

—CHAPTER 15—

**FROM THE ROOTS UP:
IBOGAINE AND ADDICT SELF-HELP**

GEERTE FRENKEN

INTASH
San Francisco, CA 94142

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**I. Introduction of Ibogaine and Addict Self-Help
in the Netherlands**

The subject of this chapter is the formation of International Addict Self-Help (INTASH), the introduction of ibogaine in the addict self-help scene in Holland, and the contribution of the addict self-help movement to the development of ibogaine treatment. It also describes the INTASH intake, treatment, and aftercare procedures and the importance of addict self-help involvement in future developments with the clinical use of ibogaine.

Ibogaine was introduced to the addict community in 1990 by Howard Lotsof and Bob Sisko from the International Coalition for Addict Self Help (ICASH) (1,2). The late Nico Adriaans, Josien Harms, and myself formed an informal organization, Dutch Addict Self Help (DASH), which today is called INTASH, in order to treat addicts with ibogaine. Nico Adriaans was one of the founders of the first addict self-help movement in Europe, the Junkiebond, which promoted innovations such as needle exchanges, decriminalized prostitution strolls, and the general attitude of humanization of the addict within the institutions of Dutch society, and inspired many other initiatives throughout the world (3-6).

INTASH performed four initial treatments with ibogaine on opiate-dependent

poly-drug users, some of whom had been in methadone maintenance programs for many years. The successful results of these treatments were impressive. "Successful" is, of course, a relative and somewhat subjective term. An outcome was regarded as successful if our subjects acutely experienced a complete elimination of withdrawal symptoms, or were left with only minor residual symptoms such as mild chills or some yawning, and elimination of cravings from approximately 5 months to 2 years. As Nico Adriaans often pointed out, "there is no substance known in the world today, besides ibogaine, that can eliminate withdrawal of high maintenance doses of methadone without causing extreme discomfort."

The goal of our self-help organization was to provide treatment with ibogaine in a nonjudgmental and trusting environment. Treatments with ibogaine were provided over a period of several months for a group of eight Dutch addicts, most of whom originated from the same town and social network. After being thoroughly informed during a month-long intake, all participants were treated in the same private setting. All subjects received a physical examination by a medical doctor and nobody suffered any adverse physical or mental consequences due to ibogaine treatment.

The philosophical approach to these treatments was "pro-choice" and not based on an absolute opposition to drug use; instead, the goal was to provide alternative treatment options to people that wanted to quit using drugs in an obsessive way. For example, in one particular case, a subject came through the treatment without any withdrawal symptoms, but nevertheless expressed the need to use heroin. In response to questions regarding his motivation to resume heroin use and whether he was still feeling withdrawal symptoms, he responded that he felt fine, but that the lifestyle of heroin use was still appealing to him. Since he requested to use heroin and he was not in his hometown, we actually helped him cop. The major concern was with the welfare of the subject, to make sure that he did not wander around town or get bad product. In addition, it was important to assure that he would only use a very conservative amount, since ibogaine sets the subject back to a pre-addictive state, which creates risk for accidental overdose.

All of the other subjects in the group stayed clean for an average period of six months. During this period, Dr. Charles Kaplan, an experienced international sociologist and drug researcher, suggested a focus group for those who had undergone treatment that would meet on a weekly basis. His German colleague, Eva Ketzer coordinated these meetings in order to collect data and to provide the subjects with an opportunity to share their experiences (7). Unfortunately, due to practical difficulties and very limited financial resources, the focus group dissolved after a several sessions.

The following 2 years focused on processing the data of these treatments, which were published in the *Journal of Substance Abuse Treatment* (8). An effort was also made to inform therapeutic communities and drug-abuse treatment

institutions in Holland about the existence of ibogaine and to request further research. Representatives of INTASH traveled the world to participate in drug-related conferences to spread awareness of the existence of ibogaine. The reception of both professionals and the international addict community was skeptical, a kind of wait-and-see attitude and often a frankly uninterested reaction. It seemed that the professionals within the drug-treatment community in Holland viewed ibogaine as a politically difficult issue. Holland was already under a lot of pressure from the newly formed European Community to change its progressive drug policy. Taking on ibogaine, a hallucinogen, was considered too much of a leap, and the attitude seemed to be one of “let some other country take the lead this time.” With the exception of a Russian and a German group, the international addict community at that time was more interested in establishing legalized methadone programs and needle exchanges in their individual countries.

It was possible, however, to interest a few key people in Holland to observe treatments or review data. The next series of ibogaine treatments in the Netherlands took place in 1992, and they were observed by the late Jan Bastiaans M.D., former chairman of the Department of Psychiatry of the State University of Leiden (9). Dr. Erik Fromberg and Dr. Delano Gerlings from the Netherlands Institute for Alcohol and Drugs (NIAD) also monitored the treatments. INTASH then moved to the United States and integrated more issues around drug abuse. In 1996 we began a Web site called “The Junkie Domain” that covered topics from art and safer injection manuals to personal reports on ibogaine experiences.

II. Intake and Treatment

There are two different types of sessions with ibogaine. People who are not necessarily substance abusers have sought to use ibogaine to benefit from its spiritual impact in what is called an “initiatory” session, in which a low dose of ibogaine is used, typically on the order of 10 mg/kg. The other method involves a larger dose, on the order of 20 mg/kg, for an addiction interruption session. The addiction interruption session is more difficult in a medical sense, because many addicts have physical and psychiatric conditions related to their substance abuse. INTASH members designed a protocol, a modification of the Lotsof procedure (1) to provide sessions for addiction-interruption in a semi-clinical setting. They reached the conclusion that a thorough professional physical and psychological screening was needed. The experience of observing most people ultimately relapse at different time intervals after their treatments indicated the need to provide some type of aftercare.

The intake procedure consisted of establishing a preliminary process during which the addict requesting treatment was gradually prepared, while a relationship of trust developed. The addict was thoroughly informed of the physical and psychological consequences of a treatment with ibogaine. Each person who seriously considered treatment was well informed about ibogaine, and went through an initial screening, which included a general physical exam history, a visit to a psychiatrist, and an optional visit to a psychotherapist. Laboratory evaluation included liver function tests, blood count, and an electrocardiogram.

Once the subject had passed this screening, INTASH did an unstructured life and drug history interview with the subject, which included information about the treatment procedure in order to prepare the subject as thoroughly as possible. It is hard for many hard-core substance abusers to imagine or comprehend that ibogaine will cause them to be clean from one day to the next without the pain and agony of withdrawal, especially for those who have been using high doses of methadone daily. Therefore the information given during intake encompassed many aspects and started with a clear and firm warning of the danger of using drugs, in particular heroin, during and immediately after the treatment. This warning was repeated on the day of the treatment, and is important because subjects undergoing the treatment need to be aware that ibogaine may potentiate opiates that are still in the system. Opiate use during treatment can lead to overdose.

The subjects were then told what happens during a treatment. Early in the morning, 10 hours after the last use of food and drugs, the subject took the ibogaine orally in capsule form. Sometimes the ibogaine was mixed with a digestive aid. This took place in the morning, when the subjects normally would have used their "wake-up" dose of drugs. An hour after administration the subjects usually noticed that their familiar morning withdrawal symptoms had disappeared and expressed a desire to lay down and get comfortable. A quiet, darkened room, specially prepared in a personalized, though non-distracting manner was made available for this purpose. The room was darkened because light bothers most subjects on ibogaine. The room was quiet because sound is usually experienced in an amplified and oscillating way. During movement, subjects generally experienced ataxia, which is loss of muscular coordination similar to that which occurs with drunkenness. Since the ataxia was sometimes accompanied by vomiting, he or she was asked to lay still with the least amount of motion possible. When closing their eyes, approximately 75% of subjects experienced vivid dreamlike visions. However, when subjects opened their eyes they usually reported no real visual or auditory hallucinations, and some level of communication was possible, but usually not preferred by the subject. Many subjects perspire heavily and were advised to wear comfortable shirts/pants that could be easily replaced. The first stage takes place for about 4 to 8 hours, during

which the subject was regularly checked by the treatment team, and members of this team are constantly available on request. During the first stage, subjects generally do not complain about any withdrawal symptoms.

In the second stage, some individuals still experience a dreamlike period, although it is often reported as less intense. There is time to evaluate the visionary experiences, which can bring about profound insight into life and death and the reasons behind addictive behavior. Some subjects request something to drink and/or light food, such as fruit. The subject usually stays awake most of the time. During this phase some individuals complain about exhaustion, which some of them interpret to be withdrawal symptoms. It is at this stage that the presence of ibogaine-experienced ex-addicts is crucial. The trusting relationship previously established with the subject gives the guide the opportunity to assure the subject that this is a common stage and that all that is needed is some sleep. Patients and ex-addicts can relate on the basis of shared experiences, which has proven to be very effective and very important in order to prevent the subject from using any drugs that they might have concealed. In many of these cases, the subject is calmed down and sleep medication can be requested and is often advised by the team.

After approximately 20, and up to 30 or 40, hours after taking ibogaine, most subjects fall asleep for a couple of hours, with or without the help of some sleep medication. They generally awaken from this sleep feeling rested, very hungry, and in need to wash up. In the course of this day, most people are able to resume normal activities. Many subjects need to spend more time in or around the treatment environment to process what has happened to them and to adjust. Some people request to talk about their experience, others prefer privacy. Most subjects experienced complete resolution of withdrawal symptoms after treatment, while a few experienced some minor residual symptoms such as minor chills or a little yawning. An increased amount of energy and appetite and a decreased sleep requirement then continues over a 3- to 4-month period, diminishing slowly. Subjects usually stay free of cravings for several months.

III. Psychological Aspects of the Ibogaine Treatment Experience

The visual and auditory experiences that may occur during ibogaine treatment potentially include the release of repressed memories. These visions are relevant to the addiction interruption process because they seem to help the individual to develop an understanding of the underlying reasons for their addictive behavior. Subjects were asked what their expectations are around these possible ibogaine

visions. Since many addicts use drugs for their consciousness-suppressing qualities, some of them express fear of ibogaine's mind-altering effects. It is then explained to them that the visions do not seem to be experienced as intensely emotional. That is to say, there is no element of release of emotions like laughing or crying as is reported with many hallucinogens. Besides, many of the repressed memories that are released are positive, since most addicts have been dwelling on the ones that are negative.

It is important to explain the similarities between an addiction interruption session and the use of ibogaine in the African tribal tradition. Some West African tribes have used ibogaine for centuries as a form of initiation that occurs once in a lifetime when a young person is to make their transformation into adulthood by reviewing their past and to "restore communication with the ancestors." (see the chapter by Fernandez and Fernandez in this volume). People taking ibogaine for addiction-interruption purposes describe the visionary and auditory elements of the experience as a state of "dreaming wide awake." Visions can occur in a repetitive mode. They often report visualizing a rapid run-through of their lives and/or the lives of family members, even of those who have already passed away. They have noted the experience of going both backward and forward in time and being able to come to an understanding of their spiritual roots. The term "spiritual" does not necessarily mean religious, but a heightened level of awareness. I like to call the experience a "journey into one's DNA."

The possible amount and intensity of released material can be so overwhelming, that people have said that they simply could not remember everything they had seen, or that it took months to remember certain visions. Therefore, the processing of released material, and the ability to verbalize these matters and learn to interpret their often symbolic content, can take extended amounts of time and continue over years. Subjects have reported experiencing a mental or spiritual transformation due to the ibogaine, which they compare to 10 years of therapy in 2 days, or taking a "truth serum." Whatever people report on their experiences, they have been observed returning from their ibogaine experiences with a greater understanding of choices they have previously made. However, this does not mean that the ibogaine experience offers them the skills to interpret and approach this material in a constructive manner that can lead to positive and productive solutions and changes in the life after treatment.

For many people, ibogaine treatment itself is not enough to maintain a substance abuse-free life. Most subjects require some type of aftercare in which these and other matters are addressed. Psychotherapist Barbara Judd, who has been working with substance abusers for more than 15 years and who has treated people before, during, and after ibogaine treatments for more than 6 years, is of the opinion that a person treated with ibogaine is more ready and willing to undergo therapy sessions compared to the average recovering drug abuser (10). Many addicts who have used ibogaine seem to be able to access sensitive material

that lies at the core of their addictive behavior without the usual feelings of trauma and fear, and the need to anesthetize these feelings with drugs as a way of defense. Their newly acquired knowledge and attitude can save the therapist time in terms of confronting the individual with possibly painful issues. In case there are traumatic issues, they need to be worked through in order to break through the cycles of self-destructive behavior and find new, positive ways to approach life and its problems. Subjects are stimulated to seek out or create support networks, which could range from attending Narcotics Anonymous meetings to organizing ibogaine support groups of their own.

IV. Aftercare

The aftercare strategy is defined through collaboration with each subject during the intake phase and after the treatment. Individualized aftercare plans are based on the life and drug history taken earlier in the interview and the subject's present situation. Any form of aftercare is, of course, optional and it's up to the subject to follow through in whatever way the subject feels is necessary. Motivation to design an aftercare strategy and intentions to follow through on such plans are taken into account when reviewing the eligibility of each individual requesting treatment. Some people might need a therapeutic community, others a halfway house, and yet others just manage on their own. What we try to do is make people aware before the treatment that taking ibogaine involves a commitment to a new way of living, that ibogaine is not just a "quick fix," and that staying clean is based on a profound change of attitude toward physical, mental, and emotional wellbeing.

Crucial aspects of aftercare that need to be considered include housing, education, jobs, and the psychological consequences of assimilation back into relationships, the family, and the community. If unanswered, these matters could otherwise ultimately cause relapse to old behavioral patterns. Based on the psychiatric evaluation, some subjects need to be made aware of options like antidepressants, nonaddictive antianxiety medications, and so on. Subjects are made aware of the availability of some fairly new antidepressants that are currently on the market, which are particularly suitable for recovering addicts. They may be helpful in mitigating possible chemical imbalances in the brain produced by the extensive use of hard drugs. Stabilizing deregulated neurotransmitters is not only important in terms of treating depression, anxiety, and other symptoms caused by extensive drug addictions, it is also crucial in terms of dealing with psychotherapy in an effective way.

All subjects receive a list with important issues relevant to any recovering

substance user/abuser, including suggestions regarding physical well-being, such as how to eat healthy, the need for exercise, how to deal with hypoglycemia, information on vitamins, the benefit of sauna, and so on.

V. Conclusions

Having covered the intake and aftercare protocol used by INTASH, the need is emphasized to include ibogaine-experienced ex-addicts in the process of treating substance abusers with ibogaine. Even if ibogaine should be made available through the medical establishment, it is crucial to do so in cooperation with ibogaine-experienced addict representatives. The presence of these peer counselors is very important because there is a possibility of a trust relationship, which reduces possible risks and optimizes the chances of a successful outcome. The use of peer counselors is a convention that is widely used in the field of treatment and harm reduction as pointed out and applied by people like Dr. Vincent Dole and Nico Adriaans (3,11). Most substance abusers prefer to receive treatment in the presence of former addicts who are experienced with the treatment procedure, because they can relate to each other through similar experiences. In a world where addicts have constantly been submitted to rejection and secrecy, many have developed low self-esteem. We therefore find it crucial to provide a treatment environment that is nonjudgmental, in which addicts feel respected and free to express themselves, and where the right to choose is always present. For example, most addicts will not change their behavioral patterns if they are being pushed into treatment by family, friends, or the judicial system. Being prepared for treatment with ibogaine means being ready and willing to take a physical and spiritual leap forward. It is therefore important that the treatment team includes ibogaine-experienced ex-addicts in order to provide loving and understanding support and guidance, in which mutual trust is the central issue. When the treatment is completed, a process of self-discovery and self-realization can start to develop, in which it is vital that the former addict can relate to others with a similar experience in order to prevent feelings of alienation from his or her environment. This has been done by creating focus groups where people can share this common ground, or by treating several members of one particular scene of drug users.

In my opinion, there is no substance in the world today as effective as ibogaine in combating addiction to opiates and other drugs of abuse including methadone, cocaine, amphetamine, alcohol, and nicotine. However, ibogaine is not a "cure" in itself, but potentially a very effective part of a larger treatment scheme. It can therefore also play a role in the prevention of the spread of drug-related infectious

diseases, like the HIV virus amongst i.v. users. Even if people do decide to return to drug use after treatment, they usually find that they need less of the drugs to get high, because they have less tolerance, and because ibogaine seems to diminish the need to use drugs. Ibogaine is a potentially powerful harm reduction and relapse prevention tool. A clinical argument can be made that ibogaine is safer and more effective than ultra-rapid detoxification with naltrexone or naloxone.

Ibogaine is potentially cost-effective and should be available to the estimated 200 million addicts in the world today. Are different countries around the world playing the waiting game as to who is going to test and market ibogaine first, as seems to be the case with Holland? Is the United States waiting for another country to take the lead? Are we going to let it? While we wait, let's consider the outcome in, for example, Russia or Eastern Europe where the prevalence of substance abuse and HIV infection has taken on epidemic proportions (12). Let's not forget that the heroin epidemic in Eastern Europe began only a few years ago and that both clean needles and treatment centers are not widely available. You only have to guess the statistics in a few years from now to know that the results are going to be very tragic. All too often ibogaine has been approached from a political perspective instead of one of medical necessity. The question of how to make ibogaine widely available as soon as possible, and in the most effective way, should not be decided by politics.

Ibogaine already is available in the currently existing international black market where it is being bought and sold in the streets and used without the proper medical screening and attention that is needed, which can lead to possibly hazardous situations. For example, there are reports of a French organization that actually takes addicts to West Africa to chew on the root in the bush, or people in Europe who sell ibogaine on the street. Ibogaine should not become just another illegal street drug with an antisocial stigma attached to it. Issues like the quality of product that is used, or the dose range, or undiagnosed physical or mental health conditions of the people who choose to take it in an irresponsible, unprepared manner can lead to negative consequences. The main concern should be the safety of the substance abusers. Possibly hazardous outcomes might lead to further delay in proper testing of ibogaine by the appropriate authorities. Only through adequate testing through Food and Drug Administration (FDA) medication testing procedures can the safety and dose range of ibogaine be established and the compound produced by pharmaceutical companies. It should then be implemented in clinical settings and the currently existing detox and treatment centers. Since there has been no funding for an FDA-approved trial, there is now the need for other sources of funding to finish these testing procedures. Spare change anybody?

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