

News Articles on Eboga & Ibogaine:

1. The Times (UK) (Simon Witter) - Ibogaine (aka eboga): A journalist investigates ibogaine, its effects & its politics.
2. Salon.com, Nov. 3 1999 (Daniel Pinchbeck) - Tripping on Iboga: A journalist travels to Gabon to be initiated.
3. The Independent (UK), Mar. 28 1999 (Ed Platt) - The Dreaming: A drug addict travels to Italy to kick his habit.
4. Time Out (UK), 7 Mar. 2001 (Judy Kerr) - Detox "Wonder" Drug May Face Ban: Green Party seek to fund ...
5. The Guardian (UK), Sept. 20 2003 (Daniel Pinchbeck) - Ten Years of Therapy in One Night: A journalist investigates.
6. Omni Magazine, Feb. 1994 (Nina L. Diamond) - Does One Trip Equal 30 Years On A Therapist's Couch?
7. Black Book Magazine, Spring 2000 (Andy Craft) - Taking the Cure: A journalist investigates.
8. Wall Street Journal, July 2002 (Gautam Naik) - An Array of New Drugs Shows Promise in Fighting Addictions.
9. South Florida Magazine (Nina L Diamond) - Brainwaves.
10. Primal Renaissance - The Journal of Primal Psychology (Don Allen) - Ibogaine: Therapeutic Miracle?
11. The Observer, Jan. 2001 (Tony Thompson) - Hallucinogen 'cure' for addicts linked to deaths. Special report: drugs in Britain.
12. Nature Medicine, 4; 377, 1998 (Karen Birmingham) - Fight to develop drug addiction therapy.
13. Ibogaine: A Retrospective and Current Analysis (1997) (Chris Lovett) - A Retrospective and Current Analysis.
14. The Lancet [Volume 352, Number 9136] Oct. 1998 (Kelly Morris) - Addiction and the use of ibogaine.
15. The Lancet [Volume 354, Number 9193] Nov. 1999 (Kelly Morris) - Data accrue on "visionary" agent to interrupt addiction.
16. LA Weekly, London, Aug. 2003 (Daniel Pinchbeck) - Daniel Pinchbeck takes ibogaine at the Ibogaine Association, a clinic in Rosarito, Mexico.
17. Focus magazine, July 2000 (Jerome Burne) - One step cure for addiction?
18. Let 'em Talk over WBAI-99.5-FM in New York (Paul DeRienzo) - Interview with Dr. Deborah Mash.
19. Chem 227: Spring 1996 (Dr. Rusay Andrew J. Schuknecht) - Ibogaine.
20. Associated Press report, Aug. 1993 - Researchers report that drug addicts in the Netherlands have cited success with ibogaine.
21. www.mapinc.org/drugnews/ - Use this link to search for recent articles in the press.
22. www.scirus.com - Use this link to search for scientific information only. Search term "ibogaine" or subject of your choice.

Ten Years of Therapy in One Night

from The Guardian (UK), 20 September 2003

by: Daniel Pinchbeck.

Could a single trip on a piece of African rootbark help a junkie kick the habit? That was the claim in the 1960s, and now iboga is back in the spotlight. But is it a miracle cure? Daniel Pinchbeck decided to give it a go. And life, he says, will never be the same again... Thursday September 18 2003 The Guardian

In 1962, Howard Lotsof, a 19-year-old heroin addict in New York, ordered from a chemist iboga, a plant used in West African rituals, and tried it for extra kicks. After consuming the bitter rootbark powder, he experienced a visionary tour of his early memories. Thirty hours later, when the effects had subsided, he found that he had lost all craving for heroin, without withdrawal symptoms of any kind. He said he then gave iboga to seven other addicts and five stopped taking drugs immediately afterwards.

In 1985, Lotsof patented the ibogaine molecule for the purposes of addiction treatment, but could not get his treatment approved. In the interim years, ibogaine had been declared, along with LSD and several other psychedelic molecules, an illegal "schedule one" substance, with potential for abuse and no medical value. Although it found dedicated support among a ragtag group of countercultural activists and left-over Yippies, in 1995 the National Institutes of Health discontinued research into the substance, and pharmaceutical companies have since ignored it, perhaps due to low profit potential.

But now, interest in ibogaine is growing rapidly, passing a "tipping point" through a combination of anecdotal evidence, underground activism, journalism and scientific research. Articles have appeared in US publications ranging from the authoritative Journal Of The American Medical Association (Jama) to the populist Star. The Jama piece, Addiction Treatment Strives For Legitimacy, described the drug's stalled and tortured path through the regulatory agencies, noting that the treatment's frustrated supporters in the US have set up an "underground railroad" to give addicts access to the drug: "While unknowable scores of addicts continue ingesting ibogaine hydrochloride purified powder - or iboga whole-plant extract containing a dozen or more active alkaloids - few trained researchers witness the events."

The Star took a more colourful approach: "Rare Root Has Celebs Buzzing" it said, trumpeting the treatment as the hot ticket for "the numerous celebs who look for relief from their tough lives in the bottom of a bottle of Jack Daniel's, a needle or prescription medicine". The article insinuates that "some of our favourite A-listers"

not only get cured but enjoy the hallucinations as an illicit "fringe benefit". Outside the US, new clinics have opened in Mexico, Canada and Europe, offering reasonably priced, medically supervised opportunities to try ibogaine as a method of overcoming addiction. In fact, at one new clinic in Vancouver, the treatment is free.

Iboga is the sacred essence of the religion of the Bwiti tribe of Gabon and Cameroon. Most members of the tribe ingest it just once in their lives, during an initiation ceremony in which massive amounts of the powdered bark are consumed. Through this ritual, they become a baanzi, one who has seen the other world. "Iboga brings about the visual, tactile and auditory certainty of the irrefutable existence of the beyond," wrote the French chemist Robert Goutarel, who studied the Bwiti. The iboga bark's visionary power is produced by a complicated cocktail of alkaloids that seems to affect many of the known neurotransmitters, including serotonin and dopamine. Its complex molecular key may lock into the addiction receptors in a way that resets patterns and blocks the feedback loops that reinforce dependency.

In an essay on ibogaine's anti-addictive properties, Dr Carl Anderson of McLean Hospital, Virginia, speculated that addiction is related to a disrupted relationship between the brain's two hemispheres, and that ibogaine may cause "bihemispheric reintegration". Ibogaine also accesses REM sleep in a powerful way - many people need considerably less sleep for several months after an ibogaine trip.

Six years ago, I became a member of the Bwiti. I had heard about ibogaine from an assistant in an anarchist bookstore in New York. On a magazine assignment, I went to Gabon and took iboga in an initiation ceremony. It was one of the most difficult, yet rewarding, experiences of my life. I had heard the substance described as "10 years of psychoanalysis in a single night" but, of course, I did not believe it. As the tribesmen played drums and sang around me until dawn, I lay on a concrete floor and journeyed back through the course of my life up to that point, witnessing forgotten scenes from childhood. At one point, I had a vision of a wooden statue walking across the room and sitting in front of me - later, I was told this was

"the spirit of iboga" coming out to communicate with me.

My Bwiti initiation was complicated by a belligerent, greedy shaman who called himself The King and demanded more money from us before, during and after the ceremony. The King was also dissatisfied with the visions I described, and threatened to keep feeding me more iboga until I reported more impressive sights. The initiation, which lasted more than 20 hours, was ultimately liberating. At one point, I was shown my habitual overuse of alcohol and the effect it was having on my relationships, my writing and my psyche. When I returned to the US, I steadily reduced my drinking to a fraction of its previous level - an adjustment that seems to be permanent.

Recently, I tried ibogaine for a second time. I took it at the Ibogaine Association, a clinic in Rosarito, Mexico. I had been contacted by a heroin addict who had been inspired to take ibogaine after reading the book I wrote about my experiences: three months after his first treatment in Mexico, he was still clean - after a 12-year dependency. He told me, "Your book saved my life." He had given Dr Martin Polanco, the clinic's founder, a copy of my book, and he had offered me a free treatment. I was curious to see how the experience would differ away from its tribal context. My new friend wanted to take it again to reinforce the effect. We went down together.

Polanco estimates that his clinic has treated nearly 200 addicts in its first 18 months. About one third of those patients have managed to stay clean - either permanently or for a considerable period; many have returned for a second treatment. "Ibogaine needs to be much more widely available," Polanco says. "We still have a lot to learn about how to administer it, how to work with it." He does not think iboga is a cure for addiction, but is convinced it is a powerful tool for treatment - and, in some cases, it is a cure. He plans to set up several non-profit clinics. "This is something that should be non-profit," he says. "After all, it is a plant. It came up from the earth. It does give you some guidance. It shows you how you really are." He chuckles. "That can be scary."

The Ibogaine Therapy House in Vancouver, British Columbia, opened last November. "So far, we have treated 14 people quite well," says Marc Emery, the clinic's founder and head of the BC Marijuana Party. "They all say that their life has improved." Emery, nicknamed the "Prince of Pot", is funding the free clinic with proceeds from his successful hemp seed business. "Ibogaine stops the physical addiction without causing withdrawal," he says, "and it deals with the underlying psychological issues that lead to drug use."

Emery estimates that treatment for each patient at the clinic costs around \$1,500 (£943), which includes two administrations of the drug. "When I found out about ibogaine, I felt that someone should be researching this, but the drug companies aren't interested because there is no commercial potential in this type of cure." Neither he nor Polanco is too concerned about ambiguous studies on ibogaine's toxicity. As the Jama article noted,

"One reviewer wrote that the drug's toxicology profile was 'less than ideal', with bradycardia [an abnormally slow heartbeat] leading the list of worrisome adverse effects."

"From the masses of reports I have studied, a total of six people have died around the time they took ibogaine," says Emery. "Some were in poor health, some took other drugs at the time of their treatment. That doesn't scare me off. I have a lot of confidence in ibogaine."

At this stage, with little scientific study, the true toxicology of ibogaine is impossible to determine - the treatment is unlicensed in other countries and illegal in the US. The decision whether or not to take such a risk is entirely personal. Emery notes that his clinic screens for heart problems and other medical conditions that might contraindicate the treatment. It also gives patients small daily doses of iboga for two weeks after their initial treatment. "Iboga tends to make anything bad for you taste really crappy. If possible, we want our patients to quit cigarettes at the same time. We think that cigarettes can lead people back to other addictions."

Emery notes that nobody has so far criticised the project, and he is seeking support from local government. "Iboga tells you to change your ways or else - it goes over all of your health and personal issues. It is like the ghost of Christmas past."

Randy Hencken drove us from San Diego to the Ibogaine Association. A 25-year-old former heroin addict who had kicked the habit after two ibogaine treatments at the clinic, he was now working for the association, going to local methadone centres with flyers and keeping in contact with former patients. The first treatment costs \$2,800 (£1,760), including an initial medical examination and several days' convalescence afterwards, but subsequent visits are only \$600 (£377) - and it seems most addicts need at least two doses of ibogaine to avoid relapsing.

The Ibogaine Association is in a quiet, dignified house overlooking the Pacific, decorated with Buddhist statues and yarn paintings from Mexico's Huichol people. I was given a medical examination by Polanco and a test dose of the drug. Twentyminutes after ingesting the test dose, I started to feel nervous and light-headed. As I took the other pills - a gel-capped extract of the rootbark powder - I realised I was in for a serious trip.

The nurse led me back to my room. My head already spinning, I lay back on the bed as she hooked me up to an electrocardiograph and headphones playing ambient music. Why was I doing this again? Ibogaine is no pleasure trip. It not only causes violent nausea and vomiting, but many of the "visions" it induces amount to a painful parading of one's deepest faults and moral failings. I had a loud, unpleasant buzzing in my ears - the Bwiti probably pound on drums throughout the ceremony to overwhelm this noise. With my eyes closed, I watched as images began to emerge like patterns out of TV static. I saw a black man in a 1940s-looking suit. He was holding the hand of a five-year-old girl and leading her up some stairs. I understood that the girl in the vision was me and that the man represented the spirit of iboga. He was going to show me around his castle.

While startling at the time, such an encounter with a seeming "spirit of iboga" is a typical vision produced by the Bwiti sacrament. In many accounts, people describe

meeting a primordial African couple in the jungle. Sometimes, the iboga spirit manifests itself as a "ball of light" that speaks to the baanzi, saying, "Do you know who I am? I am the chief of the world, I am the essential point!" Part of my trip took the form of an interview that was almost journalistic. I could ask direct questions of "Mr Iboga" and receive answers that were like emphatic, telegraphed shouts inside my head - even in my deeply stoned state, I managed to scrawl down in my notebook many of the responses.

I asked Mr Iboga what iboga was. I was told simply: "Primordial wisdom teacher of humanity!"

Later, my personal faults and lazy, decadent habits were replayed for me in detail. When I asked what I should do, the answer was stern and paternal: "Get it straight now!"

This ideal of straightness, uprightness, kept returning during the trip - a meaningful image for me, as I suffer from scoliosis, a curvature of the spine. When I was shown other faults that seemed rather petty and insignificant, I tried to protest that some of these things really didn't matter. Iboga would have none of it, insisting: "Everything matters!"

Iboga told me that I had no idea of the potential significance of even the smallest actions. I reviewed some events in my life and my friends' lives that seemed bitterly unfair. Yet, in this altered state, I felt I could sense a karmic pattern behind all of them, perhaps extending back to previous incarnations. Iboga affirmed this, dictating: "God is just!"

To many readers, these insights may sound trivial. They did not feel that way at the time. They were delivered with great force and minimalist precision. While they might have been manifestations of my own mind, they seemed like the voice of an "other". Generally, I never think in such direct terms about "God", and "primordial wisdom teacher" is not my syntax.

During the night, I had numerous visions and ponderous metaphysical insights. At one point, I seemed to fly through the solar system and into the sun, where winged beings were spinning around the core at a tremendous rate. Up close, they looked like the gold-tinged angels in early Renaissance paintings. Perhaps due to my recent reading of the Austrian visionary Rudolf Steiner, this whole trip had a kind of eco-Christian flavour to it. At one point, I thought of humans as an expression of the Gaian Mind, the earth's sensory organs and self-reflective capacities, at the planet's present state of development. If we are changing quickly right now, I considered, it is only because the earth has entered an accelerated phase of transformation, forcing a fast evolution in human consciousness.

The loud buzzing sound that ibogaine produced seemed to be something like a dial tone, as if the alkaloid were in itself a device for communicating on a different frequency than the usual one. Thinking of my girlfriend and our child, I realised that I was lucky - "You are lucky!" Mr Iboga echoed. I felt tremendous, tearful gratitude that I had been given a chance to live and love, to explore and try to understand so many things.

As so often these days, I pondered on the terrible state of the world - wars and terrors and environmental ruin. I saw sheets of radioactive flame devouring cities, huge crowds reduced to cinders. I asked Mr Iboga if this was going to be the tragic fate of humanity. The answer I received was startling - and reassuring: "Everything is safe in God's hands!"

As ludicrous as it may sound, this message has stayed with me and alleviated much paranoia and anxiety. While tripping, I decided that Mr Iboga was a form of enlightened mind, like a buddha who had chosen a different form, as a plant spirit rather than human teacher, to work with humanity, imparting a cosmic message of "tough love". At one point I asked if he would consider incarnating as a person, and the answer I got was, basically, "Already did that!" - implying that, in some previous cycle, he had passed through the perilous stages of evolution we are now navigating. I also came away from this trip with the suspicion that iboga was the original inspiration for the tree of the knowledge of good and evil in the Biblical tale. The plant's placement in equatorial Africa, cradle of humanity, would support this idea, as well as its sobering moral rectitude. The "good and evil" that iboga reveals is not abstract but deeply personal, and rooted in the character of the individual! .

Late in the night, I retched and vomited out bitter rootbark residue. I put on a CD of African drumming. Closing my eyes, I watched a group of smiling Bwiti women dance around a jungle bonfire. After that, the visions died down, although it was impossible to sleep until late the next night.

My friend in recovery had a less visionary experience. His faults were also paraded in front of him in repetitive loops that seemed endless. At one point, I heard him scream out, "No! No! No!" He saw a possible future for himself if he didn't kick heroin - becoming a dishwasher, sinking into dissolute old age with a bad back and a paunch. He asked what he could do to help save the world. He was told: "Clean up your room!" Meditating on his experience later, my friend quipped, "Ibogaine is God's way of saying, 'You're mine!' "

* Daniel Pinchbeck's book about his experiences, *Breaking Open The Head: A Visionary Journey From Cynicism To Shamanism*, is published by Flamingo.

Wall Street Journal (US) Mon, 15 Jul 2002

AN ARRAY OF NEW DRUGS SHOWS PROMISE IN FIGHTING ADDICTIONS

by: Gautam Naik

Could people be inoculated against drug addictions the way they can against some infectious diseases?

It may be possible. Despite disappointing past efforts to treat addictions with medicine, recent research indicates the approach has merit. In one study, about 50 smokers in Belgium were injected with an unusual drug, code-named TA-NIC. After taking as many as five doses in 10 weeks, two of the study's subjects quit smoking. Several others reported less desire to smoke, says Xenova PLC, the drug's British maker.

The experimental drug is one of the first attempts to design an antismoking vaccine. By producing antibodies in the user's blood, it prevents nicotine molecules from entering the brain and triggering a "high." Denied such pleasure, a smoker theoretically has less incentive to light up again.

Vaccines are just one of several new medical approaches to fight the escalating problem of addiction. Some 3.2 million Americans and 1.2 million people in Western Europe are hooked on hard drugs such as heroin, cocaine and speed, according to the United Nations. Millions more are dependent on tobacco and alcohol. Dealing with this -- in terms of health care, law enforcement and lost productivity -- costs a staggering \$300 billion each year in the U.S. alone.

Past efforts to fight addiction with medicine have been plagued by high relapse and dropout rates. And despite the huge revenue opportunity, big drug companies have barely gotten involved, largely because of the perceived stigma of dealing with a disreputable part of society. But the obvious need for antiaddiction treatments continues to make the field attractive. Last week came news that several scientists from GlaxoSmithKline PLC and Roche Holding AG are breaking away from their parent companies to form a Swiss company, Addex Pharmaceuticals, that will focus on compounds for nicotine, alcohol and cocaine dependence.

In pursuing medical solutions to addiction, some researchers are studying dopamine, a pleasure-causing chemical in the brain that transports messages from one nerve cell to another. Usually, only a certain number of dopamine receptors in the brain are turned on in response to low levels of the chemical. But when a user has an alcoholic drink

or snorts cocaine, that steady dopamine flow suddenly becomes a flood and affects many more receptors.

Denmark's NeuroSearch A/S is developing an anticocaine and antialcohol drug that raises the body's normal level of three chemicals -- dopamine, serotonin and noadrenalin -- and thereby boosts the pleasure a person feels. "It fools the brain into thinking that the person has taken alcohol or cocaine," says Ole Graff, medical director for NeuroSearch. Unlike cocaine, though, Neuro-Search's drug enhances the user's mood in a gentle and gradual way. Animal tests suggest the company's drug isn't addictive.

The drug was shown to be safe in early-stage clinical trials with 90 people. Dr. Graff says early-stage tests with cocaine addicts showed that "they no longer had any craving" for cocaine. He concedes that longer-term studies are needed.

Scientists at the Brookhaven National Laboratory in the U.S. have pinned their hopes on Vigabatrin, an epilepsy drug sold in Europe but unavailable in the U.S. In a test in February, 20 rats were given the choice of drinking from three bottles containing water, alcohol, or a mixture of alcohol and cocaine. The rats got hooked on the alcohol-cocaine mix. They were then injected with Vigabatrin. Within two weeks, they spurned the alcohol-cocaine bottle and chose to drink only water.

Vigabatrin works by lowering dopamine levels. A person's normal dopamine level fluctuates by 20% to 30%, but cocaine makes it shoot up 500%. Vigabatrin brings that level down to the normal 20% to 30% range, says Stephen Dewey, who specializes in addiction research at Brookhaven.

Vigabatrin has shown equally promising results in animal studies using heroin, amphetamines, Ecstasy and nicotine. Human trials could start by year's end, according to Catalyst Pharmaceutical Partners of Coral Gables, Fla., which has licensed the rights to develop Vigabatrin for drug addiction.

Dopamine-reducing treatments have limitations. Drug abusers could overpower therapeutic effects simply by taking bigger doses. Also, Vigabatrin takes two weeks to have an effect. And some scientists say dopamine's role in addiction may be only part of the story: One experiment with genetically engineered mice showed that although they lacked the target to which cocaine molecules attach themselves, the animals still craved a cocaine fix. The upshot: "Most likely other chemical systems in the brain, like serotonin," are involved in addiction, says Mark Caron, a scientist at Duke University, which did the tests on mice.

Taking the vaccine approach, Nabi Biopharmaceuticals tested an antinicotine vaccine in animals and cut nicotine levels in their brains by as much as 64%. Last month, the

Boca Raton, Fla., firm began human tests. DrugAbuse Sciences Inc., Menlo Park, Calif., is developing a similar vaccine for cocaine.

Britain's Xenova may be furthest along in developing both a cocaine and smoking vaccine. Both substances' molecules are tiny enough to sneak through the blood-brain barrier; to prevent that, scientists made the molecules larger, thereby blocking their entry into the brain and preventing the user's "high."

Based on early-stage human trials, "we clearly have a product that is safe," says David Oxlade, Xenova's chief executive. "More important, we have demonstrated that both smokers and nonsmokers who were given the vaccine produced nicotine-specific antibodies." But Xenova says a commercial product isn't expected before 2006.

Another approach involves ibogaine, a hallucinogenic drug derived from a West African shrub, which showed some success when used in underground treatments in the 1990s in Holland. Its reputation was tarnished when two women died after taking it. Still, academic papers and anecdotal evidence point to its antiaddictive qualities.

Deborah Mash, a pharmacologist at the University of Miami, believes in ibogaine. Backed by the government of St. Kitts, she supervised use of the drug to treat about 300 patients on the Caribbean island. She says most of the patients were American, and that they paid about \$10,000 for 12 days of treatment.

In February, Dr. Mash and colleagues won patents for an ibogaine metabolite, a compound produced when a drug undergoes chemical changes in the body. Dr. Mash believes that the metabolite won't have the unwanted mind-altering effects that ibogaine has. She has a green light from the U.S. Food and Drug Administration for clinical trials of ibogaine but wants the FDA's approval to test the metabolite. She also must find a company willing to commercialize the drug. "There are desperate addicts screaming for this," she says. "Now it all comes down to money."

A shorter version of this article appeared in the *London Times*

IBOGAINE

by: Simon Witter

It may change society and save the lives of hundreds of thousands of people (at a conservative estimate), but ibogaine development is being tied up in a bitter legal war that has already almost ruined the man who discovered it. Is this the blessed chalice, the cure to drug addiction and more? Is it the greatest pharmaceutical discovery of the late 20th century? Or will it turn out to be just another story of a maverick visionary being shafted, and all benefits lost to mankind? Simon Witter investigates....

Suzie's head felt like it had been split open. Light was everywhere. She could see her cleansed brain, and it shone with a brightness that was hard to look at, but she knew she must try. Images flickered around the screen of her consciousness, illuminated one-by-one by a dazzling beam of light, which moved on speedily, picking out new subjects with a relentlessness that she could not control.

Suzie is entering the second phase of a 36-hour experience that may well cure her addictive behaviour for ever. A few hours ago she took a dose of ibogaine, and now she lies in a waking dream, being ravished by dramatic visions that she must interpret to make sense of the way her life has turned out. Suzie's hope is that, without suffering the pain of withdrawal, she will wake from this trip and never feel the need to take heroin again. The evidence of hundreds who have gone before her point to her chances being very good.

Ibogaine, an alkaloid derived from the root of the african plant tabernanthe iboga, is a hallucinogenic substance used in the initiation ceremonies of the Gabonese Bwiti society. In the 90s, its ability to block opiate withdrawal symptoms while delivering intense therapy has put it at the centre of a raging scientific debate. If it can be brought to the mass market at an affordable price, and if it works as well as its many advocates claim, ibogaine's potential is quite extraordinary. Painlessly curing opiate addiction is in itself one of the holy grails of the medical world, but the ibogaine experience is also said to be highly effective in curing cocaine, alcohol and even tobacco addiction, as well as a variety of other addictive behaviour patterns.

Around 300 people have been treated with ibogaine this decade but, at present, it remains an extremely expensive affair. While it is legal everywhere else, ibogaine is restricted in Belgium and Switzerland and illegal in the US where, ironically, it is classed in the same category as the hard drugs from which it provides relief (a result of the panicky, post-psychedelia 1970 Controlled Substances act).

The three main players in the world of human ibogaine treatment are Howard Lotsof, Dr Deborah Mash and Eric Taub. Lotsof, the man responsible for the new interest in ibogaine, occasionally treats people in a 7-day hospital programme in Panama at a cost varying from \$8,000- \$20,000, while University of Miami neuro-pathologist Dr Deborah Mash has established a competing 14-day programme in St Kitts (\$10,000). Devout ibogaine advocate Eric Taub used to treat people on a boat in international waters. He now has clinics in Costa Rica and Italy (\$2,200), and is the source of most satisfied experience reports.

There may be up to a dozen underground outfits in the Taub mould, and the internet occasionally features mail-order deals for the crude botanical (root bark) from Africa, but until ibogaine is legal, affordable and widely available, the people taking it will largely be the privileged rich, in many cases paying through the nose to be research guinea pigs.

"I remained at each level until I was comfortable with it", remembers Bob, one of Taub's patients. "Then a very strong wave hit me and things began to escalate rapidly. There were sapphire blue tendrils that moved up the wall and became flowers, as well as other moving configurations of light. They were beautiful. I began to hear music, voices, a cacophony of other whirring, drumming, and creaking, rushing sounds. Although I was scared, I liked it. It seemed that things remained awhile until I got comfortable, then went beyond anything I had ever experienced. I was floating in a sea of physical sensations and began to close my eyes. I saw a whole universe behind my eyelids which I can only describe as the creative mind. My eyelids were the window to an array of visions floating in a void."

"The whole time my normal thought processes continued and things or people would appear visually or music would play if I thought of it. I had a sense that things I needed to find or understand were located in this mind, also that thought creates an infinite number of realities. I could open my eyes and still had a sense of being in the room but the hallucinations there were extraordinary. I felt through all of this that I might be resolving a number of different conflicts within myself very rapidly, that Iboga was teaching me. I began to sense a threshold, a jumping off point if you will, that would totally disconnect me from this reality, but at the same time I would resolve my deepest conflicts. I would reconnect to something I've lost; I would see the face of God. I became terrified, fearing for my life and sanity, and I vomited, which immediately pulled me back from the threshold."

As wild as this memory of an ibogaine trip may sound to the average reader - and it is by no means the wackiest of the many different experience reports circulating - it is just one of a hundred first-hand testimonies to the effectiveness of a new drug that is provoking a flood of scientific interest. There have been around 4,000 research papers

on the subject so far, including snappy, layman-friendly stuff like: "Quantum Coherence in Microtubules: A Neural Basis For Emergent Consciousness?".

In the 1950s and 60s, American psychologist Leo Zeff and psychiatrist Claudio Naranjo were using it in their practice, and chemical giant the CIBA corporation (now CIBA-Geigy) was investigating its usefulness as an anti-anxiety drug, but ibogaine's potential to painlessly release people from the craving for drugs was discovered quite by accident.

In 1962, Howard Lotsof - a Jewish film student from New York - was given a single dose of ibogaine. Deciding that a 36-hour hallucinogen sounded too exhausting for him to want to take, he gave it to a much more experienced friend, who came back and told him that this was a completely new kind of drug. Howard was part of a focus group of 20 or more friends self-experimenting with psychoactive drugs like Mescaline, DMT, psilocybin and LSD (all legal at the time). Some of the drugs were euphoriant, some weren't. They took ibogaine as part of that experimentation, with no intention whatsoever of giving up any kind of drug use, but 33 hours later Lotsof discovered that he was no longer dependent on heroin. For six months after that one dose he also stopped taking cocaine and all other drugs. The effect on the rest of the group was much the same.

Lotsof was 19 at the time, and knew very little about pharmaceutical development, so nothing became of this accidental revelation. As an active member of the counterculture, he spent the 60s ferrying student strikers from one area to another during the Free Speech Movement in Berkeley, California, re-acquainting himself with heroin in 69 and finally detoxing and stabilizing his life in one of the first methadone programs in 1970, after which he ran a plumbing business in New York, studied film and television again and worked as a line producer for Rock Against Racism concerts. But in the 80s he began to feel that his youthful discovery was "too important not to pursue", and started hunting for pharmaceutical grade ibogaine to conduct research with. In 1986 he had founded a New York corporation, NDA International, Inc., whose purpose was partly a humanitarian mission and partly the marketing of a proprietary pharmaceutical preparation, Endabuse, composed of capsules of ibogaine hydrochloride. He had filed patents for the use of ibogaine to treat addiction, and was well on the way to bringing this treatment to the needy millions.

Initial, over-simplified reports of the way ibogaine works suggested that the subject re-lived their entire childhood in 36 hours, during which they identify the holes they are filling with their addictive behaviour. Having understood why they're behaving this way, they wake up cured of those urges. If one dose of ibogaine really did deliver a lifetime of therapy, it would be quite simply the greatest pharmaceutical breakthrough of the late 20th century - curing all addictions, and thereby not only

freeing up all the millions tied up in fruitless drug wars, but also putting therapists all over the planet out of work.

"During my look into the void," says Bob, "I had seen all of my loved ones who are still living, and had the experience of vignettes of my relationships with them, accompanied by a profound and compassionate love. In this, my second much less dramatic phase, I lay in bed for 12 hours, experiencing hundreds of vignettes, very much like day dreams, but more vivid and in great detail. The difference was the rapidity and incredible number of vignettes and their detail and sometimes very abstract quality. These daydreams eventually just devolved into mind chatter that became annoying. I got a little something to eat, and read myself to sleep. I awoke feeling refreshed, ten years younger, and more at peace than I have been in years. I also have a sense that there are more things in heaven and earth than our eyes have ever seen."

"Ibogaine does not preclude the need for therapy," Lotsof insists. "Quite the opposite. It opens up the soul of the most repressed person, freeing old memories and making them immediately open to intense therapy. Part of the resistance to ibogaine may be that it requires doctors and therapists to work very much harder over a short period. There's no saying: 'I have a space for you next Thursday'. Someone who has taken ibogaine is ready to go right now!"

Ken Alper MD, assistant professor of psychiatry and neurology at New York University, has no problem with the spacier descriptions of the ibogaine experience: "I crossed the threshold of belief," he says, "when I saw a young man go down to Panama on 70mg of methadone a day, and come back on nothing. And he was comfortable. Pharmacologically, I don't know any other substance that can do that."

It should be noted that, while the vast majority of ibogaine experience reports are very positive, the drug does create very different experiences in different people, and some recipients have been quite the opposite of happy with the results. Janet, a Californian alcoholic who paid \$10,000 to undergo ibogaine treatment (along with ten heroin addicts) as part of Dr Mash's St Kitts programme last December, remembers it not working at all.

"It's like acid times one million. I was also seeking God in a pill" along with all of the other entheogen advocates. I saw God alright - I talked to him. And I was so sure it was real. But it wasn't. It wasn't an all-loving God. It was someone who scared the crap out of me. Some of the "addicts" became Jesus Christ and were crucified or had aliens rape them. Ibogaine worked for me for a month - you know why? Because it makes you so physically sick you can't even stand the thought of eating, much less drinking or doing drugs. The "visions/trip" were so excruciating I never wanted to be altered again. I felt I was near death during the trip because I was having trouble

breathing. "God reminded me to breathe. The embarrassment of paying such a price for a bogus deal. (I was told there was a 100% success rate with alcoholics). Those are the reasons I was able to go a month without a drink."

"I understand that there are people who believe ibogaine ended their respective addictions. Great! I would have loved the same results. But, it didn't work for me, and it didn't work for anyone else that I met who took it. After you are given ibogaine, you are supposed to follow up with antidepressants and therapy. If ibogaine ended addictions, why in the hell would you need anything after it?! All I'm saying is that addictions are tough. And so far, there is no magic bullet - not even ibogaine."

So just what is the success rate for ibogaine treatments? "If you're looking at opiate detox," says Lotsof, "I'd say almost 100%. If you're talking about interruption of chemical dependence, I'd say 10% are immediately cured, 10% aren't cured at all and the rest require three to four treatments over a two year period, because we're not just talking about a pharmacological reversal of chemical dependence. Chemical dependence is a learned behaviour that has to be unlearned. Ibogaine is an unlearning tool, as well as a substance that blocks narcotic withdrawal."

Good therapy is something all ibogaine patients stress as being a vital component of treatment. "The longterm successes of ibogaine have been compromised," according to Ken Alper, "by the lack of a systematic plan before and after the experience. Ibogaine just buys you a window of time. It doesn't substitute for therapy. It's like a near death experience - white light, a torrent of information that allows you to review your life and unstring associations from their obsessions. But how you interpret that is crucial."

"It is the best opportunity for psychological self-exploration and healing I have ever experienced," says Laura. "But it is not a penicillin shot, where the healing is done unconsciously. It requires cooperation. The most significant gift I have received from Iboga is the freedom to play without guilt. I am much more vitally in touch with all of life, less separated, more unified. I have a more awakened sense of taste and am enjoying flavors with a heightened pleasure. I am in awe of the intricacy and beauty of nature in an ecstatic way. I no longer feel a need to fix anything in me or anyone else, no need to accomplish anything although I may do either: I am relaxed into the simple joy of just being. For about seven days after my experience, I continued seeing the light energy flowing through all matter, particularly upon awakening. It shimmered all around me and I could conduct its movement by waving my arm. What fun! Now, one month after the experience, I see myself as positive, confident, free and serene."

This sounds utterly fabulous but, during her experience, Laura also saw images of her own death and vomited the drug out, later regretting her failure to grasp the

opportunity to "go through the death experience into the next dimension". Each patient clearly brings a lot of their own baggage to the ibogaine experience, but even some of the most subsequently-happy recipients have reported an element of terror, not to mention visions of the past, present and future co-existing. The idea of treating drug addiction with a psychoactive drug is one of the more controversial aspects of ibogaine - a possible hurdle on its path to mainstream acceptance - and, in view of the dramatic nature of the trip, it might be fair to assume that patients should be psychedelically experienced.

"I don't think so," Lotsof insists. "You can be naive to any other hallucinogens and simply receive the treatment. It's not an LSD-like drug. There are no significant mood swings. You're not going to experience significant euphoria or depression. It's very neutral which, to me, makes it a very safe drug. My concern would be people with cardiovascular disorders, because of the exhausting nature of the experience. To be awake for 24, 36, 48 hours, I don't want to place that kind of stress on a person who already has a serious medical condition. The data we're getting from the animal model suggest that ibogaine is actively an anti-seizure drug, but so far we haven't accepted anyone for treatment who has epileptic or seizure disorders. The patients most difficult to treat are those that come in with a focused anger. It almost overrides the psychiatric benefits of ibogaine. It's anger at somebody - that woman, that father, that mother - and throughout the entire experience they use that anger to focus on anybody but themselves."

Recent medical research suggests that ibogaine has a number of wondrous physical properties. Many patients have described the experience as being like a re-setting of their controls, and Ken Alper found that it physically did exactly that to the abnormal brain waves of crack addicts that he monitored before and after ibogaine ingestion. "Drug addiction is nature's sadistic joke," he explains. "The addictive brain is out of balance, its chemistry deviates from the normal. Ibogaine normalises the EEG, it resets the brain."

Patrick, a London-based multi-media visionary, has been disappointed by the emphasis on ibogaine as an addiction cure. "Nobody seems to be talking about its general usefulness as a tool of self-learning," he complains. But, while its power to attenuate opiate craving is so spectacular, many patients have been people wanting to revisit their past as opposed to get off drugs. "Ibogaine," Lotsof confirms, "is the most effective substance I've ever come across in terms of its use in psychoanalysis or psychotherapy."

Sarah Emanon, a therapist in her mid-50s who assists Eric Taub, has taken ibogaine three times herself, reporting spectacular success with her quest to understand her lifelong feelings of isolation. "I went back to being with my adopted mother as an infant while she was holding me. My head was bobbing, and my nose was banging

into her neck - I could feel it physically. I can still feel it - it is such an interesting sensation. Then I smelled her, and it didn't feel right. I can still remember that reaction. I didn't want to be near her. I was trying to get away because it didn't smell right..... For me, this was the beginning of owning my own process rather than projecting it onto others. I had had years and years of therapy, but I had never gotten to that piece. And I found myself witnessing that I had never bonded to that mother. And for the first time, I really experienced that lack of bonding, and why it never occurred: She didn't smell right, and there was no connection."

"I found myself asking the question: Can I remember my birth mother? And soon I was back in this other experience in which I was totally merged into another being. I could kind of feel my distinction, and yet not feel my distinction. I could kind of feel where I was this small infant, but I was part of this vast amount of soft skin also. And I could feel the warmth and the smell, and everything was me! It was bigger than me, but it was me. And I could feel this woman's tenderness. And there were points where I could feel tears hitting my body. I could feel her sadness, and it was my sadness. It was a sadness I have felt throughout my life. Then there was the experience of being taken away and being alone. It wasn't particularly painful, but it was very alone. That was my deeper understanding of what it is that I do. There was nobody to take care of me, so I learned how to take care of myself, how to be okay, and be alone. And so, throughout my life, I would have to get alone to become okay. I would be with people and lose myself, and then have to go and be alone in order to kind of gather myself again."

Long before Ken Alper's brainwave research, Emanon believed that ibogaine reset the body's chemistry. "Somehow the ibogaine seems to effect some kind of basic change that does not depend on conscious insight and memory of what is learned during the session. My hunch is that while we are working with psychological process, there is a physiological, chemical change going on. For example, when working with hypnosis, and a person is in a trance, there is the possibility of reaching the memory on the cellular level, or the level of chemical imprinting. In an ibogaine experience, the body is physiologically and chemically open so that when the memory comes and it is re-experienced viscerally, the chemical correlates of the insight are also experienced physiologically. Perhaps the body chemistry is reset somehow in a way that prevents the repetition of the patterned behavior."

Any abuse of ibogaine is surely precluded by the stressfulness of the experience. "I do feel it's important for anyone considering ibogaine to know," says Randy, who took it to explore the human mind, "that it isn't a party drug. It's a serious encounter with the self. You are there, with everything you've got. And that's all there is."

"During the worst (or best) of it, I thought more than once I must be crazy to get myself in this miserable state", remembers one female patient. "This morning I still

had my doubts, but tonight I feel very positive about the whole thing, and could conceive of doing it again in a few years. This experience reminds me of two things. Lying on the bed and experiencing this, with the accompanying suffering associated with bringing forth something new and precious was just like lying in labour, silent, with no complaint, struggling to give birth to my sons."

The appearance of ibogaine on the illegal drug market was reported in 1967 by the police of Suffolk County, N.Y., on a single occasion, when it was used to dilute heroin, and after Haight Ashbury it was reportedly used by young addicts in San Francisco as a substitute for LSD. Ibogaine suddenly disappeared from the market and it seems that the drug dealers rapidly became aware of the fact that its use would deprive them of part of their clientele. It has also been reported that a Mexican clinic recently refused to carry out ibogaine research for fear that it would provoke the wrath of local drug lords.

Frankly, whether drug barons approve of ibogaine or not is by the by. The bad news is that ibogaine - which should have been about three years away from public availability - is not going to be with us in the near future. The laborious and expensive process of bringing a new substance to the mass market has been temporarily stopped by two killer blows.

Ironically, it is a legal tussle between the two people most vital to the development of ibogaine research that is standing in the way of immediate progress. According to Lotsof, the critical toxicity studies that were required for FDA approval (without which no drug can be marketed) have been stopped by Deborah Mash, who has now patented several ibogaine-like substances. Lotsof sued her for breach of contract, both for stopping the tests and patenting analogs which (under the terms of the contract) should belong to NDA. But Mash countersued, and Lotsof didn't have enough money to go to court. One day before he lost the case by default, he was offered the services of an attorney on a contingency basis (no win, no pay). The trial is now set to go ahead in the next few months, but for Lotsof it may already be too late.

"Putting myself aside," he says, "the way the FDA development of the drug has been held up for years is terrible. Though ibogaine is a restricted substance in the US, the FDA gave a go-ahead for human testing and the DEA is cooperative on the matter. That work should have been completed by now. It has simply been stopped while competing products have been developed, which are nowhere near the stage of ibogaine. They're a series of ibogaine-like drugs called Bioactive Tricyclic Ibogaine Analog and, as far as I know, they haven't even gone into animal studies yet."

Dr Mash, unsurprisingly, vehemently disputes Lotsof's version of events, insisting that the Tricyclic Ibogaine Analogs are a whole new class of compounds synthesised by a collaborator of hers at the University of Minnesota, independently from her clinical

trial in humans with ibogaine or from the Endabuse procedure. She also says that her 1992 contract with Lotsof covers "findings relating to the procedure of administering ibogaine", and that when (during that research) she, Juan Sanchez-Ramos and Doctor Lee Hearn discovered an active metabolite called Nor-ibogaine (a wholly new molecule), and disclosed their findings, Lotsof came down to Miami and discussed the new finding, agreeing on a 50/50 split with the university, then went back to New York, announced it was all his and threatened to sue. Though Mash had borne all the development costs, the University of Miami - fearful of litigation - assigned the rights to Nor-ibogaine to Lotsof, in lieu of a 12% royalty string. He then demanded half a million dollars from the University for the first patent application, while putting through a second patent that names him as the inventor and sole owner.

"It was a such a stupid thing," says Mash. "Here's the only academic environment that has ever offered him the chance to test his drug in a scientifically credible way, and he immediately turns round and bites the hand that's feeding him. At that juncture the ibogaine project was dead for lack of funds. I worked my tail off to get the FDA to approve the tests, and when I got FDA approval to go into humans, I increased the value of his patents significantly, but he still can't bring in any money at all. It takes a lot of money to get a drug through FDA approval. I don't have it, and it's not my job to pay for the development of ibogaine so he can make all the money off it later. Nor-ibogaine, which I'm very excited about and think holds real promise, is at the point of being abandoned. We tried to negotiate with Mr Lotsof, we asked for a meeting and offered him money and a share. But he doesn't want that. He wants full control. Lotsof's ego won't let anyone else be a part of it. He has poisoned every well."

On top of the bust-up with Dr Mash, NIDA (the National Institute on Drug Abuse, a branch of the National Institute on Health in Maryland), which has already pumped many millions of dollars in grants into ibogaine research, seems to have gone cold on the whole idea. One of many theories about why this has happened is that there is a "methadone mafia" entrenched in both NIDA and the scientific/medical community that feels deeply threatened by the prospect of a proper cure to addiction. Lotsof himself is not so sure about this conspiracy theory. "Even some of the methadone people are beginning to swing around. The responsible ones would like every tool at their disposal to help people dependent on drugs, but any new technology is met with resistance by the old guard. NIDA had no just cause not to proceed with Ibogaine development. They know full well that in hospital-administered safety studies there would be little chance of medical emergencies, and their concern relating to neurotoxicity has been shown to be nil."

Dana Beal, AIDs activist, Yippie movement founder and co-author of The Ibogaine Story, feels strongly that NIDA has a problem with Howard Lotsof's background, that his roots in the counterculture and his ultimately sensible views on the state's idiotic

"war on drugs" make him someone they would rather demonise than help, however good his product. "Things Deborah Mash said to me before we stopped talking indicated that NIDA had a problem with Lotsof. Howard was too close to people like me. ONDCP (the Drug Czar) has been under instructions not to deal with legalizers since mid-93 at least."

"I spent four years working with Howard Lotsof," says Frank Vocci, Director of The Medications Development Division at NIDA, who takes great exception to this idea. "There's no way I would spend several million dollars of taxpayers' money - and we did - just to basically parry someone off in a clever fashion. I'd tell them flat-out to get lost."

Though he admits that NIDA is now concentrating on its own specific cocaine-blocking products, Vocci sighs with frustration at the suggestion that ibogaine is being held back to further them. "I'd say the converse is true. It was a major project here, and we gave this our best shot and spent an awful lot of resources and staff time on it we could have spent on something else. In 95 we asked a group of outside clinicians if we should go ahead with this drug. We got nine serious NOs and four tentative YESses. Our current policy is that we will not initiate any research from within the institute, but we will fund research on ibogaine that gets through the peer review process with a fundable score."

NIDA's decision to backpeddle on ibogaine had a lot to do with the separate deaths of two women who had taken ibogaine. As these were later demonstrated to have not been caused by ibogaine, cancelling the programme altogether seems a very harsh response. "I know," says Vocci. "But it happened and I'm sorry. You have to live with that. Two deaths in about a hundred patients, a safety risk and a pharmacokinetically variable substance with a method of toxicity that appears to be unknown - this is not what gets a drug development project a head of steam. We were presented with ibogaine as a total cure, then the ratios went down to about one in eight patients totally cured. We can do that well with non-pharmacological treatments that are a lot less risky. And the effectiveness of ibogaine has been questioned. When we do clinical trials, we're very concerned about bias, known or unknown, and the people reporting these successes are a self-selecting sample who can afford to pay \$15,000 to get off drugs. I'm not saying for a minute that they're getting a placebo - ibogaine definitely effects the brain - but they may have reason to want to believe that it works."

In a long and fascinating letter to Frank Vocci dated 3/10/95, and released a year later after a Freedom Of Information action was filed, Curtis Wright (Medical Review Officer of the Pilot Drug Staff of the FDA) outlines why - though ibogaine is a very good thing - he feels that NIDA should support but not directly develop it themselves. "Drugs that NIDA develops directly should be, as far as possible, EASY WINS'

where the pharmaceutical development questions are minimal.....Ibogaine is too big a job for your team at this time. It may prove a black hole, sucking all your resources down a single venture capital' project.....What is not speculative is that a significant number of members of the public that we serve feel that the drug deserves investigation. You face the problem of deciding how far to expend research dollars funding their desire to see the drug evaluated."

As a NIDA-approved researcher, Dr Mash noticed the organisation's change of attitude when, in a last ditch attempt to raise funds for ibogaine research, she applied for a grant to research its use in treating cocaine addiction. "They turned down my grant application, which has never happened to me before, in language that made it clear they didn't want to know. I wept when I got that, because I didn't believe we'd see that, and I thought then that ibogaine was dead". She continues to research and treat with ibogaine at her recently established Healing Visions Institute for Addiction Recovery in the Caribbean but, when trying to get investors for this venture, she found that intellectual property was a real issue, and is now petitioning the court for a designation about the Nor+ patent, "because we feel that Lotsof is not the inventor".

If ibogaine works so well - and the Mash/Lotsof legal tussle suggests that they know its future potential only too well - corporations and capitalists everywhere should be falling over each other to invest in a slice of the pie. George Soros, the billionaire businessman with an enlightened attitude to US drug policy, regularly sponsors ibogaine seminars in New York, but big business backing is palpably lacking.

"Despite what appears to be a huge market for a drug that could interrupt drug addiction," says Don Allan, "ibogaine does not fit the profile of a prescription drug that can make money for a pharmaceutical manufacturer. Most prescription drugs are administered daily over a period of weeks, months, or years. Ibogaine is generally used once in a single dose, and then followed up with several months of psychotherapy."

"Over the last 15 years," says Lotsof, "I have contacted many of the larger and some middle level pharmaceutical companies, as well as many investment houses and venture capitalists. From capital the answer is a question: Do you have FDA approval? When I respond no, they one-and-all said: 'No thank you, we've been burned before'. There has been and will be very little interest in major companies developing new medications to treat addiction. Addicts are dying at a much faster rate than the general population, and in a country like the U.S. there is a much greater chance of legal actions by the families of those who die, for whatever reason. Thus, when a pharmaceutical company makes a decision on what drug they will develop or not, they must take into consideration the risks related to litigation. The key is legal liability, and a fear of having their medications associated with addiction, treatment or not."

This may sound like a glib view of pharmaceutical philosophy, but it has some background. Swedish pigs are currently the only beneficiaries of amperozide, an anti-addictive substance discovered by accident at the turn of the decade. In 1992, Swedish police, intrigued by accounts of cure-seeking junkies breaking into farmers' barns, asked the Upjohn Corporation what amperozide was, and were told that it wouldn't be developed because "substance abuse was not a proprietary interest".

If this sounds like a gloomy prognosis for the drug, Eric Taub - who stands by his mission statement to try to treat 1% of the world's 140 million addicts - has no doubt that ibogaine will get out. "We don't have to be so bent on having it legal here. We can embarrass the US by having so much efficacy throughout the world that they will eventually come around. I have a Chinese chemist who can, in a two-to-three-year period, create 40,000 grams of the most active synthetic ibogaine. Then there's the organic. There are lots of different technologies. We've got a vegetative cloning technology where a chemist of mine can create over a million potted seedlings in 9-12 months, to be grown anywhere in the western hemisphere, just from a five-inch biomass of the plant. There's a corporation in the making that will enable us to get the seed money to develop these technologies within the next couple of years. My vision is to have an Ibeginagain ibogaine centre in every city in the world where it's legal."

"Ibogaine is a paradigm shift," says Ken Alper. "That's why it's being resisted. That is consistent with the history of every truly new development in science. The 'movement' should be less bitter. That an informal self-help culture of addicts has got this far is quite amazing. These people have no political power, no big industry connections. It takes \$20-50 million to bring a drug to the market. They're halfway through that phase with no sponsor. That's not bad. And it's not over yet."

Presented at The Eighth International Conference on Drug Related Harm Washington, DC November 19, 1994

Introduction I have been working with chemically dependent patients, some having dual diagnoses, for twelve years in outpatient settings. My observations have been that the earliest phase of recovery, the first ninety days, is the most difficult for the therapist and the patient. I would like to compare and contrast certain issues seen as obstacles by patients, some of whom were treated with the Lotsof method and some treated in traditional outpatient settings. My observations are based on a small sample of patients seen in the U.S. and overseas. These observations are inconclusive and my work is ongoing.

My involvement with Ibogaine began in June 1993, when I was approached by the International Coalition for Addict Self-Help (ICASH) and requested to provide after care for five patients who were treated with Ibogaine and were eager to share their experience and struggles. Four of the group were white males ranging in age from

early thirties to mid forties. One was a female in her thirties. Their dependencies were to heroin, Methadone and/or cocaine. Additional substance use included marijuana, alcohol and psychedelics. This group met once a week for the duration of one year.

Concurrent treatment was provided to one member of this group on an individual basis. This patient, who we will refer to as ³M² is still presently under my care. ³M² is thirty-three years old and formerly heroin/methadone/cocaine dependent. He has been using drugs since the age of fourteen.

My most recent involvement with Ibogaine has been with NDA International, Inc. where I participated in the treatment of three patients using the Lotsof method in Panama. All three patients were white males in the thirty to forty age range. Two patients¹ major drug of choice was cocaine. The route of administration for one patient was nasal and smoking. The second patient also administered cocaine by IV route. The third patient was heroin/cocaine dependent and occasionally used methadone in attempts to curb his habit. All patients had used drugs from six to sixteen years.

One of the most difficult aspects of treatment is getting the patient to enter treatment. The three major obstacles are the fear of detoxification, lack of insight, and the inability of patients to control their urges to use drugs. These are the areas where I have observed the benefits of Ibogaine treatment versus traditional methods.

Fear of Detoxification Across the board, addicts who enter outpatient treatment programs report that their fear of detoxing from drugs has prevented them from attending treatment. Although withdrawal from cocaine is not as severe or obvious as that from opiate narcotics, there is a fear of the psychological pain of never being able to use again. There is also a dread that once drug free, feelings that have been blocked by self-medicating will surface and be too overwhelming for the patient to handle.

Most heroin addicts are petrified of withdrawal symptoms and are afraid of hospital detoxification. Outpatient clients have stated to me that they have delayed treatment to avoid this anticipated discomfort.

My observations with Ibogaine treated patients have been that patients are eager to be treated when they know that Ibogaine promises to eliminate painful withdrawal, takes one administration with up to seventy-two hours of supervised care, and promises to interrupt their urges to use drugs.

Three patients: Panama Patient '1' had used approximately \$100 each per day of heroin and cocaine by IV administration for twenty of the thirty days prior to Ibogaine treatment. Patient '2', prior to treatment was using \$80 per day of cocaine and alcohol. Patient '3' was using \$50 of cocaine on a daily basis via IV injection and smoking. He

had previously been heroin dependent. I observed during treatment with the Lotsof method, all of the three patients treated appeared calm and comfortable and exhibited no signs of withdrawal. This is significant considering the extent of the level of their drug use prior to treatment with Ibogaine. For these patients to have had little discomfort during withdrawal, speaks to the importance of the use of Ibogaine in the beginning of the recovery process. As patient 'M' had stated, 'Ibogaine is a much more humane and dignified approach to detox'.

Obstacles Within Traditional Treatment Returning to the obstacles of treatment, the second being the patients' lack of insight. Insight is necessary for patients to be able to focus and develop goals while in recovery. Patients in traditional outpatient groups who have less than ninety days clean, spend more time struggling with their urges to use and dealing with their defenses, specifically denial. They do develop insight into their problems, however, it takes at least one year of group treatment meetings one or two times a week on a regular basis.

In contrast, my involvement with providing after care for the Ibogaine treated group showed these patients as having tremendous insight into their own issues, their feelings, and what might have caused them to use in the first place.

After their Ibogaine treatment, patients began to see their drug use as destructive. This realization, coupled with psychotherapy, has allowed these patients to work on how to stay clean and to focus on what they must do to maintain a less destructive lifestyle.

The reason for this insight developed by these patients appears to be the release of repressed material during the visualization stage of Ibogaine treatment. This material includes both images and racing thoughts, which somehow get processed to allow patients to have a better understanding of their emotional histories.

The urge to use drugs again, is the highest cause for people to drop out of traditional treatment. Relapse, I think, is clearly inherent in the definition of substance-related disorders. In working with people treated with or without Ibogaine, my observations have been that relapse at some point is certain.

However, according to members in the Ibogaine group, Ibogaine had reduced their urges to use, anywhere from two months to more than one year. This advantage allowed these patients to get a head start in their recovery, whereas clients in traditional outpatient treatment have a great deal of confusion around how to control their urges. Consequently, those patients have to learn very basic and concrete ways to stay clean as taught by self-help meetings, and emphasized in psychotherapy. The Ibogaine after care group did not appear to need self-help type assistance to reduce their urges, but seemed to benefit well from psychotherapy.

Conclusion In conclusion, there is difficulty treating the drug addicted patient, particularly in the early stages of recovery, because of their fear of detox, their lack of insight, and their urges to relapse . Thus far, there is no opportunity for Ibogaine treatment within the United States. It is my recommendation that there be future research done with Ibogaine, so that some of the above mentioned observations are supported by more conclusive data. The prospects for a painless withdrawal method makes Ibogaine an attractive alternative to traditional treatment methods. Because Ibogaine interrupts substance related disorders, it gives patients a head start in their recovery. It also increases the patients¹ receptiveness to psychotherapy, which is a necessary component to the recovery process.

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Time Out (UK), 7 March 2001

Detox 'wonder' drug may face ban from

by: Judy Kerr

The Government is considering imposing a ban on a controversial hallucinogenic 'wonder' drug which has fiercely divided experts working in the field of opiate addiction. Its defenders argue that it offers a miraculous pain-free 'detox' experience, but detractors allege it has potentially fatal effects. The Medicines Control Agency (MCA) said that it is conducting an investigation into the West African rainforest shrub tabernanthe iboga, from the roots of which ibogaine is derived, following an urgent demand for restrictions on the drug from a London coroner. A MCA spokeswoman told *Time Out*: 'We are considering what restrictions would be appropriate because at the moment ibogaine is not subject to any special controls under legislation covering medicines.' Dr Paul Knapman recently ruled that tabernanthe iboga was primarily to blame for the death of 40-year-old John Worsley, who died by accident last year after he took capsules containing ibogaine in a desperate bid to kick his heroin habit. Westminster Coroner's Court heard that the Kilburn-based courier had obtained six grams of a herbal preparation purporting to be ibogaine through a Norwegian chemist. Worsley took the capsules throughout the day, during which time he seemed to suffer no adverse reactions apart from vomiting and diarrhoea - a normal response to withdrawal. However, after eating breakfast the next morning, he collapsed in the bathroom and was dead when the ambulance crew arrived shortly afterwards. Police toxicologist Dr John Taylor told the court that the level of ibogaine in the dead man's blood was 'well below the normal toxic dose'. And pathologist Dr Nicholas Hunt added that although he believed the extract had caused Worsley's death, it had been made worse because he suffered from Hepatitis C, which the coroner named as the secondary cause of death. Although it is an offence to possess ibogaine in the US, Switzerland and Belgium, obtaining the drug for personal use in Britain - where it is classified as an 'unlicensed, experimental medicine' - is not illegal. Exponents argue that it also helps those addicted to cocaine, crack cocaine, alcohol and tobacco to break their habits. Nick Sandberg, who runs a website on ibogaine from his London home, stressed that despite the fact that a number of fatalities have been recorded after ingestion of the drug, no deaths have been positively ascribed to ibogaine's use. 'I believe that what Worsley took was not actual ibogaine, but an extract of the rootbark of the plant source, which we know only contains around 5 per cent ibogaine,' he explained. 'This extract is the only "ibogaine" readily available to buy in Europe right now. In addition, Mr Worsley also took these capsules 40 hours prior to his death, by which time any ibogaine in his system would almost certainly have left it.' Sandberg points out that no detoxification methods are totally safe - methadone, the heroin substitute most often prescribed, kills 200 addicts a year in the UK. 'There have never been any deaths from pure ibogaine in a clinical setting, and we would always encourage people to take it under proper medical

supervision,' he insisted. 'It offers unique benefits, such as the inducing of a dream-like state where the user frequently gains vital insights into the psychological roots of their addictive behaviour, and a period afterwards of up to two months where they no longer crave drugs.' Sandberg wants drugs companies to back comprehensive research into ibogaine, a vital step for the Government approval needed to license it for availability on the NHS. 'I would ask that if the MCA deem any restrictions of ibogaine itself to be necessary, that these would in no way hinder the development of this medication as an addiction treatment, which in the absence of any corporate funding may have to proceed via local projects carried out by drug dependency units,' he concluded. In Britain, the Green Party is so impressed with the potential of ibogaine that it has promised in its election manifesto to fund medical trials of the drug.

Reprinted from *South Florida magazine*

Brain Waves

by: Nina L. Diamond

Cocaine overdoses had become more common in South Florida than frostbite in Alaska. At the peak of cocaine deaths, about seven years ago, Dr. Lee Hearn, laboratory director of the Metro-Dade Medical Examiner's Department, was at a loss to explain why so many people were dying of coke overdoses when the blood-levels of the drug were much lower than what was usually considered a lethal dose. The bodies came in, fluids and tissues were studied, and it was more of the same. Why were all these people dying?

Just a few minutes from Hearn's office near Jackson Memorial Hospital, west of downtown Miami, neuroscientist Dr. Deborah Mash, who'd known Hearn since their grad school days at the University of Miami, was busy running the UM School of Medicine's Brain Endowment Bank, teaching neurology and pharmacology, and keeping up with a full schedule of brain research. In her mid-30s then, Mash had already made a name for herself in Alzheimer's and Parkinson's disease research, and, as a specialist in pharmacology, she routinely played detective, studying the body's response not only to outside chemicals, but also to the ones the body itself created. By 1989, Hearn had noticed something quite unusual in the blood of fatal coke overdose cases. "As I reviewed cases, I saw that cocaethylene was often present in the blood. But nobody knew what it did."

Cocaethylene, discovered about 10 years ago, is manufactured by enzymes in the liver when cocaine and alcohol are mixed. It was thought to only be present in the urine, and to be of little consequence. So, when Hearn called scientists at Yale University and asked if they knew about any cocaethylene studies, he was told that this third drug, created by our own bodies, doesn't make its way into the blood stream. "Yes it does," Hearn replied. "We see it all the time." He sent samples. Yale verified them.

With proof in hand that he wasn't imagining things, Hearn went to his old pal Mash at UM. Backed by a National Institute on Drug Abuse (NIDA) grant, Mash and her colleagues had already embarked on a study of the cocaine overdose epidemic.

"Sometimes there's more cocaethylene in these people than cocaine," Hearn told Mash.

Convinced that cocaethylene was the culprit in the majority of these surprisingly deadly overdoses, Mash was determined to prove that it was not a harmless by-product, but a killer. She and Hearn joined forces, bringing their staffs at UM and the Metro-Dade Medical Examiner's office together in the name of science.

They worked on little else for the last part of 1990, and in record time-less than six months-Mash, Hearn and their team not only were the first to prove that cocaethylene is an active drug, they also had their breakthrough findings published in the January 1991 Journal of Neurochemistry.

"Miami is a unique place to do this research," says Mash, grabbing a precious 60 minutes out of her 12-hour work day to talk about their landmark findings and continued research, and the state of chemical addiction. At least twice a month, Mash is gone for days at a time, traveling the world to deliver research papers, conduct studies and touch base with the National Institutes of Health (NIH) in Bethesda, Maryland, where she is a consultant. For three months we spoke weekly, between her airport adventures. "Cocaine is one of the primary substances people here use and abuse. Not heroin, like elsewhere. And we have a high number of cocaine emergencies and overdoses."

Mash notes it's only fitting that, "as a transit point for cocaine entering the U.S.," Miami should also be home to the most promising research.

"We were trying to understand the toxicology. Many died from what should have been safe levels of cocaine in their bodies," she recalls. "We thought maybe there was a processing contaminant, a toxic by-product created when cocaine was made in labs. But that didn't explain it. We noticed that most people-five million Americans-combine cocaine with alcohol. It's the most frequent two-way drug combo. Could cocaethylene be the culprit? We measured it in specimens of blood, brain and liver tissues and found it higher in some instances than the levels of coke itself! Then we demonstrated that it's pharmacologically active. And we found that it packs the same 'reward punch' on the brain as cocaine and alcohol do separately, but cocaethylene gives a longer and stronger high and has a much longer half-life than cocaine."

This extra kick was often the last kick. "It's more potent than cocaine in causing deaths," says Mash. "It's more lethal than cocaine."

Her work, she says, is "like reading chapters of a very good detective story." The much-published 41-year-old scientist shies away from the term "workaholic." Instead, she likes to say that "science is away of life. You don't walk away from this."

Despite the fact that she's married to prominent Dade Democratic party leader and attorney Joe Geller ("Joe who?" she quips. "I hardly ever see him."), and has been a commissioner for the City of North Bay Village since 1988, Mash's life is otherwise consumed by her scientific crusade. "Intellectually, I never grow weary of it. I love the discovery. Every day I'm faced with something new. I learn every day."

Mash grew up in Hollywood, where her teachers fast-tracked her in math and science when she showed both interest and tremendous talent. A competitive kid, she won science fairs with her biochemistry projects, and, as a senior in high school, she "discovered brain science while studying psychology." She knew then, she says, that it would be her life's work.

"I briefly toyed with being a medical doctor," she recalls. "But I wanted to devote 100 percent of my life to research."

Mash has never fit the stereotype of the stuffy scientist who's quiet, prim and unaware of life outside the lab. Far from it. In college at FSU, she looked like Cher, with waist-length black curls, an exotic aura, and eye-catching, funky leather outfits. Ever the crusader, Mash spoke out against the Vietnam War and whatever other social causes stirred her passions. At his law school graduation, her husband, Joe, blurted out an impromptu plea to stop the death penalty while on stage receiving his diploma. They were-and still are-quite the couple.

Now, her crusade is to understand, prevent and treat drug and alcohol addiction, both scientifically and sociologically. "I pore over research at home, I design experiments in the car on the way to the lab. To combat abuse, we have to understand brain changes and dependency. Then we can design specific therapeutic intervention. When we understand craving, we can know how to block it," she says enthusiastically. "We want to stop the progression, to keep people off drugs and alcohol. We all pay, and it's a hefty price tag. Just look at the crack babies."

Mash and her colleagues approach the problem from all angles. "We now have the Comprehensive Drug Research , Center at UM to study and bridge the relationship between scientists and treatment people," she says. "Classic treatment approaches have largely failed. It's an illness, and we have to design new treatments based on what we're learning about how these chemicals change the brain. We're also studying the long-term effects of drug and alcohol abuse."

She's now researching how cocaine and alcohol accelerate cardiovascular disease. "Cocaine and alcohol do major damage to the heart and brain. We're looking at heart disease and cognitive and behavioral problems in people. Cocaine may cause depletion of dopamine in the brain, which may lead to Parkinson's disease. We already know this is true of amphetamines. People taking them over time were stricken with movement disease not unlike Parkinson's."

Combining cocaine and alcohol takes an even higher toll on the body. "The dual addiction is a harder addiction to break. We're looking into that. And it causes thickening of the arteries. We think the deterioration is happening quickly, too. Hearts

that are 30 look like they're 70. We may see a young generation die off from heart disease."

Cocaethylene also plays a role in AIDS. "It may give the HIV virus a boost," Mash reveals. "And our discovery that cocaethylene is active in the body has helped spawn this new angle in HIV research."

But the most exciting, most mind-boggling development in the history of drug and alcohol treatment is the new drug ibogaine. And guess who may get to introduce this bona fide cure for addiction? That's right-Mash and her colleagues at both UM and the Metro-Dade Medical Examiner's department. As we go to press, she's awaiting approval from the Food and Drug Administration (FDA) to conduct safety trials. This is the first step-testing ibogaine on people in a controlled scientific setting-in the official process that makes a drug legal for use in the United States.

"The FDA has been very responsive on this one," Mash says, feeling 99 percent certain that they will grant her request. "We have a congressional mandate to help people get off drugs. And we know that drugs are co-factors for HIV."

Mash is just the latest link in the ibogaine story, but the one that will bridge the gap between anecdotal evidence and the scientific proof needed for FDA approval. Ibogaine is derived from the roots of Tabernaemontana iboga, a shrub native to equatorial Africa, where tribes have long used it in small doses to remain alert while hunting, and in larger doses during sacred rituals.

Back in 1962, Howard Lotsof, then "part of the New York film scene at NYU's film school, and a heroin addict, was looking for a new high, when he discovered ibogaine," says Mash. "After his 36-hour 'trip' on ibogaine, he found he had completely lost his desire for heroin, and had no withdrawal symptoms."

Lotsof gave the substance to other addicts, and they, too, were instantly un-hooked from the drugs that previously had controlled their lives. "The International Coalition for Addict Self-Help ran underground trial testing on ibogaine," Mash says, "and it was found to cure addictions to heroin, cocaine, amphetamines, alcohol and nicotine." This so-called anecdotal evidence has shown that ibogaine cures addiction almost 100 percent of the time. In 1986, Lotsof formed NDA International and secured a use patent on ibogaine for treating drug and alcohol addiction. Scientific study began in the Netherlands three years ago, with more than three dozen addicts as test cases. Mash was among the U.S. scientists and doctors invited to Leiden, Holland to witness ibogaine in action.

"It puts you into a 36-hour waking dream state. It's a psychoactive drug, but not a hallucinogen like LSD. During this altered state of consciousness, you relive your childhood experiences," she says. "You get to the roots of your addictions."

One trip on ibogaine is like 30 years on a therapist's couch.

"Ibogaine was used as a rite of passage from childhood to adulthood in Africa," says Hearn. "And now it can be used to reprogram the addict's life. He's detached from childhood recollection while on Ibogaine, but is reexamining it, coming to grips with it, perhaps understanding it for the first time. All neuroses are solvable this way, not just the ones that lead to addiction."

Using ibogaine, then, helps address the cause of the addiction. "Drug addiction is an illness of the spirit," says Hearn. "If you're going to cure it, you have to cure it at that level."

Scientists and treatment professionals have long known that trauma, insecurities, fears and the like are the very foundations of psychological distress, which includes addiction. "With addiction, people feel good because it fills a gap in their lives," notes Hearn. "The drug or alcohol substitutes for something lacking, and it's used to cope, too."

So, when you literally "trip down memory lane" with ibogaine, you come to grips with all those experiences you swept under your emotional carpet so long ago. This miracle drug also "cures the anxiety of detachment from a long-term habit," says Hearn, whose Metro-Dade Medical Examiner's lab will be involved in Mash's FDA safety trials by analyzing the long-term blood concentration of ibogaine.

So far, no one has ever had a "bad trip" on ibogaine, and the only side effect reported is slight nausea at the beginning of the 36-hour treatment. Mash has used ibogaine on monkeys and found that "it's not toxic to the brain," she says. "And there were no adverse effects in the people who took it in Holland. Toxicity only showed up in a study at Johns Hopkins University, and it was only toxic in ridiculously high doses."

While it's evident how ibogaine works psychologically, physiologically "it's still a mystery," Mash admits. "It doesn't bind to any known receptor in the brain." It has been shown to have an effect on dopamine, causing the brain to release less of this chemical, which in turn lessens the effects of cocaine.

Mash and her colleagues will test ibogaine on cocaine addicts during the FDA safety trials. Her team includes two medical doctors—one is a neurologist and the other a psychiatrist specializing in addiction—and a social worker who is an expert on inner-child work.

"Unfortunately, a negative bias has evolved surrounding the use of psychoactive drugs," Hearn laments, "because of the recreational use of drugs like LSD. But it's a mistake to label them as bad just because they're mind-active. We need to distinguish among them. Different drugs are different in their activities. This is not LSD. There are no bad trips, flashbacks or people wanting to jump off buildings to see if they can fly. Maybe ibogaine will change some of the misperceptions and open the door to research with psychoactive drugs."

Mash agrees, adding, "Treating drug dependence with a drug is still considered by people to be ironic."

But, summing up both ibogaine and her non-stop work delving into the brain, she sighs: "God works in strange and mysterious ways."

Primal Renaissance: The Journal of Primal Psychology - The official journal of the International Primal Association. (Spring, 1996)

Ibogaine - Therapeutic Miracle?

by: Don Allan

Recent interest in the drug, ibogaine, has focused on its potential to interrupt substance addictions (Blakeslee, 1993; Brown, 1994; Cappendijk and Dzoljic, 1993; Cauchon, 1994; Hudson Valley Business Journal, 1996; Jetter, 1994; Lotsof, 1995; Mestel and Concar, 1995; Nadis, 1993; Regan, 1992; Schecter and Gordon, 1993; Sheppard, 1993; Sisko, 1992, 1993a, 1993b). Ibogaine is less well known as a means to facilitate psychotherapy (Diamond, 1993, 1994; Goutarel et al., 1993; Naranjo, 1973; Taub, 1995). With four US patents applied for to interrupt substance addictions to heroin, cocaine, alcohol, and nicotine (Goutarel et al., 1993; Lotsof, 1995), ibogaine appears to be on the brink of massive infusions of investment by venture capitalists and innovative entrepreneurs.

However, the politics of ibogaine are complicated. Ibogaine is illegal in only two countries, the United States and Belgium. FDA studies to evaluate the suitability of ibogaine as a means to interrupt addiction have been ongoing in the United States since 1993 (Alcoholism and Drug Abuse Weekly, 1995; Berkely, 1995; Blakeslee, 1993; Diamond, 1993, 1994; Jetter, 1994; Lotsof, 1995; AMPS Newsletter, 1994; Sisko, 1993a, 1993b; Sheppard, 1993). The corporate pharmaceutical giants have kept watch from a distance. Molecules found in nature cannot be patented. The ibogaine molecule is extracted from a natural source, the iboga plant, which grows wild in west central Africa. No drug company has discovered a way to redesign the natural molecule with patentable improvements (Hudson Valley Business Journal, 1996). Despite what appears to be a huge market for a drug that could interrupt drug addiction, ibogaine does not fit the profile of a prescription drug that can make money for a pharmaceutical manufacturer. Most prescription drugs are administered daily over a period of weeks, months, or years. Ibogaine is generally used once in a single dose, and then followed up with several months of psychotherapy.

Ibogaine also does not fall easily into standard categories used for classifying the effects of psychotropic drugs (Blakeslee, 1993; Goutarel et al., 1993; Strassman, 1995). It is not a recreational drug, and its action is quite different from and more complicated than most hallucinogens. It does not facilitate social interaction and usually includes a period of several hours during which the person cannot or chooses not to engage in dialogue. Its physiological effects usually last from twenty-four to thirty-six hours, with nausea as a common side effect.

Clearly, much more research will need to be done on ibogaine to assess its possible benefits and hazards. Readers who want more background on ibogaine are advised to examine the existing literature available concerning its history (Berkery, 1995; Cauchon, 1994; Goutarel et al., 1993; Lotsof, 1995); its ethno-botany (Goutarel et al., 1993; Lewis and Elvin-Lewis, 1977; Schultes and Hofmann, 1980); or its chemical identity, synthesis, and toxicity (Buchi et al., 1966; Dhahir, 1971- Goutarel et al., 1993; Schultes and Hofmann, 1980; Strassman, 1995). It has received growing attention in the mainstream press (Blakeslee, 1993; Cauchon, 1994; Cowley, 1993; Diamond, 1994; Hudson Valley Business Journal, 1996-1 Jetter, 1994; Mestel and Concar, 1995; Nadis, 1993) and in the alternative press (Lotsof, 1995; MAPS Newsletter, 1994; Scher, 1994; Sisko, 1992, 1993a, 1993b; Taub, 1995).

The larger issue of the role of hallucinogenic drugs in psychotherapy and psychiatric research has been addressed with increasing frequency in the medical and scientific literature (Pletscher and Ladewig, 1994; Riedlinger and Riedlinger, 1994; Sheppard, 1993; Strassman, 1991, 1995). Strassman (1991, 1995) and Pletscher and Ladewig (1994) provide fascinating overviews of research on psychedelics that might be of interest to psychotherapists.

A Therapeutic Miracle?

To find out more about ibogaine's possible use to facilitate psychotherapy, I spoke with Eric Taub who has written about ibogaine's potential to facilitate regression. Taub is an entrepreneur who plans to develop an ibogaine clinic outside the US. He referred me to several individuals who have experienced ibogaine sessions in offshore locations. Although accurate statistics have not been gathered on the drug's potential to facilitate regressive psychotherapy, the four individuals I interviewed reported varying degrees of success with regression.

One found it to be not helpful in facilitating regression; a second found it somewhat useful therapeutically but not specifically helpful with regression; a third found it marginally successful; and the fourth reported spectacular success.

Although I would not personally recommend ibogaine for psychotherapy based on my interviews and my review of the literature, I have included below the transcript of my interview with the person who experienced the most positive results. She is an associate of Taub's, Sarah Emanon¹, a psychotherapist who spoke with me about her own experiences with ibogaine - both as a facilitator and as an experiencer- and her plans to direct an ibogaine clinic in Central America. If every person were able to achieve results like those described in her fascinating account, ibogaine might indeed merit being called a "therapeutic miracle."

The Interview

Don Allan: What could be accomplished in an ibogaine clinic outside the US?

Sarah Emanon: Maybe I should begin talking about what I would do as director of an ibogaine clinic. There would be three different types of work happening there: addiction interruption, therapeutic [meaning psychotherapeutic], and initiatory or spiritual. But regardless of which type we are doing, we are always doing all three at the same time, just different angles and aspects of it.

DA: How long does an ibogaine session last?

SE: The person is under the influence of the ibogaine for twenty-four to thirty-six hours, and it is during this time that they are feeling the physical effects of the drug.

DA: How does ibogaine interrupt addictions?

SE: In order to interrupt the addiction, ibogaine does a number of things: First, it interrupts the addiction by filling up the receptors in the brain so that the person doesn't crave the substance anymore, and it does this without withdrawal symptoms. The person does withdraw, but doesn't have to suffer.

DA: So this is a physiological process?

SE: Yes, but that does not mean the person is psychologically withdrawn from the substance. It means that physically the person will not crave the substance for a certain length of time, and there is usually some kind of "window," which varies with each person. We are finding that there is generally a ten-day window during which the person not only does not crave the drug but they feel great.

Then there is a three-month window during which the person still does not crave the drug, but this period of time may vary between one month and six months depending on the individual. But once that window is up, then all the psychological factors that originally caused the addiction will come back . . . if no other work is done. So that's why the person needs to add in the therapeutic element as part of the ibogaine experience.

DA: How is this done?

SE: This is done in a number of different ways. When we are doing the higher level of ibogaine dosage necessary for addiction interruption, the person cannot speak while the dosage is at its peak - a period which may last from two to six hours or so - and therefore cannot relate to the therapist to work on processing psychological material. This means that the therapeutic part of the ibogaine session occurs before and after the peak of the session.

DA: But is this peak period necessary if the person is not able to relate to the therapist during this time?

SE: Yes, because it is during this time that the person is physiologically withdrawn from the addictive substance.

DA: Is the ibogaine one-hundred percent effective in interrupting substance addiction physiologically?

SE: It is close to one-hundred percent effective, but I have heard of a few cases where the ibogaine was not successful in interrupting the substance addiction. But in a majority of those few cases, a second dose, i.e., a booster, was effective. That happened especially with methadone addictions.

DA: What is the usual time interval between the initial and booster sessions, in those cases where a second session is needed?

SE: It could be as soon as a few days later. If the medical doctor determines right there in the clinic that the addiction has not been interrupted, and if the client agrees, a second dose could be provided.

DA: Getting back to the therapeutic aspects of addiction interruption, what does the therapy consist of before and after the twenty-four to thirty-six hours during which they are feeling the physical effects of the ibogaine?

SE: We take medical and psychological history including biographical information about childhood, but by far the most important part of the preliminary therapy before they take the ibogaine is to get them to recognize the importance of ongoing psychotherapy after they do their ibogaine session. One of the conditions of admission to ibogaine therapy is that the client has made arrangements for continuing psychotherapy after leaving the clinic. We require a letter from their therapist back home indicating that an appointment has already been set and that the therapist is familiar with what the client is doing and what they need to work on.

DA: What does the therapy consist of after the twenty-four to thirty-six hours of ibogaine?

SE: The effects of the ibogaine last much longer than the initial twenty-four to thirty-six hours. There is a ten-day window during which the resistance of defenses is softened. During this time there is a great deal of access to one's psychological process. We use the three days after the ibogaine session to do some intensive psychotherapy at the clinic, both individual and group work.

Generally, clients will spend the first forty-eight hours in the clinic doing an intake interview and a preliminary session, and then the ibogaine session itself. After the first forty-eight hours, they will move to a guest house for the next three days while they continue intensive individual and group psychotherapy.

DA: You mentioned earlier that there are three types of ibogaine session work: addiction interruption, therapeutic, and spiritual. Are these three different types of sessions? Or are you referring to three different kinds of work that can be done within a session?

SE: The three types of sessions correspond to three different dosage levels and, also, to three different intentions one might have in going into an ibogaine session. But there is usually some overlap. For example, a person going into an addiction-interruption session will certainly have the primary intent to interrupt the addiction. Additionally, they might have the intent to find out why they began to crave the substance they are addicted to, that is, where did the problem begin?

DA: Do you recommend to them that they try to find out how their addiction got started?

SE: Yes. Often the pretherapy session helps them to set up this intent.

DA: Do you allow them to participate in ibogaine therapy if they don't have the intent to figure out how the addiction got started?

SE: Yes, the ibogaine will work to interrupt the physical addiction regardless of whether they intend to figure out how it all got started. My own approach is historical, and I like my long-term clients to begin thinking about how the addiction got started before they have the ibogaine session. But there are many different psychotherapeutic approaches to addiction, and not all of them require starting with the intent to figure out how the addiction got started. Some clients will choose to work with cognitive or behavioral therapists after their ibogaine session.

DA: Is it also possible for a client whose primary intent is to interrupt addiction to go into the same ibogaine session with a spiritual intent?

SE: Yes, in fact a client who interrupts an addiction can use the same session to help facilitate psychological work and, also, as a spiritual initiation if that is their intent.

DA: What does it mean to have an initiatory, or spiritual intent?

SE: They might want to open up spiritual centers, whatever that might mean for them as an individual. They might want to use the ibogaine session to feel more connected to whatever they feel is their spiritual connection. So they could have a

spiritual intent as well, and this is how the addiction-interruption session could have aspects of all three types of sessions,

DA: How about people who are not addicted to a substance, but who come into an ibogaine session with a therapeutic intent?

SE: In one sense, those who come into the ibogaine session with therapeutic intent can also break an addiction, but their addiction is to a dysfunctional behavioral pattern rather than addiction to a substance.

DA: Are you saying that every person who comes into a therapeutic ibogaine session is addicted to certain patterns of behavior and that the behavior patterns can be interrupted just like a substance addiction ?

SE: Yes, but there is an important difference. An ibogaine session will work to interrupt a substance addiction without any type of psychological or emotional processing. But behavioral, or psychological, or emotional addiction will not be interrupted without psychological or emotional processing. And having the right insight and intent are also part of that process.

DA: Are there other differences between a therapeutic and an addiction-interruption session?

SE: In a therapeutic session the dosage of ibogaine is low enough that the client has the option to continue psychological processing by speaking and relating to the therapist throughout all or almost all of the twenty-four to thirty-six hour intensive part of the session. This means that the client need not be overwhelmed by the physiological effects of the drug.

DA: Could you describe more about the therapeutic process in an ibogaine session?

SE: In a therapeutic session, the client begins the therapy before ingesting the drug by discussing what dynamic she wants to change, what patterns she finds uncomfortable in her life, and to the best of her ability, talking about where the pattern comes from to the extent she is capable of figuring this out at a conscious level. She begins talking about what happened in her childhood, what the dynamics were with mother, father, siblings, and anything else that might have been factor - school, religion, friends, and so on. It helps to clarify one's intent before taking the ibogaine. In this way it is often possible to home in on where the patterns came from before taking the drug.

DA: What happens once the client takes the ibogaine?

SE: After the ibogaine is ingested, the "walls" and the defenses begin getting softer and looser, and I keep probing with questions to help the client go back in time to

where the pattern originated. I try to take them back as far as we can get or as far back as necessary. Some people go back to experiences at four or five, or ten or twelve, and some go back to crib or infancy experiences, or experience around the time of birth. I have not worked with anyone on prebirth experiences, though I believe ibogaine would help to facilitate these memories based on what I have seen of primal and pre- or perinatal processes.

DA: Can you be more specific about how you take them back and what happens in the session?

SE: Yes. Once the ibogaine is ingested, I might say "Tell me more about the fears you have now." And they begin talking about their fears. And I ask them to take it back in time: "When was the first time you remember having that fear?" They might go back to an early experience; and when it comes fairly clearly, it's very visceral. They are really there in the experience. It's almost like they have been in a hypnotic trance and have regressed to the early experience. And then they usually come back to the present.

It's like a bouncing back and forth. For example, they might say "Oh here I am back at ten years old, and, aha! ... here I am now with my husband or wife now or in my situation at work, and that's going on now, and here I am back at five, and it was going on then, too.

DA: Is this type of bouncing back and forth between the past and present characteristic of an ibogaine session?

SE: Yes, it seems that this is often what happens to people during their sessions even when this is not a part of their intent in going into the session. It just happens to them spontaneously. It has never been a part of my style as a therapist to bounce them back and forth so much during a session, but this is what happens, and it works. Now I can see how it works, and it is teaching me how to get people to undo their patterns.

DA: Are you saying that the ibogaine is teaching you to be a better therapist? And that it has implications for how to conduct sessions on other occasions without the ibogaine?

SE: Yes, exactly. For example, one man I was working with kept going back to being a little boy who was terrified. In his regression his dad is very big and angry and loud and keeps slamming things around. He then comes into the present and sees his terror in relationships now, and how he doesn't open up, and that he is frightened. He goes back into the past, and again he is terrified.

Well, as lie keeps going back and forth, slowly that little boy is not so scared. That father doesn't have so much power anymore. And also what happened-and this is typical of ibogaine sessions - is that he started to go inside of his father. "Oh, he's scared, too. He doesn't know how to deal with me, or what's going on here. Now I can see . . . it's because of pressure in his life over here." And so the father begins to lose his power over the little boy, and the fear no longer has such a strong influence. And now the situation begins to change in the present, too, and the person begins to be able to act without fear.

DA: Does the change in behavior last? Does the person remember what has been learned and continue to apply it'?

SE: Well, it seems to last somewhere else other than just in the person's conscious memory. I say this because what seems to happen is that the person can remember what happened during the session, but as a practical matter he goes on with his life, and he's not thinking about what happened in his session. Three months later he might find himself saying, "Gee, I just had an experience that I would ordinarily have found very upsetting. But I just sailed right through it without any problem. How did I do it? Oh, I remember. Three months ago when I took the ibogaine, I worked through this, and now I'm not reacting the same way anymore."

Somehow the ibogaine seems to effect some kind of basic change that does not depend on conscious insight and memory of what is learned during the session.

DA: Are you suggesting some sort of physiological mechanism which changes the behavior pattern?

SE: My hunch is that while we are working with psychological process, there is a physiological, chemical change going on. For example, when working with hypnosis, and a person is in a trance, there is the possibility of reaching the memory on the cellular level, or the level of chemical imprinting. In an ibogaine experience, the body is physiologically and chemically open so that when the memory comes and it is reexperienced viscerally, the chemical correlates of the insight are also experienced physiologically. Perhaps the body chemistry is reset somehow in a way that prevents the repetition of the patterned behavior.

DA: What about the third type of ibogaine session, which you called spiritual or initiatory? Do people come into a session intending to have a spiritual experience, or do spiritual experiences just happen without necessarily intending to have them?

SE: Both can happen. Often people who come in for a therapeutic session will have a spiritual component to their session. I have some ideas about why ibogaine often facilitates spiritual experiences. I began thinking about what is happening in a

situation where a person sets out on a spiritual vision quest with the use of mescaline, for example, or even without the use of a drug. If the person is fasting out in the woods for seven days and is in a physically dangerous situation, it's really a matter of breaking down resistances and overwhelming the system in some way so that the old way of doing things cannot happen any more.

So the person is, of necessity, open to some other process. And if the person is open spiritually, it is an openness to some other force helping him or her to get through the experience.

DA: Are you saying the ibogaine overwhelms the system in some way?

SE: The ibogaine does two things. First, it gives the person some spiritual, visionary experiences. But beyond this, the ibogaine overwhelms the system psychologically or emotionally, or with hallucinations, and the person cannot function or process what is happening in the old way. This is where the spiritually enlightening experience occurs. And especially if the intent is to be open to spiritual experience, the person will be open to another force helping them get through this.

DA: Will you be accepting people at the clinic whose intent is specifically spiritual rather than therapeutic?

SE: Yes, we will.

DA: Is a different dosage used for spiritual sessions?

SE: It doesn't need to be a different dosage, but it sometimes is a little bit more than the therapeutic-session dose. But it is not as much as the dosage used for addiction interruption. We want to overwhelm the system, even if it is just for a short period of time. In a therapeutic session sometimes we are still in control when we are saying to ourselves, "Oh, yes, I remember when I was three years old. . . ." In a spiritual session, the person needs to be beyond the point where they are totally in control of what they are experiencing. With a slightly higher dose, they can be swept away, or float off, or be scooped up into an experience briefly where the initiatory experience takes place.

DA: Do you guide your clients with questions and directive therapy during the session?

SE: Yes I do. But in the case of addiction-interruption sessions, there is a period of time for at least a couple of hours when they want to be alone with their memories and their internal process. During this time they don't want to stand or sit, they want to lie down- and they are really not capable of carrying on a dialogue. This is the time when they are likely to be deeply immersed in their internal process and learning from their memories. Therapeutic and initiatory sessions might also have a period of time

during which the client is overwhelmed and does not want to engage in dialogue, but the period might be shorter and less intense.

DA: Do they talk with you very much before and after this peak time?

SE: There is a time early in the addiction-interruption session when they are really into processing through verbal dialogue with me and clarifying their intent. But then there is a point at which we have gotten all we are going to get by talking, and then they really need a period of two or three hours to float up into the experience on their own. After two or three hours there is a time when they want to talk about what they have experienced.

DA: Are therapeutic ibogaine sessions helpful for people who have done a lot of previous psychological work on themselves?

SE: That's the thing. I've done a lot of therapy work on myself. I think for people who have done a lot of work on themselves, an ibogaine session is a powerful tool.

Even though a person might never have taken this drug before, they would immediately know what to do with it if they have done a lot of previous work on themselves.

DA: How many ibogaine sessions have you had personally?

SE: Three. And they were all very different. The first session was five mg/kg; the second, six-and-one-half-, and the third was eleven. When I did the five mg/kg, I wanted to work on understanding the patterns of my relationships.

On one level, I can look at all of my relationships as failures. Obviously, I also recognize that I have grown a lot, so they were all useful, but it was as though they all fit a certain pattern. My intent in my first session had more than one component. First, I wanted to see if I could connect with any kind of memory of being with my birth mother, because I was adopted. I also wanted to see whether ibogaine could take me back to any kind of past-life experience. There wasn't anything in particular I wanted to know about past lives; it was just a curiosity.

DA: What happened in your first session?

SE: The way I approached my intent in the session was to gather pictures from my childhood, and I pored through them before the session. And so I had these pictures near me as I felt the effects of the drug come on. I started looking at them, and the emotion in those pictures started popping out at me, not necessarily of myself but of the people in the pictures - my father, my mother, and my adopted father and mother. Who they were, and their emotions, just sort of started popping out of the pictures at

me. That began the process: At first working on my father, I began to see how he was and how I reacted to him.

What I was focusing on is that he was very well armored. I remembered being a little girl and trying to "get to him," but I couldn't get through, I couldn't reach this person, and I would try harder and harder. Then I saw the current relationship I was in and how I couldn't get to him either. And it just went boom, boom, boom, boom, all the way back to my father. The back and forth thing started. That kept happening over and over, and I would get different angles of what that was all about. But something here was not complete.

Then I went back even further. I didn't realize it at the time but this was the start of a shift into phase two. I went back to being with my adopted mother as an infant while she was holding me. My head was bobbing, and my nose was banging into her neck - I could feel it physically. I can still feel it - it is such an interesting sensation. Then I smelled her, and it didn't feel right. I can still remember that reaction. It was part of the bobbing, I had no control over my neck.

. . . but I didn't want to be near her ... I was trying to get away because it didn't smell right. But I didn't know how to hold my head up! That's where I realized I retreated into myself. So here I am focusing on all these people in relationships, trying to get through to them, but they can't get through to me either. And I saw myself picking people who can't come out of themselves because I can't come out of myself. I don't know how to do that any better than they do. For me, this was the beginning of owning my own process rather than projecting it onto others.

DA: As I listen to the intonation in your voice right now, you sound like you are describing a breakthrough experience in terms of owning your own process.

SE: Oh, yeah . . . very much so. I never knew that before. Never knew that. I had had years and years of therapy, but I had never gotten to that piece. And I found myself witnessing that I had never bonded to that mother. And for the first time, I really experienced that lack of bonding, and why it never occurred: She didn't smell right, and there was no connection.

DA: Where did you go from there? This story is getting more and more interesting.

SE: I found myself asking the question: "Can I remember my birth mother?" And soon I was back in this other experience in which I was totally merged into another being. I could kind of feel my distinction, and yet not feel my distinction. I could kind of feel where I was this small infant, but I was part of this vast amount of soft skin, also. And I could feel the warmth and the smell, and everything was me! It was me . . . it was right . . . it was me. It was bigger than me, but it was me.

And I could feel this woman's tenderness. And there were points where I could feel tears . . . hitting my body. I could feel her sadness . . . and it was my sadness. It was a sadness I have felt throughout my life. And then I would go from that to my adopted mother, and the bobbing, and back and forth between the feeling of discomfort with her and the feeling of being me with my natural mother. After a while of going back and forth between the two feelings, I felt "Okay, I think I've got it now! I've got it. I see now how this all got started."

DA: Wow. Many of us involved in primal therapy could really relate to those experiences you had. Is there more that you could share?

SE: Then there was the experience of being taken away and being alone. It wasn't particularly painful, but it was very alone. That was my deeper understanding of what it is that I do. When things don't feel right, I just get alone. And I take care of myself. There was nobody to take care of me, so I learned how to take care of myself, how to be okay, and be alone. And so, throughout my life, I would have to get alone to become okay. I would be with people and lose myself, and then have to go be alone in order to kind of "gather myself again."

So there was more of an understanding of how this happens for me. I would go from feeling good with someone, and then being taken away into this kind of abandoned, empty place. Finally, when that seemed pretty much done, I was curious about the past-life stuff. When I asked that question, I was taken back to some very primitive stuff with some relief sculptures on the wall . . . maybe Mayan. I found myself walking into some dark, enclosed, wet, dank kind of enclosure. There were these relief sculptures on the walls, and I could feel the wetness and coldness of the walls. I don't know where it was. After I went into that, I didn't really like it very much. So I had had my flavor of past life, or whatever; and I decided I didn't want to do this anymore, and came back. And that's all that I got.

DA: How long did this take?

SE: All of what I described took several hours, perhaps five or six hours.

DA: Were you able to communicate during your experience?

SE: During this first session, I was able to communicate the whole time, but sometimes very slowly. Five mg/kg was not enough to overwhelm my system and push me over into speechlessness. However, there were times when I was very internal, did not want to communicate. There were times when I would choose to ignore questions from my sitters. But occasionally, they would hit upon something that seemed relevant to my internal process, and I would go with their suggestions.

DA: What happened after the five or six hours you described?

SE: Afterwards I didn't sleep all that night, and I continued to process for hours and hours and hours.

DA: Did you continue to process the issue concerning your natural and adopted mothers after you got some sleep the next night?

SE: Yes, I worked on it for six months in weekly psychotherapy sessions. I knew that there was too much there for me to just chew on by myself. I had not been in therapy immediately preceding, but the ibogaine session gave me the incentive to get back into therapy for several months. I had a lot of work to do, because I was in a marriage at the time that felt like the adopted-mother syndrome.

Two months after the ibogaine session, I separated from my husband. It was a gradual process, but it was definitely precipitated by the ibogaine session. If a person has relationship problems, and they are not ready to deal with the problems, a therapeutic session with ibogaine might not be such a good idea.

DA: How long was it between your first and second ibogaine sessions?

SE: The second one was more than a year later. The first one was around March of 1993 - and the second one was in the spring of 1994, slightly more than a year later; and the third, in December of 1994. It was perhaps a month or two before the second session when I realized that one of my old monsters was not gone. I had thought it was gone, but the way I realized it was not gone was that I went to visit my adopted mother and came home hating myself. So I realized that that was still happening, maybe a whole lot less than it used to, but there was still some level of self-hatred in me.

When I decided to do the second ibogaine session and work on this issue, I began to see how subtle the under cloth of my life was. If I had not focused on it, I would not have recognized it. I saw it only because I was determined to process the stuff through. Another motivation to do a second session was that I wanted to reconnect with my spiritual connections that I had when I was younger. Those were my two intents.

DA: Did you fulfill both intents?

SE: I probably spent the entire time processing the self-hatred, and I hardly even touched the spiritual side of things during that session. Maybe just a little bit, as I will explain later. I had a friend of mine, who is a psychologist, help me with my process during this session. After my first session, I had realized the therapeutic potential of ibogaine, and I wanted someone with me who really knew what they were doing. My

friend knew everything about me that she needed to know about my childhood to prod and poke.

DA: How did you start the session?

SE: I began with describing the kinds of things that would come up that would cause me to hate myself, and what the feeling was, and my related behaviors. So I began with current stuff, and I went back in time. What came up was not a new memory, but somehow I saw aspects of it I had never seen before, and I made connections I had never made before. The memories that came up were of my adopted mother following me around the house and saying negative things to me, like, "You are a quitter. You'll never do anything right." And, "I can tell, because look at the kind of friends you have - losers. Right? Don't you?"

I would answer with something like "Yeah, yeah, sure." And she would say, "Say 'yes mother dear' when you respond to me." And I would repeat her words, but I could never get the right tone. You know, it had to be real. But I could never get it quite right. And there would be this whole yelling thing where she would be telling me I am rude, and so on. And I would start screaming. Not screaming words, but just screaming at the top of my lungs, in terror. And she would say "Yes, I always knew you were crazy . . . you are insane, and you need help." And I would go to my room and hate myself because I had betrayed myself.

I promised myself when I was alone in my room that when she would do that, I would stay totally cool, like my father wanted me to be. I wouldn't lose it, because if I would lose it, then I would be proving to myself that I was really crazy.

In my session, I went through this over and over and over again - the rage I felt towards her, the rage I felt from her, scenes where my father was present and not protecting me, not doing anything about it. And then coming to the present to see how similar kinds of situations would make me hate myself again because it would bring up the potential of the rage, even if I didn't respond with anger. As it kept going back and forth like that in my session, that's when I started to see my relationship with my mother from a new angle.

She was huge, and I was this small being. Immediately when I saw this small, little being, I realized that this was not a horrible creature she was yelling at. I could see the sweet innocence in this little girl. And finally, my mother shriveled up into an angry little entity that I pitied. I really felt sorry for this poor creature that was yelling at a little girl.

And then she lost all of her power. This had never happened before in my memories of this incident. I was seeing it in a new and different way. Earlier I had mentioned

the under cloth of my life. It's interesting that we seem to use certain words for good reasons. During my session there was a time when I was just lying there. And it was during the silent part of my session-and there was a silent period for me at the higher six-and-one-half mg/kg dosage level when I didn't want to talk at all - and I felt this webbing that was covering my entire body, like a spider web, but tightly woven. And it stretched all the way to where my mother was in Miami several hundred miles away.

It stretched all the way to Miami. And I could feel it covering me, and I physically started ripping it off my body. And I actually used my hands during the session to peel this stuff off my body and get rid of it. That was the essence of my session.

DA: Did you ever fulfill your spiritual intention during the session?

SE: I discovered later that it was the self-hatred that had broken my spiritual connection.

DA: Are you saying that you never dealt directly with your spiritual issues during your session, but that in resolving your issue concerning self-hatred, you indirectly resolved your spiritual issue as well?

SE: I had stopped practicing regular meditation a considerable time before my session. I was still doing other forms of meditation - moving meditation, like Tai Chi. About a month after my second ibogaine session, I realized as I was lying in bed that I was feeling energy just taking over my body, and this was beginning to happen regularly. I couldn't sleep. So I started sitting up and meditating . . . and feeling this energy just kind of taking over my body.

Probably after two or three months of this I realized that my spiritual connection had been part of my intent during the ibogaine session. But I didn't make the spiritual connection during my session. Instead it happened in the weeks following my session . . . that's how I got reconnected.

DA: Are you suggesting that there are also things that can be processed unconsciously during the ibogaine session if they are a part of one's intention, even if they are not worked on consciously?

SE: It seems like that's what happened to me.

DA: Did you have times during any of your three sessions in which you were deeply into feelings-crying, anger, and so on?

SE: In my second session while I was going through what I call "the rages," yes. I became very emotional . . . crying, shaking . . . but quietly so.

DA: What do you mean "quietly"?

SE: My body was so zapped that even though I was going through rages I couldn't express the rage in a way that would be visible to an outside observer. My therapist friend had never done an ibogaine session herself, so she was telling me, "Yell at her, scream at her, get it out!" But I couldn't do it; I was not capable of that kind of outward expression.

DA: What were you feeling'?

SE: I felt as if I were yelling and screaming and getting it out. but I couldn't make my body go into a rage.

DA: Are you saying that you didn't have the physical energy to do it because of the physiological effects of the ibogaine?

SE: Yes, exactly.

DA: This is an important issue for primal process. Most primalers believe that the Pain must be fully reexperienced. I'm wondering if there is something about the quality of an ibogaine experience that makes the feelings appear subdued from an outside point of view. But are they really subdued?

SE: They are not subdued, in fact.

DA: Do you mean a person can have powerful emotional discharge without having to put the physical energy into it? Is the process occurring internally without the external signs?

SE: Well, the energy is getting into it. I could feel my whole body releasing it. It's just that I couldn't get up and yell and scream and pound my fists. But I could feel it coming out of my body.

Although we won't have time today to discuss it, there was a time during my third session in which I said to my sitter, "Is my arm shaking?" And I could feel him going through the layers of energy radiating from my body, while his hand was actually a foot above my arm! I remember that it felt like, "He must be touching my arm now, he must be touching my arm now. Oh, now, finally, he is really touching it." When he finally did touch it he said, "No, your arm is perfectly calm." My energy was discharging way up into my aura, and I could feel my arm shaking and trembling, yet it was not really shaking and trembling. It just seemed that way to me because I was releasing so much energy.

DA: What happened for you in terms of release of feelings in the therapy sessions you had in the months following the ibogaine sessions? In those sessions, did you release feelings in a more conventional manner? Or was it a more cognitive type of integration and processing at that point?

SE: The followup sessions were different after my first and second ibogaine sessions. After my first ibogaine session, my therapy sessions during the next few months had a lot of cathartic emotional expression. But after my second ibogaine session, I no longer had to process the rage I had worked on in that session; it was gone. It had dissolved.

DA: Did you have followup therapy after your second session, but for a different purpose?

SE: Yes, it was more integrative in nature, and more a matter of understanding what was going on with me spiritually. The energy that was going through my body at the time was baffling to me.

DA: Thank you. This has all been most interesting to me.²

Notes

1. Sarah Emanon is not the actual name of the interviewee. For personal reasons, she chose not to have her identity disclosed. The interested researcher should contact The Ibogaine Dossier for further information related to the contents of this interview.

2. The above interview with Sarah Emanon was conducted in March of 1995.

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A Remark by the Author

Donald J. Allan

I will share with you my mixed personal feelings about this article. In retrospect, I wish that I had written the article with a stronger recommendation against the use of ibogaine in psychotherapy.

People like reading about the very successful use of ibogaine in the session I describe in the article, but frankly I believe the article misrepresents the therapeutic potential of ibogaine. I think most people simply ignore my recommendation against ibogaine for therapy, and focus on the glamorous aspects described by the person I interviewed.

Most of the people interested in ibogaine are enamored with drug experience, and ibogaine represents an alluring, rare and exotic new drug they want to try. It might meet their expectations for spiritual consciousness expansion, but for real psychotherapy, I doubt it will ever work very well.

I believe psychedelics are of considerable benefit for some people in psychotherapy, but ibogaine would be pretty far down the list, certainly after LSD, psilocybin, MDMA. Even alcohol has some potential benefit for sessions for some clients if used judiciously.

A Word about the Author

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Tripping on iboga

by: Daniel Pinchbeck

Nov. 3, 1999

Tabernanthe iboga is an ordinary-looking shrub found in a small area of West Africa. The bush produces simple yellow blossoms and edible orange-colored citrus fruit that is tasteless and oddly sticky. Under optimum conditions, iboga can grow into a tree rising as high as 35 feet.

Despite iboga's common appearance, in those few nations that know of it, the plant is worshipped as the source of spiritual knowledge and as a tool for accessing the wisdom of the ancestors. The root bark -- scraped off, ground into powder and eaten -- contains one of the world's most powerful, long-lasting and mysterious psychedelic agents. The tribal religion associated with iboga is called Bwiti and exists in only two equatorial countries, Gabon and Cameroon. When Bwiti shamans eat iboga, they believe they are granted the power to see the future, to heal the sick and to speak with the dead.

"The Bwiti believe that before the initiation, the neophyte is nothing," my guide, Daniel Lieberman, told me on my first morning in Gabon, as we took a cab through Libreville, the nation's capital. "Through the ceremony, you become something."

"What do you become?" I asked.

"You become a baanzi, one who knows the other world, because you have seen it with your own eyes."

"How do the Bwiti think of iboga?" I asked

"The Bwiti believe that iboga is a superconscious spiritual entity that guides mankind," he said.

I had found Lieberman, a botanist from South Africa, on the Internet, where he offered to bring Westerners to a shaman's tribal village, for a fee. "I have spent time in the rain forests of Africa east and west, Madagascar and the Amazon working with shamans, brujos, witch doctors, healers," Lieberman e-mailed me beforehand. "Iboga I feel to be the one plant that needs to be introduced to the world, and urgently."

In person, the botanist was thin and pallid, in Teva sandals and safari clothes, and quite a bit younger than I expected. He said that his ghost-white complexion was due to a nearly fatal bout of cerebral malaria. "I caught it during a Bwiti ceremony a year ago," he told me. "It took me months to recover."

This was worrisome. I had expected my guide to be robust and adventurous. Instead, he turned out to be younger than me, and shakier.

Libreville was a hot and stagnant city. Sunlight reflected off gleaming glass corporate towers, the headquarters of oil companies. Because of its oil deposits, Gabon is richer and more secure than other countries in the region. Iboga is another natural resource, but one that has yet to be exploited by the Gabonese.

"Why would the Bwiti allow me to join their sect?" I asked my guide.

"Bwiti is like Buddhism," he replied. "Anyone can join. The word 'Bwiti' simply means the experience of iboga, which is the essence of love."

Over the last decades, iboga has developed a cult following in the United States and in Europe, where it is known as ibogaine. In the West, the psychedelic is being promoted as a potential one-shot cure for treating addiction to heroin and other drugs. Some researchers believe that ibogaine has the ability to "reset the switches" of addiction, freeing addicts from withdrawal symptoms and all drug cravings for up to six months. Animal tests seem to have reinforced these claims.

In America, scientists at Harvard, New York University and elsewhere are studying the ibogaine molecule, seeking to unlock its mechanism. Later this week, on Nov. 5 and 6, the NYU School of Medicine is hosting a conference on ibogaine's potential as a treatment for drug addiction. Papers will be presented by various scientists, including Kenneth Alper, the conference director and a professor of psychiatry and neurology at NYU; Stanley Glick, chairman of the Department of Pharmacology and Neuroscience at Albany Medical College; and Zbigniew Binienda, a senior research scientist in the Department of Neurotoxicology at the FDA. James Fernandez, professor of anthropology at the University of Chicago, will talk on the Bwiti's ritual use of ibogaine. The NYU conference symbolizes the growing worldwide interest in the healing powers of the sacred plant.

Because of this growing interest, a music magazine had agreed to pay my expenses to Africa. The trip was not without its dangers -- malaria being one of them, the intense tropical heat throughout most of the year another. It was in the jungles of Gabon that the deadly ebola virus first appeared. Then there were the hazards of trying a little-known, long-acting hallucinogen far from the nearest hospital. After iboga is in your system for a while, it must be vomited out -- producing what one study

euphemistically described as "tremendous cleansings." In rare cases, Bwiti initiates have overdosed and died during the initiation.

But none of this mattered to me. I was eager to try iboga for myself. I had reached a point in my New York life where I felt spiritually stunted, morally anesthetized, psychically detached. I was losing interest -- not in anything in particular, but in everything. I sometimes felt like I could float off the surface of the planet. Sick of my own culture, my own self, I yearned for access to a different dimension. But could I be guided into the African spirit world?

Lieberman and I stopped at a hotel to pick up his other client for this journey. I was expecting a young anthropologist, psychedelic explorer or beautiful hippie heiress. Instead, a short gray-haired woman greeted us wearing a "Free Tibet" T-shirt.

"I just came from Bhutan, where I got a terrible bladder infection," she announced immediately, in a familiar accent. We were introduced. "You're from New York also? What a surprise! I'm a psychoanalyst in the West Village. Maybe you know my friend who works for the New York Times? Or my sister, the novelist?"

I nodded at the familiar names, trying to recover from the shock of unwanted familiarity. I had dreamt of some pristine experience of the exotic, the "other" that I had read about in the novels of Joseph Conrad and Paul Bowles. Instead, I had traveled 7,000 miles to share my tribal adventure with a woman I might have tried to avoid at a Manhattan cocktail party.

The botanist took us to the Libreville house of our shaman. Tsanga Jean Moutamba wore a purple robe that showed off a broad stomach and a necklace of lion's teeth. "Le Roi du Gabon Bwiti," as he called himself, had eight wives and 14 children, and members of his family kept passing through the sitting room as we spoke. His manner with us was a bit gruff but friendly. The tribe packed our bags into his jeep, and the king drove us down Gabon's single highway, four hours into the dense jungle foliage that unfolded monotonously around us. Moutamba's village was located 40 kilometers outside of Lambourene, the riverside town where Albert Schweitzer built his hospital.

Over the next days I tried to learn what Moutamba's status as "king of the Bwiti" meant. I received different answers; in Gabon, it was often difficult to separate truth from fantasy. Alain Borgia Dukaga, an English-speaking Gabonese who acted as our translator, told me: "Moutamba is like Jesus to us. Most of the people now are like lacking roots, they got tied to the Christian ways and forgot their culture. Moutamba is helping to bring back our culture. We hope soon they will start teaching Bwiti again in the schools." A few days later, when relations soured between us and our shaman, Borgia (as he asked us to call him) reversed himself. "Moutamba?" he scoffed. "He's not the king of anything. He just calls himself that."

The king's homestead consisted of a complex of wooden buildings in a jungle clearing where children, hens and roosters meandered about. One roofless structure decorated with palm fronds, the "Pygmy House," honored the region's natives for discovering "le bois sacre," the sacred wood, another name for iboga. The Pygmies still live in small bands in Gabon's interior jungles, and it is theoretically possible to have a Pygmy initiation. But I will have to save that experience for another trip. Or more likely a future life.

The temple's stone walls were decorated with crude portraits of the tribal ancestors. A large wooden statue of the first Bwiti couple stood at the entryway. I stared at that statue for a while. I had read about junkies who took ibogaine without knowing anything about Bwiti. On the drug, some of them had described meeting an original African mother and father similar to the tribe's mythical founders.

Not much is definitively known about the Bwiti. James Fernandez, a Princeton anthropologist who studied the sect, concluded that the Bwiti religion worked by "indirection and suggestion and other kinds of puzzlements," leaving "many loose ends and inconsistencies." Throughout his long book on the Bwiti, Fernandez was frustrated by his failure to grasp the belief system behind it. In the end, he threw up his hands, writing that "any attempt to demonstrate the coherence of the Bwiti cosmos founders upon the paradoxes with which it plays."

The night before the ceremony, the analyst, the botanist, the king and I slept in his temple, along with various members of the tribe. When we awoke, the king gave us what the Bwiti call La Liste, a long, traditional roster of things neophytes contribute to the ritual. La Liste includes a mirror, a tin bucket, a red parrot's feather, yards of fabric, a machete, a woven mat and supplies for the next day's feast for the tribe -- a live coq du village and a large quantity of sweet liquors such as rum and cassis. Lieberman, the analyst and I spent the morning driving around Lambourene with a few of Moutamba's sons, whose gravity as they assisted us made me aware of the serious nature of the ceremony. Everywhere we went in the virtually all-black township, people peered into our car with curiosity, and Moutamba's clan seemed proud to parade "les blancs" -- the whites -- around like exotic trophies.

Back at the village, the king called us into the temple. "It was good you stayed here last night," he said. "Last night, I dreamt that le journaliste" -- he pointed at me - "will have many wonderful visions. Now you must give us the rest of the money."

This was a surprise. We had already paid the agreed-upon \$600 for the ceremony, double the fee for the average Gabonese. We reminded him of this, but the king started to shout. "You want to cheat me?" he screamed.

He demanded another \$600 from each of us. Lieberman tried to bargain with him. The argument raged on for hours. The young men of the tribe stared at us stonily, as if they were shocked we would challenge the king's authority. Although Lieberman assured us the Bwiti were pacifists, the situation did not feel safe.

"I'm not sure I like the power dynamics I see here," the analyst commented.

Finally, it was announced that the initiation would proceed even though we had cheated them. However, at the end of the ritual, the king would not give us the special oil bestowing a deeper understanding of our visions through the year. "He himself will not walk with you into the forest and explain to you the myth of the Bwiti," our guide translated. Moutamba's tribe now seemed to regard us with contempt. Bwiti no longer suggested quite the "essence of love" our guide had referred to.

At dusk, the ceremony began. The women took the analyst away and then the men came for me. The Bwiti had changed to full tribal dress -- animal skins, body painting, feathers -- and they played drums and rattles and horns. In single file, we marched from the village over a path through the jungle to the banks of a small stream. The younger men of the tribe had the sleek and muscular bodies of hunters, and the white patterns on their dark skin glowed like neon. Stumbling along with them, I felt like a tall blancmange.

I was directed to undress completely and step into the ice-cold stream. The young man assigned to be my "Bwiti father" poured a soapy liquid over me -- some kind of spirit-medicine -- and smeared a red paste across my face and torso. The Bwiti chanted while I put on the initiate's outfit -- straps of tanned animal skins and shells looped across my chest and upper arms, a short garment of red fabric and the red feather twirled in my hair. For the Bwiti, the color red is like a mystical traffic light, signaling the crossing zone between this reality and the other world.

Woozy with anxiety, I looked up at the group assembled on the slope above me as they sang and drummed a dirge-like melody. By casting off my clothes, I had symbolically died; after taking iboga, I would be reborn. Moutamba produced a plaintain that had been sliced open and filled with white powder. My Bwiti father carried this sacrament to me gingerly while the others watched with serious, expectant faces. He held it up to my lips.

Even now, whenever I think of the taste, I start to shudder. The iboga was like sawdust laced with battery acid. When I finished chewing the dry fruit, I was fed a few more spoonfuls of the drug mixed with honey. Moutamba nodded encouragingly. I struggled to hold the stuff down.

"Le journaliste a mangé beaucoup, beaucoup," he said.

I was worried as we returned to the village. Had I eaten too much?

Walking was more difficult now, as my legs had become rubbery. In a courtyard, the men sat down around me and continued playing music. One of them strummed the M'congo, a one-stringed mouth harp resembling a bow, with an eerie, almost humorous tonality. The M'congo is the essential Bwiti instrument; the voices of the ancestors are channeled through it. My Bwiti father put a bundle of leaves in my right hand and a tight whisk of dry thistles in my left and instructed me to keep shaking both in time to the music. As with many of the rules surrounding the ritual, this one was strictly enforced -- whenever I lowered the rattles, my Bwiti father would rush over to have me shake them again.

"Seeing anything yet?" the botanist asked.

"Not really." I asked him how the analyst was doing.

"She is having lots of visions -- members of her family appearing to talk to her and other things. She is in the temple, describing them to Borgia."

They fed me more iboga and brought me into the torch-lit temple. I was placed alone at the center, facing a mirror decorated with fern leaves and carved figurines. Moutamba and the tribal elders sat to my left, and the rest of the tribe on my right, about 25 people in all. Even in my stoned state, I felt acutely self-conscious. The atmosphere was tense. The king had decreed I would have "wonderful visions," and I began to realize that not satisfying him was not an option.

The analyst lay along a wall of the temple surrounded supportively by the women as she recounted her visions. "There's Buddha," she called out, staring at the ceiling. She turned around. "And I see my dead grandma over there," she said, waving at the wall. "Hello, grandma."

It was a long, awkward time before I began to see anything at all. Finally, out of the corner of my eye, I watched a large wooden statue, faceless and made of rough logs, walk across the room and sit in front of me. Then, in the scratched surface of the mirror, a small screen lit up. Pictures from New York City -- a window of my apartment, street scenes -- flashed with brief, hyperreal clarity.

"I see my apartment in New York," I said. "But nothing seems to be happening there."

"If you see a window, you must try to go through it," the king instructed me, "and if you meet somebody there, you must try to talk to them. Perhaps they have a message for you, some information."

The Bwiti insisted I should relate my visions out loud. I was not prepared for that. I had expected whatever I saw to be my own concern. But the Bwiti didn't sympathize with my ideas about privacy. "Everything you see must be shared," the king urged. "You might have a message for the tribe." But in my stoned state I was tongue-tied, and I sensed the Bwitis' rigid disapproval.

Other hallucinations passed before my eyes -- burning skulls and goblin faces, the figures of women in black dresses stretching out long white arms toward me from the edges of my vision -- but when I tried to speak of them, they disappeared. Meanwhile, the iboga was making me sick. I fought against waves of nausea. I wanted to reach the deeper visionary state, but I was also afraid of the drug. If iboga was indeed a "superconscious spiritual entity," I wasn't sure whether this entity liked or hated me. I suspected the latter was more likely. I started to perspire. My head seemed several times its normal size. I wondered if I was going to die. I vomited into my pail.

"Can I go to the hotel now?" I heard the analyst ask. The Bwiti laughed in response. "Oh, les pauvres, les pauvres," the king said, mocking us. The ceremony had many hours left to go.

I lay on a mat on the hard-packed earth, looking up at the unsympathetic faces of the tribesmen. I scorned my own foolishness: Who was I to try entering the African spirit world? In the future, I promised myself in a moment of insight, I would seek some easier assignments.

Closing my eyes, I saw Technicolor patterns. I fell into a trance, floating to the Bwiti music. Aspects of my past life flared up in my mind, like gleaming facets of a larger whole. I reviewed my childhood -- my parents' separation, my mother's loneliness, my own unhappiness. I felt myself as the product of all the forces that had acted upon me. Henry James once described human consciousness as "a helpless jelly poured into a mold." It seemed as if iboga compelled me to perceive the exact shape of that mold. It was dizzying and liberating.

Then the iboga trip became a cinematic cyclone, whirling images and ideas at me at high speed. A series of unknown houses appeared and I drifted down into them before they faded. Images of ex-lovers came and went, dancing away into the ether. I saw the sign of the now-defunct Manhattan restaurant, Teacher's Too, where I had met my first girlfriend. The letters of this sign spun around in space and reassembled, rebus-like, to spell the phrase, "Touchers Teach Too," which seemed to contain a message about my own future relationships. But what did it mean?

Sometimes the percussive music became deafening in the low-ceilinged temple. At other times the Bwiti's songs seemed awesome in their beauty. The rhythms seemed organic, as if the music was itself an emanation of the plant's essence. In my altered

state, I understood the tribe's deep relationship with this plant that showed them things. I felt how complete their culture was in itself -- so complete that no outsider could disturb it.

Late at night, the Bwiti made us rise and dance with them. Then we watched as each tribesman danced around the temple, whirling a torch, scattering shadows across the walls like living forms. "After you take iboga you will know what Bwiti is," the king had told me the day before. I felt that iboga activated an ancient symbiosis between plant and human. Perhaps what Lieberman had suggested was true, that in Bwiti, like Buddhism, there is no single deity, just a play of forms and spirits spinning across the Void.

At dawn, the Bwiti led us outside to watch the sunrise. We sang with them. We were still woozy as the ritual ended, but the king started shouting again. "Now you have been initiated, you give me presents of money!" he screamed. "I demand more money!"

We decided to check into a hotel. This required another long and tense negotiation.

"I have had visions of terrible ruin!" Moutamba shouted. Because I had not seen and spoken all my visions, the king explained, we would be in mortal danger if we did not stay another night. As Lieberman insisted we were leaving anyway, the king tried to make a bargain. Introducing the analyst to the father of a 9-year-old girl, he suggested that, instead of paying more, she should take the man's daughter and raise her in America.

We convinced one of Moutamba's sons to drive us to the Ogobue Palace, a placid hotel overlooking the river. At the hotel, I discovered that the iboga trip was continuing. I was wide awake and without hunger, despite the fact that I had not slept or eaten in more than 30 hours. Lying in bed, I watched a fleeting phantasm that drifted across cracks in the white wall. Strange men in funny hats and coats marched away, melting into the plaster. I realized these were "ancestor shades," ghost-impressions of my forefathers, a vision that the iboga trance often produced, in accounts I had read. So faint, so quickly, they melted away.

We did not see the king again. After a night's rest, Lieberman and I searched Lambourene for other Bwiti Ngongo. Our guide was eager to buy iboga seeds and powder to bring to South Africa. Off the main streets, the town's back alleys formed mazes of little houses and shacks, and each separate maze seemed its own community. Many of these communities had built their own Bwiti sanctuary from wooden boards and palm fronds, rudimentary compared to Moutamba's temple.

In one of these shrines we found Papa Simone, a young, bearded shaman, with an ascetic, intellectual appearance. I described my visions, scant though they were, to Papa Simone, and he interpreted them for me. The wooden statue, he said, was the spirit of le bois sacre itself, "which comes out and engages you in conversation." The pictures of my apartment and the city streets were a telepathic check-in, showing me that everything was calm at home. The beckoning female figures, he said, indicated what paths to take. I was sorry I hadn't known better how to follow them.

Papa Simone organized another all-night ceremony for us with his Bwiti village, a closing ritual to give us the oil that Moutamba had withheld. During this ceremony, which also involved dancing, drumming and singing, I saw what Lieberman had described as "the essence of love" in the community around Papa Simone. At the end of the night, each of the Bwiti in turn embraced the analyst, then me, and danced us around the temple fire, as violently and quickly as possible. The embraces told us -- more directly than words could -- that despite our alien language and culture and pale skin, we had been accepted among them.

The second ceremony also required eating iboga, but I could not bring myself to swallow enough to hallucinate. Papa Simone's tribe included a large, laughing man wearing a red loin cloth, his sleek black body daubed with white paint. One of the older members of the tribe, he ate iboga throughout the ceremony. He kept pointing at the bowl of shavings, then at his own eyes and then at me, trying to convince me to eat more so I would see things.

Towards morning, he announced that he was having a vision, which Lieberman translated. He said he saw the spirit of my dead grandmother, of my mother's mother, hovering over me where I sat by the yellow flames of the bonfire. "You had a very close relationship with your grandmother," he told me. "She loved you very much, but now she is dead, and she doesn't want to let you go. Her spirit is hanging over you, and she is stopping you from seeing visions, and from visiting the other world."

The tribesman's vision surprised me. My mother's mother was the only grandparent I had known -- the others had died before I was born. If the tribesman was guessing, he had only a one-in-four chance of getting that right. And I did have a close relationship with my grandmother, in a way. She had often taken care of me when I was young. As I got older, I found her a repressed and gloomy presence, and I even tried to avoid her. My grandmother had lived through a sad story of immigrant America -- her father came from Poland, but when he could not find a job in New York, he killed himself, leaving his family in desperate straits. Later on, in revenge, the family destroyed his papers and all traces of him. They never spoke of him again. This repressive act had shaped my grandmother's mental life. It was not difficult to imagine my grandma as a possessive spirit, lingering above me, protecting - preventing -- me from having

revelations. After I returned to New York, the tribesman's vision stayed with me as something uncanny and intuitively wise.

Scientists don't know exactly how iboga affects the brain. One speculative theory is that the alkaloid restores a balance between the brain's two halves. Carl Anderson of the Developmental Biopsychiatry Research Program at McLean Hospital in Virginia believes that people prone to addiction suffer from an imbalance between the left and right hemispheres. This disparity disrupts REM sleep, which, according to Anderson, is "essential for emotional regulation, learning and memory consolidation." Iboga, or ibogaine, accesses REM cycling in a powerful way -- after having taken a large dose, many people report their need for sleep is reduced by several hours, for weeks or even months. By this theory, ibogaine returns to psychically damaged people the healing power of their sleep and dreams.

When I returned to New York, I needed less sleep for a while. I mulled over the Bwiti initiation. The psychedelic had given me such strange figments, such glancing views. For a few hours, I was granted a powerful lens through which I could view my life -- that fragile assemblage of habits, moods, past events and relationships -- like an object seen through a magnifying glass. More memorable than the greed of my shaman, the emotional power of my insights stayed with me as an indelible lesson. I am still waiting to learn what touchers can teach.

salon.com

OMNI Magazine, February, 1994 edition

Does One Trip Equal 30 Years On A Therapist's Couch?

by: Nina L. Diamond

It's the closest thing anyone's seen to a bona fide cure for drug and alcohol addiction, yet, paradoxically, ibogaine's curative power seems to derive from its consciousness-altering properties. Despite the government's historic queasiness about sanctioning studies of mind-active drugs, ibogaine penetrated the bias and survived to become only the second psychoactive drug to get the green light on the long road to FDA approval (MDMA was the first). "The FDA has been very responsive on this one," says neuroscientist Deborah Mash of the University of Miami. Mash heads the team conducting the FDA human safety trials.

Mash is the latest link in the ibogaine story, but one who will bridge the gap between anecdotal evidence and scientific proof needed for FDA approval. Ibogaine is derived from the roots of *Tabernanthe iboga*, a shrub native to equatorial Africa, where tribes have long used it in small doses to remain alert while hunting and in larger amounts during sacred rituals. In 1962, heroin addicted Howard Lotsof took a trip on ibogaine and afterward found that he'd lost his desire for heroin and suffered no withdrawal symptoms (see *Mind*, July 1993 *Omni*). Lotsof gave the substance to other addicts, and they, too, were unhooked from drugs that previously ruled their lives. "The International Coalition for Addict Self-Help ran underground trial testing on ibogaine," Mash says, "and it was found to cure addiction to heroin, cocaine, and other substances."

In 1986, Lotsof formed NDA International and secured a use patent on ibogaine for treating drug and alcohol addiction. Underground trials began in the Netherlands in 1990, with more than three dozen addicts since treated as test cases. Tests will soon begin in other European countries and in Israel. Mash was among the American investigators invited to Leiden to witness ibogaine in action. "I call it a chemical bar mitzvah," she quips. "It's a psychoactive drug, but not a hallucinogen like LSD. It puts you into a thirty-six-hour waking dream state. During this altered state of consciousness, you relive your childhood experiences, get to the root of your addictions."

"Ibogaine was used as a rite of passage in Africa," says Lee Hearn, laboratory director of the Metro-Dade Medical Examiner's Department and a member of Mash's team. "Now it may be used to reprogram an addict's life. Anecdotal reports indicate that while on ibogaine, he or she is detached from childhood recollection, but is reexamining, coming to grips with it, perhaps understanding it for the first time. All neuroses are potentially solvable this way. Drug addiction," he adds, "is an illness of the spirit. If you're going to cure it, you have to do so at that level."

Mash remembers Mark, an American in Holland for ibogaine treatment. "His brain was working overtime. He was viewing his past as a detached participant, observing where he went wrong, reintegrating it. He didn't want to speak or be interrupted. I spoke to him but didn't want to be intrusive." On ibogaine, one may confront experiences long ago swept under the emotional carpet. Scientists have been startled to see that ibogaine cures the anxiety of decoupling from a long-term habit, prevents withdrawal symptoms, and relieves - although not completely eliminates - cravings. "Mark went thirty days without craving, but then it started," Mash reports. "We don't understand craving, although it's tied to relapse. An addict will tell you it's triggered by certain cues. We think it's similar to classical conditioning (see *Mind*, November 1993 *Omni*)."

Mash is testing ibogaine's pharmacologically active metabolites. "If craving returns to some extent in some people, it may be because ibogaine's metabolites are washing out over time," she speculates. "Maybe we'll need something after ibogaine for maintenance." But so far no one has had a bad trip, and the only side effects reported are slight nausea and imbalance at the treatment's beginning. In monkey studies, Mash found no brain toxicity. "Toxicity only showed up in a study at John Hopkins University, and it was only toxic in near-lethal high doses." Yet ibogaine's physiological mechanism remains a mystery. It doesn't bind to any known brain receptor, says Mash, whose team includes a neurologist, a psychiatrist specializing in addiction, and a social worker expert in "inner child" work.

"A negative bias has evolved surrounding the use of psychoactive drugs," Hearn laments, "because of recreational uses of substances like LSD. It's a mistake to label them as bad because they're mind active. Maybe ibogaine will change some misperceptions and open the door to research with psychoactive drugs." Mash agrees. "Treating drug dependence with a drug is still considered ironic." Also ironic, she adds, is the first trials are taking place in Miami, the premiere transit point for cocaine in this country.

The Observer, Sunday January 7, 2001

Hallucinogen 'cure' for addicts linked to deaths. Special report: drugs in Britain

by: Tony Thompson

A powerful hallucinogenic drug that has been linked to dozens of deaths around the world is becoming increasingly popular among Britain's heroin and crack users, who believe it can offer an instant, painless cure for their addictions.

Extracted from the root bark of a west African plant, ibogaine has been used in spiritual rituals in parts of Gabon, where it is said to open up ancestral memories and enable people to re-evaluate life experiences. It is banned in the US, Belgium and Switzerland but legal in the UK where it is classified as an unlicensed, experimental medicine. Concerns over its safety and high price have prevented it from growing in popularity.

But Observer investigations reveal an increasing number of mail-order outlets supplying British addicts with an extract of ibogaine at £20 a gram. Tourists are also bringing it back from Amsterdam, where it is openly available.

Only a few countries, including Panama, Costa Rica and Italy, have clinics that administer ibogaine under scientific conditions in treatment programmes costing several thousand pounds. In Britain, many users are now taking the drug in their own homes under the supervision of friends or other addicts.

On Wednesday an inquest opens into the case of a London man who died after ingesting ibogaine in an attempt to cure his heroin addiction. His may be the first death in the UK related to the use of the substance and represents a setback to those who want it used more widely.

'People say it is like having 10 therapy sessions all at once,' says Chris Sanders of the Ibogaine Project, a UK-based initiative campaigning for more research to be carried out into ibogaine's potential benefits to drug addicts.

'It's often called a wonder drug but the reality is that it's not a total cure in itself, just a way of giving an addict a fresh start. It has a powerful effect on the body - you need to be fit to be treated with it. I can't say I'm happy about people using it on their own.'

Sanders believes deaths linked with ibogaine have occurred when users 'cured' of their addiction return to using drugs. Because ibogaine 'resets' many brain functions relating to drug use, users who take their usual dosage soon after treatment risk overdosing. The only major clinical trial of ibogaine, which took place in Amsterdam

in the early Nineties, was abandoned after an addict died of an overdose after being treated.

While even ibogaine's strongest supporters admit there are dangers, those who have been treated with it are almost evangelical in their desire to enable others to benefit. As well as curing addiction to drugs, alcohol and tobacco, they claim it can have a positive effect on other psychological disorders.

The effect of the drug varies according to the dosage. Less than one gram produces stimulant and aphrodisiac effects. Up to three produces a mellow euphoric trip during which the user may experience various hallucinations. Up to six grams, the maximum safe dosage, produces powerful near-death and other deep spiritual experiences. Those taking the highest doses of ibogaine report that they first enter a dream-like phase that lasts several hours and consists of vivid visions of past memories, almost as if they were watching a film of their own lives. The second phase consists of high levels of analytical mental activity during which users are frequently reported to comprehend for the first time the reasons why they drifted into drug-using.

Dr Colin Brewer who runs a specialist addiction clinic in London, the Stapleford Centre, is sceptical about whether the drug is beneficial.

'It has an enormous placebo effect and in that sense has more to do with voodoo than pharmacology. In order to evaluate it, you would have to conduct experiments alongside another drug like LSD, which no one is going to risk because of the harm it can do.'

Nature Medicine, 4; 377, 1998

Fight to develop drug addiction therapy

by: Karen Brimingham

A new phase in the acrimonious legal struggle over the development of the anti-addiction drug ibogaine began last month when the trial was moved to Florida. Because the trial centers on work carried out at the University of Miami, the suit was dismissed for jurisdictional reasons by courts in New York. Now the Miami judicial system is faced with resolving a case that involves the U.S. Food and Drug Administration (FDA), a senior neuroscientist, a Caribbean drug treatment center, the National Institute on Drug Abuse (NIDA) and the ibogaine use-patent holder, Howard Lotsof.

Lotsof discovered ibogaine's anti-addictive potential thirty years ago when he experimented with the drug as a 19 year old heroin addict. Since that time, he claims to have spent 17 years and \$1 million trying to bring the drug to market as an addiction therapy (Endabuse) through his Staten Island company, NDA International, Inc.

Ibogaine is purported to cure heroin and cocaine addiction by removing the physiological and psychological characteristics of dependency without inducing withdrawal symptoms (*Nature Med.* 1;288, 1995). Remarkably, it is claimed that ibogaine achieves this effect in one dose.

Legal proceedings began last April when Deborah Mash, Professor of Neurology at the University of Miami and principal investigator in the FDA-approved Phase I trials of the drug filed a motion accusing Lotsof of fraud. Mash alleges that Lotsof covertly took out a patent on an ibogaine metabolite (Noribogaine plus) that is more effective than the parent compound - a discovery made by Mash but not attributed to her. Mash is demanding that the patent, issued to Lotsof in January 1997, be canceled and requests compensation. Her petition makes clear distinction between her reputation as a "world renowned scientist in the field of neurology" and Lotsof's lack of scientific background.

Lotsof counter-sued in August, claiming that Mash and the University of Miami violated their 1992 contract to perform the Phase I study. He further alleges that Mash is currently infringing his company's intellectual property rights for her own commercial benefit at a drug treatment facility on the Caribbean Island of St. Kitts.

Mash agrees that early clinical studies of the drug were suspended and says it was for good reason: In 1993 a woman in the Netherlands died, reportedly due to an ibogaine overdose, while being treated in a hotel room. Mash says she had an ethical

responsibility to stop human testing while the affair was investigated. Furthermore, she says that NDA International was not providing financial support for the study.

Despite these problems, Mash and Lotsof were still on good terms. After the Dutch death, Mash helped Lotsof set up a program in Panama, where subjects were to be treated in medical surroundings and monitored at the University of Miami. But by the time NIDA held an ibogaine consensus meeting in 1995, their relationship had deteriorated beyond repair. The NIDA advisory panel ruled against further studies of the drug - some believe for reasons of toxicity and others say on political grounds - and the ibogaine story looked to have come to a close.

Not so, according to Mash, in 1996 a group of private individuals who had "enough respect for her as a scientist" funded a treatment center called Healing Visions in St. Kitts. Here she used ibogaine to treat private customers - one Chicago lawyer is said to have paid \$12,000.00 for treatment - and all outside the reaches of US patent law.

Despite criticism that she has chosen an unconventional route to proceed with her research, Mash insists that working in St. Kitts is the only way she can collect patient data. She is dismissive of Lotsof's patent rights which she says, "won't last for ever" and plans to file for clinical trial approval in the US once she has sufficient preliminary evidence that ibogaine is safe and effective. She freely admits that she is staking her scientific career on the drug.

Lotsof is equally determined to see the project through, since he too has devoted his life to the pursuit of ibogaine as a cure for dependency. He has hired a new lawyer in Miami and is awaiting a trial start date.

Ibogaine: A Retrospective and Current Analysis (1997)

by: Chris Lovett

INTRODUCTION

In our society today, the United States along with many other countries are facing the ever-ubiquitous problem of substance abuse and chemical dependency. While addiction is not a new affliction to mankind, many new therapies and treatments are being developed rapidly as we begin to comprehend more fully the neurochemical bases of the brain and behavior, and the pharmacological actions of many addictive substances. Also, as we gain more knowledge about the mechanisms of action of chemical agents that are capable of treating addiction or alleviating withdrawal symptoms, we gain insight into the very nature of chemical addiction. One of these agents being currently researched along with ketamine and MDMA is Ibogaine, which has been proposed as being effective in treating opiate addiction (Lotsof, 1985), cocaine and amphetamine addiction (Lotsof, 1986), alcohol dependency (Lotsof, 1989), nicotine/tobacco dependency (Lotsof, 1991) and various combinations of these substances (Lotsof, 1992).

Ibogaine (12-methoxyibogamine), the principal indole alkaloid of the Central West African shrub *Tabernanthe iboga*, has also been known in the past by the tradename Lambarene(TM). Between 1939 and 1966 Lambarene(TM) was marketed in France for its general stimulant effects on the body including fighting fatigue and promoting a sense of well-being. More recently, ibogaine has been known by the tradename Endabuse(TM) as an anti-addictive pharmacological agent. The United States federal government, in response to the resolutions of the World Health Assembly of May 1967 and May 1968, illegalized ibogaine, placing it on the Food and Drug Administration's Schedule I list of "controlled substances analogous to lysergides and to certain CNS stimulants including LSD, DMT, psilocybin and others. Fortunately, in 1991 the National Institute on Drug Abuse (NIDA) decided to include ibogaine on the list of drugs to be evaluated in the treatment of drug dependency, a decision that has prompted much research in the last few years, although the mechanisms of action still remain evasive and unclear to researchers.

HISTORY

Botanical Origins Ibogaine is obtained most commonly as the principal indole alkaloid from the root bark of *Tabernanthe iboga*, a shrub indigenous to Central West Africa and particularly Gabon. Henri Baillon of the Museum National d'Histoire Naturelle in Paris established the genus *Tabernanthe* in 1889, and named the sample which had been brought back from Gabon to France in 1864 by Dr. Griffon du Bellay, a navy surgeon, *Tabernanthe iboga* (Goutarel, 1992). *Tabernanthe* is in the

Apocynaceae or dogbane family, and ibogaine has also been isolated from *Tabernanthe pubescens*, *Voacanga schweinfurthii* and other *Voacanga* species, ten species of the related *Tabernaemontana* genus, and is the major alkaloid of the bark of *Tabernaemontana crassa*. While ibogaine is the principal active alkaloid *T. iboga* also contains voacangine (carbomethoxy ibogaine), the positional isomer tabernanthine (13-methoxyibogamine) and ibogamine, all of which may contribute to the overall effects of *T. iboga* (Ott, 1993). In 1901 the principal alkaloid of *T. iboga* was isolated from the roots of the plant and named Ibogaine by Dybowski and Landrin (1901).

Religious Uses of *Tabernanthe iboga* Among the indigenous peoples of Gabon, Africa, the Mitsogho have been using the roots of *Tabernanthe iboga*, which they call eboka or mbassoka, as part of their Bwiti initiation ritual ever since their migration to the area. The Bwiti ceremony is strictly for males among the Mitsogho, a rite of passage from adolescence to manhood. By chewing the scrapings of the eboka root, the amount used in the ritual containing up to 6.25 grams of ibogaine, the candidate for initiation, or "banzi", hopes to embark on a spiritual journey coming eventually to the Village of the Bwiti. Here he will encounter Nzamba-Kana, the father of humankind, the first man on Earth, and his wife Disumba, the mother of humankind and the first woman on Earth.

The ritual is preceded by a day of fasting and abstinence from sex, and then begins with the banzi chewing a large amount of root-bark and stems of eboka under the close supervision of his "mother", a former initiate. The banzi's skull is struck three times with a hammer to "break open the head" freeing the spirit, and his tongue is pricked with a needle to enable him to relate his visions. After these and other preliminary symbolic rites, the young candidate is led into a temple and placed on the left side, which symbolizes womanhood, darkness and death. About twenty minutes after the eboka begins to be absorbed, the banzi repeatedly and violently vomits, afterwards becoming drowsy and losing motor coordination. The "mother" monitors the pulse and body temperature of the initiate by touch continuously for the first ten hours of the experience until the visionary effects begin to occur.

On the journey towards the Village of the Bwiti, the banzi passes through four distinct levels or stages, encountering his ancestors along the way who encourage him to go further as he begins realizing that his spiritual substance is timeless, and that the concept of death has no meaning. He feels himself carried by the wind to the infinite Village, while hearing the Ngombi harp which is played throughout the ceremony, representing the link between his village of earthly men and the Village of the Bwiti in the beyond. When he reaches the Village, and encounters Nzamba-Kana and Disumbu, all is suddenly engulfed in intense sparks of light which slowly form into an enormous ball, Kombe, the sun. Kombe questions the banzi, and asks him why he has come. He says, "I am Kombe, the Chief of the World, I am the essential point! This is

my wife Ngondi (the moon) and these are my children Minanga (the stars). The Bwiti is everything you have seen with your own eyes," (Gollnhofer and Sillans, 1983).

The wind then carries the initiate back to his earthly village, where the elders greet him and invite him to take his place on the right side of the temple, the side of men and life. The new initiate will not encounter the Bwiti again until the day of his death, and eboka is not consumed again except for in small doses as a stimulant to aid in hunting.

Eboka is also used in an initiatory rite of the Ombudi order of the Mitsogho, an order of women healers, though they consume much smaller quantities than the Bwiti initiates. Along the coast of Gabon, the Fang people also use Tabernanthe iboga in their own Bwiti initiation rites which are essentially the same as those of the Mitsogho and the ritual language used is Mitsogho. The Fang differ, however, in that they allow women to be initiated, and they have also integrated some elements of Christianity into their syncretic ceremony. During the Fang eboka experience, the initiate may encounter saints, Noah, Jesus Christ, the Virgin Mary, Lucifer and Adam instead of Nzamba-Kana and Disumba as with the Mitsogho (Gollnhofer and Sillans, 1983). This supports my own personal view that when a visionary plant or entheogen such as Tabernanthe iboga is used as a religious sacrament, the effect is strongly culturally-dependent and not just the sum of its chemical alkaloids.

Therapeutic Uses After the isolation of ibogaine from Tabernanthe iboga in 1901 by Dybowski and Landrin, there was very little research done on the effects of ibogaine other than by a few French pharmacologists including Phisalix, Lambert, Heckel, Pouchet, Chevalier and Closmonil. For approximately the next forty years, little interest was shown in ibogaine and it was regarded as an obscure cardiac stimulant.

Renewed interest in ibogaine occurred in 1939 when Wurman published his Doctorate of Medicine thesis in Paris entitled, "Contribution a l'etude experimentale et therapeutique d'un extrait de Tabernanthe manii d'origine gabonaise," (Contribution to the experimental and therapeutic study of an extract of *T. manii* from Gabon). This led to the dry extract of the roots of Tabernanthe manii being prepared in tablet form and given the tradename Lambarene(TM) in honor of Dr. Schweitzer.

Lambarene(TM) was produced in France, and contained about 200mg of extract or 8mg of ibogaine per tablet. The package label described it as: "a neuromuscular stimulant, promoting cell combustions and getting rid of fatigue, indicated in cases of depression, asthenia, in convalescence, infectious diseases, greater than normal physical or mental efforts by healthy individuals. 2-4 tablets daily. Rapid and prolonged action not followed by depression. May be administered to hypertensives."

Lambarene(TM) was of particular interest to post-World War II athletes and French mountaineers because of its antifatigue properties, and continued to be marketed in France until 1966 when ibogaine was prohibited in France. Since 1989, ibogaine has also been banned by the International Olympic Committee, the International Union of Cyclists and the French State Secretariat for Youth and Sports (Gouteral, 1992).

Ibogaine has also been used as a psychotherapeutic agent as well as a stimulant. Beginning in 1969, Claudio Naranjo, a Chilean physician, while training at the Institute of Personality and Research of U.C. Berkeley, conducted many psychotherapy sessions using ibogaine as a psychological catalyst. He used a dosage of about 200mg-300mg per patient, and termed the state ibogaine brought about as "oneirophrenia" and ibogaine as an "oneirophrenic" substance (Naranjo, 1973).

Naranjo reported that this "oneirophrenia" would last about six hours and that his subjects would experience an enhancement of their fantasies which were rich in Jungian archetypes. These fantasies involved animals, the subject himself, with or without others, and were easily manipulated by both the patient and by the psychotherapist. Naranjo, after conducting over fifty case-studies of the psychotherapeutic use of ibogaine, concluded that ibogaine was a "non-toxic drug that clarifies thoughts and permits a very thorough introspection while preserving the patient's emotional character which is indispensable for the stimulation of thought and imagination. I doubt that there is anything that can be achieved with a drug that cannot be done without it. However, drugs can be psychological catalysts that make it possible to compress a very lengthy psychotherapeutic process into a shorter time and change its prognosis. Although ibogaine cannot open a door by itself, it can be considered as the oil for its hinges," (Naranjo, 1969).

Anecdotal Anti-Addictive Reports In 1962, Howard Lotsof and a group of six or seven friends, all of whom were at the time in various stages of addiction to either cocaine or heroin, each took a dose of about 500mg of ibogaine. They then experienced an approximately 36 hour waking dream-state in which childhood memories and formative experiences were relived and re-examined, each of them gaining insights into how their addictive personality traits formed, where their lives went wrong, so to say (Mash, 1997).

Lotsof, along with five of the others who took that initial dose of ibogaine, permanently gave up the use of drugs entirely following this incredible, unexpected experience, amazingly suffering no withdrawal symptoms whatsoever. Lotsof himself rebuilt his life at this point, dedicating himself to curing drug addicts by providing them with ibogaine. He went on to found the New York corporation NDA International, Inc. in 1986, with the purpose of marketing ibogaine hydrochloride under the tradename of Endabuse(TM). Each capsule of Endabuse(TM) contains 1 gram of ibogaine hydrochloride and is used in the rapid interruption of drug and

alcohol addiction with virtually no withdrawal symptoms. Lotsof also filed a number of patents between 1985 and 1992 for methods of using ibogaine in treatments to cure the addiction to substances including narcotics (Lotsof, 1985), cocaine and amphetamines (Lotsof, 1986), alcohol (Lotsof, 1989), nicotine (Lotsof, 1991) and combinations of these drugs (Lotsof, 1992).

Between 1988 and 1990, in conjunction with the International Coalition for Addict Self-Help (ICASH) and the Dutch Addict Self-Help (DASH) groups, Lotsof began conducting underground trials in the Netherlands with more than three dozen addicts successfully being treated. Thanks to Lotsof's inspiration, research has been and continues to be done on ibogaine at Evans University of Rotterdam, at the Addiction Research Foundation in Toronto, at Albany Medical College, N.Y., and through the Committee on Problems of Drug Dependence at the National Institute of Health, Bethesda, Maryland. Very promising treatment of addicts is currently being conducted by Deborah Mash and others, officially outside of the United States, through Healing Visions: Institute for Addiction Recovery, Ltd. In addition to directing this treatment of addicts, Deborah Mash, Professor of Neurology and Molecular and Cellular Pharmacology, along with Dr. Juan Sanchez-Ramos, both of the University of Miami's School of Medicine, have conducted F.D.A. approved Pre-Clinical and Phase I Human Safety and Efficacy trials funded mostly by the National Institute on Drug Abuse (NIDA) and the Multidisciplinary Association for Psychedelic Studies (MAPS), (Mash, 1997). MAPS: FEATURE: Ibogaine-- C. Lovett, Part II · To: maps-forum@xxxxxxxx · Subject: MAPS: FEATURE: Ibogaine-- C. Lovett, Part II · From: maps-forum@xxxxxxxx · Date: Tue, 5 Aug 1997 23:43:11 -0400 (EDT) · Reply-to: maps-forum@xxxxxxxx · Sender: owner-maps-forum@xxxxxxxx Ibogaine: A Retrospective and Current Analysis By Chris Lovett For Principles of Pharmacology and Toxicology I, UC Santa Cruz, 1997. Part II

PHARMACOLOGY

The pharmacology of ibogaine is extremely complex and not very well understood at the moment. It has been shown to affect the neurotransmitters serotonin (5-HT) and dopamine, to act as a competitive antagonist at the MK-801 binding site of the NMDA receptor complex, and to act as an agonist at the kappa and mu opiate receptors. Ibogaine also has various effects with various durations depending on the dosage. In the following table, human dosages are based on a body weight of 50-100 kg:

USAGE DOSE	HUMAN DOSAGE(ORAL)	EFFECT	DURATION
Lambarene(TM)	8mg/tablet (0.08-0.04mg/kg)	Stimulant	2-6hrs.
The Mitsogho	50-150mg (0.5-3mg/kg)	Stimulant	4-8hrs.
Claudio Naranjo	200-300mg (2-6mg/kg)	Oνειrophrenic	4-8hrs.
Lotsof in 1962	500mg (5-10mg/kg)	Anti-addictive	24-30hrs.
Endabuse(TM)	1000mg		

(10-20mg/kg) Anti-addictive 24-30hrs. The Mitsogho 2-6g (40-100mg/kg)
Entheogenic 24-36hrs.

At the dosages listed above, ibogaine has been found to be relatively non-toxic, about as much so as aspirin or quinine, with a wide therapeutic range of 10-50mg as a stimulant, and 300-1000mg as an oneirophrenic or anti-addictive (Dhahir, 1971).

Synthesis and Properties The synthesis of ibogaine and ibogamine was first elucidated by G. Buchi et al. (1966) at the Massachusetts Institute of Technology. They prepared both ibogamine and 12-methoxy ibogamine in the form of their racemates, starting with nicotinamide and proceeding through a 13-step sequence involving an isoquinuclidone intermediate. The correct structure of ibogaine was established by M Bartlett et al. (1958), through chemical studies and x-ray crystallography. The physical properties of ibogaine are as follows:

12-methoxyibogamine: C₂₀H₂₆N₂O. Molecular Weight 310.438. C 77.38%, H 8.44%, N 9.02%, O 5.15%. Alkaloid Melting Point@xxxxxx: 152-153 C; HCl salt: 299-300 C (decomposes). pKa: 8.1 in methylcellosolve. The isolated alkaloid is a solid at room temperature consisting of small, red prismatic needles forming from an ethanol solvent. It is practically insoluble in water; soluble in ethanol, ether, chloroform, acetone and benzene. The HCl salt is a crystalline solid at room temperature. It is soluble in water, methanol and ethanol; slightly soluble in acetone and chloroform; practically insoluble in ether. The amount of ibogaine found in Tabernanthe iboga is as follows: root(1.27%), root-bark(2-6%), stems(1.95%) and leaves (0.35%). (Merck, 1996).

Toxicity LD50s are as follows (compare with usage table above): Rat (ORAL): 482 mg/kg Rat (INTRAGASTRIC): 327 mg/kg Rat (INTRAPERITONEAL): 145 mg/kg Guinea Pig (INTRAPERITONEAL): 82 mg/kg

Chronic toxicity studies were done by H. Dhahir in his Ph.D. Thesis (1971), and his findings, as follows, are from his experiments with rats. Ibogaine was administered for 30 days at a dosage of 10 mg/kg intraperitoneally each day, with no damage found to the liver, kidneys, heart or brain. 40 mg/kg was administered each day for 12 days with no damage found to the liver, kidneys, heart or brain. Dhahir contrasted these results with the fact that serotonin is very toxic at dosages four times lower, causing severe kidney damage. He concluded that ibogaine was a relatively non-toxic alkaloid with a wide therapeutic range of 10-50mg as a stimulant and 300-1000mg as a psychotherapeutic agent (Dhahir, 1971).

There has only been one study conducted which has found toxicity or neurotoxicity of any form. This was done by O'Hearn and Molliver (1993) using repeated dosages of 100 mg/kg intraperitoneally on rats, which is near the LD50 for rats (i.p.), and above

the LD50 for guinea pigs (i.p.). Also, since these doses were administered intraperitoneally, the drug is not subject to the first-pass effect, which I will discuss shortly, as it would be when given orally in a therapeutic setting. They found degeneration of Purkinje cells in parasagittal zones of the cerebellar vermis. This was associated with loss of the microtubule-associated protein (MAP 2) and calbindin. However, similar neurotoxicity studies were done by Molinari, Maisonneuve and Glick (1996), in which no toxicity or neurotoxicity was found whatsoever. This supports the findings by Sanchez-Ramos and Mash (1994), who conducted Pre-Clinical studies in which African Green monkeys were given 5-25 mg/kg orally for four consecutive days and no neurotoxicity was found.

Pharmacokinetics and Biotransformation There is very little pharmacokinetic data available at this time regarding the adsorption, distribution and elimination of ibogaine in the body. What research has been done mostly addresses how the anti-addictive effects of ibogaine persist for so long in the body, when the half-life according to Dhahir (1971) is only 1 hour. Two types of results have been found to account for this. First, L. Hough, S. Pearl and S. Glick (1996) hypothesize that ibogaine's long acting effects are due to its persistence in body fat, the drug being slowly released over time. One hour after injecting rats (i.p.) with a dosage of 40 mg/kg, they found ibogaine levels to be 106 ng/ml in blood plasma and 11,308 ng/g in fat tissue. After twelve hours, the levels were 20 ng/ml in blood plasma and 700 ng/g in fat.

Deborah Mash et al. (1995), however, believe that the long-term action of ibogaine is due to its principal metabolite 12-hydroxyibogamine, also called noribogaine. In their study they found that both ibogaine and noribogaine act as competitive antagonists at the MK-801 binding site of the NMDA receptor complex, which may be a cause of ibogaine's ability to interrupt drug-seeking behavior.

What is also known about the adsorption of ibogaine, is that when administered orally, it is subject to a substantial first-pass effect, being rapidly metabolized by the liver (Hough et al., 1996). Thus, the bioavailability of ibogaine is diminished when administered orally than when administered intraperitoneally, and this effect is reflected in the rat LD50s. Another established property of ibogaine relating to its pharmacokinetic effects is that it has a heptane/water partitioning coefficient of 28 (Zetler et al., 1972). This is not surprising, based on the high adipose-tissue solubilities observed by Hough et al. As is readily apparent, many more pharmacokinetic studies need to be conducted on ibogaine before we begin to understand the action of this highly complex drug.

Pharmacodynamics As with the pharmacokinetics of ibogaine, very little is understood currently about its complex mechanisms of action. There has been a prolific amount of research in the last few years on ibogaine, and various

neurotransmitter and receptor systems have been identified as being involved in its mechanisms, including dopamine, serotonin, the NMDA receptor complex and the mu and kappa opiate receptors.

Ibogaine's binding competitively to the MK-801 binding site of the NMDA receptor complex has been shown to suppress morphine withdrawal and dependency in rats, (Trujillo et al., 1991) and (Popik et al., 1995). This action has also been shown to interact with the kappa opiate receptor in inhibiting opiate dependency (Glick et al., 1996). Mash et al. (1995) found that the principal metabolite of ibogaine, noribogaine, also acts antagonistically at the MK-801 binding site. Ibogaine's action as an agonist of kappa and mu opiate receptors has also been demonstrated by Glick et al. (1995) to be effective in inhibiting morphine and cocaine self administration in rats. Ibogaine's action on the dopaminergic system has also been studied, with activity being observed in various brain regions, but not generally in the nucleus accumbens, a supposed site of the neural basis of addiction. Ibogaine has been found to affect dopamine transporters in an unknown way, decreasing extracellular dopamine levels in the striatum, increasing levels in the frontal cortex, and leaving the levels in the nucleus accumbens unchanged (Ali et al., 1996). As evidence of a direct anti-addictive effect, Maisonneuve et al. (1992) have found ibogaine's effect on the dopaminergic system to inhibit the activity of morphine-preferring rats.

Finally, ibogaine affects the serotonin transporters causing an elevation in serotonin levels. Mash et al. (1995) found this to be true of noribogaine as well. In addition, both ibogaine and noribogaine have been found to inhibit serotonin re-uptake in rats, which has been linked to an attenuation of alcohol consumption in rats that preferred alcohol (Rezvani et al., 1995) and (Rezvani and Mash et al., 1995).

Sweetman et al. (1995) perhaps best sums up the state of our knowledge of the pharmacodynamics of ibogaine by suggesting that multiple mechanisms of action are responsible for ibogaine's inhibitory effects on substance addiction. As can be inferred from the ever expanding supply of scientific data, the pharmacodynamics of ibogaine, and its principal metabolite noribogaine, are very complex, effecting multiple sites simultaneously, and a full understanding of their actions may not be possible with our current knowledge of neuroscience and its accepted mechanisms of action for chemicals that affect it. MAPS: FEATURE: Ibogaine-- C. Lovett, Part III · To: maps-forum@xxxxxxxx · Subject: MAPS: FEATURE: Ibogaine-- C. Lovett, Part III · From: maps-forum@xxxxxxxx · Date: Tue, 5 Aug 1997 23:50:03 -0400 (EDT) · Reply-to: maps-forum@xxxxxxxx · Sender: owner-maps-forum@xxxxxxxx
Ibogaine: A Retrospective and Current Analysis By Chris Lovett For Principles of Pharmacology and Toxicology I, UC Santa Cruz, 1997. Part III

CONCLUSIONS

Last year, in 1996, Deborah Mash and Juan Sanchez-Ramos received F.D.A. approval for the next step of ibogaine research: Phase I human safety trials, evaluating the use of ibogaine in treating cocaine abusers. Unfortunately, the National Institute on Drug Abuse decided in August, 1996 to reject their application for funds, so currently their research is on hold. They have been partially supported by organizations like the Multidisciplinary Association for Psychedelic Studies (MAPS), and the Heffter Research Institute, but these organizations are very small and severely limited in funds.

Ibogaine is also almost impossible to find on the black-market. Perhaps this is because members of the larger underground power-structures in our country that have interests in the vast money-generating power of addictive drugs such as heroin and cocaine, as well as the legal corporations with vested interests in the alcohol and tobacco industries, do not want addiction to be cured. It would be bad for business! Not to mention all those high-level, high-paying bureaucratic positions as well as the laboring police forces that depend on the "War on Drugs" for an occupation. If there were not victims of drug-addiction to apprehend and condemn, or "dangerous" substances to write new laws about, to classify into arbitrary lists, to conduct demographic studies in relation to, and to use as a bludgeoning tool to promote genocide among the peoples of inner-city ghettos, what would our government do with itself? Probably shift its efforts towards increasing our nuclear weapons production, no doubt.

But if the government or any mysterious underground power structures are really factors in the delay in the legalization of ibogaine for anti-addictive use, is only speculation at best, paranoia at worst. What is important is that addicts are being treated by Deborah Mash and others, officially outside of the United States. In addition, Howard Lotsof's NDA International, Inc. has been manufacturing Endabuse(TM) capsules, also outside of the United States, preparing for what seems to be the imminent legalization of ibogaine for therapeutic use.

There exists no reason why further steps in drug-development for F.D.A. approval of ibogaine should be prevented. There has been no toxicity shown in any pre-clinical animal studies using dosages within the proposed therapeutic index, even at its upper limit, and the F.D.A. has given approval to continue with Phase I human safety trials. Perhaps the reason why the NIDA decided not to fund these trials is that ibogaine's mechanisms of action are still poorly understood. If this is the case, then the NIDA is forgetting a fundamental principle of scientific research. All models, including models of drug-action, are only models. These models only approximate truth, approximate reality. Just because we cannot find the correctly shaped model to depict the mechanisms of ibogaine does not mean that it is dangerous. It means perhaps our model-based representations of reality are beginning to fail us. Our limits of understanding are beginning to exceed our limits to construct representational models.

We are in need of a new paradigm or meta-paradigm to conceptualize within, perhaps one that does not take as an inherent principle the concepts of physicality and reductionism. This is the root of the fear surrounding ibogaine, not fear of the compound, but fear of our own conceptual limits. Perhaps with a new world-view, a new paradigm within which we can conceptualize the workings of ibogaine and many other elusive concepts, this extremely non-toxic spiritual salve which is ibogaine can be used to heal and relieve those people experiencing the pain from within that is the cause of addiction.

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The Lancet [Volume 352, Number 9136] 17 October 1998

by: Kelly Morris

The use of cocaine, a highly addictive stimulant and euphoriant with few physical withdrawal symptoms, is increasing. Up to 10% of ever-users will become heavy users, particularly if they inject the drug or smoke "crack", the free base. And many users, notes John Marsden (Institute of Psychiatry, London, UK), do not seek help until they are in crisis, often with financial worries or relationship problems. Current treatments for addiction can work well, but "there is a high degree of dropout in treatment and a high degree of relapse", says Frank Vocci (US National Institute on Drug Abuse, Bethesda, MD, USA). Treatment "has traditionally been non-pharmacologically based", adds Walter Ling (University of California at Los Angeles, CA, USA), although antidepressants such as selective serotonin reuptake inhibitors and desipramine are also used, particularly for the depression, anhedonia, and sleep disturbances that can accompany cocaine withdrawal. With only half of addicts who complete treatment remaining abstinent, the hunt is now on for new treatments. Cocaine blocks the presynaptic dopamine transporter in the mesocorticolimbic dopamine system, increasing synaptic dopamine which is thought to produce the drug's rewarding effects. Ligands that block the dopamine transporter, especially those with a slow onset and long duration of action, "should increase dopamine levels, possibly block cocaine's binding to the transporter, and may reduce anhedonia and craving", explains Vocci. Such drugs include methylphenidate, which is in phase II trials, and two new dopamine-reuptake inhibitors, which are in phase I trials. Phase III trials are planned for selegiline, which reduces dopamine metabolism, and amantadine, which may block dopamine reuptake, adds Vocci. On the other side of the synapse, dopamine-receptor antagonists could block cocaine's rewarding effects but might have side-effects. Dopamine-receptor agonists could replace the need for cocaine in a dependent person, but might be addictive themselves, although "a long acting one or a partial agonist may not be", speculates George Koob (Scripps Research Institute, La Jolla, CA, USA). His team is working on dopamine-receptor partial agonists, such as terguride, which act as antagonists when cocaine is present but which are not reinforcing alone (*J Pharmacol Exp Ther* 1998; 286: 123138). For some years, research interest has focused on modulating the dopamine system but with limited success, notes Ling. Several groups, including Koob's, are approaching addiction from the other end by trying to immunise against cocaine. Antibodies raised to cocaine could stop the drug entering the brain and reduce the user's high, without the side-effects associated with neurotransmitter manipulation. ImmuLogic (Waltham, MA, USA) has a cocaine-linked hapten in phase I trials. And, a team led by Don Landry (Columbia University, NY, USA) has used catalytic antibodies, which increase cocaine breakdown, to prevent cocaine reinforcement and overdose in rats (*Proc Natl Acad Sci USA* 1998; 95: 1017681). The many neurotransmitters that indirectly modify the dopamine system are also potential drug targets. For example,

-aminobutyric acid (GABA) reduces synaptic dopamine, so Stephen Dewey (Brookhaven National Laboratory, NY, USA) is investigating vigabatrin, an irreversible inhibitor of the enzyme that breaks down GABA. In August, Dewey reported that vigabatrin stops cocaine increasing synaptic dopamine in baboons and abolishes the preference of animals for an environment associated with cocaine (Synapse 1998; 30: 11929). Vigabatrin is long-acting and does not cause withdrawal effects or tolerance. "Perhaps most importantly, it is not addictive", says Dewey who is planning to start clinical studies soon. Deborah Mash (University of Miami, FL, USA) argues that agents that affect several neurotransmitter systems may be the best way to treat addiction. She is testing ibogaine, which is isolated from a plant used by African tribes in religious rituals. Unable to get funding to complete US phase I trials, Mash has begun residential treatments in St Kitt's, West Indies. "We were able to show that we can give ibogaine safely . . . patients can be swimming in the Caribbean 72 hours later." Mash thinks that noribogaine, a metabolite of ibogaine that acts via the serotonin transporter and opioid receptors, is the key to success. So, whether ibogaine works depends on how quickly an addict metabolises the drug. Another factor important for long-term recovery seems to be the "visionary experiences" induced in some patients. "Ibogaine gets you thinking about the nature of your self-destructive behaviour and then the metabolite kicks in to ward off the craving", says Mash who hopes to develop noribogaine patches as maintenance therapy. "We're probably going to find that certain types of drug therapies are optimally suited to particular types of people", speculates Marsden. But, he says, drug therapies may not benefit the most chronically affected individuals, who may be unmotivated or hard to reach. An alternative is to use cognitive-behavioural therapy. One approach which is yielding "exciting" results says Marsden, is "contingency contracting", in which addicts are rewarded for their abstinence with grocery and entertainment vouchers. These seem to act as specific reinforcers, says Ling, who stresses that contingency contracting is not a matter of paying addicts to stay clean, as some critics say. "Addicts will ride across town to give you a clean urine for a few dollars when previously thousands of dollars might have passed through their hands daily from illegal transactions." Most researchers agree that combined strategies are needed to beat cocaine addiction. "What we hope for is a therapeutic agent that will provide a window of opportunity for psychosocial and behaviour-modification interventions", says Landry. For now, Marsden urges the adoption of proven strategies, such as rapid response in crisis and residential programmes. "Science will help us but it's not something that we should rest a lot of hope on in the near future", he warns.

The Lancet [Volume 354, Number 9193] 27 November 1999

Science and medicine: Data accrue on "visionary" agent to interrupt addiction

by: Kelly Morris

Few therapies exist for drug addiction, and unfortunately one agent that has shown promise-- the plant alkaloid ibogaine--is mostly given in unsafe settings by addict self-help groups, says Deborah Mash (University of Miami, FL, USA). This means there is a "poverty of clinical data" on the effects of the preparation. However, Mash now has preliminary findings from almost 100 patients, and at a series of talks in the UK this month, she presented her results and called for further research to be top priority. Ibogaine's anti-addictive properties have been shown in animals; in human beings, ibogaine often causes "dream-like states" at treatment doses but is quickly cleared from the bloodstream. The persistent metabolite noribogaine should act to raise mood, ward off craving, and help an addict enter long-term therapy via its actions on both the serotonin transporter and on opiate receptors μ and (see *Lancet* 1998; 352: 1298). After a single treatment, Mash's team found that Beck Depression Inventory scores improved significantly (mean 18 vs 4), and remained low for at least a month. There were also significant decreases in craving scores and in physician-rated signs of opiate withdrawal. Adverse events seen during the acute treatment phase were nausea, vomiting, mild tremors, and transient ataxia; initial drops in heart rate and blood pressure occurred in a few patients, mainly "crack" cocaine abusers. "Whether the visions are important [for efficacy], I cannot yet say", notes Mash, "but there are very profound experiences associated with ibogaine that can be life-transforming". Despite these promising results, further drug development is likely to be hindered by continuing controversies. Ongoing litigation over patent rights between the University of Miami and Howard Lotsof, the discoverer of ibogaine's anti-addictive effects, seems likely to deter potential investors. In addition, some experts have reported cerebellar Purkinje-cell loss in rats treated with high doses of ibogaine. However, Mash found no such damage at necropsy of one former patient who died from other causes. Finally, proponents of ibogaine believe that clinical use of a US schedule-I drug is politically unpalatable in the USA, despite evidence of the lack of abuse potential.

LA Weekly, London
AUGUST 22 - 28, 2003

by: Daniel Pinchbeck

In 1962, a young junkie named Howard Lotsoff ordered iboga, a plant used in West African rituals, and tried it for extra kicks. After consuming the bitter root-bark powder, he experienced a visionary tour of his early memories. Thirty hours later, when the effects had subsided, he found that he had lost all craving for heroin, without withdrawal symptoms of any kind. He then gave it to seven other addicts, who were using either cocaine or heroin; five stopped taking drugs immediately afterward.

Thus were ibogaine's anti-addictive properties discovered accidentally. A little more than two decades later, Lotsoff patented the ibogaine molecule for purposes of addiction treatment, but the FDA wouldn't approve it; ibogaine was subsequently declared, along with LSD and a number of other psychedelic molecules, an illegal "Schedule 1" substance, with potential for abuse and no medical value. Despite the dedicated enthusiasm of a ragtag group of countercultural activists and leftover Yippies, the National Institutes of Health (NIH) discontinued research into the substance in 1995.

Now, suddenly, through a combination of anecdotal evidence, underground activism, journalism and scientific research, interest in ibogaine is approaching the proverbial tipping point: Articles have appeared in publications ranging from the *Journal of the American Medical Association (JAMA)* to *The Star*. The JAMA piece, "Addiction Treatment Strives for Legitimacy," describes ibogaine's stalled and tortured path through the regulatory agencies, noting that the treatment's frustrated supporters in the U.S. have set up an underground railroad to provide addicts access to the drug: "While unknowable scores of addicts continue ingesting ibogaine hydrochloride purified powder — or iboga whole-plant extract containing a dozen or more active alkaloids — few trained researchers witness the events." *The Star*, unsurprisingly, takes a more colorful approach: An article headlined "Rare Root Has Celebs Buzzing" trumpeted the treatment as the hot ticket for "the numerous celebs who look for relief from their tough lives in the bottom of a bottle of Jack Daniel's, a needle or prescription medicine." The article insinuates that "some of our favorite A-listers" not only get cured but enjoy the hallucinations as an illicit "fringe benefit."

Outside of the U.S., new clinics have opened in Mexico, Vancouver and Europe, offering reasonably priced and medically supervised opportunities to try ibogaine as a method of overcoming addiction. In fact, at one new Vancouver clinic, the treatment is free.

The Ibogaine Therapy House in Vancouver, British Columbia, opened last November. “So far, we have treated 14 people quite well,” says Marc Emery, the clinic’s founder as well as the head of the B.C. Marijuana Party. “They all say that their lives have improved.” Emery, nicknamed “the Prince of Pot,” is funding the free clinic with proceeds from his successful hemp-seed business. “Ibogaine stops the physical addiction without causing withdrawal, and it deals with the underlying psychological issues which lead to drug use.”

The Vancouver clinic currently has three full-time employees: two facilitators and one screener. Emery estimates that treatment for each patient costs around \$1,500, which includes two administrations of the drug. “When I first found out about ibogaine, I felt that someone should be researching this, but the drug companies aren’t interested, because there is no commercial potential in this type of cure,” he says. Emery is deeply concerned about ambiguous studies on ibogaine’s toxicity. As the article in the JAMA noted, “One reviewer wrote that the drug’s toxicology profile was ‘less than ideal,’ with ‘bradycardia [an abnormally slow heartbeat] leading the list of worrisome adverse effects.’”

“From the masses of reports I’ve studied, a total of six people have died around the time they took ibogaine,” Emery says. “Some of them were in poor health, and some took other drugs at the time of their treatment. That doesn’t scare me off. I have a lot of confidence in ibogaine.” At this point, with little scientific study, the true toxicology of ibogaine is impossible to determine — the treatment is unlicensed in other countries and illegal in this one. Emery notes that the Ibogaine Therapy House screens for heart problems and other medical conditions that would contraindicate the treatment. His clinic also gives patients small daily doses of iboga for two weeks after their initial treatment. “Iboga tends to make anything bad for you taste really crappy. If possible, we want our patients to quit cigarettes at the same time. We think that cigarettes can lead people back to other addictions.”

Iboga is the sacred essence of the Bwiti religion of Gabon and Cameroon. Most members of the tribe ingest it just once in their lives, during an initiation ceremony in which massive amounts of the powdered bark are consumed. Through this ritual, each participant becomes a *baanzi*, one who has seen the other world. “Iboga brings about the visual, tactile and auditory certainty of the irrefutable existence of the beyond,” wrote the French chemist Robert Goutarel, who studied the Bwiti.

The iboga bark’s visionary power is produced by a complicated cocktail of alkaloids that seems to affect many of the known neurotransmitters, including serotonin and dopamine. Its complex molecular key may lock into the addiction receptors in a way that resets patterns and blocks the feedback loops that reinforce dependency. In an essay on ibogaine, Dr. Carl Anderson of McLean Hospital, Virginia, has speculated that addiction is related to a disrupted relationship between the brain’s two

hemispheres, and that ibogaine may cause “bihemispheric reintegration.” Ibogaine also accesses REM sleep in a powerful way — many people need considerably less sleep for several months after an ibogaine trip.

Six years ago, I became a member of the Bwiti. I had heard about ibogaine from a clerk at an anarchist bookstore in New York’s East Village. On a magazine assignment, I went to Gabon and took iboga in an initiation ceremony. It was one of the most difficult, yet rewarding, experiences of my life. I had heard the substance described as “10 years of psychoanalysis in a single night,” but of course, I did not believe it. As the African tribesmen played deafening drums and sang around me until dawn, I lay on the temple’s concrete floor and journeyed back through the entire course of my past up to that point, witnessing forgotten scenes from childhood. The experience lasted more than 20 hours. At one point, I was shown my habitual overuse of alcohol and the effect it was having on my relationships, my writing and my psyche. When I returned to the U.S., I steadily reduced my drinking to a fraction of its previous level — an adjustment that seems to be permanent.

Last winter, I had the chance to try ibogaine for a second time. I took it at the Ibogaine Association, a clinic in Rosarito, Mexico, just a half-hour’s drive from San Diego, that’s been open for 18 months. I went because I was contacted by a recovering heroin addict who had been inspired to take ibogaine after reading my account of it. Three months after his first treatment in Mexico, he was still clean — after a 12-year dependency. He gave Dr. Martin Polanco, the clinic’s founder, a copy of my book, *Breaking Open the Head*, and the clinic offered me a free treatment. I was curious to see how the iboga experience differed when it was removed from its tribal context. My new friend wanted to take it again to reinforce the effect. We went down together.

Polanco estimates that his clinic has treated nearly 200 addicts since it opened. About a third of its patients have managed to stay clean; many have returned for a second treatment. “Ibogaine needs to be much more widely available,” he says. “We still have a lot to learn about how to administer it, how to work with it.” Polanco plans to set up several nonprofit clinics, including one for Mexican addicts who cannot afford the price for foreigners. “This is something that should be nonprofit,” he says. “After all, it is a plant. It came up from the earth. It does give you some guidance. It shows you how you really are.” He chuckles. “That can be scary.”

Randy Hecken, a 27-year-old former heroin addict, drove us from San Diego to the Ibogaine Association. Randy had kicked the habit after two ibogaine treatments at the clinic, and he was now working for the association, going around to local methadone centers with fliers, keeping in contact with former patients. The first treatment costs \$2,800, including an initial medical exam and several days’ convalescence afterward,

but subsequent visits are only \$600 — and it seems that most addicts need at least two doses of ibogaine to avoid relapsing.

The Ibogaine Association is in a quiet, dignified house overlooking the Pacific, decorated with Huichol yarn paintings and Buddhist statues. Polanco gave me a medical examination and a test dose of the drug. Twenty minutes after ingesting the test dose, I started to feel nervous and lightheaded. As I took the other pills — a gel-capped extract of the root-bark powder — I realized I was in for a serious trip.

The nurse led me back to my room. My head already spinning, I lay back on the bed as she hooked me up to an EKG machine and headphones playing ambient music that calmed me down from a sudden attack of panic: Why was I doing this again?

Ibogaine is no pleasure trip. It not only causes violent nausea and vomiting, but many of the “visions” it induces amount to a painful parading of one’s deepest faults and moral failings. I had a loud, unpleasant buzzing in my ears — probably the Bwiti pound on drums throughout the ceremony to overwhelm this noise. With my eyes closed, I watched as images started to emerge like patterns out of TV static. I saw a black man in a 1940s-looking suit. He was holding the hand of a 5-year-old girl and leading her up some stairs. I understood that the girl in the vision was me, and the man represented the spirit of iboga. He was going to show me around his castle.

This kind of encounter with a seeming “spirit of iboga” is a typical vision produced by the Bwiti sacrament. In many accounts, people describe meeting a primordial African couple in the jungle. Sometimes the iboga spirit manifests as a “ball of light” that speaks to the baanzi, saying, “Do you know who I am? I am the Chief of the World, I am the essential point!” Part of my trip took the form of an interview that was almost journalistic. I could ask direct questions of “Mr. Iboga” and receive answers that were like emphatic, telegraphed shouts inside my head — even in my deeply stoned state, I managed to scrawl down many of the responses in my notebook.

I asked Mr. Iboga what iboga was. I was told simply:

“PRIMORDIAL WISDOM TEACHER OF HUMANITY!”

Later, my personal faults and lazy, decadent habits were replayed for me in detail. When I asked what I should do, the answer was stern and paternal:

“GET IT STRAIGHT NOW!”

This ideal of straightness, uprightness, kept returning during the trip — a meaningful image for me, as I suffer from scoliosis, a curvature of the spine. When other faults were shown to me that seemed rather petty and insignificant, I tried to protest that some of these things really didn’t matter. Iboga would have none of it, insisting:

“EVERYTHING MATTERS!”

Iboga told me that I had no idea of the potential significance of even the smallest actions. I reviewed some events in my life and my friends’ lives that seemed bitterly unfair. Yet in this altered state, I felt I could sense a karmic pattern behind all of them, perhaps extending back to previous incarnations. Iboga affirmed this, dictating:

“GOD IS JUST!”

Delivered with great force and minimalist precision, these insights might have been manifestations of my own mind, but they seemed like the voice of an “other.” Generally, I never think in such direct terms about “God,” and “primordial wisdom teacher” is not my syntax.

During the night, I had numerous visions and ponderous metaphysical insights. I seemed to fly through the solar system and into the sun, where winged beings were spinning around the core at a tremendous rate. Up close, they looked like the gold-tinged angels in early-Renaissance paintings. At one point, I thought of humans as an expression of the “Gaian Mind,” the Earth’s sensory organs and self-reflective capacities, at the planet’s present state of development. If we are changing quickly right now, I considered, it is only because the Earth has entered an accelerated phase of transformation, forcing a fast evolution in human consciousness.

The loud buzzing sound that ibogaine produced seemed to be something like a dial tone, as if the alkaloid was in itself a device for communicating on a different frequency from the usual one. Thinking of my girlfriend and our child, I realized that I was lucky — “YOU ARE LUCKY!” Iboga echoed. I felt tremendous, tearful gratitude that I had been given a chance to live and love, to explore and try to understand so many things.

As I do so often these days, I pondered the terrible state of the world — wars and terrors and environmental ruin. I saw sheets of radioactive flame devouring cities, huge crowds reduced to cinders. I asked Mr. Iboga if this was going to be the tragic fate of humanity. The answer I received was startling — and reassuring:

“EVERYTHING IS SAFE IN GOD’S HANDS!”

This message has stayed with me; it has alleviated much paranoia and anxiety. While tripping, I decided that Mr. Iboga was a form of enlightenment, like a Buddha, who had chosen a different form, as a plant spirit rather than human teacher, to work with humanity, imparting a cosmic message of “tough love.” I asked if Iboga would consider incarnating as a person, and the answer I got was, basically, “ALREADY DID THAT!” — implying that, in some previous cycle, he had passed through the

perilous stages of evolution we are now navigating. I also came away from this trip with the suspicion that iboga was the original inspiration for the “Tree of the Knowledge of Good and Evil” in the biblical tale. The plant’s placement in equatorial Africa, cradle of humanity, would support this idea, as well as its sobering moral rectitude. The “good and evil” iboga reveals is not abstract but deeply personal and rooted in the character of the individual.

Late in the night, I retched and vomited out bitter root-bark residue. I put on a CD of African drumming. Closing my eyes, I watched a group of smiling Bwiti women dance around a jungle bonfire. After that, the visions died down, although it was impossible to sleep until late the next night.

My friend in recovery had a less visionary experience than mine. His faults were also paraded in front of him in repetitive loops that seemed endless. At one point, I heard him scream out, “No! No! No!” He saw a possible future for himself if he went back on heroin — becoming a dishwasher, sinking into dissolute old age with a bad back and paunch. He asked what he could do to help save the world. He was told:

“CLEAN UP YOUR ROOM!”

Meditating on his experience, my friend quipped, “ibogaine is God’s way of saying: ‘You’re mine, bitch!’”

This article was originally published in the UK newspaper:
The Independent on Sunday 28th March 1999

The Dreaming

Could the root of an obscure African plant contain the secret to combatting addiction? The search for a substance capable of breaking the chains of chemical dependency - the so-called "magic bullet" - is one of the enduring preoccupations of modern medicine. Most people have concluded that the search is a futile one - that addiction is a disease without cure. Yet a growing alliance of activists claim that conventional wisdom is wrong: there is a substance capable of ending an addicts' craving for a fix - it is called ibogaine, and it is said to possess miraculous powers of healing.

Ibogaine is a naturally occurring alkaloid found in the root of an African plant called tabernathe iboga. In Africa, ibogaine is used in religious ceremonies to induce visions, but in the West, it is being used to treat addictions to heroin, cocaine, alcohol and nicotine. Howard Lotsof, the man who first drew attention to ibogaine's anti-addictive properties, claims that after a single dose of ibogaine most people abstain from using drugs for more than three months. It is an astonishing boast to make on behalf of a drug that is illegal in America, and almost unheard of in Britain. If ibogaine were made widely available, Lotsof believes the effects would be revolutionary: "I think there could easily be a 30 per cent reduction in drug use within three years - for many drugs of abuse, that is."

So far, there is little hard data to assess ibogaine's performance. Despite the reams of testimony posted on the Internet, the drug remains an expensive luxury and is comparatively rare; only about 300 people have been treated with it in the past decade. I decided to find someone who had taken ibogaine and could vouch for it's effects. Chris Sanders, the organiser of the Ibogaine Project in London, did not know of anyone in the UK who had taken the drug; nor did Howard Lotsof. But Karl Naehar, whose "clinic" in northern Italy is the only place in Europe where Ibogaine treatments are currently available, told me he had recently treated an Englishman called Richard.

"I've got no veins left," said Richard Harper, by way of a greeting, when I arrived at the semi-detached house on the outskirts of Sheffield where we had arranged to meet. It is Richard's parents home: outside, flanked by rows of terraced housing, the road falls towards the centre of the city; inside, a giant television dominates the comfortable sitting-room, and a print of a Monet painting hangs above the sofa where Richard sits beside his mother, Phyllis.

He pulls up the sleeve of his sweater to show me his forearm. Beneath an elaborate tattoo, his skin is pallid and paper-thin, for Richard has what William Burroughs called 'the look of borrowed flesh common to all who have survived the Sickness'.

A scraggy Yorkshireman with dark hair, brown eyes and a tightly-drawn face, Richard had been a heroin addict for more than ten years. "I used to mess about with anything going, and I'd use heroin to come down," he says, as he lights the first of a series of hand-rolled cigarettes. "But you soon stop buying ecstasy or amphetamines, and you just buy more heroin. After a while, it's like having a mistress - a strange girlfriend with very expensive tastes." He laughs - a peculiar, compacted snort. He talks rapidly, yet it is not always easy to understand what he is saying, for the years of abuse have flattened his voice.

Five years ago, Richard discovered he could break down crack, mix it with heroin, and inject it - a cocktail which gave him a high like no other. "Basically, it was like being strapped to a rocket," he says, with muted relish. It was then that his drug use slipped out of control: "The race was really on. I thought my life was mapped out for me - it was going to be a short one, and an expensive one. It was no good trying to quit - I've been through 12 step programmes, I spent 12 weeks in a clinic, six weeks in rehab... I was all right as long as I was taken out of society, but as soon as I was put back again, I relapsed."

Two years ago, Richard moved to Cumbria with his partner and their two sons in a bid to escape the city and its ready supply of drugs. "I really thought I could just white-knuckle it - you know, detox on my own. But you can't face that need every day. It's an impossibility." A year ago, when he first heard about ibogaine, he had reached the point where he could barely contemplate another attempt to end his drug use: "You do a few detoxes, and after a while you can't face doing another. The last few times I tried, I split before it was over because the craving was too much to bear."

It was his mother, Phyllis who first told him about ibogaine. Five years ago, Phyllis Harper knew next to nothing about what she calls the 'drugs game', but thanks to her son's addiction, she has become something of an expert and is now a Family Support Worker attached to a drugs project in Sheffield. "It was very painful watching Richard killing himself with drugs, and I wanted to help other people in the same position - so now I work in a drug rehab with families of other addicts." When she saw a paper presented on ibogaine at a drugs conference, she thought it sounded wonderful: "I said, why have I never heard of this before?" She soon found out why: like most medics, Phyllis's colleagues were dismissive of ibogaine. "They said it just was a big con."

Yet Richard was willing to try anything. "I was suspicious, but I thought, what the hell? Let's give it a go." When Phyllis began to research ibogaine treatments, she was deterred by the fact that both Howard Lotsof charges \$10,000 for treatment in the Caribbean. Later, her enquiries led to Karl Naeher: the cost of treatment in Italy was \$2,000.

Richard and Phyllis flew to Italy in March. "It was like stepping into the unknown - especially with a drug addict by my side," recalls Phyllis. "I had all these dollars stuffed in my knickers - if Richard had known where the money was, the temptation would have been too much for him." She laughs. At first, Richard was convinced that they were being set up, yet Karl Naehner came to their hotel room as arranged, and at seven in the evening, Richard swallowed a bitter-tasting powder dissolved in a cup of water; his ibogaine 'treatment' had begun. For eight hours, he lay in his darkened hotel room, as a series of bizarre images played across his mind: "It was weird," he recalls. "I thought it was going to be like a trip, but it wasn't; I didn't know if I was conscious or unconscious - I didn't know what was going off."

Most people who have taken ibogaine claim to have had vivid hallucinations: one man reported on the Internet he had a vision of his soul rising through the universe. 'I was travelling at an incredible speed. The stars were blurring past me - it must have been the speed of light or faster,' he wrote. Another said he had been confronted by a series of images - 'like little movies' - drawn from his past, while yet another witnessed scenes of apocalyptic destruction: 'buildings being blown to pieces by the force of wind or shock waves reminiscent of Department of Defense nuclear blast footage... Continents and coastlines altered.' One man recently reported a terrifying encounter with a malevolent spirit. Everyone agrees that ibogaine is not 'a party drug': it is 'a serious encounter with the self.'

Towards dawn, Richard's experience reached its climax in a vision which he still finds painful to recall. "I reached this door, and it opened, and inside there were these puppets. Models of Punch and Judy. God, it was a macabre scene," he mutters. "There were chopped-up fingers in the gutter, and a monotonous chime going off in the background. Every time Punch bashed Judy, the bell rang, and a voice said, 'Wind him up and he'll do it again' - over and over. 'Wind him up and he'll do it again'."

The first - and most intense - phase of his experience was over. It was morning. At first, Richard thought the drug had failed, and he was distraught: "He was crying like a baby," recalls Phyllis. "He was saying, 'Ma, it's not worked, has it? What's going to happen to me now?'" It was Phyllis who pointed out that the drug must have had some effect: "I said, 'You're not rattling are you?' And he said, 'No, I'm not.'" Phyllis mimics the surprise in his voice as Richard realised he was suffering none of the usual pains of withdrawal. "So I said, 'Well, when did you have your methadone last?' 'Two days ago', he said. 'Well, you're not rattling any more, are you?'"

Phyllis had brought Richard's methadone to Italy, but she found, to her delight and astonishment, that he did not want it. "I kept thinking the withdrawal's got to come soon," adds Richard. "But it didn't come. I kept waiting, and it didn't come." The craving which had dominated Richard's life for years was in abeyance, and as he lay in bed, the second phase of his experience began - a period of intellectual evaluation,

or what Lotsof calls 'massive thinking'. "It allowed me to have thoughts which weren't overshadowed by drugs. It left me very open, and it allowed to think about what I was doing to myself and to everybody else. When you stop using heroin, it's normally weeks before you get your emotions back, but it was all there within 12 hours. I was euphoric - I just had floods of emotion going off." Richard pushes his hand across his eyes. "Loads of recall," he adds, indistinctly. "Lots of memories which I'd buried for years."

He lowers his head and for a moment, says nothing. Phyllis grips his hand and resumes the story on his behalf: "It was amazing. He was sitting in bed all day, laughing and crying. He wanted to ring his dad, his partner - he wanted to say sorry to everyone he'd ever done wrong to." Richard disappears to the kitchen, and when he returns, he has recovered his equanimity. "I felt free, and I felt as though a lot of questions had been answered for me," he says.

Michael, a 35-year-old German who had been addicted to codeine, methadone and heroin for several years, was treated by Karl Naeher in September. "It was certainly the best way of quitting a drug that I have ever come across," says Michael. He slept for four hours after taking ibogaine, and when he woke, he found that his familiar craving for opiates had gone: "I was able to quit methadone without any cravings whatsoever. I don't know what changed, but I do know that my past is not such a burden now. Ibogaine has given me a new freedom. It isn't a drug: it's something divine - which sounds stupid, but it's true." It is not unusual for people to talk of a mystical encounter with the 'spirit' of the plant itself: 'I was infused with the Iboga plant spirit - a vast nature diva that seemed to be walking with enormous, silent, measured steps over the earth.'

A journalist who has witnessed an ibogaine ceremony in the Cameroon compares it to a "religious rave". As the initiate embarks on the ibogaine "journey", there is singing and dancing, while a priest invokes the saints and the spirits of his ancestors. The ritual lasts from six in the evening to nine the next day. James Fernandez, an ethnographer who studied the Bwiti religion, said they value ibogaine because the "euphoric insomnia" it induces allows them to dance all night.

Dan Lieberman, a South African ethnobotanist and photographer who was profoundly influenced by his initiation into the Bwiti religion in the Gabon, is attempting what he calls "technology transfer from the Bwiti to the West"; in other words, he intends to recreate some of the rituals which accompany the use of ibogaine in Africa.

Lieberman is visiting Britain this month to give a series of talks on tabernaemontana iboga - between 19 and 30 April [1999] he will lecture in Brighton, London, Bristol, Totnes and Edinburgh.

"For a start," says Lieberman, "I use the rootbark powder and not the isolated alkaloid or extract, which gives one a fuller sense of what the ceremony is about. As opposed to a hospital, I chose a farm in a beautiful African setting, a special diet is arranged and the initiate/patient is cared for gently. In the indigenous context, you are looked after for weeks before the initiation and weeks after the fact - and that itself is hugely healing."

Besides blocking opiate withdrawal, and 'interrupting' craving, ibogaine is said to induce a visionary state which can last for up to two days - a state of 'lucid dreaming'. By helping an individual explore their past, ibogaine grants them insight into the source of their compulsive behaviour, and helps them break the pattern of addiction - or so the theory goes. "Ibogaine allows people to experience their reactive mind more closely than ever before, and they realise they don't have to react the way they have been reacting," says Eric Taub - an American therapist who is one of the main sources of ibogaine treatment.

In the last ten years, rumours of the drug's potency have begun to gather currency. Herbert Huncke - who turned William Burroughs onto heroin - said that ibogaine was the 'closest thing yet' to the cure that the Beats were looking for in the fifties. "Howard Lotsof found the first thing that actually helps you quit - if you want to," said Huncke, before dying from respiratory failure induced by a heroin overdose. An impromptu network has sprung up to make ibogaine available to as many people as possible: Howard Lotsof and his one-time collaborator, Deborah Mash, run competing programmes in hospitals in the Caribbean, while Eric Taub offers treatment in less formal surroundings. Underground 'clinics' have been set up in other parts of the world, and a community of activists, addicts and former addicts has emerged to promote ibogaine's cause - case notes, reports and advice flow across the Internet every day, and a London-based Ibogaine Project has just been set up.

Yet the establishment is not convinced. Ibogaine has been described as the 'quintessential orphan drug', for it is scorned by the medical profession and starved of the commercial backing required to assess its potential; recently, a messy tangle of commercial litigation has derailed the campaign to bring ibogaine to the market. If this substance works as well as people say it does, it seems barely credible that knowledge of its healing properties should have been kept secret for more than 35 years; yet the drug's proponents claim that is exactly what has happened, for it was in 1963 that Howard Lotsof first experienced ibogaine's ability to interrupt addiction.

Lotsof was 19 years old - a film student with a heroin habit and a taste for psychedelic adventures. He was living in New York, where he was part of a circle of twenty friends who experimented with drugs: "It was a time of enormous interest in psychedelic substances, and we were literally working our way through the pharmacopeia," he says. Lotsof was the first of his group to try ibogaine. Thirty hours

later, as the drug began to wear off, he noticed its most profound effect. "For the first time in months, I did not want or need to go score heroin."

Of the seven members of the group who were regularly using heroin or cocaine, five quit for six months or longer after taking ibogaine, even though none of them had intended to stop using drugs. "I recognised immediately that something unique had happened," says Lotsof. Yet he did not pursue his discovery, and on a trip to Nepal in 1969 he re-acquired his heroin habit.

When Lotsof returned to New York in 1970, he enrolled in one of the first methadone programmes. Methadone is a maintenance drug prescribed to addicts as a substitute for heroin, yet many consider it more addictive than heroin itself. Lotsof believes his experience with ibogaine was crucial when he came to wean himself off drugs. "Most people lose track of what it's like to live without addiction, but I knew that addiction was reversible - and knowledge is power." It was not until 1981 that he decided it was time to explore the chance discovery he had made almost twenty years earlier. "I wanted to do something which would have permanent value, and the most positive thing I could think of doing was to try and get ibogaine into the system."

He soon found he had the support of other veterans of the psychedelic movement - including his friend Dana Beal. As one of the leading members of the Yippies - the Youth International Party - Beal was pivotal in the student revolts of the sixties, and by 1981, he had become a player in America's drug reform movement. He was to become one of ibogaine's most vocal advocates: "The ibogaine ideal beats heroin chic every time," he told me, decisively, when I met him at Smoky Bear's Picnic in Hyde Park last September. Beal - one of a couple of hundred hippies who lay around on the grass, smoking spliffs - was in London to help organise the upcoming 'May Day' events, when a million people around the world will march in a series of events celebrating cannabis.

When Lotsof first told him about ibogaine, he was intrigued: "The idea of an 'addiction interrupter' was part of our heritage - William Burroughs had said it would have to have certain qualities, so there had always been a candidate substance in our minds. It was reaching back into one of the strains of the Yippie heritage: here's a candidate substance - so let's study it." Beal, who distinguishes between 'life drugs', such as marijuana and psychedelics, and 'death drugs' - addictive white powders - believes that the revolutionary spirit of the sixties had been sapped by an epidemic of addiction. "We were willing to pay any price to win the fight against addiction." Beal diverted much of the meagre resources at his disposal into helping Lotsof research ibogaine's anti-addictive properties.

In 1986, Lotsof founded a company called NDA International and filed patents for the use of ibogaine to interrupt addictions to opiates, cocaine, amphetamines and alcohol.

NDA International set about marketing a patented ibogaine medication called Endabuse. Since ibogaine was illegal in America, some of Lotsof's friends began to organise unofficial treatments in Holland. At first, the results seemed to confirm Lotsof's claims: some people relapsed immediately, yet others stayed clean for months at a time.

Meanwhile, Dana Beal had concluded that ibogaine "worked". He declared that the dissemination of information about ibogaine was as crucial to the drug reform movement as the legalisation of marijuana. "We said this is the second thing we want to push, besides marijuana."

It was not all good news, though, for the early ibogaine treatments resulted in two deaths. Although their exact cause was never established - the first was attributed to a heroin overdose, and the second to heart failure - the deaths dampened enthusiasm for ibogaine, and raised questions which have yet to be answered to everyone's satisfaction.

Sinister conspiracies are often adduced to explain the lack of official interest in ibogaine. Eric Taub was a jeweller when he first heard about ibogaine. He promptly decided it was his mission in life to treat 1% of the world's 140 million addicts, yet when he tried to set up a clinic in Mexico, he claims he was prevented by local drug barons. "They would have felt threatened by having a clinic available in their area that could have such a profound effect on alleviating drug abuse," he says, "especially if it were to catch on and get the attention of the American government." Taub now Karl Naeher's business partner, treats patients on a boat in international waters in the Caribbean.

The US government is often accused of attempting to suppress ibogaine, and some people argue their actions are racially motivated: "It is our view that the African origins of ibogaine and the political nature of the United States 'War on Drugs' are the major reasons why ibogaine has not been thoroughly tested and approved," says Dhoruba bin Wahad, a black activist who has always maintained that the 'War on Drugs' is a camouflage for racist oppression. "The 'plague' of crack-cocaine and heroin addiction has hit the African-American and Latino communities exceptionally hard, but law enforcement is not the way to deal with addiction. Prohibition creates a multi-billion dollar business which corrupts not only law enforcement officers but entire communities, and suborns the whole political process."

The theories proposed by ibogaine's supporters share a theme: each assumes that it is the drug's effectiveness which has led to it being suppressed. Yet the lack of interest in ibogaine could just as easily be explained by the fact that most medics doubt it will live up to expectations. Colin Brewer of the Stapleford Centre - a research-based addiction treatment centre - is a doctor known for his willingness to consider

unconventional methods of treatment, yet he insists that the ibogaine phenomenon has been hyped beyond reason. He regards the publicity surrounding the drug as dangerously misleading: "Drug addicts are a very vulnerable population, and they're always desperate for a quick fix. I don't think there's much evidence that it possesses any specific effect - there's been some interesting research, but it needs to be replicated. The jury's still out." He dismisses the findings which suggest that drug-addicted laboratory rats injected with ibogaine appear to lose their craving for heroin, cocaine and nicotine: "Rats don't go to parties," he says, acerbically.

Chris Sanders - the organiser of the Ibogaine Project in London - makes a measured plea on the drug's behalf: "We want the authorities to look at it seriously. We're not saying it's a wonder drug or a panacea, but for long-term addicts in particular it's a useful treatment." Yet Colin Brewer doubts that there will ever be a clinical trial of the drug's performance - it is, after all, a hallucinogenic drug. "I imagine that no one will ever do trials in humans except for those people who are suspect because they are too keen on it, and the truth will never emerge."

But then it is partly ibogaine's underground status which commends it to people like Michael and Richard. From the moment he first heard about the drug, Michael knew he wanted to try it, ("here was a remedy which promised an experience in itself"), and the fact that it was an unofficial treatment only added to its appeal. "If a doctor came up to me and said, I have a remedy for you, I would not have been so open to it, and it might not have worked so well. It is better as an underground weapon against addiction."

In the meantime, the 'clinics' providing ibogaine treatments will continue to prosper, for many people see no need to wait for confirmation of the drug's efficacy. Howard Lotsof concedes that the most effective way to use ibogaine is "just to give it to drug addicts and let them take it themselves." He is blessed - or burdened - with a messianic vision of bringing ibogaine to the masses, and he knows that ibogaine will never be widely available until it is endorsed by the medical establishment. "I wasn't interested in getting this drug to 500 people - I wanted to get it to five hundred thousand, or five million people. And the only way to do that was to get it medically approved."

Lotsof remains optimistic. Fifteen years ago, when he began the self-appointed task of bringing ibogaine to the world, there was one scientific paper on ibogaine's anti-addictive properties, and there are now 140: Lotsof believes the ibogaine bandwagon has generated an unstoppable momentum, and he predicts that a government-funded trial of the drug will begin in America within three years.

FOR THREE days, Richard lay in bed in Italy: he was too tired to move, but he was at peace. On reflection, he did not find it hard to explain the significance of his vision of

Punch and Judy: "I've always had a compulsion to hurt myself, and I don't understand why. I think Punch is my darker side, and Judy - who was getting battered every time she tried to say no to anything - is my gentler side. It said a lot to me about my obsessive-compulsive behaviour." The treatment had worked better than either Richard or Phyllis had dared hope - or so it seemed at first.

It is dark outside, and Richard's father, his girlfriend and his two young sons have returned from their afternoon's outing in Sheffield; as they crowd into the sitting-room, the assessment of Richard' treatment is universally enthusiastic. "He was a new man when he came home - he was glowing," says Lyndsey, his girlfriend. "It was like having my son back again," adds Phyllis.

Yet when Richard returned to England, circumstances - some of his own making - conspired against him. He had gone on a "major binge" the night before he went to Italy, and he picked up an infection in his groin which required treatment when he returned home. Later, he was involved in two car crashes, and the fact that he was living in a small town with no support network did not help - the intervention of a therapist is considered essential to prolong periods of abstinence. Richard relapsed once or twice, and on medical advice, he returned to using methadone and diamorphine; although he had been clean for two months. "I wish it had had a fairy tale ending," he says, calmly. "But it didn't."

Still, his experience conforms to the predictions of Howard Lotsof, who claims that ibogaine never fails to block opiate withdrawal - "its pretty much a done deal" - and concedes it is a matter of speculation how long the interruption of craving lasts. Richard insists that the treatment did exactly what it promised to do: it ended his drug use temporarily, and it gave him the chance to end it permanently. He now has a place lined up in a clinic in Manchester where he will attempt to detox once more. "He's more positive now," says Phyllis. "The treatment moved him on somehow. But he's talked the talk before. Now he has to walk the walk."

Richard says he will return to Italy to take ibogaine again, if necessary, but he would like to see the drug made available in Britain: "Look at the money it would save!" he says, with rare enthusiasm. "It takes two weeks or more to detox in a clinic - you can do it in a day with ibogaine, and then you're ready for therapy. This is the best it's ever been for me, and I attribute that to ibogaine," he adds. "I'm surviving on prescription, I'm not spending money on drugs and I'm looking to get off. I feel inside that it's over."

Focus Magazine, July 2000

One-step cure for addiction?

by: Jerome Burne

Beneath a brilliant vault of stars, a young man is sitting on a rug somewhere out in the South African veldt. But he only has eyes for the extraordinary parade of images inside his head. There is a tremor to his legs that makes it hard to stand and he's regularly gripped by waves of nausea. However, none of that matters.

For several hours all his attention has been focused inwards, on scenes from his childhood, many of them painful... his mother shouting at him the time his father left: he sees their flushed faces, hears their harsh words, feels his own fear and anger. It's only a memory, but it's a turbo-charged memory. Think holiday snap compared with a film shot in Imax.

He's taken a drug, of course, but one that is not illegal. The sheer intensity of the ibogaine experience is something that even the most voracious drug-taker would only want once or twice in a lifetime. In fact he is taking it as a one-off cure for a heavy heroin habit. Not only does ibogaine give you psychological insights that normally come only after months of therapy, but it takes away all craving for the drug of choice - heroin, cocaine, alcohol, nicotine.

The man on the blanket is one of scores of addicts who, over the last few years, have taken ibogaine while in the grip of a \$100-a-day habit, and emerged 30 hours later, free of a desire to take it and with none of the dreadful symptoms of withdrawal. A group calling themselves INTASH (International Addict Self-Help) are enthusiastic about the drug. "In the world today there is no substance as effective in combatting opiate narcotics, stimulants, alcohol and nicotine addiction as ibogaine. Being prepared for treatment with ibogaine means being ready and willing to take a physical and spiritual leap forward," said a spokesperson.

Ibogaine is one of several alkaloids found in the West African shrub called Tabernanthe Iboga. The first reports of it came from French and Belgian explorers in the the last century. "In small quantities it is an aphrodisiac and a stimulant of the nervous system," wrote one traveller in 1864. "Warriors and hunters use it constantly to keep them awake during the night watches."

These travellers took it home, which is why, like coffee or cocoa, it was first used in the West as a tonic. French chemists crystallised it at the turn of the 20th century (about the same time cocaine was crystallised from cocoa) and it was used as a treatment for sleeping sickness and for convalescents. Pills containing 8mg of

ibogaine were sold in France in the 1930s under the Lambarene trademark. It was claimed they got rid of fatigue and improved appetite.

The iboga was initially used by the Mitsogho, a tribe from the area of Africa that is now part of Gabon. The Baka pygmy tribe of the Congo basin are also thought to have been among the first to learn the use of the plant. For 300 years it has been an integral part of the once-in-a-lifetime rite of passage by which boys become men and any males who do not complete this initiation test will forever be branded as girls. [Editor's note: I don't think this is true. Women are initiated same as men as far as I am aware - Nick]

And it certainly is a test. Candidates must chew about 100g of iboga root shavings over a period of eight hours. They are washed and purified in the river and when their legs give out they sit in the chapel and gaze into a mirror. "Behind them sit their mothers or fathers of iboga, calming their anxieties and listening carefully to their excited mumblings as the iboga works upon them," wrote one observer. "They may already be experiencing a sense of departure from self and of visionary encounter. Their mumblings may convey important information to the entire membership."

The guide who stayed with the man on the blanket through every moment of his inner journey was Dan Lieberman, a South African ethnobotanist but never an addict. For \$3000 he will take you on a 10-day initiation trip of your own. I meet you at the airport and from that moment you don't have to do anything," he says. I stay with you all the time. When you take the ibogaine you are in a super-aware state between sleeping and waking. Your body is in a deep coma but your mind is completely aware. You work through all sorts of past traumas. Some people do it for self-discovery, others to beat addiction."

Lieberman first encountered ibogaine when he was studying Bwiti religious initiation rituals in Cameroon. These rituals involve consuming large amounts of bark scraping from the iboga root. Initiates have described their extraordinary experiences: they encountered menacing animals, met with higher spiritual entities and talked to their ancestors. At the end, many said they had a sense of the whole course of their lives.

While Lieberman works on his own and gives his client the actual plant material, a more high-tech - and thus expensive - anti-addiction programme using the ibogaine extract is available from Dr Deborah Mash. Professor of Neurology at the University of Miami School of Medicine in Florida.

Another key player in the ibogaine story, she is the only academic to have run preliminary trials on humans at a university, although she has never taken it or any illegal drug. She has a state-of-the-art medical set-up on St Kitts in the Caribbean, where, for \$10,000, you can get proper screening, nurses, heart monitors and a

Harvard professor who oversees the proceedings and will draw up your own personal rehabilitation programme.

"We have had people who have been on really high doses of methadone, which is a horrible drug to kick," says Mash. Seventy two hours later they are free of it and swimming in the Caribbean. It is an amazing treatment."

Mash has now treated around 70 addicts - 'our first one is still clean two years later' - and a summary of 30 cases was presented at a landmark conference on ibogaine in New York last November. Delegates heard that 25 of these 30 addicts had had no further cravings, not even any withdrawal symptoms after 24 hours. "It doesn't work for absolutely everyone," says Mash, "but it is a hell of a lot better than anything else we've got."

Her view is echoed by someone in the front line of the fight against drug addiction and who believes in ibogaine's potential. "The normal treatment for addiction is individual and group psychotherapy plus methadone," says Patrick Walsh of the US National Probation service in New York, "but we are not making good progress. If we can keep 10-20 % of youngsters off drugs just for the time they are on probation, we figure that's a success." British figures, for all the talk of a new drugs tsar, are not much better

The use of ibogaine as a cure for addiction is largely down to the efforts of a New Yorker, one-time film student Howard Lotsof. In the 'swinging Sixties' he was a heroin addict until someone handed him a mysterious drug, promising it would get him really high. Lotsof had a remarkable time, seeing visions and being taken back through his personal history, but what really amazed him was that afterwards his craving for heroin had vanished.

As reported by those who have taken ibogaine, he suffered no withdrawal symptoms - he didn't have to make an effort of will, he simply didn't want it any more. Wondering if it was a fluke, he persuaded six of his addict friends to take it. Five of them also came off heroin, and stayed off. There followed a period of 'informal' testing to discover the optimum dosage and conditions under which it should be taken before, in the mid-'80s, he patented ibogaine as a cure for heroin, cocaine and alcohol addiction.

So how does ibogaine produce such a remarkable range of effects on the body? Unfortunately, the most straightforward answer at the moment is that we don't know exactly. Not least because the research into ibogaine has been done on laboratory animals, which reveals little about the brain mechanisms involved in intense visions of childhood. Another problem is that, despite years of research, we don't even really know why people become addicted in the first place.

However, we do know that ibogaine reduces the amount of dopamine, which is one of the key chemical messengers in the brain. Research has shown that everything we find enjoyable - from Morris dancing to sex - produces a burst of this chemical that then hits one of the brain's pleasure centres, called nucleus accumbens. It is thought that all addictions - cocaine, heroin, nicotine, shopping - trigger such a dopamine rush to satisfy the addictive cravings.

Researchers at Albany Medical College in New York state, such as Professor Stanley Glick, have made rats addicted to cocaine or morphine and succeeded in training them to press a bar in their cage to get supplies of the drug. They found that an injection of ibogaine decreased the amount of morphine the rats gave them by 50 %. Like humans, some almost gave up completely, whilst others needed several doses. One curious finding was that while ibogaine reduced the amount of activity by male rats on cocaine or amphetamines, it actually speeded up the female rats on the same drugs. But addiction is obviously not just a mechanical matter of having a dopamine problem. Nearly everyone in the ibogaine network stresses the importance of following up an ibogaine experience with some sort of counselling. "What ibogaine does is to buy a window during which the resistance of the body's defences is softened," says US therapist Sarah Emanon. "After taking ibogaine the person doesn't crave the drug and feels great. But if they don't make use of that time to consolidate what they have discovered, they are very likely to relapse."

Both the people who have studied the chemistry of ibogaine and those who are interested in what it does psychologically conclude that it somehow resets the brain and mind so they work more effectively. It is almost as if ibogaine overwhelms the system psychologically and emotionally with the hallucinations," says Emanon, "so the person cannot behave or interpret what is happening using the old destructive patterns."

After researching ibogaine at a molecular level, Alan Leshner, director of the US National Institute on Drug Abuse in Maryland, concludes: "There is evidence to suggest that ibogaine treatment might result in the 'resetting' or 'normalisation' of neuroadaptations related to sensitisation or tolerance induced by addiction."

Whatever the brain mechanisms turn out to be, ibogaine involves a dramatic change in the approach to addiction. Previous attempts to fight drugs with drugs have either involved trying to block the effect of the illegal drug or find a substitute, but none have been effective. "Ibogaine presents a potential new strategy for treating addiction to diverse drugs classes," concluded Professor Piotr Popik of the US National Institutes of Health, Maryland in a major review of the scientific literature on ibogaine.

So why isn't ibogaine part of every drug rehabilitation program, in stead of, for the most part, being administered surreptitiously in hotel rooms in America and Amsterdam? "Although it does have remarkable properties," says Professor Glick, "from the point of view of the medical establishment there are problems with it."

"The original work on it was done by an ex-hippie and one-time drug addict with no background in pharmacology. It's a naturally occurring plant alkaloid, which no one knows how it works - and it is a powerful hallucinogen."

The image problem aside, such a remarkable cure for addiction should be a big enough money spinner for the pharmaceutical companies to snap up. Glick, one of the organisers of the New York conference, explains why it isn't. "Pharmaceutical firms are not very interested in such anti-addiction drugs. Addiction has got obvious negative associations and there is not nearly as much money there as you might think. We only spend about \$65m on developing addiction pharmacotherapy, which is a fraction of the estimated \$200 - \$600m average cost of bringing a single new drug to market."

One of the big mysteries of ibogaine is: how can a single dose apparently keep on working in the body, months after it should have been broken down by the liver and evacuated? Dr Mash now thinks she knows the answer.

It seems that the liver turns ibogaine into something called noribogaine, which stays in the body and behaves like a Prozac implant, raising the levels of serotonin in the brain and keeping patients happier and free of cravings. Mash currently plans to develop a noribogaine skin patch to help reformed addicts stay clean.

Panels

Ibogaine and regression

Because of its ability to stimulate memories of vivid early experiences, ibogaine has attracted the interest of therapists who are particularly interested in regression. There have been no formal studies, but reports vary from positive to very negative.

Therapist Sarah Emanon is someone who has found it very valuable. "I gathered pictures from my childhood and I pored over them before the session. When the effects of the drug came on, the emotions of the people in the pictures - my father and mother, and my adopted father and mother started popping out at me."

Going back: "I saw that my father was very well armoured. I remembered being a little girl and trying 'to get to him, but I couldn't reach this person. Then I saw my current partner and saw how I couldn't get to him either. And it just went boom, boom, boom - all the way back to my father."

"Then, I went back even further, to being with my adopted mother as an infant while she was holding me. Then I smelled her, and it didn't feel right. I didn't want to be near her. I was trying to get away but I didn't know how to hold my head up. That's where I realised I retreated into myself."

"So here I am focusing on all the people in relationships, but there is no communication either way. And I saw myself picking people who can't come out of themselves because I can't come out of myself. This was the beginning of owning my own process rather than projecting it onto others."

Ibogaine trip - a personal account

When I ate iboga, I found myself taken by it up a long road in a deep forest until I came to a barrier of black iron. At that barrier, unable to pass, I saw a crowd of black persons also unable to pass. Suddenly my father descended from above in the form of a bird. He gave to me then my iboga name, Onion Messenger, and enabled me to fly up after him over the barrier of iron.

As we proceeded, the bird who was my father changed from black to white - first his tail feathers, then all his plumage. We came then to a river the colour of blood, in the midst of which was a great snake of three colours - blue, black and red. It closed its gaping mouth so that we could pass over it.

On the other side there was a crowd of people all in white. We passed through and they shouted at us words of recognition until we arrived at another river, all white. This we crossed by means of a giant chain of gold. On the other side there were no trees, but only a grassy upland.

Return or die. On the top of the hill was a round house made entirely of glass and built on one post only. Within I saw a man. The hair on his head piled up in the form of a bishop's hat! He had a star on his breast, but on coming closer I saw that it was his heart in his chest beating. We moved around him, and on the back of his neck there was a red cross tattooed. He had a long beard.

Just then I looked up and saw a woman in the moon - a bayonet was piercing her heart, from which a bright white fire was pouring forth. Then I felt a pain in my shoulder. My father told me to return to Earth. I had gone far enough. If I went farther I would not return.

In July 1996, Dr. Deborah Mash was interviewed by Pacifica radio reporter Paul DeRienzo. This is a transcript of that interview, which was broadcast on Let 'em Talk over WBAI-99.5-FM in New York.

Interview with Dr. Deborah Mash

by: Paul DeRienzo

Dr. Deborah Mash is a faculty member in the Department of Neurology of the University of Miami, School of Medicine with a secondary appointment in Cellular Molecular Pharmacology. Dr. Mash's area of expertise is called Neuropharmacology and Neuroscience and her doctoral dissertation was on Alzheimer's disease and the study of how the brain degenerates and how to restore function to the brain. Mash completed a fellowship at Harvard University and joined the faculty at the University of Miami in 1986, and currently runs one of the nation's largest post-mortem programs, a human brain bank consisting of tissues from people suffering degenerative and neuropsychiatric disorders. Dr. Mash has studied brain illnesses such as Parkinson's and Alzheimer's disease, but much of her work has centered on drug abuse, how drugs affect the brain and why certain people are more vulnerable to addictions. She is currently studying Ibogaine, a drug originating in the Iboga plant, which grows in Central Africa, primarily in Gabon and Congo. In those countries Iboga is used in religious ceremonies but the active ingredient in Iboga, which is called Ibogaine, has been shown by anecdotal evidence and some animal tests to have anti-addiction properties.

Paul DeRienzo: How did you find out about Ibogaine?

Deborah Mash: Ibogaine came to my attention by a sequence of three somewhat synchronous events that occurred in my life. I had been working with a collaborator on the discovery of coca-ethylene. I don't know if your familiar with this, but if you drink and use cocaine your body makes a third drug, which is the ethyl-homologue of cocaine. We demonstrated, I think in 1990, that coca-ethylene could be formed in the human body by the liver, that is circulated in blood, and gets into the brain, and is more potent and more reinforcing then cocaine itself. We suspected that it might even be more lethal and went on to demonstrate that indeed it is a longer acting and more potent euphoriant then cocaine, so that it has something to do with the cascade of addiction when people co-abuse cocaine and alcohol. We also demonstrated that it's more lethal. We were actually trying to explain an epidemic of cocaine overdose deaths in Dade county.

In the course of doing that research, we were getting credit and a lot of national attention for these findings and I was traveling around giving talks. A gentleman came up to me at a public forum, an African-American man who asked me if I'd heard

about something from Africa that could be used to wean people off cocaine and heroin. At the time I was probably quite abrupt with him, rolled my eyes back and said "Uh huh, thank you very much, excuse me but I have to talk to some other people about my recent discovery."

About a month later I heard a presentation by Dr. Stan Glick from the Albany Medical School at the College of the Problems of Drug Dependency who had been feeding Ibogaine to rats that had been trained to self administer opiates and cocaine. Glick had reported that Ibogaine seemed to inhibit drug taking behavior in an animal model of addiction that had some validity, and again, here was this Ibogaine in front of me. The third thing that happened, I received a phone call from someone who actually knew about the Ibogaine project and said this is something I should take a look at.

So with that backdrop, of good things happen in threes, I raised the question, "well what is Ibogaine?" As a scientist I became very intrigued with wanting to know exactly what it was. What's the molecule? What does the structure look like? Who had been using it and was there something to this?

PD: Is Ibogaine like LSD and other hallucinogenic drugs?

DM: No, I don't even think of Ibogaine as LSD or any hallucinogens, but unfortunately Ibogaine is classified with those as a Schedule I drug, which makes it very difficult to study in a laboratory or in an academic medical center. Those type of drugs have no medical use and are basically verboten and very highly regulated.

Ibogaine has a very unique structure, it's almost as if that plant has created a magical structure that has a very rigid backbone, that is somewhat serotonin-like. Serotonin is a neurotransmitter that is associated with drugs like Prozac and with depression and changes in the brain that are normal with aging. Ibogaine also has another alkaloidal piece that hangs off the side of this rigid backbone that seems to resemble cocaine. It's a molecule that seems to have affinity for the opiate side, and has some affinity for the cocaine side and as a pharmacologist that really grabbed my attention. There's something real fundamental about this molecule that maybe explains its efficacy, and if these anecdotal reports that were out there in the addict self-help movement were true and could be validated, then together with our knowledge of the structural chemistry of the molecule, we might get some fundamental insight into the process of addiction itself.

PD: How did you begin to study Ibogaine?

DM: I love a puzzle and I'm a woman with a mission. I couldn't believe that this was true and yet there was something that I felt intuitively in my own heart that; if there was something to be gained by this, if by some miracle of miracles that this plant

could really be used to help people -- if it were an addiction interrupter, if there was something about the pharmacology, if there was something about the molecular structure? Maybe, it wasn't this molecule, maybe it wasn't ibogaine, but maybe ibogaine was a stepping-stone that would take us in a fundamental direction, then it couldn't be ignored.

I cast aside my good judgment and I was at a point in my academic career when things were going very well and I felt that we've got to have the answer. I began to assemble a team of investigators. This not just me, from the beginning we've had a wonderful collection of over 20 people from various disciplines like pharmacology, cardiology, neuropsychology, neurology, psychiatry, toxicology and pharmacokineticists, who have come together to study this project. So, it's not only me.

PD: What's pharmacokineticist?

DM: A pharmacokineticist is someone who models how the body handles a drug. Whether it converts it to a metabolite, how it clears it, the bioavailability and male-female differences -- We needed a lot of help with this project.

We also needed to get a Schedule I license to work with Ibogaine and that task itself took a considerable amount of time.

We set out on this course to study Ibogaine in a credible laboratory, in a credible medical center with appropriate people looking over everyone's shoulder, so that we could collect appropriate data. Even to possess this drug requires filing with the Drug Enforcement Administration to get permission to go forward, and we did that.

We also had to go to our academic institution to what's called the Human Subjects Review Board to ask permission to put Ibogaine into people. That was no small feat because you have to go up in front of people from all various disciplines, medical ethicists, clinicians and other scholars. I had to convince my university that this was an appropriate path. Luckily I had a good reputation with my medical center and they looked at our proposal for researching Ibogaine and decided it would be appropriate to proceed.

Then we had to convince the Public Health Service to garner some sort of support from the National Institute on Drug Abuse which had been funding my research for a number of years. We had to ask the colleagues 'at the top' for some validation that this was an appropriate path.

Finally we had to get the application submitted up to the Food and Drug Administration and work with the FDA to begin this research. You hear people

complain about the FDA, but my experience was absolutely wonderful. I had some of the best interactions with clinicians and scientists at FDA to really help us to craft an appropriate study.

My experience along those paths were very positive and so the Ibogaine project was launched.

PD: I've spoken to a NIDA scientist, whose name I won't use, who feels there's a lot of resistance to Ibogaine research. He says that there's an entrenched group of people who just don't want to see this.

DM: I think that's probably true. When you think about how science moves and shakes and evolves -- resistance is true in every discipline, it's not just special to Ibogaine. Whether you're inventing a new AIDS drug, coming up with something that's left field, any type of novel approach that doesn't come from the established medical community, there is going to be resistance. Unfortunately, Ibogaine is a Schedule I substance and people try to lump it in with some of the things that were abused in the 60's. This is really unfortunate, because we have a stigma attached to something that could be profound in many ways.

PD: I've never heard of people abusing Ibogaine. Is it a widely abused drug?

DM: Ibogaine has no abuse potential, but a lot of mistakes were made in the 60's and we understand that the path of medical research that happened with some of the other psychoactive substances, in the late 50's and early 60's, quite frankly through it all back. People made many mistakes. You cannot have abuse of a substance that threatens the foundation of society, that's just not permitted. Ibogaine got lumped in with some of the others that were out there like LSD.

But let me give you an example:

If you train a rat to discriminate LSD, and you give the rat Ibogaine and you ask the rat to tell you [the scientist] if it looks like LSD? The rat will say no, because Ibogaine is not LSD-like, it is not LSD.

This molecule is unique, this molecule does something to human consciousness, something to the brain, something to craving and withdrawal signs that's very different than anything we know about right now.

PD: What's come of the discoveries of active metabolites of Ibogaine such as noribogaine?

DM: When the International Coalition for Addict Self-Help and the Dutch Addict Self-Help movements were in high gear there was information making the rounds that Ibogaine was a magic bullet. Ibogaine is not a magic bullet, but if it does have a long lasting effect, and there was data coming not only from people, but also from Stan Glick's animal experiments where the effect seems to persist. How do you explain that? Ibogaine either sticks around in the body for a very long time or its converted to something else that might stick around in the body for a very long time. Long enough that at least some of the late effects, the "after-effects," to use a word that Stan Glick coined in his papers, might be attributed to an active metabolite.

Working together with (Hearns) my same colleague that worked with me on the coca ethylene mystery, we discovered that Ibogaine is converted to 12-hydroxyibogamine, or what.s been misnomered as noribogaine, it should actually be decmethylibogaine, but who cares, that's the chemistry and noribogaine is the way it's referred to. The metabolite does seem to persist in the body, at least in humans, it's cleared in some animals much faster then it is in man. We don't know all the pharmacokinetics yet in humans, because those studies are still under way, but noribogaine does seem to persist in the body. If noribogaine is formed in the brain, which we don't know yet, it's going to be trapped in the brain because it's a polar metabolite; it has a charge on the molecule that means it's going to be trapped in the brain. We were real excited about that because we thought that this might be a fundamental finding that might point us in new direction.

PD: I recently read an article in the New York Times where it was reported that Ibogaine works on a part of the brain called the cerebellum. What regions of the brain are affected by Ibogaine?

DM: That was a controversial piece of data that came from the Johns Hopkins group where they actually thought that Ibogaine maybe causing a type of activation within the cerebellum. The cerebellum is a cauliflower looking structure that's in the back of the head. It's associated primarily with the function of balance and fine-motor control. If you learn to ride a bicycle it's your cerebellum, if you learn to play the piano your activating your cerebellum.

The cerebellum has become very interesting right now in neurosciences because we're beginning to think that associated or patterned learning may have something to do with the function of the cerebellum. When you think about self-administering drugs, somebody's whose locked into an intractable self-destructive pattern of drug use, be it cocaine, opiates or alcohol, then maybe the cerebellum is somehow linked in the circuitry.

Nonetheless, I never bought into the idea that this was important because those of us who are interested in the addiction circuit have been focusing on a whole other part of

the brain which is up in the forebrain, closer to the frontal lobes, the part of the brain called the nucleus accumbens, and the amygdala and hypothalamus and these other limbic structures of the "old brain," One thing that's for sure about the brain is that we're just scratching the surface, there could be crosstalk between the cerebellum and these forebrain loops, and how Ibogaine fits into this whole scheme is still quite a mystery.

PD: The article quoted research by researcher Mark Molliver at Johns Hopkins University who reported finding that there was some damage to the brain's "purkinje" cells. Haven't you done a study that found there wasn't any damage?

DM: Neurotoxicity is a flag that can significantly hinder drug development and drug discovery. When the FDA hears neurotoxicity you're slow tracked very quickly. The Johns Hopkins group was feeding very high doses of Ibogaine to rats, who may metabolize the drug very differently than mouse, monkey and man. They did show if you give near lethal doses of Ibogaine in a regimen where you're repeating the administration with only a short reprieve to the animals, a very high dose every 12 hours for about 7 days, what the Johns Hopkins group demonstrated was that there was a drop out in the cerebellar purkinje cells, a certain class of cells, a large cell that lines up along the midline of the cerebellum.

That was interesting data, also very concerning data, but we had the opportunity also to give Ibogaine to primates as part of our safety data that we would submit to the FDA. We were never able to, under relevant dose regimens, to demonstrate any toxicity at all. Researcher Helen Molinari from Albany has done a fundamental study called a dose run-up. She's given so-called efficacious doses in a rodent model, self-administration of opiates and cocaine...

PD: What's an efficacious dose for Ibogaine?

DM: ...pharmacologically effective doses, they block drug self-administration. At that dose a rat is functioning, he's in a cage, he's responding for cocaine, you give him Ibogaine at the efficacious dose and he stops taking the cocaine or he stops taking the opiate. This is the work that's come out of Stan Glick's lab. Helen Molinari demonstrated convincingly that when you look at efficacious doses that there was no toxicity.

If you take too much dilantin, which is a very good drug that's used for seizure control you get neurotoxicity, many drugs that are active in the brain at high doses will damage the brain, but nobody is ever going to take those doses. That's why you do these studies and that's why you work very closely with the FDA so they can make those judgments.

We've looked at human beings, people who've gone outside the United States to take Ibogaine, addicts who have abused drugs. I hate the word addict, but I'm going to use it because it's simpler.

PD: Why do you hate the word addict?

DM: It does carry a stigma, and it puts a pre-judgment that there's something socially wrong who abuses drugs. I don't look at it that way. Drug dependence is a disease, a neurological disorder in the same way as Alzheimer's and Parkinson's or cancer or diabetes. It's a disorder that needs to be corrected and some people are at risk for becoming drug dependant and many people do self-medicate. We have to humanize the discussion.

We studied people who were desperately seeking some help for their addiction to either cocaine or heroin and we looked at them before and after, with very sophisticated neurological testing. Dr. Juan Sanchez-Ramos developed a very sophisticated way to look for neurological soft signs that wouldn't be deemed clinically relevant by a neurologist doing an exam in their office and we failed to demonstrate any persisting effects of Ibogaine on the part of the brain called the cerebellums. We've always been very confident that this drug could be used in a safe and appropriate way.

PD: We're getting into the more controversial because there have been people who've died after Ibogaine treatments. What do you know about those situations, why did they happen?

DM: There were only two Ibogaine deaths that have been reported, that I'm familiar with and these were deaths that were attributed to Ibogaine. One death happened during a series with a Swiss psychiatrist Peter Baumann, who had used Ibogaine as an adjunct to psychotherapy. A woman reportedly died under the influence of Ibogaine. The woman was very sick, she had a very sick heart and she shouldn't have been given Ibogaine under any circumstances.

It's so important to study Ibogaine in a clinical setting. It comes from the underground that people might be able to get their hands on some Ibogaine. God only knows how they would? Because Ibogaine is a hard drug to make, manufacture and acquire. Nonetheless, people cannot do Ibogaine in a hotel room,.

The second death, the one that occurred in the Netherlands, we don't completely know the mechanism of lethality, but it did appear to be respiratory collapse in this case. The bottom line is that you need to be under medical supervision. Ibogaine cannot be given in any way, shape or form outside an established medical center. If someone turns up and says, "I've heard in the underground that I know where to get Ibogaine"

please avoid that. This information needs to get out to the self-help movement; Ibogaine is an important drug but it is not to be used outside the medical establishment, not ever, ever, ever.

PD: That seems like a big difference between Ibogaine and the other so-called hallucinogenic drugs, I've never heard of anyone dying of an LSD or MDMA trip?

DM: LSD has a very wide therapeutic safety margin; you can't easily overdose on LSD, for example. MDMA is another story, there have been MDMA deaths, not due to overdoses but to systems overload. The people who do the dervish dancing under the influence of MDMA and get themselves into a situation where you've been dancing for six or seven hours, not drinking fluids, and then they drop, because their brain doesn't regulate their core body temperature and deaths have occurred.

Ibogaine has been used in Africa, in God only knows what dose range, because nobody has any of that information, but it has been used by millions of people and in addition there have been hundreds of treatments that have been done. While the caution flag has gone up about Ibogaine deaths, and this is something we cannot ignore, if Ibogaine is used in an appropriate clinical setting, with doctors and supporting medical personnel, that there's a low chance of an adverse event.

PD: You have a big clinical trial in the works right now?

DM: Unfortunately that trial is now slow-tracked to the point of stopping because we can't pay for it. We have a grant application to the Public Health Service asking them to pay for the Phase I clinical trial.

PD: What is a Phase I clinical trial?

DM: The stepping-stones for a new drug application are Phase one, two and three. Then the drug is released to the public and you have post-marketing surveillance.

Phase one is safety. We're asking simple questions about how the drug is metabolized, adverse events, who can get ibogaine, who shouldn't get ibogaine. This is the very first attempts to put Ibogaine into people. We have a dose-escalation design, so we're going to walk-up the dose, very slowly in 2 milligram per kilogram increments, until we get to the range where we think it would be active as a blocker of opiate withdrawal or as an active dose range for blocking drug craving.

PD: What is that effective dose range?

DM: We don't know yet. I think that what's been used by the underground is too high. I think that the dose range that's out there, that people are suggesting is an appropriate dose range is way too high. We can probably cut it back by half.

Ibogaine is a strange drug, the preliminary data suggests Ibogaine's bioavailability is poor. There maybe some tricks that we can develop in the laboratory to improve bioavailability. The more we learn about the drug the better we are at designing how the drug should be administered and what's the safe range for the drug. We need to get up to probably 14 to 15 milligrams per kilogram and we'll be in striking distance of asking the next fundamental question; is this drug efficacious? Does it work?

This is a Phase two design now where the FDA would give us permission to design a small study and ask very specific questions, either in a cocaine dependant, patient volunteer group, or an opiate detoxification program.

The gold standard comes when you move into what's called the double-blind study that would be done at multiple medical centers. There would be many more people joining in that to test Ibogaine in a way to say is it efficacious or not. If it stands the test of the double-blind then you've got a winner. How are we going to blind it? is the problem.

PD: What's going to be the placebo?

DM: We do have some ideas about how we might blind this and I'm sure the FDA would have their own set of suggestions and if National Institute on Drug Abuse was supporting it, they would have some ideas too.

How do we pay for this study? You can't do this kind of research without money and as an American population hooked on her pharmaceuticals, we all know what it costs. My mother spends nearly \$400 a month on her medication to stay alive. She's 73 years old and a lot of the elderly cannot afford to get their medications. It costs a lot of money to bring a drug to market. Unfortunately Ibogaine doesn't meet the orphan drug standard and there's nobody to pay for it.

PD: Orphan drugs being drugs that don't have enough potential users to justify its development?

DM: Exactly! So there's other mechanisms to pay for development of an orphaned drug, but ibogaine doesn't fit. There's the dilemma, we have someone who holds use patents who hasn't been lucky enough or smart enough, and hasn't been able to get out of the box. And in terms of getting an investment strategy together, you don't have venture capital backing Ibogaine, you don't have the public health service backing it and you don't have an angel whose stepped out of the shadows say I'll pay for this.

PD: Why not? Something that has this potential that so many people seem to recognize, why hasn't an angel stepped out of the shadows?

DM: The National Institutes on Health struggles every year in the congress to get money to take care of a lot of different diseases. We spoke about the AIDS activists and the great work that they have done to make sure medications are in the pipeline. They fought very hard to make sure that dollars were there. Anytime that you have a disease with that kind of national and worldwide impact together with cancer, schizophrenia, Parkinson's, Alzheimer's. One in five the nations elderly by the turn of the century will be afflicted with Alzheimer's disease. Who is going to pay for all big-ticket items that are going to cost our society a lot of money? It all comes back to you and me, because it comes out of our tax dollars and the wisdom of the congress and the president to put those tax dollars behind an institute.

National Institute on Drug Abuse, under the direction and leadership of Dr. Alan Leshner, has fought very hard to secure dollars for substance abuse, but our institute compared to some of the others, like cancer, is a small institute. When you look at the research pie and you see how Dr. Leshner and the peer review system are going to spend those dollars and allocate that money for a lot of great ideas that are coming right up the pipeline, Ibogaine looks like its kind of left out.

PD: What about other addiction treatments and their supporters? Is the methadone establishment, which is unpopular in segments of the African-American community, effecting what's being studied?

DM: Addiction is multi-factorial and I've been trained to look for the left and the right sides of an argument and of your data. Addiction is something that involves the brain, we're learning more about that, but it's also a disease of the spirit, it's also a disease of personality. A disease of the way a person looks at him or herself, his world, his society and his family and school. It's clear to me that if you want to get at the addiction process you've got to hit it on multiple levels, you can't just hit it on a neurochemical level.

Methadone is important, and many people tell me "thank God for methadone," and there is an industry that's grown up around methadone. I'd like to see people come off the drugs all together, but for some people methadone seems to work and helps addicts to function in life and it gives them a quality of life that's meaningful. It's also very hard to get off methadone and people who use methadone substitution for an illegal opiate find out that after they've been on it for a while that it's very scary to detox off of methadone.

There are certainly a lot of good protocols for detoxing off of opiates, Ibogaine is one way but there's a lot of other ways too. Again, we've got to study it. That's all I've ever wanted to do, I just want to be able to study it. If Ibogaine has an ability to detox off of opiates, which I have seen with my own eyes, because I had an opportunity to go to

the Netherlands and sit with someone who was coming off quite a bit of methadone, heroin and cocaine that he'd been using for a long time.

I saw it block signs of opiate withdrawal, I sat there at his bedside and with him while he was under the influence of the Ibogaine and watched him step out of his opiate dependence. That was a profound observation, he's a very special young man, and I've watched him progress. He was someone who had all the strikes against him, his mythology, who he was, who he believed he was since he was 14 years old made him a very afflicted young man. I've talked about Ibogaine being a chemical bar mitzvah by allowing you to make that transition from arrested development -- to borrow a rock and roll term -- to be locked into an adolescent pattern to being able to delay gratification and to look at yourself in a way where you become an adult and merge with the tribe.

How do you feel normal? How do you visualize yourself? What is the road to recovery? And does Ibogaine have something to do with this? Is there a piece of Ibogaine that makes sense in changing and developing coping skills so that you're not going to be vulnerable to relapse? I think there is, but I want to study it.

PD: You mentioned about how Ibogaine was used in Africa as a bar mitzvah or coming of age in Gabon. One of the reasons given by the non-scientists who are experimenting with Ibogaine for using such large doses is that there's something to be learned from the actual visions born of the passage within the Ibogaine experience as practiced in Africa.

DM: I'm ok with that idea too and I think as a scientist, whether or not you have to have the visions, or those visions are healing is something that could be studied empirically. We could test that and I've designed a protocol that would allow us to get at that. Again, we've got to have the money to study the drug. Unless someone steps out and says this is an appropriate way to go and should be studied I'm not very optimistic about Ibogaine. It need something now, we've taken, together with my collaborative team at the University of Miami School of Medicine, we've taken this thing just about as far as we could launch it. Without the finances, without the research dollars, without a foundation to support us, without venture capital money this thing ain't going to go much farther.

PD: How much does it cost?

DM: It's going to cost millions. The Phase one protocol itself is a million dollar protocol. Are you going to take a million dollars out of the precious research budget and give it to something that's a little far left.

PD: Where do people go if they want more information about Ibogaine?

DM: You can also call me at 1-800-UMBRAIN. People who want information about Ibogaine should go to the scientists and clinicians and we can provide you with information. Please, if you think you can get your hands on some Ibogaine, God only knows if it is Ibogaine, someone could be telling you it is Ibogaine and it could be something else, it's very dangerous. If adverse things occur and they're linked to Ibogaine for any reason, it will close the door on research permanently. For those who need it, for those who are desperate for a treatment, we want to be able to provide that opportunity in an appropriate medical establishment. Please don't support individuals who are using Ibogaine in an illegal and illicit way, in unauthorized medical settings, or no medical settings.

It's so important that this message get out to the community, to the self-help movement that unauthorized use of Ibogaine is inappropriate and it will close the door forever on Ibogaine research.

PD: What about Ibogaine and cigarettes?

DM: There was the suggestion Ibogaine would be useful for nicotine addiction. I've seen it actually block nicotine use, at least in the first few days after Ibogaine was administered. I'm not certain if it has long-term efficacy. Nicotine is really an addictive substance, we've had this whole debate in the congress, in the media about nicotine. That is a damn addictive substance for sure, and nicotine fits right in the addiction circuit we were talking about in the brain, this is why Ibogaine is very intriguing, because it maybe affecting the circuit by hitting or tweaking a few different pieces of the chemical circuit in a way that makes it multifunctional, so it is efficacious against alcohol, nicotine, cocaine, heroin and other opiates. That's neat, if Ibogaine is multifunctional, it's a real fundamental finding. I don't know if Ibogaine is going to be useful for long-term treatment of nicotine addiction. I don't think that administering it in the same way as for heroin and cocaine detox would be appropriate for nicotine, but there might be some indications.

PD: It could be that studying Ibogaine will give insight into how the brain operates that could lead to a whole new class of drugs that haven't been discovered yet?

DM: I do believe that Ibogaine will open the door for some fundamental information about how the brain works, what goes wrong when the brain becomes addicted, how we can heal the addicted brain and how we can heal inner wounds.

Chem 227: Spring 1996

Ibogaine

by: Dr. Rusay Andrew J. Schuknecht

Throughout the world, morals vary from culture to culture. What one culture may view as being "right", another may view as being "wrong". Today in the U.S. one of the most strongly felt morals is that which is placed on substance abuse and the use of "drugs". Even if there is a proven therapeutic value to a drug, many people may find it unacceptable to use "drugs" because of these in bred morals. One such drug is ibogaine. Ibogaine has been used for hundreds of years by tribes in West Africa as a means to improve hunters' awareness yet allow to them maintain a perfect stillness for very long periods while waiting for game on the African plains. Ibogaine is also used in tribal rituals, where higher doses produce hallucinations. However, in the U.S., ibogaine is a controlled substance and viewed as being a "wrong" kind of drug. Some researchers claim that ibogaine is a compound that can offer a cure for addiction to several highly addictive and destructive legal and illegal drugs: heroine, nicotine, and alcohol. Even though these therapeutic claims have been made for many years, ibogaine has only just recently begun to be tested in clinical trials.

Ibogaine is classified as a hallucinogenic substance. It is derived from *Tabernanthe iboga*, a shrub found in western Africa. It can also be isolated from the roots of *Ervatamia yunnanensis*. The first reported synthesis of this substance was published in the *Journal of American Chemical Society* in 1966.

Tribes in the Congo and the Gabon region of West Africa have been using ibogaine for many years. Chewing the *Tabernanthe* root by tribal hunters is very common on hunting trips which last many days. It reportedly allows them to remain motionless for many hours while waiting for their prey. The root is also used in a tribal ritual in which boys pass on to men. This ritual usually lasts for three days during which the boy does not eat or sleep. It is believed that the supplicant has a near death experience.

Due to it's hallucinogenic properties, the *Tabernanthe* root managed to find it's way out of Africa and into modern day drug culture. In 1962, a former heroin addict named Howard Lotsof took ibogaine looking for a new way to get high. After a 36-hour hallucinogenic experience, he no longer craved heroin. Most remarkably he did not experience any of the severe withdrawal symptoms that are normally observed with heroin. Lotsof shared the drug with six other addicts, five of whom lost their desire for heroin. These amazing results prompted Lotsof to secure patents on the use of ibogaine for treating drug and alcohol addiction. Although about 40 addicts have

been treated in the Netherlands since 1990, ibogaine has not yet been approved for use in the U.S.

Howard Lotsof, now president of Staten Island based NDA international, just recently persuaded several U.S. researchers to investigate the potential uses of ibogaine. One of these researchers is Stanley Glick, chairman of the Pharmacology and Toxicology Department at Albany Medical College. Glick and other scientists noticed that in rats treated with ibogaine before being injected with morphine the release of Dopamine was partially blocked. In other tests, Glick found that after an ibogaine injection, rats with free access to morphine reduced their narcotic intake. He also noticed that ibogaine alleviated withdrawal symptoms of rats hooked on morphine.

Based on Glick's and other scientists' promising results on rats, FDA advisors approved ibogaine to be tested on humans in 1993. The FDA approved these studies even though researchers at Johns Hopkins found that in tests on animals ibogaine led to the degeneration of nerve cells in the cerebellum. However, ibogaine was found to be toxic at both high and low dosage levels, and further studies would be needed to find a safe and effective level for humans. Unfortunately, in a case study on humans in 1994, one of the patients died during the treatment and to this day ibogaine remains banned as a therapeutic drug in the United States.

In the case of ibogaine, I feel that the potential of a cure for such addictive and destructive substances as heroin, nicotine, and alcohol far out weighs the negative image that being a controlled substance puts on it. While it is important that a safe and effective dosage must be found, I think that ibogaine is a possible miracle drug that may help thousands of victims regain control of their lives and once again become productive members of society.

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From *Black Book Magazine*, Spring 2000

Taking the Cure

by: Andy Craft

The government doesn't want you to know about a rainforest shrub that cures "the great twentieth-century malaise" after one dose. But who's really keeping Ibogaine from the people who need it?

I wake up and the bed is all wet. It's 8am. I haven't pissed in it and neither has she. I move and the bedclothes peel away from my sweaty body, letting in a bit of cold air. It's freezing. She gets up and deals with the kids, who are watching TV. I can't stand the TV in the mornings. She puts the kettle on, turning up all the rings of the stove so it will heat up the kitchen. Makes the veins stand out a bit better.

I want the relief and the warmth now. I need to smell it behind my nose and feel the heat behind my eyes now. I keep pushing the plunger and it all goes in. I wonder whether to flush it, to try to wash every last particle of smack out of the works with blood and shove it into me.

I try once and I don't lose the vein. I don't feel stoned, none of that comforting thickness in my throat. Just a little smacky hint. She bundles the kids off to school. I turn the TV off and she turns it back on again. I can see myself in the mirror on the mantelpiece. A week's growth, a really stupid haircut I used to be so good-looking I can't stand to look. I used to have some potential I don't know where it went I used to have some prospects. I turn away from the mirror.

For this man and his problem, there is a God - in a gelatin capsule. The "magic bullet" solution to this man's problem might be Ibogaine. Derived from *Tabernanthe iboga*, a plant which grows in the rainforests of Gabon and western central Africa, Ibogaine is a naturally psychoactive alkaloid which has two extraordinary properties: Firstly, for the 300 persons who have tried Ibogaine over the past decade, of those who used the drug to detox off of opiates, 99 percent reported that the drug removes almost entirely the withdrawal symptoms of addiction to all the major opiates. Approximately 10 percent of those suffering from dependencies on cocaine, alcohol, methamphetamine, and tobacco reported an interruption of chemical dependence with one treatment of Ibogaine.

The remainder needed three or four treatments over approximately a two-year period.

Ibogaine's other property, however is profound enough to challenge the paradigm governing a good chunk of Western medical science: Ibogaine is also a powerfully psychoactive drug, inducing, at therapeutic doses, hallucinations or visions unlike any

produced by LSD, psilocybin, STP, or mescaline. While under the influence of Ibogaine, the patient has an experience that can only be described as transcendental, after which the proverbial "craving monkey" is off the addict's back for months. A second dose keeps it off, and follow-up care seems to keep it at bay. The visionary experiences for Ibogaine users are strikingly familiar, even alarming. Lives that were consistent paragons of destruction, degradation, and agony have now, after a shared experience the like of which they could not possibly have imagined, dramatically turned around.

Much has been written about Ibogaine, and the most common route taken by journalists, in the hope of rendering their story sensational, is to try to prove that the government is doing its utmost to stymie the efforts of scientists involved in Ibogaine research. Dana Beal is the man who organizes the marijuana marches down Broadway to Battery Park, and the co-author of a book called *The Ibogaine Story*, a confusing tome which brings in the CIA, the FBI, Hitler the Black Panthers, and the Knights Templar.

He alleges that The Establishment doesn't like psychedelic drugs, The Establishment wants to keep the war on drugs going, and The Establishment is in bed with the pharmaceutical giants. There might be some truth in these allegations. It is true that the pharmaceutical companies have no interest in Ibogaine, since it is only used once or twice. Scott Reines, MD of Merck Research Laboratories, in his recommendation to NIDA (National Institute on Drug Abuse), said they should not proceed with human testing of Ibogaine and that the rationale for use of the drug would appear to be insufficient to justify the necessary resources.

It's hard to find much in the way of substance or sense from conspiracy theorists. The truth, as it were, can only be approached by balancing between those who have used the cure-all, and those who would like their names to be synonymous with the cure for the great twentieth century malaise.

It is impossible to talk about Ibogaine without talking about Howard Lotsof, an erstwhile hippie who was involved with the Berkeley Free Speech Movement (and later, in the '70s' Rock Against Racism). From 1962-63 he was part of a focus group composed of students studying the effects of hallucinogens. Lotsof eventually got into heroin the same way that most people do, it was exciting, it felt great, and addiction was something that happened to other people. It was not until after a few months that he noticed he had a habit. As he was working his way through the usual pharmacopoeia, he was introduced to Ibogaine. He took some and emerged from a 32-hour experience noticing that not only was the physical desire to use heroin completely absent, but the psychological desire had vanished, too. The craving monkey was gone.

Lotsof is not a scientist. He graduated from NYU film school and thought he was going to be an artist, but since 1982 he has been involved in addiction research and treatment in one alternative capacity or another. It was Lotsof who brought Ibogaine to the attention of NIDA. It was Lotsof who brought it to the attention of scientists like Stanley Glick, from the University of Albany, whose work testing Ibogaine on rats conclusively demonstrated efficacy in animals (Glick says that rats are very much like humans and love to self-medicate).

By 1986, Lotsof, supported by his friends and family got busy with his own Ibogaine research. He formed a company (NDA International, and because Ibogaine has been a class-one drug [in the US] since the '60s, began flying addicts to Holland, where they were given Ibogaine in hotel rooms. All his "patients" reported similar experiences: "seeing" their lives spinning out before them like a video and the perception of an absolute reality beyond addiction and the ego. When they came out of the hallucinogenic trance, all withdrawal symptoms, and more significantly all desire for drugs, had vanished. It was during this time that three important things happened: Lotsof managed to patent the use of Ibogaine and any of its derivatives, known or unknown, to treat chemical dependence: a woman he was treating died while under the influence of the drug, thus ending the Dutch operations, and he met Dr Deborah Mash, a professor of neurology from the University of Miami.

Ultimately, all three incidents did more to hinder the development of the wonder drug than any purported government sponsored obstruction.

The death of the Dutch woman scared everybody at NIDA away from Ibogaine and tainted much of the research being done. Mark Molliver, a neuroscientist at Johns Hopkins University of Medicine, found that injecting massive doses of Ibogaine directly into the brains of rats caused damage to their nervous system. Lotsof's total lack of academic credibility, and his association with Dana Beal and the movement to legalize marijuana, did not help. But more damaging than anything was the relationship which developed, flourished, then dramatically deteriorated between Deborah Mash and Howard Lotsof.

Dr Mash, after watching Lotsof treat people in Dutch hotel rooms, had been very impressed, even astonished. In 1992, she and Lotsof arranged a deal wherein Lotsof would supply the Ibogaine and all the research he had done, or caused to be done; while Mash's connections at the University of Miami would supply the addicts, the expertise, and facilities to do the phase-one dose escalation studies, which had been approved by the FDA. These are studies in which humans were given tiny gradually increasing doses of Ibogaine in order to observe the exact mechanism and safety of the drug.

The deal could have been lucrative for both. Most of the money would have gone to Lotsof and most of the fame would have gone to Mash. Then the problems started.

During '93 and '94, Mash submitted four grants to NIDA to fund various aspects of Ibogaine research, each of which was refused. In August 1996, she submitted a grant to NIDA for \$1.5 million to underwrite a team of 22 researchers. This was blocked by the peer review (a committee consisting of ten scientists appointed by NIDA to review the work upon which her application for the grant was based). She was rejected by the team with the blithe and unexplained verdict "Not For Further Consideration," which was a damning indictment. A government that wages war on drug users via legislation like "three strikes and you're out" is unlikely to be sympathetic to the use of a rainforest psychedelic to treat addicts from the inner city.

Conversations with Dr Reese Jones, a professor of psychiatry at the Langly Porter Institute in California who performed research in the '60s with LSD, and Herbert Kleber, a professor of psychiatry at Columbia University and former advisor to Bill Bennett (Bush's drug czar and author of such timeless classics as *The Children's Book of Virtues*), reveal something much less sinister but much more petty: Scientists routinely dismiss one another's work, often hacking to pieces the reliability of the methodology and the veracity of every little piece of data, and this often out of infantile jealousy. Dr Jones admits to having done this, Kleber says it has been done to him many many times, and Frank Vocci of NIDA says that even if a scientist's work is 80 percent funded, the rejection of the other 20 percent can be "...a clobbering, like, 'Why d'you even come here with that?'" Despite FDA approval for phase-one dose escalation in August 1993, NIDA continues to reject the funding of Ibogaine research in humans. Mash said such a trial would cost around \$300,000. With an annual budget of \$80 million, Mash's need for approximately \$300,000 does seem relatively manageable, but the reasons are the same today as they were four years ago: the research upon which all grant submissions rest must be deemed meritorious by the peer review committees.

Such intransigence and obduracy of Mash's NIDA colleagues, and the deaths of two more addicts while under the influence of Ibogaine, led to the total breakdown of all communication 4 between Lotsof and Mash. About three years into their alliance, each had set up 1 offshore treatment facilities of their own; with Lotsof's retreat in Panama, and Mash based on the Caribbean island of St Kitts. Mash's operation survived, while Lotsof's center without luck or capital, works under contract with hospitals in Panama. They are now suing one another, and the lawsuits are pending. Lotsof blames the failure of his Panama operation on the publicity accorded Mash's facility via the Internet, and sites Mash's connections and ruinous lawsuits against him as the reason for the demise of his facility. (Mash's husband Joe Geller, as well as being her business partner and attorney is the Democratic Party chairman of Dade County. It is true that the couple invited a group of private investors to help fund the

Healing Visions Institute For Addiction Recovery Ltd on St Kitts. It is also true that Mash's suit against Lotsof alleges that he did not diligently pursue the securing of a patent for an Ibogaine derivative she discovered, asserting that this was grounds for nullification of the contract between them. She also brought suit against him in the Netherlands for the death of the woman mentioned earlier. That suit was thrown out of the Dutch courts, and Lotsof was exonerated (Mash is attempting to bring the case to court in Germany).

Mash cites Lotsof's lack of academic credibility as the reason for the failure of the Panama operation, but it could be that his prices were a bit steep: one of Mash's patients who had first approached Lotsof was quoted a cure-all figure of \$35,000. (Lotsof is still referring patients to another facility called the Panama Ibogaine Project.) "There's too much shit going on around here," proclaims Dr Deborah Mash, scurrying about the endless, chilly corridors of the University of Miami's School of Medicine. She's all high heels and hairdo, organizing a million things at once. She's a formidable lady, extremely sure of herself and says she has treated 78 people on St Kitts since her facility opened in 1996. Patients are charged on a sliding scale, with a high end of \$12,000. She reckons it works out to about half the cost of the average treatment center. I ask her what this meant in terms of the demographics of her clientele and she describes them as being mostly the Hazelden and Betty Ford failures. She calls them her "Iboganauts" which, though corny is fair enough because they have all been out there in space.

A 29-year-old man we'll call Anthony remembers his Ibogaine journey. "I was in a chair, watching scenes from my life, like a video, but of my life. From all life, from the beginning of time, in full color. And above me was this presence. I mean it was God. Definitely a holy presence, like the omnipresence of everything that encompasses energy and all of life, but it was looking through my eyes. I knew the Ibogaine was my friend, that it wouldn't hurt me, that it was going to work with me, show me what I needed to know. I saw myself in the womb, growing into a man. I saw a medicine man on a horse and he winked at me.

When he winked I knew, I just knew at this time that everything was OK, that this is who I am, and that everything was going to be OK." Anthony had been using heroin for 6 years, and 80 milligrams of methadone a day for 3 years, when he found Deborah Mash. "Other treatments..." he recalls, "nothing ever got a hold of me. I mean I've cried with my family, with therapists. I'd feel good after but later it was just like another thing I did. I went straight out and got high, without even knowing why. I've been to five rehabs, spent thousands of dollars." Post-treatment, Anthony has been clean for a year and says that the idea of using is repellent to him.

Another man who was opiate addicted says he could feel "...a spirit of Ibogaine. That there is some conscious direction going on there. I don't feel it is just some random

chemical reaction going on, but that there is this purpose and meaning and direction and guidance. I've been trying to get away from dope for seventeen years.

Nine, ten treatment programs, AA, NA.... I feel like a new man. I don't wanna do dope...I'm completely free of narcotics for the first time in 25 years." It has been suggested that the Ibogaine experience is very similar to the fourth step of the AA program, in which the alcoholic makes a "searching and fearless moral inventory" of him- or herself. The Iboganauts who had done a fourth step in AA or NA have said that the Ibogaine experience was nothing like sitting at a desk with a pen and paper, writing down a laundry list of good and bad. They all emphatically agreed that their lives were shown to them in totality and that it was as brutal and choiceless as it was penetrating and revealing, with a scope and intensity beyond their wildest expectations. Ibogaine gives you a glimpse of what is possible, but the rest is work.

Aftercare is an important part of the process. Even the cravings will return after a few months if issues are left unaddressed. Subsequent doses of Ibogaine are sometimes given, but it is imperative that patients take care of themselves. Anthony sees a shaman every three months. Some go to AA. Most go to weekly support-group meetings. They are, after all, members of a fairly exclusive club.

However, the Iboganauts all regard Ibogaine as an indispensable tool. Alastair a man of nearly 50, had been using heroin for 25 years. When he turned up at Deborah Mash's door he had one foot in the grave and said it wouldn't have taken much to push him over. He claims that Ibogaine is the most valuable tool for recovery. "You have to do your recovery," he says, "but Ibogaine gives you the best leg up you can possibly have." Ibogaine is obviously of scientific interest. In November, Dr Kenneth Alper of New York University's School of Medicine organized the first-ever international Ibogaine conference. While the event was well-attended and touched off a flurry of publicity, it remains to be seen whether it will have any affect upon the obduracy of the dreaded peer review committee. Most in the scientific community are biological reductionists, and as such, defenders of the unassailable importance of the chemical nuts and bolts, and the scientific method. They revere the sanctity of skepticism and the need, at the costs of their all-important reputations and livelihoods, to remain dispassionate about their subject matter. I asked Mash about the fact that she is studying the numinous while wearing her biological reductionist's hat, and she told a story of a conversation with a colleague about Ibogaine almost a decade ago. He shook his head at her and advised her, in his professorial wisdom, to let it go, that it was not something she should pursue in her lifetime. She said, "I have seen this very powerful transformation that occurs in these people, that enables them to get at the root causes of their self-destructive patterns of addiction. He shook his head and said, 'Come on. Deborah, that's Paul on the road to Damascus,' meaning (that was the patient's) conversion, his sudden belief. Well, I've seen that on the island."

Mash is also working on synthesizing a metabolite created by the liver after the use of Ibogaine, which she believes is chemically responsible for keeping the craving at bay. She is looking for someone to be her partner in going after that metabolite. She adds, in her defense, that this is what the government wants, what the biological reductionists want, and that since she can talk biological reductionism with the best of them, a metabolite like that could be of more interest than a profound hallucinatory experience. A metabolite like this would be developed in the form of a transdermal patch. Could these be marketable? One cannot help but wonder.

Still, it remains that a man with no scientific qualifications discovered the drug's miraculous and beneficent effects. Lotsof holds the worldwide patents to its use, but is in fierce litigation with a woman who, with her own ambitions to develop a patch that could be sold by the millions, is suing him for \$50,000 more than he has. Each has tried separately and together to convince a jealous scientific establishment whose members serve the interests of politicians who pay their wages that they hold the keys to the kingdom of heaven. Both have been met with skepticism and resistance. Without any keys to copy, it seems, everyone wants a piece of the gate.

An Associated Press report. (August 29, 1993)

Drug might help cure addictions Researchers report that drug addicts in the Netherlands have cited success with ibogaine.

MIAMI – Researchers at the University of Miami next month will conduct the first scientific human experiments in the nation on a drug that possibly could cure cocaine, heroin and alcohol addiction. The drug, ibogaine, is found in the root of a West African plant, the iboga. It was used by the Bwiti African tribe in ritual ceremonies. Ibogaine was popular on the streets of San Francisco and New York before the government classified it in 1970 as having no medicinal use. Researchers say that addicts in the Netherlands have reported success with the drug. Researcher Juan Sanchez-Ramos cautioned that ibogaine's potential as a treatment for drug addiction and possible side effects cannot be determined until it has been properly tested. It could have zero impact, or it could revolutionize drug therapy, Sanchez-Ramos said. But if ibogaine works, Miami researcher Deborah Mash says, it could have lasting rewards for American taxpayers. The cost of drug dependency to the American people carries a very heavy price tag, said Mash, an associate professor of neurology at Miami. Mash and Sanchez-Ramos are on a team of researchers that earlier this week won approval from the Food and Drug Administration to test ibogaine on people. Researchers argued in favor of using the hallucinogen, citing favorable results that the International Coalition for Addict Self Help in Holland had in weaning addicts off drugs with ibogaine. Although researchers from Johns Hopkins University in Baltimore have found that high-level doses of ibogaine cause nerve damage in the brain, Mash's studies on primates show that low levels of the drug demonstrate no significant neurotoxicity. Advocates also dismiss the possibility that users will become dependent on the drug. It has no potential for abuse, and its non-addictive, said Bob Sisko, director of the Dutch group that treated addicts.