A PRELIMINARY REVIEW

# **ibogaine** in the treatment of chemical dependence disorders: clinical perspectives

H. S. LOTSOF

THE PRIMARY PURPOSE OF this paper is to provide general information to the clinician who will be using the Lotsof Procedure[sm] (Goutarel, 1993) developed by NDA International, Inc. in which Ibogaine is administered to treat chemical dependence disorders. This is a preliminary report. The patient base upon which my conclusions have been made totals thirty-five treatment episodes. All clinical observations conducted after 1963 have been made on patients treated outside of the United States.

Ibogaine is not a substitute for narcotics or stimulants, is not addicting and is given in a single administration modality (SAM). It is a chemical dependence interrupter. Retreatment may occasionally be needed until the people being treated with Ibogaine are able to extinguish certain conditioned responses related to drugs they abuse. Early data suggests that for many patients, a period of approximately two years of intermittent treatments may be required to attain the goal of long-term abstinence from narcotics and stimulants. The majority of patients treated with Ibogaine remain free from chemical dependence for a period of three to six months after a single dose. Approximately ten percent of patients remain free of chemical dependence for two or more years from a single Ibogaine treatment. An equal percentage return to drug use within two weeks after treatment. Multiple administrations of Ibogaine over a period of time are generally more effective in extending periods of abstinence. It is noteworthy that twenty-nine of the thirty-five patients successfully treated with Ibogaine had numerous unsuccessful experiences with other treatment modalities.

Dedicated to the work of
J. Bastiaans
and N. Adriaans,
in memory of N. Kribus

## A BRIEF HISTORY

Ibogaine is a naturally occurring alkaloid found in Tabernanthe iboga and other plant species of Central West Africa. It was first reported to be effective in interrupting opiate narcotic dependence disorders in U.S. patent 4,499,096 (Lotsof, 1985), cocaine dependence disorders, U.S. patent 4,587,243 (Lotsof, 1986) and poly-drug dependence disorders, U.S. patent 5,152,994 (Lotsof, 1992). The initial studies demonstrating Ibogaine's effects on cocaine and heroin dependence were conducted in a series of focus group experiments by H. S. Lotsof in 1962 and 1963. Additional data on the clinical aspects of Ibogaine in the treatment of chemical dependence were reported by Kaplan (1993), Sisko (1993), Sanchez-Ramos & Mash (1994), and Sheppard (1994).

Prior to Ibogaine's evaluation for the interruption of various chemical dependencies, the use of Ibogaine was reported in psychotherapy by Naranjo (1969, 1973) and at the First International Ibogaine Conference held in Paris (Zeff, 1987). The use of Ibogaine-containing plants has been reported for centuries in West Africa in both religious practice and in traditional medicine (Fernandez, 1982; Gollnhofer & Sillans 1983, 1985). An overview of the history of Ibogaine research and use was published by Goutarel et al. (1993).

Claims of efficacy in treating dependence to opiates, cocaine, and alcohol in human subjects were supported in preclinical studies by researchers in the United States, the Netherlands and Canada. Dzoljic et al. (1988) were the first researchers to publish Ibogaine's ability to attenuate narcotic withdrawal. Stanley D. Glick et al. (1992) at Albany Medical College published original research and a review of the field concerning the attenuation of narcotic withdrawal. Maisonneuve et al. (1991) determined the pharmacological interactions between Ibogaine and morphine, and Glick et al. (1992) reported Ibogaine's ability to reduce or interrupt morphine self-administration in the rat. Woods et al. (1990) found that Ibogaine did not act as an opiate, and Aceto et al. (1991) established that Ibogaine did not precipitate withdrawal signs or cause dependence.

Cappendijk and Dzoljic (1993) published Ibogaine's effect in reducing cocaine self-administration in the rat. Broderick et al. (1992) first published Ibogaine's ability to reverse cocaine-induced dopamine increases and later reported on Ibogaine's reduction of cocaine-induced motor activity and other effects (1994). Broderick et al.'s research supported the find-ings of Sershen et al. (1992), that Ibogaine reduced cocaine-induced motor stimulation in the mouse. Sershen (1993) also demonstrated that Ibogaine reduced the consumption of cocaine in mice. Glick (1992) and Cappendijk (1993) discovered in the animal model that multiple administrations of Ibogaine over time were more effective than a single dose in interrupting or attenuating the self-administration of morphine and cocaine, supporting Lotsof's findings in human subjects (1985).

Popik et al. (1994) determined Ibogaine to be a competitive inhibitor of MK-801 binding to the NMDA receptor complex. MK-801 has been shown to attenuate tolerance to opiates (Trujillo & Akil 1991) and alcohol (Khanna et al. 1993). MK-801 has also shown to blockade "reverse tolerance" of stimulants (Karler et al. 1989). Ibogaine's effects on dopamine and the dopamine system (dopamine is a substance hypothesized to be responsible for reinforcing pleasurable effects of drugs of abuse) were found by Maisonneuve et al. (1991), Broderick et al. (1992) and Sershen et al. (1992). Ibogaine binding to the kappa opiate receptor was reported by Deecher et al. (1992). Thus we begin to see a broad spectrum of mechanisms by which Ibogaine may moderate use of substances as diverse as opiate narcotics, stimulants and alcohol.

## CLINICAL PRACTICE

The effects of Ibogaine treatment are viewed in three categories: acute, intermediate and long-term. The acute and intermediate effects have sometimes been referred to as the effects and aftereffects. The two major effects of Ibogaine are the ability to interrupt narcotic and stimulant withdrawal, and the attenuation or elimination of the craving to continue to seek and use opiates, stimulants and alcohol (Lotsof 1985, 1986, 1989). Knowledge concerning the use of Ibogaine in treating alcohol dependence is limited to: 1) a single alcohol-only dependent patient, 2) the attenuation and, in some cases, cessation of alcohol use in persons treated for poly-drug dependence disorders. Ibogaine's ability to treat nicotine dependence (Lotsof, 1991) has been

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observed in poly-drug dependent subjects treated primarily for opiate and/or cocaine use.

There are some general considerations in reviewing the use of Ibogaine. The primary obligations of the treatment team are four-fold: 1) to earn the trust of the patient, 2) to maintain the comfort of the patient, 3) to assist the patient in interrupting their chemical dependence and 4) to supply the psychosocial support network needed by the majority of patients to enable them to develop a sense of personal accomplishment and the ability to function as productive members of society. This is a process the Dutch treatment community refers to as normalization.

In the Lotsof Procedures℠, for which a manual is now being prepared, the sense of conflict seen in most treatment modalities between the doctor and patient over the immediate cessation of drug use does not exist. The patients have been allowed, if narcotic-dependent, to continue their use of narcotics until a certain time prior to treatment with Ibogaine. There is no conflict over opiate use before treatment, as our position has been that Ibogaine will either work to interrupt chemical dependence or it will not. Patients dependent on stimulants are not maintained on stimulants and this has not created a problem for the patients or the medical staff.

Prior to our conducting Ibogaine treatments in hospitals, addicted patients were allowed to use their personal supply of narcotics until the evening before treatment. However, during hospital-administered Ibogaine sessions, the narcotic-dependent patient is maintained on medications prescribed by the principal investigator during the three to five day intake process preceding their treatment with Ibogaine. Even under these circumstances, patient distrust of the medical establishment and extreme fear of going into withdrawal has resulted in the smuggling of narcotics into hospital environments. In order to protect the patient from possible overdose due to narcotics, stimulants or other drugs, a thorough physical examination is performed on all patients upon their admission to hospital environments. The examination and a search of the patient's possessions prior to treatment with Ibogaine serve two important functions. The first, is to limit the possibility of accidental overdose from hidden drugs. The second is to provide a complete understanding of the patient's physical health, since many of the people seeking treatment for chemical dependence have masked various and often numerous medical problems for years or even decades by self-medicating with illicit drugs.

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### ACUTE EFFECTS REGIMEN

The acute effects of Ibogaine are *dramatic*. The initial reaction is usually noted within forty-five minutes after the oral administration. Full effects are generally evident within two to two and a half hours. The earliest subjective indication by patients of Ibogaine's effects is the report of a pervasive oscillating sound. The patient tends to lie down and, if asked to stand or walk, shows signs of ataxia.

The protocol for the Lotsof Procedures℠ stipulates that the patient remain in bed with as little movement as possible from the time of Ibogaine administration. This is because nausea associated with Ibogaine use has proven to be motion-related and/or, in later stages (those longer than four hours after administration), possibly to be a psychosomatic reaction to previously repressed traumatic experiences. In addition to keeping the patient as still as possible, we use a non-phenothiazine anti-nauseant, since phenothiazines may interfere with the psychoactive properties of Ibogaine. If the patient vomits in less than two and a half hours after the administration of Ibogaine, an examination of the regurgitated material should be made to determine how much Ibogaine may have already been absorbed by the patient. A rectal infusion of Ibogaine to supplement the lost portion of the dose may be provided if it is not possible for this dose to be administered orally. The rectal administration should occur only if the patient has previously consented to this mode of dosing.

### VISUALIZATION

One of Ibogaine's principal effects during its first phase of action is to produce a state which emulates dreaming, except that the subject is fully awake and has the ability to respond to the treatment staff's questions. In most cases, people under the influence of a therapeutic dose of Ibogaine do not wish to speak. They prefer instead to pay close attention to the visual presentation of memories or phenomena that they are experiencing. These phenomena have been noted to have both Freudian and Jungian connotations.

The presentation of visual material is rapid. Some patients have described it as a movie run at high speed. Others describe it as a slide show, each slide containing a motion picture of a specific event or circumstance in

the viewer's life. In either case, the presentation of visual material is so compressed and fast moving that distracting the patient for even a moment may interfere with the process of abreaction. Therefore, during the primary phase of Ibogaine treatment, the intrusion of the medical staff should be kept to a minimum.

**AUTONOMIC RESPONSES**

During the first through the fifth hour there is a moderate rise in blood pressure of ten to fifteen percent and, in some cases, an associated decline in the pulse rate. The most significant autonomic changes occur between one and a half and two and a half hours after administration of therapeutic doses of Ibogaine. In many cases pulse rates are elevated due to pre-administration anxiety.

On two occasions, persons with transient hypertension were treated. In one of those instances the patient's blood pressure dropped to normal levels during the primary and secondary stages of treatment. The second hypertensive exhibited little change at a 23mg/kg therapeutic dose, but showed significant changes on two occasions when provided with only a 1.6mg/kg test dose. The two 1.6mg/kg doses were supplied due to our concern over the patient's hypertension. He had been previously treated with an 18 mg/kg dose by Dutch Addict Self-Help (DASH) with no apparent negative results. This alleviated some of our concern for the patient's safety. Variation in individual patient reactions should be anticipated.

**FEMALE PATIENT SAFETY**

One 24-year-old female patient treated with Ibogaine for chemical dependence died from undiagnosed causes in the Netherlands. Although her autopsy did not determine the cause of death, it reported Ibogaine levels of 0.75mg/liter in blood. This level has not been seen to be toxic in animal research or in our prior human experience. Subsequent to this death and to the previously reported death of a Swiss woman who received Ibogaine during a psychotherapy session in Europe (totally unrelated to NDA's research program), the FDA excluded women from the present clinical trials taking place at the University of Miami. However, the FDA decision is contrary to the gender guidelines of the National Institutes of Health. The guidelines with regard to women call for the inclusion of women at the earliest stages of clinical trials, as this would provide the greatest determination of drug safety for women. Thirty percent of NDA International's patients have been women who have shown no negative effects from taking Ibogaine either during or after treatment. However, considering all of the circumstances, the Procedure should be administered only in a hospital or clinic with the patient under continuous staff observation and electronic monitoring.

An ongoing international research program is developing evidence to determine a hypothesis for the cause of death of the woman in the Netherlands. We are additionally seeking Swiss government cooperation concerning the death of the Swiss woman. The results of this research may facilitate either an exclusion criteria or an antidote allowing Ibogaine safely to treat chemical dependence in women.

**COGNITIVE EVALUATION**

During the second phase of Ibogaine's action in the Lotsof Procedures℠, the patient experiences the intellectual evaluation of his or her previous life experiences and decisions. This occurs after the visualization phase, which generally ends abruptly in three to five hours. However, individual reactions and variations are the norm and not the exception within the parameters of the Procedure.

When various decisions were made by the patient in the past, those decisions appeared to be the only options available at the time. However, due to Ibogaine's ability to catalyse the reevaluation of one's life, actions and behavior, it is possible for patients to understand that alternatives to their original decisions were available. This knowledge appears to allow the patient to modify their current behavior and cease their drug dependence.

**BEHAVIORAL IMMOBILITY**

During the periods of visualization, and extending into the stage of cognitive evaluation, patients will demonstrate a state of behavioral immobility (Depoortere, 1987). Brain wave patterns associated with dreaming and sleep, but distinct from those states, are represented by rhythmic slow activity of 4-6 Hz. These EEG patterns are associated with a state characterized by a lack of movement. Some early observers of the Lotsof Proceduressm (Kaplan, personal communication, 1990) initially believed that the condition represented paralysis, but when patients were asked to stand and move around, the patients were able to do so, albeit with difficulty.

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**ATTENUATION OF NARCOTIC WITHDRAWAL**

One of the major acute effects experienced with Ibogaine treatment is the attenuation or elimination of narcotic withdrawal in opiate-dependent patients. This is extremely important to the narcotic-dependent patients who live in fear of going into withdrawal.

The treatment team's experience in the field is of the utmost importance in dealing with this aspect of the Procedure. Withdrawal symptoms are a combination of physical and, in many cases, psychosomatic manifestations that are anxiety-driven. Therefore, it is imperative for the medical and paramedical staff to have experience in identifying and distinguishing between these varieties of symptoms. Provided below are examples of psychosomatic withdrawal manifestations demonstrated by two of the patients treated outside the United States.

**Example One**

On one occasion I was called into the room by a colleague about twenty hours after Ibogaine had been administered to a twenty-five year old male heroin-dependent patient. The patient had been using approximately 1/4 gram of heroin a day, but had increased his daily intake to two grams while in the Netherlands.

I was informed that the patient was complaining of muscle spasms. I asked the patient if this was true, and he responded in the affirmative. I asked if I might see these spasms. The patient agreed, showing me the calf of his leg. He was exhibiting what appeared to be involuntary movements. I checked his pupils and observed that they were not dilated, nor was he exhibiting any other form or manifestation of withdrawal. When I turned to my colleague for discussion I noticed the patient's spasms had ceased. Upon reexamination of his calf, the spasms returned. I turned away once again, but continued to watch him and the spasms ceased again. I informed the patient that I believed the spasms to be psychosomatic in origin. I placed a pillow under the patient's calf to give it support and covered the patient with a blanket. The spasms did not occur again.

**Example Two**

On another occasion I received a call from a person involved with Dutch Addict Self-Help (DASH) groups who had been observing a number of treatments. She informed me that a Yugoslavian woman in her mid to late twenties had been complaining of narcotic withdrawal during Ibogaine treatment. However, the DASH observer did not believe this to be the case, as there were no observable signs of withdrawal.

When I arrived, the patient was sitting on a couch. I checked her pupils and observed they were not dilated, and asked her if she was in withdrawal. The patient said she was.

"How are you in withdrawal? What are its manifestations?" I asked.

"I'm sick," she said.

I asked her if her eyes were tearing.

"Yes," she said, but her eyes were not tearing.

"Is your nose running?"

"Yes," she said, but her nose was dry.

"Do you have goose bumps?" I asked.

"Yes," she said, but I pointed out to her that she did not have goose bumps, and finally I said, "Do you have diarrhea?"

"Yes," she said, but I had no way to determine the validity of her statement.

The patient requested that I provide her with funds to return home. I told her I did not think it wise for her to leave at this time, but would give her carfare in the morning. The following day the DASH observer told me that the patient had left about four hours after I did, informing the observer as she left that she had not been sick, but had only said she was. This example should further demonstrate the importance of hospital administered treatments with a full medical staff of psychiatrists, neurologists, internists, therapists, nurses, peer counselors and patient advocates capable of evaluating and responding to any aspect of the patient's condition at all times.

The complaint of experiencing narcotic withdrawal after leaving the treatment environment has been reported in three cases. We have provided additional treatments six months to a year after the initial treatment to patients who were re-addicted and stated they had experienced some form of withdrawal within a week of their first Ibogaine treatment. Our working group decided to keep patients making such complaints under observation for periods equal to the number of post treatment days during which the patients stated they previously experienced withdrawal symptoms.

Our findings have been that, under the above conditions of monitoring, the reported withdrawal signs are usually symptoms of anxiety or anxiety related conditions that the patients characterized as withdrawal. These symptoms included nausea, diarrhea or increases in blood pressure in one hypertensive patient.

There have been two incidents which did not appear anxiety related, in which diarrhea occurred five to seven days after treatment in patients who had previously used one gram of heroin a day. These episodes were easily controlled with a single administration of an appropriate medication and did not occur again.

**AFTEREFFECTS: INTERRUPTION OF CRAVING**

The acute interruption of craving to seek and use drugs of abuse is unique to the Lotsof Proceduressm as a treatment modality for chemical dependence disorders. This effect is generally not noticed by the patient until the principal actions of Ibogaine (visualization, cognitive evaluation, behavioral immobility and significant residual stimulation) are no longer evident and the patient has had the opportunity to sleep. The initial recognition of lack of craving is usually noticed forty-eight to seventy-two hours after Ibogaine administration. In a minority of treatments, recovery and the absence of craving may be evident to the person being treated in as little as twenty-four hours. The medical staff, on the other hand, usually notes the absence of craving in the patient in forty-five minutes to one and a half hours after Ibogaine administration.

Our experience gained in recent years through the treatment of twenty persons outside the United States has shown that the majority of patients may need a series of treatments before the conditioned responses (craving) to a long history of chemical dependence can be extinguished. However, for three of these patients, a single treatment interrupted chemical dependence for a minimum of two years. The advantage of Ibogaine is that it allows patients time periods free of craving during which the psychiatrist, social worker, therapist, paraclinician and the patient often bond into a cohesive working group to accomplish a state of long-term non-dependence by the patient to the drug(s) of abuse for which the patient is under treatment.

**PSYCHOSOCIAL SUPPORT**

All aspects of treatment for chemical dependence disorders common to other treatment modalities are common to the use of Ibogaine. The patient's characteristics in terms of psychopathology and behavior, societal accomplishments, as well as the skills of the treatment team are significant to treatment outcome.

In rare cases, when the patient already has the occupational, educational, and professional skills needed to succeed in society, the task may be somewhat easier. In cases where the patient does not have those societal skills, or lacks medical care for disorders other than chemical dependence, care and training must be provided through psychosocial support structures.

Trauma suffered by the patient during childhood appears to play an important part in the drive for love and the fear of abandonment that are common to many of the patients we have treated (Bastiaans, 1991).

All psychosocial support paradigms should be available for the patient after the completion of an Ibogaine treatment. Their use should be contingent upon the evaluation of the patient's needs and progress.

One of the primary differences that social workers, counselors or therapists offering psychosocial support notice in post-Ibogaine treated patients as compared to untreated subjects, is the rapidity with which the support can and must be provided to aid the patient in accomplishing goals and making decisions. Ibogaine presents a symptom-free window of opportunity, of which the patient and therapist must take advantage. One patient put it this way: "Ibogaine and 12-Step (groups) both help you to get in touch with your soul. Ibogaine is like rocket fuel for that process." (*Village Beat*, 1990) This means moving quickly and dramatically to assist the patient to establish goals while the patient has the ability and desire to do so.

Ibogaine generally produces a receptive psychological state in the patient. This produces a relationship between the patient and the therapist which is mutually rewarding and beneficial, but requires the person providing psychosocial support to work both harder and faster than is the norm for other treatment modalities. Prior to the use of Ibogaine in the treatment of chemical dependence, it may have taken the therapist three to twenty-four months (Judd, personal communication, 1993) using traditional methods to assist the patient in reaching a state of well-being free of drug craving (Kaplan et al., 1993). This advantage that Ibogaine treatment provides enables the psychosocial support staff to assist patients in making decisions which facilitate their normalization and integration into society as self-fulfilled and productive human beings.

Many of the accepted parameters of distance between the therapist and the patient are not effective in Ibogaine treatment. Patients require closer and more intensive

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guidance, and are generally more open to it. They require faster intervention to learn societal skills and to overcome and objectively understand various traumas experienced during their lives. Therefore, Ibogaine is not a treatment modality for clinicians whose pre-ference is to simply administer a pill or tablet and then distance themselves from their patients.

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**REDUCTION OF THE NEED FOR SLEEP**

In all cases, Ibogaine temporally reduces the patient's need for sleep to as few as three or four hours a night. This effect may last a month or more, gradually returning to normal. Two theories have been put forth concerning the cause of this effect. One theory suggests the reduction in the need for sleep is due to the long-lasting bioavailability of Ibogaine or one of its metabolites. This is in keeping with the parmacokinetic studies conducted at the University of Miami (Mash, 1995). The second theory suggests the cause is due to the decrease in the psychological requirements for sleep associated with the necessity to dream. Evidence supporting this theory is that Ibogaine promotes an intense emulation of dreaming that lasts for many hours during its acute stage of activity.

The reduction in the need for sleep is viewed by the majority of patients as a discomfort, since they have used drugs and sleep as an escape mechanism. These patients may require some mild form of sedation during the first days after treatment with Ibogaine. Normal precautions should be taken in providing sedatives to persons with a history of chemical dependence. In a minority of cases, patients have used this newly available time to advantage in their busy work schedules.

**LONG-TERM EFFECTS**

Long-term effects are those which may be noticed from one to twenty-four months after treatment, and in some cases even longer. The following three examples illustrate this point.

**Example One**

A heroin-dependent couple was treated. The woman of 26 was a relatively new addict of three months while her 27-year-old husband had a history of over ten years of heroin use. At the time of their treatment, a protocol of treating one patient at a time was followed. These were early treatments and the medical and paramedical support staff were familiarizing themselves with what might be expected during such treatments.

Portions of the treatments were observed by Dr. Carlo Contoreggi, Deputy Medical Director of the Addiction Research Center of the National Institute on Drug Abuse in Baltimore and Dr. Lester Grinspoon of the Harvard School of Medicine.

The husband was treated first, and his wife was completely cooperative and helpful during his treatment. The following day, when the wife was administered her dose of Ibogaine, her husband demanded that he be allowed to leave his room and remain in bed with her. He informed the medical and paramedical staff present that unless he got his way he would create a disturbance to interfere with his wife's treatment. Rather than deal with a belligerent and angry patient, we decided it would be less harmful to let him have his way. He continuously disturbed his wife during her treatment. This resulted in a policy of treating couples simultaneously in separate rooms.

He recovered before his wife, as she had been administered Ibogaine twenty-four hours after his treatment. He complained that he was getting bedsore, was no longer able to stay in bed and asked for permission to go for a bicycle ride. Upon his leaving, his wife broke down and cried in the arms of a female paraclinician, stating she did not know if she could remain with her husband, but she was afraid he would die if she left him. This was a concept he continuously stressed to her during their treatment.

After treatment, he followed a pattern of controlling his wife's contacts with other persons, including the treatment team, which was denied access to either of them. We later learned that they both returned to heroin use. However, three months later, the wife determined that her husband was incapable of loving himself or her and this was not the life she wanted. She stopped using heroin, enrolled in nursing school, filed divorce proceedings against her husband, and is now specializing in psychiatric nursing.

While initially she did not recognize that her decision to stop heroin use was due to her Ibogaine treatment, as the months went by, she realized that her determination to change her life was catalyzed by her experience with Ibogaine.

**Example Two**

A cocaine/cocaine-base dependent patient was treated with the Lotsof Procedure and experienced an acute interruption of his drug use. During his Ibogaine treatment, he had a strong impression that if he continued drug use God would punish him. He remained drug-free

for about thirty days, after which he increased his drug use over the next months. He was then retreated. The dose he received proved to be inadequate due to his vomiting of the oral dose, and to a bowel movement immediately after the rectal administration of Ibogaine, which he requested to compensate for the loss of his oral dose. His drug use continued, but far below his original pretreatment levels.

About six months after his retreatment, the first Ibogaine therapy group sponsored by the International Coalition for Addict Self-Help, directed by psychotherapist Barbara Judd, CSW, was established in New York. The patient attended these sessions until fifteen months after his original treatment, when he recognized that he had to move away from his drug-infested neighborhood. Thereupon he moved to Florida.

In Florida, he has remained drug-free, even though he has access to cocaine. He is employed in the construction industry by a business with strict non-drug use guidelines that is owned and run by former drug users.

**Example Three**

One of the most important concepts learned by persons treated with Ibogaine is that addiction can be reversed. Persons dependent on drugs such as opiates or cocaine are not able to recognize that chemical dependence is a reversible phenomenon.

This third example is of the only chemically-dependent person from the 1962-1963 study to receive a series of Ibogaine treatments at therapeutic levels. The individual remained free of addiction for approximately three and a half years as a result of his series of treatments.

During that period he moved to California, married, and worked in pharmaceutical sales. He later lost his job and, when offered a ride back to New York, accepted it and returned to a life of minor drug dealing and use that resulted in his arrest and imprisonment.

After his release, he worked for a while as a machinist, then slowly fell back into heroin use and addiction in 1969. Luckily, this was a period when methadone programs were expanding, and he was able to enter one of the better programs run by Beth Israel Hospital. At that time, the programs were well-staffed with doctors, nurses and adequate counselors, and the patient reached a point in his life when he recognized that the life of a heroin addict was not what he wanted. It was not just the heroin, but the scene itself, wherein a human life was without value, where sometimes a human being would be murdered for two cents worth of an innocuous powder in a glassine envelope. The patient was ready to quit heroin, but was a slave to the craving to use opiates for the anxiolytic relief they provided.

Over a period of more than two years, the patient stabilized himself on methadone. He tried heroin once, two weeks after starting methadone, was satisfied with the level of blockage that methadone offered, and never used heroin again.

During the next few years the methadone programs changed. Many of the competent counselors were unable to continue in their positions due to the stress and sense of frustration in their work, a condition common in the treatment community. The Federal government placed more and more restrictions on methadone patients' freedom of movement and, though methadone is anticipated to maintain the methadone client for a period of twenty-four hours, in many cases it does not. For this patient, withdrawal signs were setting in at eighteen hours and not twenty-four. The patient began a slow detoxification process from 100mg of methadone per day that took approximately eighteen months.

The final stage of detoxification was followed by the patient's entry into University-level training, for which he had obtained a scholarship to a prominent university. At the time of the detoxification, the philosophy among methadone patients was that you could not get off methadone. However, having previously had the Ibogaine experience, the patient stated that he knew addiction was reversible. That knowledge allowed him to successfully leave addiction behind.

**CURRENT TREATMENTS: A SELF REPORT**

The following report is from the type of patient we had been seeking for years: a medical doctor who needed to be treated with Ibogaine. The subject was chemically dependent on 600mg of Demerol a day, and had attempted to stop his drug use a number of times, without any lasting success. Our particular interest in this subject was the hope that, as a medical doctor, he might provide us with some professional insight into the results of his treatment. He kept notes and prepared a report on the four different doses he received. His report is presented below in its entirety.

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and had a full-blown experience from a 10mg/kg dose. The patient participated in a research protocol which called for an intermediate dose of 10mg/kg of Ibogaine. This dose was administered as part of a pharmacokinetic study, and was not expected to have a therapeutic effect, but it did. As part of the protocol, he was also administered a known therapeutic dose of 20mg/kg.

**1st day - 100mg (test dose #1)**

"I've taken my Ibogaine dose and went to bed, and stayed laying down. I felt nothing, until the medical staff arrived to do the 1 hour tests. I was surprised because in my mental measurements, I thought I had taken Ibogaine about 20 minutes earlier. When I stood up, I felt a little drowsiness, and it was difficult to walk in a straight line. I was feeling photophobia and every little noise seemed to be much louder than in reality. The sounds were very disturbing to me.

During the two hour testing, symptoms were worse. It was very difficult to walk in a straight line, and the room seemed to beat, like a heart. I felt very tired, and the only thing I wanted was to rest in bed. Each head movement seemed to make things worse.

When I stood up for the 3 hour test I felt that the symptoms were disappearing. I was very hungry and ate. After eating, I was a little nauseated. For the following hours I felt nothing, except for sensation that my mind images were richer in details than before, like a 3-D movie.

I ate with no nausea, slept very well, and awakened in very good condition."

**2nd day - 25mg (test dose #2)**

"After this dose of Ibogaine I felt nothing different from my normal state."

**3rd Day - 10mg/kg (experimental dose)**

"For the first two hours I felt a little different, like I had smoked marijuana. I was very calm and relaxed and all the tension of the beginning of the procedure was gone. The room seemed to be a little different and the colors around me sharper than normal. The lights and sounds were disturbing to me, like the first time. Suddenly, with my eyes closed I began to see images that appeared in screens, exactly like TV or cinema screens. These screens were appearing in small sizes and then they would get bigger as I focused my attention on them. Sometimes they appeared small and would then begin to grow, like I was walking in their direction, and sometimes they were going from left to right, in a continuous way.

The images on the screens were moving in slow motion and were very sharp and well defined. I saw trees moving with the wind, a man with bells in his hands, various landscapes with mountains and the sunset. At this time I was a little nauseated, and when the doctors asked me to stand up for some tests, I vomited. From all of the hundreds of images I saw this day, I recognized only two: the first, an image of myself as a child, static like a photo. This image began to approach me and get bigger, but something in the room happened and I opened my eyes, losing the image. The second image I recognized was one of some horses dancing in a circus. It was a TV show that I had seen two days before. The time seemed to go very quickly, because after about four hours (in my mind), they told me I had taken Ibogaine nine hours earlier! It was very difficult for me to speak in English or in Spanish. I was only able to speak in my native language. At this time the images started to appear at a slower rate and for another two hours I saw only screens with no images on them. About 10-11 hours after the beginning of the experiment they disappeared.

I ate very well and stayed awake all night long, falling asleep only about 7 AM, almost 24 hours after the medication had been administered. During the night I had some insights about my life and about the things I realized I was doing wrong. I stayed all the following day very tired, sleepy, but very happy and relaxed, in a way I never was before."

**5th day - 20mg/kg (therapeutic dose)**

"The first 3 hours were similar to the last time; photophobia and a bad sensation with little noises. After that the images began to appear, in a slower rate than the other time. There were less images, but I was recognizing all of them as part of my childhood. I saw myself playing in my father's farm, riding a motorcycle, playing with a cousin, feeding a fish and other things. I saw some recent images, like one of my father, laughing in the living room of my house. This happened about a year ago. I understood that I had a happy childhood, and there was no one to blame for my addiction, only myself. I felt their love coming from my parents and relatives. I was feeling the same time distortion that I felt the other day, and after many hours I suddenly had an insight. It was that my mind and the universe were the same thing, and that all the people in the universe and all things in the

universe are only one. I saw many mistakes I was doing in my life, so many attitudes I could not have, and this helped me to decide very strongly that I will never use Demerol again. Now I can see very clearly that I don't need Demerol to live my life. And I feel better if I don't use it. During the first 8 hours after taking the Ibogaine I vomited 4 or 5 times, always when I tried to move. I was able to sleep about 4 AM, and to eat only about 9 AM the following day. I awakened feeling weak, tired and drowsy. As the hours were going, I slept a lot and began to feel better and in the morning of the following day I was normal."

**Differences in day-by-day life after the experience**

"I returned to my normal life with absolutely no cravings, with better appetite than before, and highly self-confident. Now I can see differences in some aspects of my personality, things are changed. For example, I used to avoid driving at night, because it reminded me of a car accident I had years ago. Now I can drive anytime, day or night, without anxiety. I'm sure that this is caused by Ibogaine, because now I'm not the same very anxious person I was. I'm not as shy as I used to be, too. It's easier now to contradict people when I think they are wrong, and to make them know what I want and what I think. I used to accept all that other people said only to avoid a discussion, even when I was sure that my point of view was the correct one.

These are the main happenings in my Ibogaine experience and the main differences I can perceive in these few days."

**Some Months Later**

"The most important thing I learned with all that happened is that I can never underestimate the power of the addictive personality I have inside. I can never say I'm cured because if I do this, I will forget to protect myself from drug using thoughts. I must know I have a chronic disease that will be quiet in its place until I decide to give it a chance to grow. This decision, and that's the point, is a conscious decision. If I give in, the disease will be out of control in a few days. But, if I could be strong to take real and honest control of my Demerol using thoughts, I will be free forever.

A few days ago, because of professional needs, I had to keep two Demerol doses with me, in my house, all night long. To protect myself, I gave them to my wife. But, it was amazing to see how I was not anxious to use them but, to give them to the patients that needed them. I clearly felt that Demerol was a strange thing in my environment. I wasn't curious about the place my wife had put them, I wasn't feeling any craving. I was only looking forward to the moment I could give them to the patient and say: I've done it. And I did it, because of all of you from NDA.

I don't want to be boring, but I have no words to say how grateful we, my family and I, are. I will remember you for a lifetime."

Needless to say, this patient provided particular advantages in terms of his treatment outcome. He had a career, was highly motivated, and did not require the significant psychosocial support needed by so many others who do not have his background.

**SUMMARY**

We have only been able to track a significant minority of patients for follow-up observations, about twenty-five percent. In many cases we have maintained direct contact with the patients for only two months after treatment. In a single case, for five years. The difficulty concerning patient contact has been one of geographic distances, both national and international, as our patients have come from diverse cities and countries. This factor, as well as the normal problems in tracking a chemically dependent population, must be taken into consideration when evaluating the findings of this paper.

General conclusions based on study observations are that a single administration of Ibogaine is an interrupter for chemical dependence disorders. A series of treatments given over a period of time will produce more significant results. It may allow some of the persons treated to free themselves completely, (or for a period of years) from dependence to, or the use of, opiates and stimulants, including cocaine and nicotine. Data on alcohol dependence treatment in human subjects is minimal.

A single treatment of Ibogaine has the ability to significantly attenuate opiate withdrawal in all patients. In ninety percent of cases treated, a single treatment can interrupt an individual's craving to continue drug use for periods of time ranging from as short as two days to as long as two and a half years. Concurrently, Ibogaine has demonstrated the ability to precipitate the release of repressed memories and to foster a process of abreaction. I believe these are important aspects of Ibogaine's ability to interrupt chemical dependence.

In order to obtain the greatest benefit for those treated with Ibogaine, a psychosocial support structure should be in place. Providers

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of the Procedure should be knowledgeable in the field of chemical dependence treatment, and patients should be shown kindness and respect. In many cases, such an approach will be the first attentions of this kind the patient may have experienced in decades.

Patients are deserving of kindness and respect, and such care is an important part of the healing process. Ultimately, physicians and support staff should be specifically trained in the Lotsof Procedures℠ to fully understand the physical and psychological transformation of the patient, the advantages of the Procedure, and the providers' responsibilities in administering Ibogaine to treat chemical dependence disorders. Eventually, the understanding of Ibogaine's actions may yield important data about memory, learning, dreams and sleep, as well as chemical dependence, tolerance and abuse. •

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## Healing Cocaine Addiction with MDMA

Dear MAPS,

In 1984 I was a regular cocaine user (at least 3 times per week) and had experienced paranoid spells, tremors and continual craving during use. My first MDMA experience was in August of that year and continued on a semi-regular basis for years, meaning at least once every two months.

The motivation to do deep introspective work while on MDMA became greater as time went on, especially around religious/spiritual themes. I prayed deeply during my trips for "deliverance" from my dependence/lack of control relative to cocaine. I noticed after the second year that my coke use had dropped markedly. By 1988-89 (January) I had stopped completely and have been clean for five years. From 1986-89 my MDMA use was sporadic as compared to 1984-85. I believe that a sincere desire to stop using coke was imperative, but also know that MDMA allowed me to source inner places of both unhappiness and power which were necessary in my recovery.

*(The writer goes on to describe a uniquely spiritual moment that surfaced during a later MDMA session...)*

During October 1992, I experienced a mystical vision while using MDMA. I had taken approximately 125 mg initially at about 7 p.m. and another 50-70 mg at around 9 p.m. I was on an open deck looking south on a moonlit night, about two hours after sunset, and saw cloud formations moving in a seemingly deliberate way - one from the east (a dark one) and the other from the west. In between I saw another cloud with a figure emerging from behind it. As I stared at this arrangement for about 5 minutes, the central formation took the form of my mother-in-law's face. She looked concerned and scared as she looked at the dark formation. My mother-in-law was in a hospital in Charleston, SC dying of cancer. As the outside clouds moved closer together a large white arm reached from the westerly formation to envelope the cloud containing my mother-in-law's image. My inner sense was that she was relieved of the tension and pain, that I sensed earlier. Within ten minutes the combined clouds created an aura around the moon. I learned several hours later that she had died at 6:00 p.m. I know that her spirit came before me that night.

Sincerely, S.J.