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Geerte**

An ibogaine treatment protocol

(Site owner's note: Ibogaine is an unlicensed medication and it is increasingly recognised that there may be risks associated with its usage. Please read [these notes](#) prior to considering ibogaine treatment)

The following presentation was written by ibogaine researcher Geerte for the Lindesmith Centre. She is also co-authoring a comprehensive treatment manual with Dave Hunter, for publication in 2000.

LINDESMITH PRESENTATION, MARCH 2, 1998

Geerte

International Addict Self-Help

www.cures-not-wars.org/junkie/

www.Ibeginagain.org

junkiedomain@yahoo.com

My name is Geerte and I represent INTASH, which stands for International Addict Self-Help. I would like to inform you about the contribution of the addict self-help movement in the development of Ibogaine treatments. I will be talking about the introduction of Ibogaine in the addict self-help scene in Holland. I will also discuss the present involvement of the addict self-help movement in treatments with Ibogaine, in which I will shed light on what actually happens during the intake, the treatment and the after-care procedure. I will then talk about the importance of addict self-help involvement in future developments with Ibogaine treatments.

Ibogaine was introduced to the addict community in Holland -which is where I'm from- in 1990, by Howard Lotsof and Bob Rand from the International Coalition for Addict Self Help. The late Nico Adriaans, Josien Harms and myself formed an informal organization that today is called INTASH, in order to treat addicts with Ibogaine. For those who don't know who Nico Adriaans was I would like to explain that he was one of the founders of the first addict self help movement in Europe, through whom eventually things like needle exchanges, decriminalized prostitution strolls and humanization of the addict within the institutions of Dutch society became a reality and an inspiration to many other initiatives throughout the world.

Witnessed four initial treatments with Ibogaine on poly-drug users of whom some had been in methadone maintenance programs for many years. The results of their treatments proved to be impressingly successful, which led to the foundation of our organization. What is perceived to be successful is of course a relative and somewhat subjective term. In our opinion we considered it a successful outcome to see in all of our subjects an elimination of withdrawal symptoms ranging from approximately 85% to 100% and elimination of cravings from approximately 5 months to two years. And, as Nico Adriaans often pointed out, and I quote "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 and still is to provide treatment with Ibogaine in a non-judgmental and trusting treatment environment. We provided treatments with Ibogaine over a period of several months for a group of 8 Dutch addicts, many 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.

We approached these treatments and do so to this day, with a "pro-choice" attitude, that is to say we were not anti-drug use, but we wanted to provide alternative treatment options to people that wanted to quit using drugs in an obsessive way. For example there was one particular case in which we treated a subject who came through the treatment without any withdrawal symptoms, but nevertheless expressed the need to use heroin. We asked him why, was he feeling withdrawal after all? 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 at that point not in his home town, we actually helped him cop. Because we were and still are, foremost concerned with the welfare of the subject and wanted to make sure that he did not wander around town or get bad product and 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 which we wanted to prevent.

All other subjects in the group stayed clean for an average period of six months. During this period we worked with Dr. Charles Kaplan, who is a highly experienced and accomplished international sociologist and drug researcher, and who suggested that we form a focus group that would meet on a weekly basis. His German colleague by the name of Eva Ketzer coordinated these meetings in order to collect data and to provide the subjects with an opportunity to share their experiences. All subjects received a physical examination by a medical doctor and nobody suffered any physical or mental consequences due to Ibogaine treatment. Because of practical difficulties and very limited financial resources the focus group dismantled after a couple of sessions.

The following two years we focused on processing the data of these treatments, which were published in 1994 in the peer reviewed Journal of Substance Abuse Treatment. We also informed therapeutic communities and several drug abuse institutions in Holland on the existence of Ibogaine and requested further research into this treatment procedure. We traveled the world to participate in all types of drug-related conferences to spread awareness around the existence of Ibogaine. Both from the professionals as from the international addict community we received a very skeptical, a kind of wait and see attitude and often 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 their progressive drug policy. Taking on

Ibogaine, an hallucinogen no less, was considered too much of a leap, and the attitude seemed to be one of "let some other country take the lead this time." The international addict community at that time, with the exception of a Russian and a German group was more interested in establishing legalized methadone programs and needle exchanges in their individual countries. We were however able to interest a few key people in Holland to observe some treatments or review some data.

The next series of Ibogaine treatments in the Netherlands took place in 1992 in which the late Dr. Bastiaans, who was a medical doctor, was present to observe. Results were monitored by Dr. Fromberg and Dr. Delano Gerlings from the NIAD, the Dutch Institute for Alcohol and Drugs.

INTASH then moved to The United States and integrated more issues around drug abuse on the way. Since 1996 we have a web site called The Junkie Domain (www.cures-not-wars.org/junkie) that covers anything from art and safer injection manuals to personal reports on Ibogaine experiences.

There are two different approaches to a session with Ibogaine. People who are not necessarily substance abusers can use Ibogaine to benefit from Ibogaine's spiritual impact in what is called an "initiatory" session and this takes place with a low dose of Ibogaine. The other method is the full dose for an addiction interruption session. The present situation of INTASH's involvement with Ibogaine is rooted in 1996, when we started working with an organization that mainly performed initiatory sessions with low doses of Ibogaine. This organization had also done a few addiction-interruption sessions with addicts. However they found that these sessions were not only more difficult in a medical sense, many addicts having physical and psychiatric conditions related to their substance abuse, but also in a psychological sense, whether it be the preparation, the actual treatment procedure or/and the providing of after-care. Since the INTASH members had this specific knowledge from years of experience we designed a protocol particularly for these addiction-interruption sessions, in which we modified the Lotsof procedure to provide sessions in a semi-clinical setting. First of all, we came to the conclusion that a thorough professional physical and psychological screening was needed. Second of all we had seen most people relapse at different time intervals after their treatments and wanted to provide some type of aftercare that was obviously needed.

My current role within INTASH besides being an addict self-help representative is one of Ibogaine counselor, advisor and ethnographer and I will try to shed some light on what takes place during the intake, the treatment and the after-care procedure. Treatments by the organization that I refer people to take place in several different countries and are done for cost price, which is around \$2200,- per treatment.

The intake procedure consists of establishing a preliminary process during which the addict requesting treatment is gradually prepared, while a relationship of trust develops. The addict is thoroughly informed of the physical and psychological consequences of a treatment with Ibogaine. Each person who seriously considers treatment with Ibogaine and who is well informed about Ibogaine goes through an initial screening which consists of a blood test, an EKG, a visit to a psychiatrist and an optional visit to a psychotherapist. The blood is screened by professionals for liver abnormalities, blood count and general health, the EKG checks the functioning of the heart and the visit to the psychiatrist is needed for a professional evaluation of one's past and present state of mental health. Basis of exclusion is problems with the liver, heart and/or lungs and psychiatric conditions beyond depression (mood-disorders) like psychosis, schizophrenia, etc. (personality-disorders). Once the subject has passed this screening, I do an unstructured life and drug history interview with the subject,

which includes information about the treatment procedure in order to prepare the subject as thoroughly as possible. Ibogaine has been proven not to be toxic and not to create dependency. It is hard to imagine and comprehend for many hard-core substance abusers, that Ibogaine will cause them to be clean from one day to the next without major pain and agony, especially for those who have been using daily high doses of Methadone in maintenance programs. Therefore the information given during intake encompasses many aspects and starts with a clear and firm warning of the danger of using drugs, in particular heroin, during and right after the treatment. This warning is repeated on the day of the treatment and is important because subjects undergoing the treatment need to be aware that Ibogaine potentiates opiates that are still in the system. More opiates during treatment can lead to overdose. The subject is then told what happens during a treatment.

The actual treatment takes place in three stages, through which the subject is guided by a team of Ibogaine-experienced ex-addicts, a medical doctor, a psychiatrist and a psycho-therapist and several other medical personnel.

Early in the morning, ten hours after one's last use of food and drugs, the subject takes the Ibogaine orally in capsule form. Sometimes the Ibogaine is mixed with a digestive aid. This takes place in the morning, when the subject normally would have used their wake-up dose of drugs. An hour after administration the subject usually notices the fact that their familiar morning withdrawal symptoms have disappeared and will express a desire to lay down and get comfortable. A quiet, darkened room, especially prepared in a personalized, though non-distracting, manner is made available for this purpose. The room is darkened because light bothers most subjects on Ibogaine. The room is quiet because sound is usually experienced in an amplified and oscillating way. The subject generally experiences ataxia during movement, which is loss of muscular coordination similar to drunkenness. Since the ataxia is sometimes accompanied by vomiting, he or she is asked to lay still with the least amount of motion as possible. When closing the eyes, approximately 75% of subjects experience dream-like visions. I will get back to this visionary stage later in my talk. However, when subjects opens his/her eyes and are talked to, there seem to be no real visual or auditory distortions and some level of communication is possible but usually not preferred by the subject. Many subjects perspire heavily and are advised to wear comfortable shirts/pants that can be easily replaced. The first stage takes place for about four to eight hours, during which he or she is regularly checked by the treatment team and where 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, that can last approximately 30 to 40 hours, several things can happen. Some subjects still experience a dream-like period, although it is supposedly 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 very light food like fruit. The subject usually stays awake most of the time. During this phase some subjects 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 previously established trust relationship between the subject and this guide, gives the guide the opportunity to assure the subject that this is a common stage and that all that is needed is some sleep. They 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 he or she might have saved. In many of these cases the subject is calmed down and sleep medication can be requested and is often

advised by the team.

During the third stage most subjects fall asleep for a couple of hours, with or without the help of some sleep medication, after which they generally awake 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 facility to process what has happened to them and to adjust. Some people request to talk about their experience, others prefer privacy. Some subjects experience up to about 15% of withdrawal symptoms after treatment, like some minor chills or a little yawning. An increased amount of energy and appetite and a decreased sleep requirement then continues over a three to four months period, diminishing slowly. Subjects usually stay free of cravings for several months.

Once the subject is informed of these practical aspects of a treatment with Ibogaine, I attempt to prepare him or her for the possibility of dream-like visions during the first and part of the second stage, even though approximately 25% of all subjects report not experiencing any visions. The visual and auditory experiences that possibly occur during Ibogaine treatment have demonstrated the ability to release repressed memories. The relevance of these visions in relation to the addiction interruption process is obvious when they seem to help the individual to develop an understanding of the underlying reasons for their addictive behavior. I usually ask the subjects 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 people have reported not experiencing Ibogaine as a euphoriant and that the effects of the visions on the mind do not seem to include actual processing on an emotional level. That is to say, there is no element of release of emotions like laughing or crying as is seen in many hallucinogenics. Besides, the repressed memories that are being released are usually positive, since most addicts have been dwelling on the ones that are negative.

It has proved important to explain the similarities between an addiction interruption session and the use of Ibogaine in the African tribal tradition. As Howard Lotsof explained, 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." People taking it for addiction-interruption purposes describe the visionary and auditory elements of the Ibogaine 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 past away. They have noted the ability of going both backward and forward in time and being able to come to an understanding of their spiritual roots. With spiritual I do not mean religious, but I mean a heightened level of awareness. I like to call the experience a "journey into ones 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 ten 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 previously made choices. 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. We have learned from experience that for many people Ibogaine treatment on itself is not enough to maintain a substance abuse-free life. Most subjects require some type of after-care in which these and other matters are addressed. Psychotherapist Barbara Judd, who has been working with substance abusers for over 15 years and who has treated people before, during and after Ibogaine treatments for over 6 years has noticed that a person treated with Ibogaine is more ready and willing to undergo therapy sessions compared to the average recovering drug abuser. Many addicts who have used Ibogaine have seem to be able to access sensitive material that lays 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 a lot of 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 it's problems. Subjects are stimulated to seek out or create support networks, which could range from attending Narcotics Anonymous meetings to organizing Ibogaine focus groups of their own.

The after-care strategy is defined through collaboration with each subject during the intake phase and after the treatment. Individualized after-care plans are based on the life and drug history taken earlier in the interview and the subjects present situation. Any form of after-care is of course optional and it's up to the subject to follow through in whatever way they feel is necessary. Motivation to design an after-care 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 half-way 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 towards physical, mental and emotional well-being.

Crucial aspects of aftercare that need to be considered are for example housing, education, jobs and the psychological consequences of assimilation back in to relationships, the family and the community. If unanswered, these matters could otherwise ultimately cause reasons for relapsing in old behavioral patterns. Based on the psychiatric evaluation some subjects need to be made aware of options like anti-depressants, non-addictive anti-anxiety medications, etc. Subjects are made aware of the availability of some fairly new anti-depressants that are currently on the market which are particularly suitable for recovering addicts. They seem to be extremely helpful in medicating possible chemical imbalances in the brain produced by the extensive use of hard drugs. Stabilizing de-regulated 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 psycho-therapy in an effective way.

All subjects receive a list with important recovery issues, as they are also presented on the Junkie Home Page web site. These tips are relevant to any recovering substance user/abuser and also include things that deal with the physical well-being, like how to eat healthy, the need for exercise, how to deal with hypo-glucemia, info on vitamins, the benefit of sauna etc.

That covers the intake and after-care protocol that is currently in use through INTASH and the treatment procedure that is used by the organization that INTASH refers subjects to.

I would like to emphasize the need for Ibogaine-experienced ex-addicts in the process of treating substance abusers with Ibogaine. Even though we believe 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 that reduces possible risks and that 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. 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 a low self-esteem. We therefore find it crucial to provide a treatment environment that is non-judgmental, in which the addict feels 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 to his/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. The aim of the INTASH members is for Ibogaine to become available to any person requesting treatment. Since the organization we work with can only treat relatively small groups of people, Ibogaine is currently not as effective as it could be if it were to be available in large amounts.

I would like to conclude by saying that in my opinion in the world today there is no substance as effective as Ibogaine in combatting addiction to opiate narcotics, cocaine, amphetamine, alcohol and nicotine as well as methadone.

However, I don't see Ibogaine as a cure on itself, but as 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 IV users. And even if people do decide to return to drug use after treatment, they usually find that they need less drugs to get high, not just because they have more tolerance, but also because Ibogaine seems to diminish the need to use drugs. Ibogaine has proven itself to be the ultimate harm reduction and relapse prevention tool. A clinical argument can be made for Ibogaine over the Ultra Rapid Detox with Naltraxone because Ibogaine is safer and more effective in the long run. On top of that Ibogaine is much more cost effective and cost only a few dollars to manufacture. The unavailability of Ibogaine in light of an estimated 200 million addicts in the world today is totally inappropriate. 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 when we realize that the rate of substance abusers and the rate of people contracting HIV is rapidly taking on epidemic proportions as has been reported by Dr. Grund who often travels to these regions. Let's not forget that substance abuse has just hit these people only a few years ago and that both clean needles and treatment centers are

not 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 I run into situations where Ibogaine is approached from a political perspective instead of one of medical necessity. It is not up to political standpoints if Ibogaine should be available or not. People with any political or/and financial clout and any social consciousness should concern themselves with the question of how to make Ibogaine widely available as soon as possible in the most effective way. It is not a matter of debate if Ibogaine should be available, it already is available.

My concern is with the currently existing international black market where Ibogaine is being bought and sold in the streets and where it is 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. We don't want to see Ibogaine becoming just another illegal street drug with an anti-social 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. My main concern is the safety of the substance abusers. And possibly hazardous outcomes might lead to further delay in proper testing of Ibogaine by the appropriate authorities. And even in the safest possible situation provided by for example the INTASH intake and counseling and the organization we refer people to for treatment, the element of risk remains. It is an element we do not wish to take, but are forced to take. And even though we provide Ibogaine for cost price, it's not as cheap as it could be if it were to be provided by the established medical institutions. As long as Ibogaine is not tested and made widely available in a responsible way to every addict requesting treatment, we will have to continue our current way of working in the best way we possibly can. Only through adequate testing through FDA medication testing procedures can the safety and dose range of Ibogaine be established, produced by pharmaceutical companies on a mass productive scale and then be implemented in clinical settings and the currently existing detox and treatment centers. Since NIDA stopped the funding for the Ibogaine FDA trial, we are now in need of other sources of funding. We do have the protocol to finish these testing procedures, but we need 3 million dollars to make it a reality.

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