An examination of internal family systems interventions for trauma with implications for ethical psychedelic-assisted treatment

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ABSTRACT

Though several treatments effectively address the pervasive impact of trauma, they do not achieve complete symptom resolution for all clients, inspiring the search for alternatives. Internal Family Systems (IFS) therapy has grown popular, especially in informal psychedelic-assisted treatments (PAT). Compared to stereotypes of empirically validated, exposure-based treatments, IFS has novel facets with widespread appeal. The model encourages improved quality of interactions among multiple, naturally arising “parts” or subpersonalities potentially generated by traumatic experience. The body of IFS literature is extensive, enthusiastic, and thought-provoking. Outcome data for applying the model to Post-Traumatic Stress Disorder are limited. Attempts to operationalize and falsify the theory’s assumptions and proposed mechanisms will likely prove challenging. Nevertheless, the model’s popularity underscores a problem with perceptions of the empirically-supported treatments. Contemplating ethical ways to present the IFS approach given the state of relevant research, we note strategies that would apply to recommendations for PAT of any type. These strategies include detailed psychoeducation about empirically-supported treatments, candid description of the experimental nature of alternatives, frequent assessments of improvement, and detailed monitoring of potential iatrogenic effects. Drawing on facets of IFS to improve perceptions of the empirically validated treatments might provide an efficient way to appeal to more clients, decrease drop out, and increase gains as we await results of empirical investigations of IFS-influenced PAT. These steps can allow clients to choose an approach consistent with their own impressions of a credible intervention, potentially leading to better outcomes.

KEYWORDS

internal family systems, trauma, psychedelics

POST-TRAUMATIC STRESS DISORDER AND FIRST-LINE TREATMENTS

Effective therapeutic interventions for trauma symptoms are of paramount importance. Most individuals will encounter at least one traumatic event during their lives. A substantial proportion of them will experience multiple traumatic events (Pugach, Nomamiukor, Gay, & Wisco, 2021). These exposures frequently culminate in a range of psychological reactions, including intrusive thoughts, avoidant behaviors, persistent negative affect, and hyperarousal, which often meet the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD). Although estimates regarding the prevalence of this disorder vary, the lifetime base rate can approach 20% in some high-risk groups (Yuan et al., 2021). Based on replicated randomized clinical trials, the American Psychological Association endorses multiple variations of Cognitive Behavioral Therapy (CBT) as the treatment of choice. Endorsed treatments include Cognitive Processing Therapy (CPT), Cognitive Therapy (CT), and Prolonged Exposure Therapy (PE; APA, 2017). Comparable recommendations for these first-line, empirically-supported treatments emanate from other authoritative governmental bodies.
They recommend that these modalities serve as the initial therapeutic interventions for individuals who do not recover spontaneously or who fail to respond to pharmacological treatments (NICE, 2018).

In fact, guidelines across multiple nations and professional organizations coalesce around these recommendations for empirically based psychotherapies (Hamblen et al., 2019). Pharmacological interventions—including fluoxetine, paroxetine, sertraline, and venlafaxine—might outperform placebos, but they generally do not surpass CPT or PE in ameliorating symptoms of PTSD, depression, or insomnia (APA, 2017; Coventry et al., 2020). Meta-analytic reviews support the efficacy of PE, CPT, and Eye-Movement Desensitization and Reprocessing (EMDR), as well as narrative exposure therapy (Cusack et al., 2016; Raghuraman, Stuttard, & Hunt, 2021) and neurofeedback (Steingrimsson et al., 2020). Most meta-analytic reviews focus on symptom severity rather than diagnostic category, so estimating a percentage of who recovers is difficult. Effect sizes look promising, though critiques of the literature remain, as discussed below. Recommended interventions like Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) can create decreases in symptoms that average approximately 1.4 standard deviations (Mavrazouzi, Meginn-Viggars, Daly, et al., 2020). Economic estimates suggest that all these interventions are comparably cost-effective (Mavrazouzi, Meginn-Viggars, Grey, et al., 2020). For context, effects of this size compare favorably to the impact of cognitive behavioral treatments for depression (approximately 0.8; Cuijpers, Miguel, Ciharova, et al., 2023) or psychotherapeutic interventions for mixed depression and anxiety (approximately 0.5; Cuijpers, Miguel, Harrer, et al., 2023).

Despite this documented promise, clinicians often eschew these methodologies unnecessarily in actual practice, even after comprehensive training in evidence-based exposure therapies. This trend persists despite evidence suggesting that patients perceive these therapies positively, even if the exposure elements induce discomfort (See Trivasse, Webb, & Waller, 2020; van Minnen, Hendriks, & Olff, 2010). Therapists need not show reluctance about these approaches, especially given their efficacy. This resistance to evidence-based methodologies continues to perplex both researchers and clinicians (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). These evidence-based treatments for PTSD, like many treatments, are not free of shortcomings, however. Drop-out rates average 14–16% and can range as high as 65% (Lewis, Roberts, Gibson, & Bisson, 2020). The treatments have less impact on quality of life and related concerns than on PTSD symptoms, so improvements would be most welcome (Coventry et al., 2020). They also might not perform as well for those with co-morbid problems (See Mitchell et al., 2023). These drawbacks inspired work on a number of alternative approaches including psychedelic-assisted treatment (PAT).

THE RELEVANCE OF PSYCHEDELICS

Despite these optimistic reviews, the extant literature on the endorsed treatments is replete with critical evaluations. Many of these criticisms focus on methodological limitations inherent in the trials. Others emphasize the omission of crucial aspects of the treatment process, including the therapeutic alliance (e.g., Norcross & Wampold, 2019). These methodological and clinical criticisms, coupled with suboptimal outcomes and attrition rates, have catalyzed the examination of a range of alternatives with a range of promise. Multiple trials have supported increased physical activity (including yoga (Ong Gaffney, Gulden, Jennings, & Page, 2023) and aerobic exercise (Björkman & Ekblom, 2022)), as well as hypnotherapy (Abramowitz, Barak, Ben-Avi, & Knobler, 2008; Rotaru & Rusu, 2016). At least one randomized clinical trial showed some improvements from music therapy (Beck et al., 2021). Authors of a recent scoping review of transcranial magnetic therapy suggest that despite varied results, that approach also shows promise (Adu, Shalaby, Chue, & Agyapong, 2022). In contrast, other lines of research suggest some approaches are not worthy of further pursuit. For example, psychoeducation alone has had little positive impact (Brouzos, Vatikiotis, Mavridis, Vassilopoulos, & Baourda, 2022), and benzodiazepines appear contraindicated given their risk of abuse and lack of efficacy (Guina, Rossetter, DeRhodes, Nahhas, & Welton, 2015).

One intriguing intervention with multiple promising randomized clinical trials involves Psychedelic-Assisted Therapies (PATs). The most empirically substantiated PAT for trauma incorporates an 18-session protocol that uses MDMA as the active ingredient in up to three separate sessions (Mitchell et al., 2023). In addition, preliminary studies offer support for a ketamine-assisted protocol, but not for simple administration of ketamine without appropriate support (Du et al., 2022). The empirical literature on other psychedelic tryptamines, including psilocybin, LSD, and DMT, remains conspicuously sparse (See Averill & Abdallah, 2022). Reviews underscore the promising therapeutic potential of these psychoactive molecules when preparatory sessions lay the groundwork, drug administration includes support, and integration sessions after the psychedelic experience are numerous and detailed enough to help clients make sense of the effects (Henner, Keshavan, & Hill, 2022). The prospect of augmenting empirically validated PTSD therapies with psychedelic sessions appears compelling. Elaborate media coverage suggest that the approach also has considerable appeal (Yaden, Potash, & Griffiths, 2022). But alternative approaches also have a big influence on the way providers conduct PAT, especially Internal Family Systems.

INTERNAL FAMILY SYSTEMS, TRAUMA, AND PSYCHEDELICS

The limitations of established treatments have also engendered the proliferation of Internal Family Systems (IFS) therapeutic approaches (Schwartz, 2013; Schwartz & Sweezy, 2019), which we detail below. The rise in popularity of IFS is notable. The seminal text outlining the model (Schwartz & Sweezy, 2019) boasts a citation count exceeding 1,100 on Google Scholar. IFS
has influenced the development and practice of PATs for trauma quite dramatically. The MDMA treatment manual for PTSD, for instance, integrates IFS terminology, primarily to explicate the acute psychoactive effects of the compound within their framework (Mithoefer, 2017). An illustrative case study on ketamine-assisted treatment for PTSD similarly incorporates an IFS-based intervention (Halstead, Reed, Krause, & Williams, 2021). Over 130 scholarly articles explicitly mention “Internal Family Systems,” “psychedelic,” and “trauma.” Numerous scholars have posited that IFS harbors significant potential for optimizing the efficacy of PATs (Wolfson, 2023). Many authors extol the model for its utility in facilitating the integration of psychedelic experiences for therapeutic ends (Morgan, 2020). In addition, multiple authors document that this model has had a large impact on PAT practice (Bathje, Majeski, & Kudowor, 2022; Dore et al., 2019).

A recent review also points out that many models of the PAT process suggest that an IFS approach is necessary across all treatment stages (Cavarra, Falzone, Ramaekers, Kuyper, & Mento, 2022). Other work emphasizes that many authors view the IFS model as a lens for interpreting trial outcomes in PAT studies, even when investigations do not include IFS techniques (Whitfield, 2021). At least a subset of theorists assert that IFS is the clear path for better PAT.

Despite this burgeoning enthusiasm, the published empirical support for IFS, particularly in the context of trauma-related interventions, remains conspicuously limited. A recent publication by Hodgdon and colleagues starkly acknowledged the absence of research investigating the model’s effectiveness in alleviating PTSD symptomatology or related psychological distress (Hodgdon, Anderson, Southwell, Hrubec, & Schwartz, 2022). Unlike CPT, CT, PT, and EMDR, meta-analytic estimates of effects are unavailable, as published, randomized clinical trials of IFS for PTSD are apparently rare. Consequently, the widespread adoption of IFS in trauma treatment appears to stem more from its intuitive appeal than on rigorous scientific scrutiny. This predicament appears with other models for other psychological struggles, of course. Multiple authors have emphasized problematic rates of adoption of empirically-supported treatments since before IFS became popular (Lilienfeld et al., 2013; Onken, Carroll, Shoham, Cuthbert, & Riddle, 2014).

Nevertheless, IFS’s popularity in PAT makes focusing on the model particularly relevant. Given this context, an exploration into the factors driving the widespread adoption of IFS, despite its limited empirical support, can offer valuable insights for enhancing the appeal (and adoption) of evidence-based models. Perhaps the empirically-supported approaches could improve their popularity (and frequency of use) if practitioners of those treatments understood more about IFS and why the approach has resonated with the PAT community. A brief look at the model itself could prove illustrative.

**SUMMARIZING IFS**

The IFS model originates in family systems theory, which focuses on the dynamics within a family to provide treatment directions for an individual. IFS posits the existence of a constellation of subpersonalities or “parts” within the individual. Seminal literature (Schwartz & Sweezy, 2019) also borrows from positive psychology. The authors reference self-compassion, mindfulness, meditation, inner child constructs, and spirituality. References to psychodynamic models are also frequent (Brown, 2020). The model suggests that trauma, or at least extremes in pain and negative affect, appear etiologically relevant for the development of some of these parts. These subpersonalities assume diverse roles, each focused on returning affect to equilibrium. Nevertheless, at times these parts inadvertently generate maladaptive behaviors or affective extremes. The model emphasizes that recognition and validation of these subpersonalities can facilitate their harmonious alignment, thereby enhancing overall psychological functioning.

Therapeutic techniques in IFS often involve explicit dialogues with these subpersonalities, aiming to clarify their roles and positive intentions (Brown, 2020). Originators of the model emphasize that these dialogues can also yield constructive recommendations for more adaptive interactions among the subpersonalities. Treatment providers encourage clients to acknowledge each part, for example. IFS further categorizes these subpersonalities into archetypal roles, thereby normalizing their functions, efforts, needs, and capabilities. For example, “managers” are subpersonalities tasked with preempting extreme negative emotional responses and reducing exposure to aversive stimuli. But they might also exert inhibitory control, curtailing opportunities for positive reinforcement. Conversely, “firefighters” are predisposed to take swift, robust action to mitigate extreme negative emotional states, albeit often at the cost of generating additional complications. Extremes in negative affect, abuse, or neglect can generate “exiles.” Exiles are parts that managers might isolate to prevent painful memories from dominating consciousness. These subpersonalities have the potential for adaptivity, but when their actions become extreme, they engender more harm than benefit.

Keeping these internal parts aligned would prove challenging for anyone, and acknowledging that fact might lead clients to increase their own self-compassion. One appealing aspect of the model is the inherent validation, normalizing, and acknowledgement. These parts appear in reaction to trauma, but to no fault of the client. Each is performing as best as it can. The facilitation of inner alignment and optimal functioning of subpersonalities represents a hallmark of successful Internal Family Systems (IFS) therapy (Schwartz & Sweezy, 2019). The client addresses parts as a mechanism for improvement. The acknowledgment of the benevolent intentions of these subpersonalities renders behavioral lapses both comprehensible and easier to forgive. This compartmentalization of behavior to specific subpersonalities might also mitigate self-blame, facilitating easier reconciliation with one’s actions. The authors suggest that clients might prove more forthcoming about negative affect and behavioral lapses when they arise from parts rather than themselves (Saying, “a part of me is very angry at someone important in my life,” might prove easier than “I
am very angry...”). The model offers a framework that potentially normalizes internal conflict, thereby negating the perception of self-hypocrisy. Case studies within the IFS framework often exude a novel sense of optimism and enthusiasm (Brown, 2020; Halstead et al., 2021; Lucero, Jones, & Hunsaker, 2018), and success stories are effusive and numerous. Acknowledging these conflicting parts can facilitate better acceptance of each (Schwartz & Sweezy, 2019).

**Efficacy, Mechanisms, Falsifiability, and Confounds**

The published outcome study on IFS for PTSD focused on pre and post measures from 17 clients with traumatic childhood experiences (Hodgdon, et al., 2022). Thirteen completed the 16-session protocol and the outcomes were encouraging (Mavranouli, Megin-Viggars, Daly, et al., 2020). The authors emphasize the small sample and absence of a control group; they encourage cautious interpretation and generalization. This publication is the only one currently available to offer empirical support for IFS for trauma. The effect size is larger than estimates for other trauma-focused treatments, but small samples can show high variability as estimates of population effects. Only replication will reveal the accuracy of this estimate, but smaller effects with comparable sample sizes have inspired randomized clinical trials before.

Future randomized clinical trials would likely benefit from an examination of underlying mechanisms, which would facilitate enhancements and generalization. If we understand the cause of the improvements, we can likely enhance them. But the model presents unique challenges for falsifiability, the hallmark for scientific theory (Popper, 2005). Data that would suggest that the model is not true are not easy to envision. Empirically substantiating—or refuting—the existence of the hypothesized, distinct, subpersonalities presents difficulties that undermine the model’s scientific rigor. For example, distinguishing between categorical subpersonalities likely requires large data sets with multiple indices (Haslam, 2019). Currently, empirical evidence supporting the distinctiveness and functionality of the internal subpersonalities is lacking. More importantly, measures for testing their discriminant validity do not exist. The steps toward developing them also seem less than clear.

An example might help illustrate the operationalization problem. The model suggests that firefighters differ from managers in that they appear only when managers falter, leading to extremes in over-corrective behavior (Brown, 2020; Schwartz & Sweezy, 2019). But the model is less clear on where the firefighters reside in memory. Only the client can tell if the firefighter is present, though outsiders can note the presence of extreme negative affect and maladaptive, over-corrective behavior. Investigators have tackled comparable problems in attempts to measure constructs that only an individual can access. For example, the Mystical Experiences Questionnaire, an index of subjective effects of psychedelics and comparable feelings of joy, connection, and ineffability, requires self-reports. But development of an index of mystical experiences was a complex, multistep project (Barrett, Johnson, & Griffiths, 2015). Generating items to address contact with the subpersonalities and the distinctions among them does not seem straightforward. This series of operationalization problems raises concerns about the model’s specificity and, consequently, its utility in empirical research. Even if IFS works, we might not be able to understand why. Without measures for isolating and testing these parts and how they function, evaluating the model with scientific rigor seems difficult. These limitations not only hinder the advancement of IFS within evidence-based practice but also raise questions about its compatibility with the scientific method.

Advocates for IFS might emphasize that despite the absence of these operationalized measures, the model does offer a unique approach to managing internal conflicts, which likely improves therapeutic alliance and decreases dropout. Nevertheless, empirically validated treatments like motivational interviewing offer comparable benefits without necessitating the posting of unobservable, intrapsychic entities (Miller & Rollnick, 2012). These approaches help clients resolve ambivalence and improve outcome in other treatments, including some that have aversive exposure components (Avruch & Shaia, 2022; Guzick, McCabe, & Storch, 2021; Strodl & Yang, 2021; Westra et al., 2011). In short, we remain unclear on how to measure the discriminant validity of subpersonalities or their level of discord, other than by documenting the intensity of symptoms. If the treatment proves efficacious for PTSD in randomized clinical trials, identifying underlying mechanisms consistent with the theory will be extremely difficult. Without a clear understanding of mechanisms, extending the treatment and improving it will prove cumbersome and potentially wasteful.

Notwithstanding these methodological constraints, case studies within the IFS framework often exude a novel sense of optimism (Brown, 2020; Halstead et al., 2021; Lucero et al., 2018). The details of the improvement process seem informative. But alternative explanations for these outcomes rarely receive consideration. The non-specific factors of therapeutic alliance, such as warmth and genuineness, invariably contribute to the therapeutic outcome with effects that can be independent of type of treatment (See Kamil-Britt, Gordis, & Earleywine, 2023; Norcross & Wampold, 2019). Furthermore, the IFS techniques parallel empirically-based treatments, thereby prompting inquiries into more parsimonious explanatory models for observed therapeutic gains. Much of IFS seems remarkably like cognitive processing and exposure. For example, therapists encourage conversations among the parts, thanking them for their efforts, and reassuring them that extremes that might have proven adaptive earlier in life are no longer necessary (Schwartz & Sweezy, 2019). These cognitive challenges are consistent with cognitive processing approaches that do not rest on the same assumptions (Resich et al., 2016). Cognitions, of course, are not visible to others, but they do
manifest in measurable ways that do not rely on self-report. Interventions that modify them also can improve symptoms of depression and anxiety (Fodor et al., 2020). IFS therapists also encourage discussions among the parts using techniques that lead to exposure to associated negative affect and memories (Schwartz & Sweezy, 2019). These strategies parallel approaches that rely on extinction, especially PE. If IFS works through these mechanisms, cognitive-behavioral therapists might relish applying comparable techniques to improve their clients’ symptoms. The empirically-validated treatments could improve by adapting the presentation of the therapeutic techniques to create the kind of engagement and devotion that IFS appears to generate. Learning from IFS might also help empirically-validated approaches appeal to PAT practitioners.

The paucity of empirical support and lack of clarity about mechanism might lead practitioners of IFS to emphasize that similar early enthusiasm surrounded Eye-Movement Desensitization and Reprocessing (EMDR), an approach that requires looking left and right rapidly and repeatedly and discussing generated memories and thoughts. EMDR lacked empirical substantiation in its nascent years but subsequently succeeded in rigorous clinical trials (Luber & Shapiro, 2009; Mavarezouli et al., 2020). Debate about the mechanisms continues (Wajdi et al., 2022), but the impact on symptoms seems evident. The IFS approach might seem equally promising and has a compassionate feel (Mok, 2023). Nevertheless, clinical intuition can misguide. For example, initial effusive enthusiasm for several pharmacological treatments for psychotic and mood disorders waned as subsequent research revealed more modest effects (Ioannidis, 2008; Kirsch et al., 2008; Leucht, Arbter, Engel, Kissling, & Davis, 2009; Moncrieff & Kirsch, 2015). Psychoeducation as well as benzodiazepine use seemed appealing for PTSD at one time as well, but more data led to less enthusiasm (Brouzos et al., 2022; Guina et al., 2015).

Advocates for IFS might also, understandably, point to their own successes and the successes of their colleagues. These successes can provide valuable insights for generating hypotheses about the treatment and underlying mechanisms. As with any clinical impressions, however, addressing the cognitive biases that might inflate the perceived effectiveness of IFS (or any treatment model) is imperative (Meehl, 1973). While many mental health professionals are trained not to generalize from single cases, the lay public often relies on anecdotal reasoning. Problematic encoding, selective memory, and confirmatory biases can compromise the reliability of this evidence. Neither clinicians’ subjective experiences nor clients’ testimonials can supplant the necessity for rigorous empirical research (Kahneman, 2011; Lilienfeld et al., 2013). Cases, no matter how successful, are no substitute for meta-analytic support from multiple trials. One might emphasize the lack of harm, but engaging in treatments that lack empirical validation, including IFS or novel applications of PAT, risks delaying interventions with evidence, potentially exacerbating conditions. This approach can prove particularly troublesome for clients with limited resources, raising issues related to morality (Lilienfeld, 2011).

**ETHICAL CONCERNS**

Professional guidelines universally advocate evidence-based treatments, particularly for trauma-related symptoms. These guidelines hinge on ethical principles including respect for autonomy, beneficence, and nonmaleficence. These principles are common in both medicine and psychology (APA, 2021; Varkey, 2021). Under the principle of respect for autonomy, clients sufficiently educated about their treatment options can make informed decisions. Thus, any engagement in psychedelic-assisted therapy (PAT) or IFS should rest on a comprehensive understanding of the availability of empirically validated treatments for post-traumatic stress disorder (PTSD), including Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) (APA, 2017; NICE, 2018). Details on the experimental nature and limited empirical support for alternatives seem essential. Informed clients are then free to choose.

The principle of beneficence refers to the ethical obligation to promote well-being and act in the client’s best interest. This principle goes beyond merely avoiding harmful actions and implies a proactive approach to helping others. Beneficence encourages clinicians to maximize client well-being through evidence-based practices. Formal tracking of progress across sessions aligns with this ethical mandate. This tracking circumvents prolonged engagement in ineffective treatments, a practice that has generated spirited debate, especially when symptoms initially worsen before improving. Nevertheless, despite clinical lore, evidence suggests that symptom deterioration in PTSD treatment is uncommon compared to deterioration in wait-list controls in treatments like PE (Jayawickreme et al., 2014).

Nonmaleficence, or the imperative to do no harm, adds to these ethical principles. The potential for adverse effects in psychological interventions, even those with empirical backing like mindfulness, necessitates vigilant monitoring (Hirshberg, Goldberg, Rosenkrantz, & Davidson, 2022; Van Dam et al., 2018). Frequent and comprehensive assessments of potential iatrogenic effects can mitigate risks and serve both the individual client and the broader agenda for treatment validation and legalization. These principles underscore: 1) the necessity of relying on empirically-supported interventions, 2) the need to inform potential clients about these recommended treatments, 3) the mandate to inform clients of the experimental nature of alternative approaches, and 4) the indispensable nature of frequent assessment of symptoms, including those that might arise in response to the treatment.

**CONCLUSION**

Internal Family Systems (IFS), an approach gaining traction for trauma treatment, enjoys popularity within psychedelic communities. The framework posits that maladaptive coping behaviors and extreme emotions stem from interactions among internal subpersonalities. Despite its
appeal, a host of alternative, empirically-supported interventions exist, many of which have key components that lend themselves to easier operationalization. The burgeoning popularity of IFS might inspire changes in existing evidence-based approaches to adapt key elements that contribute to its allure. Those who support empirically-validated approaches could learn a great deal from IFS’s popularity. These elements could include the normalization of post-traumatic stress disorder (PTSD) symptoms and the acknowledgment of internal conflicts regarding both symptoms and treatment. These steps could enhance alliance and engagement. Augmenting evidence-based therapies with strategies that address ambivalence and internal conflict, akin to the approaches in IFS, might enhance treatment outcomes and retention rates. The incorporation of motivational interviewing sessions at the onset of evidence-based interventions could serve to address and mitigate internal conflicts and ambivalences without positing intrapsychic entities (The motivational interviewing approach has improved other CBT interventions (Avruch & Shaia, 2022; Guzik et al., 2021; Westra et al., 2011).

Informing clients about endorsed, empirically-validated treatments, including those that involve neither IFS nor psychedelic elements, might be the most defensible approach from an ethical perspective. The discussion should extend to specifying MDMA-assisted therapy as the most empirically-supported of the psychedelic interventions for PTSD and elucidating the potential for challenging psychedelic experiences (Mitchell et al., 2023). An ethically sound approach necessitates transparent discussion regarding the limited empirical substantiation of IFS for PTSD treatment. Especially for clinicians employing IFS or other comparable methods, routine evaluations of symptom severity and potential iatrogenic effects are imperative to avoid squandering valuable resources. Treatment responses are highly variable. Adhering strictly to these guidelines might not only help uphold ethical standards, but also mitigate risks of jeopardizing legal and governmental support for psychedelic therapies.

REFERENCES


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