it and purging it out of my mind and body."
<b>Meaningful Experiences</b>	15	<b>General</b>	
Insight into Addiction	9	Typical	<i>P(7-347)</i> "[deceased family] just kept coming to me telling me that they forgave me for being addicted."
Spiritual Experiences	8	Typical	
Forgiveness	6	Variant	
Life Review	4	Variant	<i>P(11-75)</i> "The one that sticks with me the most is seeing everyone I know die in my family."
<b>Challenging Experiences</b>	9	<b>Typical</b>	
Psychologically Challenging Experiences	6	Variant	<i>P(4-323)</i> "I struggled with a little bit of PTSD over it"
Physically Challenging Experiences	6	Variant	
<b>Impact of Ibogaine on Addiction Recovery</b>			<i>P(2-79)</i> "every minute of the day [drug] was still on my mind. It was crazy, it was like it was a part of me, and ibogaine took that away."
<b>Physiological Benefits</b>	15	<b>General</b>	
Alleviated Cravings	13	Typical	
Alleviated Physical Withdrawal Symptoms	8	Typical	
<b>Psychological Benefits</b>	15	<b>General</b>	<i>P(14-43)</i> "ibogaine acted as a door opening or turning a page in a book, a new chapter, and allowing me to start fresh, but I definitely wasn't healed overnight."
Life Restoring	8	Typical	
Spiritual Benefits	5	Variant	
<b>Facilitators of Addiction Recovery Post-Ibogaine</b>			<i>P(3-298)</i> "[family member] would really respect me by listening to me, retaining what it is that I say, respecting my feelings and my needs"
<b>External Support</b>	15	<b>General</b>	<i>P(12-42)</i> "my brother also got clean..., I would call him every day just to talk and get some motivation"
Family	11	Typical	
Mental Health Professionals	8	Typical	
Friends	5	Variant	<i>P(7-347)</i> "you cannot go back to the same place that you were when you were doing drugs because you're just going to go right back to that person. So, I moved"
Community	5	Variant	
<b>Self-Support</b>	12	<b>Typical</b>	
Movement and Exercise	5	Variant	<i>P(8-255)</i> "The biggest way I combated it was by having structure in my day and constantly expressing gratitude"
Staying Busy	4	Variant	
Meditation	3	Variant	
<b>Suggestions to Improve Support Sensitively Understanding Recovery Continuity of Support</b>			<i>P(14-43)</i> "The biggest way anyone can be a support is by not having expectations and understanding that this is just another step in the journey, another step forward"
<b>Sensitively Understanding Recovery</b>	9	<b>Typical</b>	
<b>Continuity of Support</b>	5	<b>Variant</b>	
<b>Disclosure of Ibogaine Experiences</b>			<i>P(5-312)</i> "I told all my counselors and shared all my experiences with them... they couldn't believe that I was doing as well as I was"
<b>Disclosure</b>	15	<b>General</b>	
With Mental Health Professionals	12	Typical	<i>P(11-75)</i> "I didn't tell my family about it because I was afraid that it wouldn't work."
With Family	11	Typical	
<b>Non-Disclosure</b>	8	<b>Typical</b>	
With Family	6	Variant	
With Friends and Other Supports	5	Variant	
<b>Engagement with Treatment Professionals and Services</b>			<i>P(11-75)</i> "That's why I dropped the psychiatrist. She had barely heard of ibogaine. I didn't want to have to convince anyone of my decision or that it was legitimate."
<b>Mental Health Treatment</b>	14	<b>General</b>	<i>P(9-70)</i> "My therapist is really supportive of the whole experience that I've been through with ibogaine. He doesn't dismiss it. He's interested in what it did for me."
Not Helpful	9	Typical	
Helpful	8	Typical	
Involved Medication	8	Typical	
Deciding to Seek Therapy	5	Variant	

(continued)



Table 3. Continued

Domain and category	n	Frequency	Quote
<b>Engagement with Treatment</b>			
<b>Professionals and Services (cont.)</b>			
<b>Beliefs</b>	<b>10</b>	<b>Typical</b>	
About Therapy and Treatment Services	6	Variant	<i>P(6-361) “Most mental health professionals don’t know what they’re doing, so they just prescribed pills”</i>
About Therapists	5	Variant	
<b>Inpatient</b>	<b>9</b>	<b>Typical</b>	
Not Helpful	5	Variant	<i>P(13-235) “I went to traditional 12-step based treatment centers which I didn’t find very helpful especially for addressing trauma.”</i>
Helpful	3	Variant	
<b>MAT Outpatient</b>	<b>5</b>	<b>Variant</b>	

telling me that I’m gonna end up that way if I don’t clean up my act” *P(7-347)*. Another participant’s insightful vision included seeing a memory of themselves smoking a cigarette as a teenager and realizing that what they were putting in their body was killing them.

Participants who reported not having any visions also gained insights into their addiction. One participant who sought treatment for addictions to kratom and alcohol gained insight through deep introspective thought rather than visions. Others could not recall specific visions, yet still gained insights: “I feel like it was like *Men in Black* like I had these deep experiences and then I lost most of my memory. For me, the best way I can describe it is just that I felt more complete. I felt like there was a little bit of resolve following treatment, less anxiety, and a deeper understanding of why I do some of the things that I do” *P(13-235)*.

**Spiritual experiences.** Participants’ spiritual experiences during ibogaine’s oneiric phase included direct interactions with God, a higher power, or a higher self ( $n = 3$ ), and deceased loved ones ( $n = 3$ ). Spiritual experiences offered some participants enduring benefits nearly a year after treatment. For example, one participant described how their spiritual ibogaine experience involving ego-death continues to give them “the drive to do things while I’m still alive” *P(4-323)*. For another, an out-of-body experience profoundly changed their understanding of mortality: “it really convinced me pretty much overnight that this is not the end when we leave this life. I don’t know what happens, but I do think something survives in us” *P(9-70)*.

**Forgiveness.** Participants felt forgiveness for themselves in addiction and toward others extending back to childhood: “I basically shattered these memories with this metaphorical katana of forgiveness...stuff I’m ashamed of, people I’ve hurt, people that have hurt me, stuff that happened to me when I was a kid” *P(8-255)*. Two other impactful experiences of forgiveness included participants being forgiven by deceased family members.

**Life review experiences.** Some participants described visions that involved vividly revisiting a memory. Recall the participant whose insight into their addiction was derived from a life review experience, a memory of themselves as a teenager smoking cigarettes: “The most meaningful experience I had was a vision of myself in a particular moment of my life that I didn’t even know that I remembered. It was me during freshman year in high school and I was smoking a cigarette on

my back porch and I had this epiphany that this stuff that you’re putting in your body is killing you, it’s absolutely killing you” *P(4-323)*. Life review experiences were less common overall and represented special cases of participants gaining insights into their addiction.

**Challenging experiences.** Many participants described either psychologically or physically challenging ibogaine experiences. Although rare, the two participants who had both physically and psychologically challenging experiences described them as traumatic ( $n = 2$ ). Unprompted, nearly all participants shared their meaning-making process regarding their challenging, sometimes traumatic, experiences.

**Psychologically challenging experiences.** Witnessing distressing visions during treatment was often the source of psychologically challenging experiences. With one exception, participants described distressing visions as purposeful—teaching a lesson or providing insight. One participant described protracted distress from an ibogaine vision where they repeatedly experienced dying a gruesome death: “I struggled with a little bit of a PTSD over it, after the fact. They were very, very brutal. But looking back at it now it’s kind of a metaphor for, ‘you’re tearing yourself apart’” *P(4-323)*. Only one participant described enduring and unresolved distress at the time of their interview, eight months after a challenging experience. They attributed their unresolved distress to their uncertainty about the veracity of a vision where they witnessed their father molesting them as a young child.

**Physically challenging experiences.** Physically challenging ibogaine experiences were typically transient but involved severe headaches, vomiting, diarrhea, and lack of sleep during ibogaine treatment. A single participant described many of these physiological symptoms enduring for 10–14 days post-treatment. Other participants described ibogaine’s effect on the body as “hellish” and “taxing.” One participant described feeling “roughed up” and “thrown around” by ibogaine. The majority of participants’ physically challenging experiences resolved when the acute effects of ibogaine wore off.

**Impact of ibogaine on addiction recovery.** The impact of ibogaine on the short- and long-term processes in addiction recovery was overwhelmingly described as positive. Participants believed that ibogaine’s pharmacological effects in



reducing withdrawal symptoms and cravings potentiated its psychological benefits. Participants experienced and described benefits from ibogaine's pharmacological and psychological effects as discrete features of ibogaine's impact on their addiction recovery.

**Physiological benefits.** All fifteen participants reported that the pharmacological effects of ibogaine offered them physiological benefits—reducing withdrawal symptoms and acute cravings. Most participants contrasted ibogaine's detox efficacy with their previous experiences in residential inpatient treatment, noting that ibogaine's detox efficacy was superior to other detox treatments they had undergone in the past.

**Alleviated cravings.** Nearly all participants described ibogaine treatment as either eliminating cravings or reducing them substantially: “it was just unlike anything that I’ve ever tried, and I’ve tried everything to get off of heroin” P(9-70). Another participant who had also completed multiple inpatient and outpatient addiction treatments before using ibogaine shared: “I’d get over the sickness and be doing my day-to-day life, but every minute of the day, it was still on my mind. It was crazy, like it was a part of me. And ibogaine took that away” P(2-79). Substantial relief from cravings was also reported by participants who sought treatment for disordered eating behaviors and addictions to alcohol, caffeine, nicotine, and ketamine ( $n = 4$ ). Ibogaine's effect in reducing cravings were commonly described as physiological: “it rewired my brain” P(5-312); “it really felt like it was ripping the addiction off of my brain like Velcro” P(10-111); “it definitely helped me detox, I know that for sure. It kind of reset my brain” P(15-169).

**Alleviated physical withdrawal symptoms.** Relief from withdrawal symptoms was common ( $n = 8$ ), but ibogaine's effect on relieving withdrawal symptoms varied among participants. For instance, “I did go through some physical withdrawals, and I don't think that people should be told that they won't... my withdrawals several days after my experience with ibogaine were at least 80% less than they would have been at that point, or even more.” P(9-70). Conversely, another participant experienced such a significant reduction in the severity of their physical withdrawal symptoms that they considered ibogaine's efficacy a potential threat to their long-term recovery—a quick fix.

**Psychological benefits.** All participants reported psychological benefits. In addition to *General* and *Variant* subcategories, two *Rare* subcategories emerged, each containing data from two different pairs of participants who described ibogaine treatment as (a) potentiating self-improvement, and (b) increasing confidence and motivation in recovery.

**Life restoring.** Life-restoring benefits of ibogaine were commonly described. These benefits were seldom associated with specific visionary experiences; instead, participants attributed these benefits to ibogaine's combined physiological and psychological effects. One participant simply shared, “It saved my life. Honestly, I'd probably be dead right now if

I hadn't gotten the treatment. I owe my life to it” P(7-347). Other participants echoed this sentiment, describing a sense that they had a “new beginning,” “a fresh start,” “a clean slate,” or were “reborn.”

Another participant shared a more tempered perspective on ibogaine's life-restoring benefits: “From my point of view, ibogaine acted as a door opening, or turning a page in a book, a new chapter, and allowed me to start fresh. But, I definitely wasn't healed overnight” P(14-43). Like this individual, other participants contextualized their descriptions of ibogaine's life-restoring benefits in a personalized narrative of their long-term recovery, the beginning of which was marked by ibogaine treatment: “Like when I was injured overseas, the ibogaine said to me, ‘you are a builder, I had to injure you to keep you from going back overseas so many times,’ so it gave me some direction to start a new life outside of the military” P(6-361).

**Spiritual benefits.** Both religiously affiliated and non-religious participants described spiritual benefits from ibogaine treatment. Their experiences were grounded in their racial, ethnic, and cultural contexts. Although rare, two participants who described no prior religious affiliations before using ibogaine described spiritual benefits from ibogaine treatment without spiritual visionary experiences during ibogaine treatment: “I got a lot closer to my dad, I had a lot more self-respect, and I got a lot closer to God” P(3-298).

## Interpersonal experiences

**Facilitators of addiction recovery post-ibogaine treatment.** After completing ibogaine treatment, all participants took an active role in supporting their ongoing addiction recovery. Some executed continued care plans they developed before undergoing ibogaine treatment, while others more intuitively developed and executed their recovery support plans post-ibogaine.

### External support

**Family.** Family members were readily accessible supporters, and all fifteen participants maintained active relationships with family members before and after their ibogaine treatment. Supportive family members were described as open-minded, good listeners, drug-free, non-judgmental, and offering words of encouragement. One participant said, “My mom, she was really reassuring and encouraging, saying that she would help me however was necessary” P(13-235). Relying exclusively on family for recovery support post-ibogaine was uncommon ( $n = 4$ ). Most sought support from other personal and professional resources.

**Mental health professionals.** Most participants sought mental health treatment to support their addiction recovery post-ibogaine ( $n = 8$ ). Most of these participants had no experience with therapy before undergoing ibogaine treatment ( $n = 5$ ). Participants' processes in selecting professionals and evaluating their quality are reported under Engagement with Treatment Professionals and Services.

**Community.** Participants engaged with various communities to support their post-ibogaine addiction recovery (e.g.,





mutual help groups, veterans' support groups, and talking circles). Those who used mutual help groups struggled with the decision to disclose their use of ibogaine to group members, while those who used non-recovery community support described only positive experiences with community support. Despite struggling with disclosing their use of ibogaine, participants attending mutual help groups reported those groups helped them grow and protect their recovery.

**Friends.** Fewer participants described using their friends to support their recovery post-ibogaine. Friends who were described as supportive understood the long-term process of recovery and were drug-free or had previous experience with psychedelics. No participants described using friends exclusively or primarily.

**Self-support.** Nearly all participants took an active role in growing and protecting their recovery post-ibogaine. They tended to consider and incorporate interpersonal connection or support in their descriptions of supporting their own recovery. One rare subcategory emerged: two participants planned to move to a different state or country for the purpose of living with drug-free friends or family members immediately after ibogaine treatment.

**Movement and exercise.** Exercise or other movement-based activities (e.g., yoga, surfing, martial arts) to support recovery post-ibogaine were frequently described. Most participants in this subcategory found that these activities helped compensate for lacking social support: "I don't really talk to anyone because I don't know anyone who's done it [ibogaine]... I train jiu-jitsu, so I have good environments to put myself in... that's my therapy" P(2-79). Less common were participants who described using exercise and movement-based activities to help them reconnect to their ibogaine experiences ( $n = 2$ ).

**Staying busy.** Fewer participants supported their recovery by keeping themselves occupied with work or other responsibilities. Those who grew and protected their recovery by staying busy warned against isolation and emphasized the importance of engaging with positive and collaborative people.

**Meditation.** Few participants described attending meditation groups to support their recovery. The frequency with which they participated in meditation groups varied from sustained daily practice to enrolling in a single 7-day meditation retreat.

**Suggestions to improve support.** When asked about suggestions to improve post-ibogaine support, nearly all participants noted that they felt uncomfortable answering the question because they did not want to discount the support they had already received. Consequently, the interviewer encouraged participants to respond with what they felt would have represented the most ideal post-ibogaine support for them.

**Sensitively understanding recovery.** Several participants noted how their family members carried unrealistic expectations post-ibogaine. One wished their family were "a little more patient" P(15-169), and another wished their supporters better understood that addiction recovery is "an

ongoing process, a life-long journey" P(13-235). Suggestions for professional supporters included avoiding focusing on past or present consequences of substance use, regardless of saliency.

**Continuity of support.** Participants commonly suggested that family members and loved ones should aspire to offer more consistent support post-ibogaine, such as patience, understanding, and optimism. Without exception, participants in this category qualified their suggestions with their frustrations about supporters' unrealistic expectations and diminishing support in the weeks following their ibogaine treatment.

### Disclosure of ibogaine experiences

#### Disclosure

**With mental health professionals.** Most participants described feeling comfortable sharing openly about their ibogaine experiences with mental health professionals. Many had openly shared details of their ibogaine experience with a therapist at the time of the interview ( $n = 7$ ). Those without an active relationship with a therapist said they were willing to share their experiences with a mental health professional ( $n = 5$ ).

**With family.** Openly sharing detailed accounts of their ibogaine experience with family members was common. Although a majority described being fully transparent with all their family members, a sizable minority chose to withhold specific details.

#### Non-disclosure

**With family.** Although uncommon, participants withheld details about ibogaine treatment and often concealed minor details, such as the cost or unpleasant physiological experiences. Those who shared the least with their family members withheld details to avoid disappointing them.

**With friends and other supports.** Participants concealing their use of ibogaine from friends and other supports, including peers and members of mutual help groups, was less common. Most discussed feeling unsure how mutual help groups would react to their use of ibogaine and feared rejection.

### Behavioral health system experiences

**Engagement with treatment professionals and services.** Most participants reported multiple experiences with mental health or addiction treatment professionals and services before and after ibogaine treatment.

**Mental health treatment.** Nearly all participants had experiences with mental health professionals and behavioral health care. Most received medication as part of their mental health treatment prior to using ibogaine ( $n = 8$ ), which they viewed negatively. Unprompted, several participants also described their decision-making processes around seeking therapy post-ibogaine. For example, "It was different after ibogaine, I was there [in therapy] because I wanted to be there. There was no other reason to deal with all these



problems so I don't go into a deep state of depression or make a really bad decision" P(8-255).

**Not helpful.** Descriptions of unhelpful experiences with mental health professionals were common. Participants cited a lack of a felt connection with the therapist and previous negative experiences, including with mandated treatment. One participant noted how multiple mental health professionals failed to contextualize ibogaine's risks for them accurately: "a lot of counselors just threw their hands up and said, 'oh it sounds dangerous'... well yeah, I could also be shooting drugs on the street, that's dangerous too" (P5-312). Other participants echoed this sentiment, describing mental health professionals' lack of knowledge about ibogaine and negative judgments and dismissiveness towards ibogaine as unhelpful at best.

**Helpful.** Helpful experiences engaging with mental health professionals and treatment services were common, but few described only helpful experiences ( $n = 3$ ). One participant described their therapist's positive reactions to ibogaine as the most salient helpful mental health treatment experience post-ibogaine: "the verbal support and I think the excitement on [the therapist's] part that it was working out" P(10-111). Those who sought therapy often persevered through multiple stigmatizing therapy experiences for months or years before finding a therapist who understood their choice to use ibogaine. One participant described undergoing ibogaine treatment without professional support arranged because they could not find a therapist willing to work with them.

**Involved medication.** Before undergoing ibogaine treatment, most participants received pharmaceutical medications as part of addiction and mental health treatment. Medications for mental health and addiction treatment included antidepressants, Lithium, Gabapentin, Naltrexone, and Seroquel. These participants, without exception, felt negatively toward the medication they were prescribed and described their desire to discontinue using all substances, including psychotropic medications.

**Deciding to seek therapy.** Reasons for seeking therapy included struggling with depression post-ibogaine treatment: "I had this emotional breakdown where I just started bawling and crying... I called my mom and yelled at her, and told her everything I hated about her... I was almost suicidal. I just felt so erratic and capricious" P(8-255); feeling unable to talk to family and friends: "I was depressed, I was miserable I had to talk to somebody" P(6-361); or share openly in traditional recovery groups: "I wanted to be able to talk about some things that I'm not really comfortable sharing in a meeting" P(9-70).

One participant described insights from their ibogaine experience as shifting their previously negative attitudes towards mental health professionals: "Just the act of talking about it I think is healing in itself. Really, I guess grasping that after having done the ibogaine has made me take that more seriously" P(14-43). Recall that this participant described experiencing no visions during ibogaine's *oneiric* phase, instead gaining insights through deep introspective thinking.

## Beliefs

**About therapy and treatment services.** Several participants believed that therapy and addiction treatment services are effective only if someone is willing to participate fully ( $n = 3$ ). For instance, "You have to be interested in doing something to try to implement things they're showing you" P(2-79). Participants' other beliefs pertained to inpatient treatment and were largely negative.

**About therapists.** Fewer participants shared general beliefs about therapists and beliefs that were shared were negative. One participant stated they believed that mental health professionals "are professional diagnosis makers, they are not healers, and they don't give you the tools to learn how to heal yourself" P(3-298). Overall, these participants tended to view therapists as unskilled and embodying a stigmatizing worldview (e.g., "corporeal" and "dismissive of alternative treatments").

**Inpatient.** Most participants attended inpatient treatment several times before using ibogaine ( $n = 8$ ), with one participant recounting a total of 15 inpatient admissions across two decades.

**Not helpful.** Participants attributed their unhelpful inpatient treatment experiences to the lack of trauma-informed care and psychological support. Those with more long-standing addiction treatment histories noted how the lack of continued care after inpatient treatment often contributed to their near-immediate relapse.

**Helpful.** Helpful inpatient treatment experiences before ibogaine treatment were uncommon. However, one participant found the substance-free environment provided by inpatient programs helpful, and another attending a specialized inpatient treatment center for veterans described beneficial therapeutic components of the program (e.g., individual and group counseling).

**MAT outpatient.** Compared to other accessible addiction treatments, Participants least frequently used MAT outpatient programs before ibogaine treatment. Few participants described MAT treatment as unhelpful or harmful ( $n = 2$ ), and no participants found it helpful.

## DISCUSSION

The present study identified, categorized, and noted the relative frequencies of emergent themes in the addiction recovery experiences of a diverse group of individuals who sought ibogaine treatment for predominantly opioid and polysubstance addictions. We applied a social-ecological model of addiction and recovery to gain a deeper understanding of their individual, interpersonal, and systemic experiences and how these intersected with ibogaine treatment.

Previous researchers have identified and investigated a variety of individual, interpersonal, and behavioral health system experiences as independently relevant to long-term recovery from addiction. Collectively, these studies suggest that intersecting experiences across social-ecological



dimensions are consequential for post-ibogaine recovery outcomes. However, no studies have characterized how these intersecting multidimensional experiences impact the process of addiction recovery post-ibogaine.

The present study is the first to investigate and characterize multidimensional experiences post-ibogaine treatment in the same qualitative study and among the same participants. We aimed to holistically present themes in participants' addiction treatment and recovery narratives using social-ecological dimensions that previous research has demonstrated influence addiction and recovery trajectories (Karriker-Jaffe et al., 2020; Sussman & Sussman, 2011; Weinberg, 2000). Further, the present study investigated the impact of previous addiction treatment attempts and experiences of stigma in behavioral health settings on people's decisions to use ibogaine and seek professional support post-ibogaine, which are unique contributions to existing literature.

Within the individual dimension, participants in this study demonstrated a high degree of personal investment and motivation in recovery leading up to and after their ibogaine treatment. Most had multiple treatment attempts before ibogaine, and nearly all engaged in multiple methods of recovery support following treatment, whether through formal treatment or via support from family, friends, or exercise. Multiple unhelpful addiction treatments and disappointing experiences with mental health professionals led many participants to research ibogaine as an alternative treatment. Scheduling their ibogaine treatment involved investing a large sum of money, traveling internationally, and committing a substantial amount of time to treatment (up to two weeks). Thus, the participant's decision to undergo ibogaine treatment was experienced as taking a leap of faith.

Most participants identified at least one psychologically or physically challenging aspect of ibogaine treatment, typically describing vomiting and diarrhea as the most uncomfortable effect of the drug. Despite this, most participants tended to describe recovery-related benefits of ibogaine treatment as exceeding their expectations. Consistent with previous research, participants described both meaningful visionary experiences and reductions in cravings (Alper et al., 1999; Brown & Alper, 2018; Davis et al., 2017; Mash, Duque, Page, & Allen-Ferdinand, 2018; Noller et al., 2018). Expanding previous qualitative research into ibogaine treatment for addictions to opioids (Brown et al., 2019; Camlin et al., 2018) and stimulants (Schenberg et al., 2017), participants with less well-recognized addictions (e.g., caffeine, ketamine, and compensatory behaviors related to eating disorders) also described recovery-related and psychosocial benefits from insightful visionary experiences enduring between 75 and 361 days post-ibogaine treatment.

Interpersonally, previous research suggests that sustained improvements in family and social relationships and a sense of increased social connection post-ibogaine treatment are common and may be essential for successful post-ibogaine outcomes (Brown & Alper, 2018; Davis et al., 2018). Consistent with these findings, we found that supportive family and social relationships were described as critical to

ongoing recovery post-ibogaine. Participants described ideal support persons as understanding of the long-term nature of the recovery process, open-minded, patient, and non-judgmental.

Participants generally felt comfortable sharing details of their ibogaine experience with professional and familial support people. Although rare, some participants concealed information about their ibogaine treatment (e.g., financial cost, specific visionary experiences, or attendance) from familial supporters or members of an addiction recovery group. Non-disclosure was consistently related to participants' fears that their ibogaine experiences and growth in recovery post-ibogaine would not meet their family's expectations or that they would be rejected by support group members. As such, intersecting with the interpersonal level of the social-ecological model were participants' potential feelings of shame or mistrust experienced at the individual level.

At a systems level, previous studies have found that having multiple unsuccessful past addiction treatments before seeking ibogaine treatment is common (Brown & Alper, 2018; Davis et al., 2017, 2018). Participants' unsuccessful treatment experiences intersected with their individual and interpersonal experiences of shame, mistrust, and fear of judgment, which were often realized in their engagement in services. For example, participants often experienced traditional addiction treatment as stigmatizing or unsupportive (e.g., being told by professionals they would succumb to addiction if they attempted to stop taking methadone and that their decision to use ibogaine was unnecessarily risky).

People experiencing addiction are often stigmatized in medical and behavioral health settings, even when providers know about stigma and actively try to address it (Henderson et al., 2008). Experiencing addiction-related stigma also leads to poorer treatment outcomes, greater mental health problems, and more reluctance to access addiction treatment services (Murphy & Russell, 2023). Unique to participants in the present study, stigmatizing experiences did not deter interest or motivation to seek ibogaine treatment. Although participants described stigmatizing experiences as mere roadblocks on their path to long-term recovery through ibogaine treatment, our findings around non-disclosure supports the notion that stigmatizing experiences are likely to stifle an individual's acute motivation in recovery, regardless of whether they decide to ultimately receive ibogaine treatment.

The highly personalized visions and subjectively meaningful insights experienced by participants during ibogaine's *oneiric* phase were described by most as motivating them to seek the support of mental health professionals. Participants often felt that therapy would help them process their ibogaine experiences and achieve sustained recovery. Those who initiated mental health treatment after using ibogaine spoke about how their meaningful insights during ibogaine treatment softened their negative views of mental health professionals and the field of psychology. All but one participant described revisiting cynical or pessimistic attitudes toward addiction treatment services and professionals and had either reinitiated formal addiction



treatment focused on their mental health (i.e., working with a therapist) or expressed openness to reinitiating treatment. Participants linked their personally meaningful ibogaine experiences and insights to their increased motivation and openness to seeking behavioral health services post-ibogaine. Thus, how mental health providers respond before, during, and after clients express interest in or decide to use ibogaine is consequential.

### Implications for treatment

Given the critical importance of psychosocial support in addiction recovery, clinicians working with clients seeking ibogaine treatment should consider encouraging familial involvement in treatment. Family members of those seeking ibogaine treatment may benefit from psychoeducation to help them understand the long-term process of addiction recovery, know what to expect from ibogaine treatment, and correct any potentially harmful expectations about ibogaine's efficacy. Relatedly, as more and more people are using psychedelics, including ibogaine, to support addiction recovery, clinicians should prepare for discussions about these substances (e.g., researching risks, benefits, and subjective experiences). Unfortunately, several participants in this study found that the mental health professionals they worked with before completing ibogaine treatment were uninformed or held negative views of ibogaine. Negative beliefs about the efficacy of mental health and addiction treatment services both emerged from and were reinforced by these experiences.

Because people with addiction often experience internalized stigma, shame, mistrust, and perceived rejection, it is extremely important for providers to approach all conversations with clients experiencing addiction, including those

about ibogaine, non-judgmentally and with an open mind. Experiencing stigma results in less treatment seeking among those with addictions (Keyes et al., 2010) and premature dropout from treatment (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013), which increases the chance of negative use-related consequences, overdose, and death. We encourage clinicians to adopt an inclusive, non-abstinence-based definition of recovery when working with clients interested in ibogaine. Viewing recovery as “a process of behavior change characterized by improvements in biopsychosocial functioning and purpose in life” (Witkiewitz, Montes, Schwebel, & Tucker, 2020, p. 9) may be helpful in this regard.

To our knowledge, only one study has investigated attitudes toward ibogaine among mental health and addiction treatment professionals. This study found that attitudes were mostly negative and that negative attitudes were primarily driven by social norms rather than an informed desire to mitigate client risk (Rieckmann et al., 2007). Clinicians working with clients interested in ibogaine treatment for severe addictions are encouraged to conceptualize it as akin to experimental chemotherapy for treatment-resistant cancers. As with experimental chemotherapy for treatment-resistant cancers, the decision to use ibogaine for treatment-resistant addictions may represent for clients a thoroughly considered, calculated risk. Conversely, for clients with comorbid medical conditions (i.e., heart or liver disease), the treatment may be more harmful than the disease. Clinicians may best support clients interested in ibogaine treatment by helping them explore the landscape of conventional and experimental treatment options available to them, weighing the relative risks of each against the risks of continuing to live in addiction. For a summary of key takeaways and recommendations for clinicians, see Table 4.

Table 4. Key takeaways and recommendations for clinicians

Takeaway	Recommendation
<p>Clients interested in ibogaine may negatively respond to clinicians who:</p> <ul style="list-style-type: none"> <li>• Lack knowledge about ibogaine</li> <li>• Express to clients their stigmatizing views about non-traditional addiction treatments such as ibogaine</li> </ul>	<ul style="list-style-type: none"> <li>• Prepare to provide psychoeducation regarding the risks and benefits of ibogaine treatment</li> <li>• Inquire about clients' negative or stigmatizing addiction treatment experiences</li> <li>• Collaboratively explore the pros and cons of a variety of traditional and non-traditional addiction treatments</li> <li>• Acknowledge clients' motivation, initiative, and personal investment as strengths</li> </ul>
<p>Many clients interested in ibogaine conduct their own research about treatment, are highly motivated, and are willing to invest personal resources.</p>	<ul style="list-style-type: none"> <li>• Provide clients with psychoeducation regarding common experiences during ibogaine treatment</li> <li>• Express interest in clients' subjective ibogaine experiences and support meaning-making</li> <li>• Help clients explore and process challenging or traumatic experiences in therapy post-ibogaine</li> </ul>
<p>Ibogaine treatment experiences tend to be highly impactful and physiologically and psychologically challenging</p>	<ul style="list-style-type: none"> <li>• Encourage family involvement in treatment and provide psychoeducation to family members regarding the long-term nature of the recovery process</li> <li>• Encourage clients to take an active role in growing and protecting their recovery post-ibogaine</li> </ul>
<p>Post-ibogaine support is critical to long-term recovery</p>	



## Limitations and future directions

Our findings should be considered in the context of several limitations, including those intrinsic to qualitative research. Given that only 19 people among the 48 contacted for recruitment responded, some findings may be vulnerable to self-selection bias. Our findings may best generalize to those who undergo ibogaine treatment at a medical clinic and subjectively report a positive treatment outcome. Although the generalizability of qualitative findings is necessarily limited, purposeful sampling, a demographically diverse research team, systematic stability checking, and member checking collectively support the credibility, and trustworthiness of our findings (Hill, 2012; Williams & Morrow, 2009).

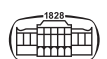
## CONCLUSION

Our findings contextualize individuals' decision to use ibogaine and seek continued recovery support post-ibogaine in their multidimensional addiction and recovery narratives. For example, despite their multiple unsuccessful treatment attempts and experiences of addiction-related stigma in behavioral health treatment settings before using ibogaine, participants' decision to use ibogaine often represented both a substantial investment in their long-term recovery and a willingness to risk it all to recover from their addictions. We speculate that subjectively meaningful ibogaine treatment experiences may confer recovery-related benefits that ameliorate the detrimental effects of previous stigmatizing and unsuccessful treatment attempts within the behavioral health system (e.g., negative attitudes towards treatment professionals and reduced help-seeking). Further research investigating the impact of insightful ibogaine experiences on post-ibogaine help-seeking behaviors and motivation in recovery is needed to better understand the complex, reverberating effects of these acute experiences on individuals' evolving addiction recovery processes across multiple social-ecological dimensions.

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