The Social Life of Ibogaine:
Meanings of medicine through Ibogaine and its providers

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(Picture from http://www.ibogaine.co.uk/)
Summary

Tabernanthe Iboga has been used for centuries as a sacramental medicine in Gabon. Since the 1960s, Iboga and ibogaine, a reduced alkaloid form of Iboga, have been used in the West for treatment of opiate and other addictions, as well as for detoxification, psychosocial disorders and psychospiritual exploration. This study seeks to understand through Iboga how meanings of medicine are contingent upon providers and therapeutic contexts they offer, and how this challenges hegemonic notions of efficacy, risk and healing.
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List of Abbreviations

CBT—Cognitive Behavioral Therapy

EBM—Evidence-based medicine

SAM—Single administration modality

TCAM—Traditional, Complementary or Alternative Medicine
1.1. Ibogaine*: The Stuff of Medical Anthropology

Anthropologists (Lévi-Strauss 1963; Turner 1967) have long investigated the relationship between symbols, meanings and medicine. Language allows us to understand cultural meanings (Geertz 1973), which medical anthropologists apply to healing systems. The word “medicine” is embedded in a milieu of cultural values and expectations (Helman 2001:140), and can mean different things to different people in different contexts. Many authors have discussed how a medicine’s effect is intertwined with several other factors besides pharmacological effects (Helman 2001; Van der Geest et al 1996). This includes attributes of the drug, the recipient, the person who prescribes the medicine, and the physical setting (Helman 2001:136). Thus anthropologists are behooved to investigate why people provide particular medicines, how and why they move contexts, and how social relations influence (and are influenced by) medicines (Whyte et al 2002:9).

In some cultures, medicines are used sacramentally, including hallucinogenic medicines. These medicines are used reach transcendent states where “the visionary content of his drug experience helps to identify the cause of the individual’s illness…and how it should be dealt with” (Helman 2001:154). Iboga, or *Tabernanthe Iboga*, of Gabon is one such medicine. Iboga is used in Gabon and Cameroon in the Bwiti religion “to induce a spiritual enlightenment, stabilize community and family structure, meet religious requirements and to solve problems of a spiritual and/or medical nature. The root bark has been used for hundreds of years as part of a Bwiti coming of age ceremony and other initiation rites and acts of healing” (Samorini 1993:10). It is a powerful, sacred visionary plant, and is a risky undertaking if taken improperly. Ibogaine is a less potent psychoactive alkaloid derived from the roots of the *Tabernanthe Iboga*.

In the West, users of heroin, methadone, cocaine, methamphetamines, prescription opiates (such as oxycodon), alcohol and tobacco have all been reported to

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* For the sake of brevity, Iboga and ibogaine will be presented as a single medicine, Ibogaine. In reality they are quite different, as one is a derivative of the other. Some consider Iboga to be safer because it lacks chemical additives used to cut the alkaloids; some consider ibogaine to be safer because it is less potent than Iboga. All of the providers I spoke with offer ibogaine, but not all of them offer Iboga. Thus it seems more accurate to reference ibogaine throughout, unless quoting a provider who specifically refers to Iboga.
benefit from addiction interruption through ibogaine (and Iboga). Moreover, ibogaine has been used in psychotherapy “to facilitate a reduction of ‘pathologically acquired or learned’ associations of cues or internal representations with corresponding motivational states and behavior” (Freelander: online). It is also used to facilitate spiritual exploration.

Although the exact mechanisms of action are not yet fully understood, ibogaine is reported to remove drug withdrawal symptoms and drug cravings while simultaneously providing a psychoactive space for drug users to understand and reverse their drug using behavior (Sandberg 2001: online). Iboga takes people to an altered state of consciousness, and in the case of addiction interruption, “Neurochemically transports the addict to a physically and psychologically pre-addicted state, where they can evaluate their habits from the standpoint of a non-addict without having to suffer through any terrifying withdrawal symptoms. It is frequently reported that subjects using Iboga experience visions of an informative or healing nature directly relating to the problem that prompted them to seek help” (www.ibeginagain.org).

Ibogaine is generally not advocated to be a cure, but a catalyst of a larger, longer-term rehabilitation or therapy strategy. Ibogaine is not addictive in itself, although it can be taken more than once to further long-term treatment strategies.

Attention to Ibogaine has grown considerably since the 1960s. According to a US study conducted by Alper et al (2008), the total number of recorded individuals to have used Ibogaine therapy is 3,414, of whom 68 percent were motivated by treatment of substance-related disorders (18). However, this figure does not include “hidden” participants in the “Ibogaine subculture”. A 2004 prospective longitudinal study conducted at the Vrije University in the Netherlands concluded that 67 percent of the people who use Ibogaine treatment quit using all kinds of substances, and 33 percent reduced their drug intake from primary to secondary drugs (i.e., from opioids to alcohol only) (Bastiaans 2004:25). Iboga is associated with other hallucinogenic substances and is therefore illegal in many countries. Its medicinal value is overlooked, as is the case with Schedule 1 substances in the US (which many other Western European countries mirror). Many advocates have used ibogaine to overcome their own addictions, leaving the shadow of a marginalized population on the movement. Iboga is therefore sometimes considered an effort by drug users to legalize illegal substances (Alper et al 2001:253).
Biomedicine is the dominant healing system in most Western countries, and medicine is its primary therapeutic tool (Whyte et al 2002:12). Most Western legal structures are informed by biomedicine, and are tied to powerful politico-economic interests. Many authors have noted an increasing distrust in synthetic biomedicines resulting from the “medicalization” of non-medical domains of life (Whyte et al 2002; Wirth 1995). Many reasons have been documented for this distrust, but generally biomedicines are seen as unnatural, toxic, impeding the body’s natural immunity, along with criticisms of the commercial character of pharmaceutical production (Whyte et al 2002:63). Many people turn to “alternative” medicines without a biomedical understanding of their effectiveness. When biomedical measures cannot determine the efficacy of these treatments, they are often disregarded. Generally no other standard is considered an acceptable alternative for determining its efficacy and safety. Thus a tension emerges.

Interest in traditional, complementary or alternative medicines (TCAM) have grown considerably in the West, and oftentimes are sought after biomedicine has not effectively healed a person. The term TCAM was developed by the US National Institute of Health Office of Alternative Medicine to address the growing body of therapies offered (Adler 2002:412). Defining TCAM has proven problematic, as this umbrella term is forced to include ideas of “ethnomedicine”, “religious” or “ritual healing”, the use of herbs and plants, and various forms of manipulation (Waldram 2000:604). Inherent in the term TCAM is the implicit assumption that biomedicine is the dominant system to which other systems must try to legitimize or differentiate themselves. The term “traditional” is rooted in Eurocentrism and the idea of modernity and progress, and with it the supremacy of technological innovation (Barnes 2005:241). It also assumes that TCAM is static.

Ibogaine is an interesting example of the “indigenization” of a “traditional” medicine into Western contexts. Despite what many consider its medicinal quality, not everyone in the West agrees that Iboga is a medicine. Thus a logical point of investigation of ibogaine begins with how notions of the word “medicine” can change according to different contexts. Generally speaking, Iboga is used in very different contexts in Gabon or in Western Europe. Although these cultures or cosmologies are not bound, it is safe to say that Iboga does not carry the same meaning in Europe as it does in Gabon. This is because Western European healing systems are largely dominated by the biomedical cosmology, where etiologies and ontologies differ from
the millennia old bwiti tradition that centers on Iboga. This study is not concerned with the efficacy of ibogaine per se, but how the meaning of a medicine like ibogaine can change from one location to the next, with efficacy central to those discussions. It uses the vantage point of the providers as they have all undergone a treatment themselves as well and now provide it in spite of any legal restrictions or clinical acceptance.

Through the empirical data and the theoretical concepts utilized, I will argue that the biomedical cosmology alone is inadequate to explain how and why ibogaine works. Providers and advocates differ in their explanations, yet all seem to agree that the Neoliberal, capitalist paradigm informed by evidence-based medicine that dominates pharmaceutical development, along with the stigma of drug users who contribute to the underground development of ibogaine, will inhibit the mainstream integration of ibogaine as a treatment option. This study uses ibogaine to demonstrate how the meanings and transactions of medicine can change according to their contexts and actors involved. This study illustrates the supremacy of the biomedical paradigm vis-à-vis evidence-based medicine, whilst highlighting many of its inconsistencies in an attempt to show alternative means for understanding efficacy. It is not the intention of this study to discount biomedicine completely, but to challenge the hegemony that is quick to scrutinize “alternative” treatments but less inclined to turn that scrutiny inward. It is, however, the intention of this study to show how the use of biomedical discourse is used to uphold political-economic interests, particularly in the context of addiction.

1.2. An Abbreviated History of Ibogaine Development

Although Iboga has existed for thousands of years in Gabon, Howard Lotsof is generally the person credited with discovering the addiction reversal properties of ibogaine. The first written records of Western discovery of Iboga date back to 1819 (and was actually marketed in France from 1939 to 1966 as an antifatigue medication) (Paicheler 2007:119). In 1962, Lotsof was a 19-year-old heroine user in New York City. He had been given ibogaine to try and, assuming it was a recreational drug like LSD or psilocybin, was completely surprised to discover after a 36-hour trip that he was not craving heroin and was not experiencing any withdrawal symptoms. He had also gained incredible personal insights which he spoke widely about. He gave ibogaine to friends who were heroin users and they too experienced similar effects.
Believing ibogaine to be an invaluable solution for drug users who wanted to quit, Lotsof set out to develop it and to bring it to the pharmaceutical market. He coordinated with members of the Psychedelic Psychotherapy Movement, of which Dr. Leo Zeff and Dr. Claudio Naranjo belonged. Dr. Naranjo had studied ayahuasca and began using ibogaine, first on himself and then on his patients. He obtained a French patent in 1969 for “new medication acting at the level of the central nervous system, useful in psychotherapeutic treatment and in drug prevention” (Paicheler 2007:126), but in 1968 ibogaine had been classified as a Schedule 1 restricted substance in the US (along with LSD, mescaline and mushrooms), so could not move forward in the US.

The 1970s were “a moratorium for ibogaine as heroin ravages the hippie underground” (Paicheler 2007:127). In the early 1980s, when crack exploded in the inner-cities, cocaine with the yuppies, and heroin to middle-class white, militant action against drugs in the US took off, particularly with the Black Panther movement in the cities (Paicheler 2007:127). Aligning with allies in the Rock Against Racism movement (which later becomes Citizens Against Heroin and the legalization for marijuana movement), Howard Lotsof started the Staten Island Project in 1981 to secretly dispense ibogaine treatments. He set up a charitable foundation, the Dora Weiner Foundation, but discovering a lack of interest for funding, he developed a research company in 1986 called NDA International to attract investors. Through NDA, patents for ibogaine were obtained and research developed. Between 1984 and 1991, Lotsof worked to have the US National Institute for Drug Abuse (NIDA) take a more serious look at ibogaine.

Because ibogaine was illegal in the US, fuelled by the “War on Drugs” initiated during the Reagan years, initial research was conducted in Holland, where the Dutch model of prevention and Harm Reduction provided a more sympathetic atmosphere. NDA International provided ibogaine to researchers at the Pharmacology Department of Erasmus University of Rotterdam, beginning on rats in 1988. From 1989 to 1993, informal (i.e., non-medical) tests were carried out in the Netherlands through the help of International Coalition of Addict Self-Help, Dutch Addict Self-Help, and NDA International. Dr. Jan Bastiaans collaborated with NDA International in 1992, collecting 30 volunteer addicts to test the effects of ibogaine, the results of which were medically evaluated and later published by Dr. Ken Alper in the American Journal of Addictions (see Alper et al 1999) (Sandberg 2001: online). Dr.
Bastiaans is considered an influential figure in the history of the psychotherapeutic use of psychedelics through his work with pharmacological use of psychedelics to treat World War II related trauma. Together Bastiaans and NIDA International developed protocols for evaluating the safety of ibogaine through animal studies. However in 1993, a Dutch woman died under his supervision, one of the first recorded ibogaine-related deaths. Although the official Dutch inquiry found no wrongdoing on the part of Dr. Bastiaans, he was forced to give up his practice by the Medische Tuchtraad (Freedlander: Online).

In 1989 Lotsof filed for another patent in treating alcohol addiction, and enters into a contract with Dr. Stanley Glick at the Department of Pharmacology and Toxicology at the Albany College of Medicine in the US to test the long-term reduction of morphine cravings through in rats. His research showed “that rats trained to self-inject with 0.75 mg of morphine, enough to feel pleasure but not enough to be ‘hooked,’ stop within one weekend of ibogaine treatment and that the dosages of 40 to 80 mg of ibogaine lessen the amount of morphine the addicted rats will take for several weeks” (Paicheler 2007:133). Dr. Glick continued to work to see if they could isolate the long-term derivative of ibogaine in order to provide treatment without psychedelic effects. Another research team at the Medical College of Virginia showed that ibogaine causes no identifiable physical dependence. However, issues of effectiveness and toxicity had not yet been addressed. Tests were carried out under the biomedical model in clinics in Panama and St. Kitts, with informal trials being carried out in the United States, Britain, the Netherlands, Slovenia and the Czech Republic (Mačiulaitis et al 2008:189).

A push for clinical trials seemed promising as different scientists were able to demonstrate to the NIDA that therapeutic doses of ibogaine were not neurotoxic, with the FDA Center for Drug Evaluation and Research (CDER) agreeing to a Phase I (preparatory phase) clinical trial. However, changes following the 1994 Congressional election brought strong right-winged Republicans, which consequently led to funding and leadership changes in the FDA and an end to all discussion related to clinical trials with ibogaine.

By 1995, pharmaceutical industry representatives were pressuring the review committee at the NIDA to put an end to clinical trials of ibogaine, citing safety concerns over the death of a woman at a clinic in Panama. Officially the project organizers were not found guilty of negligence, “but the lack of scientific knowledge
about the effects of ibogaine hindered the establishing of an actual cause of death” (Sandberg 2001: online). Dr. Nash was able to show a lack of cerebral damage to the woman (Penchalar 2007:151). Lotsof “subsequently pointed out that the death, whilst tragic, was likely caused by concurrent opiate usage and, with regard to the second point, that any drug that could put, say, cancer or AIDS into complete remission for a period of months would be being developed as a matter of national urgency” (Sandberg 2001: online).

Simultaneous problems between the University of Miami and NDA over patent and funding led to a lengthy legal battle between the two and an end to the clinical trials. Dr. Mash has operated an ibogaine treatment center in the Caribbean since 1996 (Freedlander: Online). In 2002, the University of Miami won the patents for noribogaine, a metabolite of ibogaine. Dr. Glick signed a contract to bring the ibogaine derivative 18-MC into clinical trials (Vastag 2002:3101). Clinical tests are still underway in Mexico, Canada, with further clinical studies planned in Israel and New Zealand. The Multidisciplinary Association for Psychedelic Studies in California is currently funding a study that tracking 20 patients from a treatment center in Vancouver (Vastag 2008:173).

Many advocates of ibogaine recognize the need for pharmaceutical industry participation for market development, but drug companies are resistant. Patents are more limited because the drug is derived from a natural source, and ibogaine is not a maintenance drug and as such does not provide sufficient financial return to shareholders. Many advocates suggest that a treatment “arising out of African rituals similar to sorcery, promoted by former hippies, ex-junkies, and African American activists, and erroneously labeled a hallucinogen, ibogaine is laboring under a bad image, as much in terms of deserving to be taken seriously as from the standpoint of morality” (Penchalar 2007:154).

1.3. Statement of Interest

Two years ago I picked up a book about the 2012 prophecy, which included the author’s experience with ibogaine at a clinic in Mexico. A friend who had used this drug to overcome a heroin addiction had recommended it to him. I was curious about this hallucinogenic plant that could seemingly “cure” drug addictions. My interest in sacred hallucinogens came about following a personal exploration of the commercialization of ayahuasca, a hallucinatory drink used by many South American
indigenous populations. I became more curious about the commodification of revered hallucinatory medicines than with the medicines themselves, and wondered to what extent the sacred, transformative effects could be “indigenized” into Western contexts. Mostly, I wondered if the perceived power of the medicine was strong enough to overcome the consumerism that so readily defines Western societies. When I discovered a similar medicine, Iboga, was “successfully” treating addictions and other psychosocial illnesses, I became even more fascinated at how a perceived “drug” could “heal” “addictions”, and the meanings therein. I was particularly interested to develop my knowledge of addiction and treatment strategies to enhance my career in harm reduction.

Embarking on a research topic is overwhelming for many reasons, not least of which is knowing where narrow the focus. Through the Medical Anthropology coursework, I became interested in the social lives of medicine. As such, it seemed a good fit to focus on the social life of ibogaine. Because of time and budget restrictions, I decided to focus solely on the perspective of the providers, as access was more likely and all providers have experienced ibogaine themselves. I stayed in Western Europe to meet my financial and time limitations. I wanted to better understand how and why providers offer a treatment which some say is dangerous, ineffective, illegal, and morally suspect. Perhaps it is ultimately an attempt to “de-exoticize how we think about drugs” (Bourgois 2000:190).

1.4. Research Objectives

If a drug like ibogaine exists and works as well as people say it does, then why is not being developed and used as a mainstream substance abuse treatment? The main research objective of this study is to investigate the difficulties of conforming a drug like ibogaine to the biomedical model. Although it is not within the scope of this research to analyze the clinical methods of ibogaine testing, it can analyze the discourse used by actors. It is now recognized that good laboratory and clinical practice environment is essential for ibogaine’s future, but the issue of stigma associated with drug users continues to shadow efforts. This research intends to investigate the power of the biomedical model and means of establishing efficacy, which in itself is flawed. Many proponents of ibogaine are quick to point out that “most of the medicines used to treat mental disorders as classified in DSM and ICD-10 coding systems are not only based on theory lacking in sound evidence, but also
stand on shaky ground as far as efficacy and specificity of use” (provider’s unpublished document). As safety concerns are often cited as the reason for blocking its development, an investigation in to various meanings of risk and safety is warranted, along with a critical analysis of whose values determine the legally enforceable definition. Thus this study seeks to disentangle the meanings associated with ibogaine, and with it, addiction, drugs, and medicine, and what that means for the development of ibogaine into a legitimate treatment tool.

1.5. Research Question and Sub Questions

In order to reach these research objectives, the following research question was utilized:

*What are the meanings and transactions that define Ibogaine from the perspective of providers in Western European contexts?*

The main question is divided into the following sub questions:

- What cosmology informs the Ibogaine treatments, and how do providers frame ibogaine to clients?
- Do advocates inherently accept the need for modern pharmacology to support the acceptance of Ibogaine?
- How do the providers construct and address risk?
- What is at stake for the providers, including legal, livelihood and self-image considerations?

The following chapter will present the theoretical framework and core concepts used to support my argument, and to answer the research questions above.
Chapter 2: Theoretical Framework and Core Concepts

2.1. Introduction

Providers offer the experience of Ibogaine in spite of resistance to its mainstream acceptance. Evidence of the medicine’s scientific efficacy and safety is needed to become a legally sanctioned medical treatment tool, despite thousands of anecdotal accounts of its effectiveness. The power and authority of science and biomedicine is clear; the criticism surrounds how biomedical hegemony “has affected our understanding of the efficacy of traditional medicine” (Waldram 2006:616) so that a seemingly neutral science can mask very loaded claims to power.

This study will utilize concepts of pharmaceutical anthropology, which analyze how the meanings and transactions of medicine change. It also utilizes concepts of symbolic healing, along with a deconstruction of the notions of efficacy and risk to understand how Ibogaine can be positioned and understood according to different actors. Part of the discussion of varying notions of medicine and drug use is a brief theoretical analysis of addiction and biopower, and the stigmatization that follows certain type of drug use. In order to organize these concepts and attempt to account for the different levels of influence affecting Ibogaine and its providers, this study will utilize the multi-level theoretical perspective.

2.2. Multi-Level Perspective

Because this study depends upon providers who come from different backgrounds but are united in a common practice, I utilize the multi-level perspective. According to Van der Geest et al (1990), the multi-level perspective “insists that the object of research should not be isolated but rather seen as linked to ‘higher’ and ‘lower’ levels of social organization” (1026). Kinsman (2008) suggests this approach is useful because the different levels have their own discourse and emic view of the world. These include the macro-social, the intermediate-social, and the micro-social. The providers are situated within the horizontal and vertical linkages, which are explored to show the flow of ideas and communication between the different levels. This will help situate how the meaning of Ibogaine changes within the large network
of actors without assigning primacy to any single factor. By applying the multi-level perspective, it will “reveal the different meanings of [Ibogaine] carrying the same name at different levels of social organization” (Van der Geest 1990:1026).

Because this study is limited to the providers’ perspectives, I will also refine multi-level perspective in a sense by looking at variations within the individual level of providers. It is a horizontal analysis, again not assigning primacy to any single actor. Based on the data collected on this study, three “types” of providers were revealed, illustrating meaning changes both horizontally and vertically. Below is a diagram illustrating this flow of ideas:

**Figure 1: Multi-Level Perspective Diagram**

This diagram illustrate the flow of ideas horizontally (between providers) and vertically (between levels). It is used here to show that people at different levels can see ibogaine very differently. This study focused on providers; thus the providers are considered the individual. Ideas flow from the higher perspective to the lower, but the lower is also able to influence the higher (i.e., activism, providing in spite of legal restrictions). Power also flows between and within levels.
2.3. Medicine: Meanings and Transactions

By referring to the works of cultural anthropologists such as Lévi-Strauss (1963) and Turner (1967), Whyte et al show how anthropologists have long investigated the relationship between symbols, meanings and medicine (2002:10). The emergence of medical anthropology as a separate discipline led to the contextualization of medicines and healing practices in terms of shared cultural meaning, in the fashion of the earlier cultural anthropologists. In this way, medicines as objects are consumed as culturally defined symbols. Moreover, pharmaceuticals have also provided the “prototype” for the commodification of medicines (12). The authors suggest that “the assumption that some substances contain an innate power seems to be very widespread and it is an important reason for the diffusion of medicines from one culture to another” (4). However, when the context changes, the perceived power of the medicine may also change, according to culturally informed notions.

Whyte et al (2002) discuss medicine as “things” in terms of their social uses and consequences and not in terms of their chemical structures. This is considered pharmaceutical anthropology, and is different than ethnopharmacology because it is concerned with the medicines themselves and not the biochemical properties and effects of “indigenous” medicine (5). According to Whyte & Van der Geest (1988), “pharmaceutical” is defined as: “pertaining to or engaged in pharmacy”, which is defined as: the art or practice of collecting, preparing and dispensing drugs, especially for medicinal purposes” (5). It recognizes medicines have meaning and are transactable, and these characteristics are intimately linked.

Pharmaceutical anthropology also analyzes the co-existence of biomedicines and indigenous medicines and how their relationship to one another affects people’s perceptions of their effectiveness (Whyte & Van der Geest 1988:3). They argue that indigenous medicines and biomedicine carry meaning in contrast to each other, particularly when anthropologists reveal the medicinal logic. Through this contrast, indigenous medicines have gained ideological clout, particularly in response to attacks on “biomedicine’s expropriation of health” (Whyte et al 2002:11).

According to Whyte & Van der Geest (1988), medicines are material objects grounded in a “natural science”, and although they occur in the natural world, their meaning depends on the cultural and social contexts to endow them with the power to
transform (3). Medicines also move. Whyte et al (2002) outline five characteristics of medicines:

1) They are objects that can be commodified and thus have politico-economic consequences
2) They have power to transform, a power which people must believe to exist in order for it to be considered medicine
3) Those transformative powers can be used under different circumstances
4) Medicines can be both harmful and healing, depending on the dosage and their application
5) Medicines are used to bring about change in a person, whether this applies to their body, mind, “situations and modes of understanding” (6).

Van der Geest and Whyte (1989) discuss the “thingyness” of medicines in relation to understanding why medicines are so central to health care, and how this centrality facilitates social and symbolic processes. Because medicines are concrete things, they can be separated from the provider, whereby the medicine itself contains the power to heal. They suggest that therapy is reified in medicines because the perceived efficacy lies in the medicine itself, and not the skill of the therapist (1988:4). This reification can be applied to Ibogaine, whereby the expectation of the medicine’s efficacy is perceived to exist regardless of who or where it is administered. Medicines become an autonomous object through this reification, allowing a person to take responsibility for their health and gain control. Because medicines are commodities, they must be acquired through transaction. They suggest a paradox emerges between greater and lesser self-reliance through the ability for self-care against a distant dependence on the impersonal market of technologically produced synthetic pharmaceuticals (1988:5). The authors suggest this has implications for social relations because pharmaceuticals “objectify the healing art of physicians and make it into some-thing that can be used by anyone”, thereby breaking the hegemony of professionals and enabling people to heal themselves. One of the “charms” of medicine, as they identify it, is that it allows for a private, individual experience, removing any direct social control that may be exercised by a practitioner. In this way they consider medicines are “vehicles of individualization” with the power of liberation (347-9).
Other authors agree to this point on an individual level, but suggest social control does in fact still exist, originating at a political-economic level. According to Petersen and Lupta (1996), the increasing favor of Neoliberal approach to public health care in the West has led to an emphasis on “individual and collective entrepreneurialism in health and welfare”, whereby “individuals are atomistic, rational agents whose existence and interests are prior to society; skepticism about the capabilities of political authorities to properly govern; vigilance over attempts of such authorities to govern; an emphasis on markets over planning as regulators of economic activity; and so on” (10). The mechanism of Neoliberal rule is not the imposition of constraints on citizens but the use of technologies of human science (such as medicines) to govern autonomous citizens from a distance. They argue that the discourses used (including “self-help”, “equity”, “access”, “empowerment”, “participation”) emphasize both self-regulating and productive individuals who serve their self and social interests (12).

Through this, the modern society is not seen as imposing or authoritarian, but “as part of a set of institutions and agencies that are directed at enhancing personal freedoms and individual development” (Petersen & Lupta 1996:12). This implies the laws in place are there to protect people’s “individual entrepreneurialism in health and welfare”, through technologies established by “experts” (12). Thus a person is “empowered” to take control of their health through a seemingly neutral medicine. The transaction to acquire the medicine is therefore not limited to the provider of the medicine; it is part of a larger political-economic framework of the Neoliberal state and biomedical industries (including pharmaceutical companies which actively propagate the benefits of synthetic medicines for profits, not for the health of consumers). In this way, a person is empowered through the decision of whether to take a medicine or not, but what medicines are made available to them and that they believe they should select medicine as a solution in the first place is largely influenced by the political economy of medicine.

Related to this point is the propagation of the “chemical road to success” (Helman 2001:142). According to Helman, drug use has become normalized in Western societies partially because doctors communicate a model for dealing with problems by medicating instead of confronting them (2001:142). The “chemical road to success” encourages the use of either legal or illegal chemical comforts to bring about mental, physical, social, sexual or economic “success”. Helman also suggests
that “success” includes the removal of anxiety, guilt, worry, grief or anger, something which previous generations considered normal (2001:142). Doctors partly learn this behavior through influences by colleagues, pharmaceutical representatives and advertising (2001:141). It has also been suggested that their reason for acceptance today is that they do not interrupt the ability of a person to work, and may even enhance a person’s productivity (Helman 2001:142).

Helman (2001) talks about the social and cultural rules that distinguish between acceptable or reprehensible “chemical comforters”, as well as their normalization in Western societies (142). Cultures differ on what is most commonly used, and these differences can change over time. In the case of addiction, the definition of problem versus normal intake of a substance depends upon culturally defined boundaries (Wilton & DeVerteuil 2006:653). Generally in Western cultures, substances such as coffee, tobacco, tea, alcohol, chocolate, and some psychotropic drugs (usually the medically prescribed ones) are considered harmless in small quantities. However, most of these have been considered morally reprehensible at some point in history, illustrating the cultural construction of social categorization. Some psychotropic medicines become fashionable, which lessens the social stigma associated with dependence (for example, anti-depressants or sleeping pills). However, “upstanding citizens” are often quick to distinguish between socially acceptable, normalized, medically sanctioned drug use over “hard drugs”, which “interfere with consciousness” and cause a person to “lose control” (Helman 2001:141). When one considers that Ibogaine is often labeled a “hallucinogenic drug”, is largely sought by marginalized citizens, it interferes with consciousness and causes a person to lose control, it is not hard to understand why there is so much resistance to its acceptance.

2.3.1. Addiction, Morality and Biopower

The stigmatization that follows drug users is one of the most important considerations in addressing why a treatment like Ibogaine is not pursued in the mainstream. Despite the popular disease notion of addiction, drug users are not seen as innocent victims with a disease but moral and social deviants deserving of punishment. Sontag (1988) argues the unsafe behavior of drug use, “is judged to be more than just weakness. It is indulgence, delinquency” (25). The indignation of drug use and its physical affects on the body threaten our aesthetic sensibilities, as drug
users are often unkempt and in very bad shape. Sontag argues that, “moral judgments attached to disease are aesthetic judgments about the beautiful and the ugly, the clean and the unclean, the familiar and the alien or uncanny” (41). Drug usage changes the individual and leads to the “dissolution of the person” (41). Moreover, drug users are often found in abandoned, dark, unclean environments, particularly in urban settings. This further adds to the moral assumptions about a clean atmosphere, or “miasmic theory”, where urban squalor combines with germ theory to generalize an atmosphere as dirty, and thus contributing to the spread of disease. It is considered by many to be disgraceful and disgusting, and thus easy to overlook and demonize.

Politically, many drug policies, and particularly those of the United States, are characterized by the Protestant ethic linked with the rise of capitalism, as defined by Weber (1976 [1930]). This entails that “life should be lived rationally, in a profit-maximizing way, with no room for such excesses as drunkenness, overeating, gambling, idleness, thriftlessness, and so on” (Petersen & Lupta 1996:15). Therefore, should one succumb to an unregulated lifestyle and engage in risky behavior such as drug use, it is seen at least partly as a failure of a person to live according to these ideals. Of course this approach ignores “the impact of such factors as class, gender, and ethnicity both on life chances and on those individual decisions predisposing to ‘unhealthy lifestyle’, and on the consequent tendency to ‘blame the victim’ for what are seen as structurally induced problems” (Petersen & Lupta 1996:16).

Bourgois discusses the structural violence that often leads to drug use. Addiction, he says, is a self-destructive medium “for desperate people to internalize their frustration, resistance, and powerlessness” (2003:319). The political economic constraints limiting many people’s chances are overlooked in favor of biomedical interventions, “dedicated to solving complex social ills by developing laboratory-based, high-tech potions that promise quick-fixes and easily replicable efficient outcomes” (2000:173). Substitution and aversion therapies are pushed, so the issue often discussed within the biomedical community is not whether a medication is effective, but determining the correct dosage for its effectiveness. The exacerbation of substance abuse has nothing to do with the pharmacological properties of the drugs used, but the “polarization of the structural roots that generate self-destructive behavior and criminal activity,” where, “greater proportions of the population are being socially marginalized” (2003:319). Bourgois suggests the exacerbation of
substance abuse also serves to highlight “the effect, or at least the meanings, of drug use are largely culturally constructed” (319).

Bourgois (2000) draws a medical and political distinction within methadone treatment to illustrate Foucault’s biopower at work, or the “historically entrenched institutionalized forms of social control” used to discipline bodies. The discussion of methadone is important in reference to Ibogaine, as it is often used to treat methadone addictions and ibogaine has been shown to be less harmful than methadone (Alper et al 2008). Bourgois suggests that biomedical doctors in the 1960s redefined heroin addiction as a cure for heroin by blocking the brain’s synapses that create pleasure and pain produced by heroin, thus enabling addicts to live productive and healthy lives (170). By defining methadone maintenance as a “drug treatment”, “the state and medical authorities have created distinctions between heroin and methadone that revolve primarily around moral categories concerned with controlling pleasure and productivity: legal versus illegal; medical versus drug…illustrating how the medical and criminal justice systems discipline the use of pleasure, declaring some psychoactive drugs to be legal medicine and others to be illegal poisons” (167). This distinction is culturally constructed.

Bourgois uses Foucault’s understanding of the disciplinary impact of the power/knowledge nexus to highlight this point. His ethnographic research illustrates that methadone addicts who do not obey clinic rules are at the mercy of the clinicians who can increase, decrease or refuse their dosage all together. Studies that document negative side-effects of methadone treatment often conclude they are a result of “dosage acclimatization problems”, holding the addict responsible for causing dosage inconsistencies and the range of side effects that can occur. The literature surrounding methadone treatment discusses dosage level as a purely pharmacologically determined objective, “obscuring the repressive fact that addicts…are terrified of being thrown into violent withdrawal symptoms by a sudden decision of the clinic doctor or the nurse dispenser” (183). This also highlights the political and medical distinction, where “addiction-as-disease” model dominates biomedical discourse, whereas “the criminalizing and healthiest versions of biopower that dominate in law enforcement, and popular culture” are at work on the ground (184).

Bourgois’ argument shows how biomedical discourse is entangled with legal policies. The stigma associated with drug users and development of alternative drug treatment options is ignored by focusing on biomedical considerations alone. This
study will use this discussion to show how ibogaine providers and advocates resist and integrate the biomedical power/knowledge nexus. One could go one step further in arguing that addicts at least partially resist the biopolitics of the state by accessing ibogaine treatments which fall outside of government regulation or powerful market interests.

2.4. Symbolic Healing

Waldram (2006) defines “symbolic healing” as the process of manipulating healing symbols (605). It involves “manipulation of the symbolic aspects of the patient’s life situation, changing his or her perceptions of that situation with real effects at not just the cultural and psychological levels but potentially at the biological level as well” (Shupe & Hadden 1989: Online). Because human beings exist fundamentally through symbolic meaning and social interaction, we are able to identify healing processes through the manipulation of symbols (Larsen 2007:286). According to Shupe and Hadden (1989), symbolic healing is a logical component of healing because meanings provided by culture are what people use to respond to the physical world (online).

According to Kirmayer (2004), “symbolic healing involves mapping a personal problem onto a collective mythic world through emotionally charged symbols. The emotion evoked by the symbols then insures that manipulating the symbols within that mythic world will lead to corresponding transformations of patients’ illness experience” (36). He goes on to say that the “ability of metaphor to link sensory, affective and conceptual aspects of experience allows us to construct a model of healing transformations that can begin to explain how symbolic processes influence bodily experiences of pain, the pathophysiology of disease, and the emotionally charged meanings that give suffering its bite” (37). The context and symbolic actions of healing allow for a metaphorical reinterpretation of the illness experience. By mapping the experience into the symbolic space created by the healing system, meaning is instilled for both the clinician and the person experiencing the illness. Thus by manipulating the symbols, or adopting new metaphors, new meaning is or ways of thinking about the illness come about, which are often linked to physiological processes (37).

According to Larsen (2007), symbolic healing should not be reified as a specific form of healing, but instead is useful for understanding the symbolic and
sociocultural dimensions of any type of healing (285). TCAM therapies such as Ibogaine are often said to differ from biomedicine because of their emphasis on symbolic healing. Biomedicine is often criticized for being reductionistic, focusing on the parts of an individual body and the removal of physical symptoms, and therefore lacking concern for a patient’s search for meaning in the illness. This also partially explains the rising popularity in TCAM therapies.

It is erroneous to position symbolic healing as something dichotomous from biomedicine (Helman 2001; Waldram 2006). According to Kirmayer (2004), “at the heart of any healing practice are metaphorical transformations of the quality of experience (from feeling ill to wellness) and the identity of the person (from afflicted to healed). Moreover, Van der Geest (2005) argues that biomedicine has a symbolic component. The metaphoric logic of specific modalities of healing often follows from the associated model of affliction” (34).

In many systems, changes occur both in the removal of physical symptoms, on a symbolic level, or both (Barnes 2005:239). Kirmayer also suggests that the distinction between psychological healing in biomedicine “vs.” the symbolic action of other healing modalities is not as clear and sustainable as people often think. Research on the “many types of placebo effect makes it clear that symbolic stimuli and psychological attitudes and expectations can exert myriad effects on physiology, facilitating healing or aggravating disease” (36). He goes on to say that these are not limited to psychosocial interventions, but “any intervention will have psychological and social effects based on its meaning for the patient and others whom they interact. Consequently, the material and symbolic effects of healing must be considered part of one interacting system” (36). The link between the conceptual framework or attitudes and physiological changes may not be obvious.

Many scholars predicate discussions of healing on discussions of differing notions of the self, which is ultimately linked to search for meaning. A person’s fundamental nature, according to Barnes (2005), is directly related to notions of personhood, and to their vision of some ultimate possibility or what is ultimately possible for a person to become, whether in life or after death. Barnes quotes an acupuncturist who suggests, “the need people have for transformation is more that a symptom getting better, or learning to live with imbalances. It’s about changing their fundamental nature” (2005:252). Through the healing process, the meaning of an illness shifts for a person, but more fundamentally, the meaning of the self and his or
her place in the world, which is understood according to their own culturally informed symbols. The experience with Ibogaine is said to create a space for a person to evaluate their entire self and feel at peace.

Of utmost importance to this study is how providers frame the healing process. The “application of a diagnostic label has metaphorical connotations that can change the meaning of suffering and illness experience” (Kirmayer 2004:37). Kleinman (1980) discusses the disease/illness axiom in medical anthropology, which distinguishes disease as the malfunctioning of biological or psychological processes, and illness as “the psychosocial experience and meaning of perceived disease” (72). Sickness is the social experience of both the disease and the illness. One can experience a disease without experiencing illness, and one can experience illness without disease. Related to this is the curing/healing distinction. Many have argued that “curing” refers to primarily biological processes which emphasize the removal of pathology or physical symptoms, whereas “healing” refers to “broader psychosocial processes of repairing the affective, social, and spiritual dimensions of ill health or illness” (Waldram 2006:604).

Waldram (2006) says that the disease/illness and curing/healing is useful, but tends to be represented as dichotomous, whereby disease is associated with curing and biomedicine, and illness with healing and traditional medicine. This is erroneous because every medical system is a cultural system engaged with both healing and curing, and many traditional medical systems may attempt to cure physical symptoms, something he suggests anthropologists skip over in order to investigate the ritual aspects of healing in traditional medicine. According to Van der Geest (2005), even though biomedicine defines a problem according to the physical symptoms of an individual, “getting better is the result of restoring the whole”; by repairing a part, doctors are attempting to restore the entire system (141). He suggests science provides ultimate explanations, or “the type of knowledge from which [people] derive hope, comfort and security” (139), which can be healing. According to Kirmayer (2004), “all healing traditions involve “a basic logic of transformation from sickness to wellness that is enacted through culturally salient metaphorical actions” (34).

2.5. Efficacy and Risk

Waldram states plainly that, “medical anthropology continues to be vexed by the issue of the efficacy of traditional medicine systems and practices” (2006:603).
Biomedicine is the dominant system, whereby other medical systems need to legitimate or differentiate themselves. One of the most obvious obstacles to mainstream integration of Ibogaine is the need for clinical trials to gather scientific evidence and to demonstrate safety, as defined by biomedical criteria. The “gold standard” of double-blind randomized control trials has become the only acceptable means for establishing efficacy. Therefore, “studies of traditional medicine that do not employ the gold standards or that assess efficacy in culturally meaningful terms tend to be quickly dismissed as unscientific romanticism” (Waldrum 2006:616).

Like many medical anthropologists, MacKenzie-Cooks (2006) highlights the issue that, “the conceptual framework in which a therapy is embedded plays a crucial role in determining its efficacy—and, conversely, that medical science provides an inadequate conceptual basis for understanding and effectively using therapies abstracted from traditional medical philosophies” (680). Ibogaine does not conform to biomedical tests, as it is both impossible and unethical. A person cannot be “blinded” by a placebo, as they are quite aware when nothing happens. Furthermore, to give a placebo to a withdrawing addict would cause tremendous suffering and harm once his or her withdrawal symptoms began.

Evidence is popularly believed to be what separates science from other “medical” activities. Evidence-based medicine (EBM) purports to separate subjective or “intuitive” methods of individual clinical practice from the rigors of the scientific method. EBM grew out of criticisms that doctors “are not infallible” and made medical interventions based on tradition or preference and unsupported by evidence (Lambert 2006:2634). Evidence is achieved through methodological clinical decision-making derived from the most recent clinical research. It is based in positivist philosophy of science and is therefore considered neutral. Statistics are more important than subjective human experience. To have evidence is “to have some conceptual warrant for belief or action” (Goldenberg 2006:2621), although the supremacy of EBM is so widespread that the word “evidence” is often inherently understood to involve scientific rigor. Lambert (2006) argues that, “ethnographic and other forms of anthropological research, for example, can plainly produce evidence just as much as the next RCT [random-control trial]. The problem lies, rather, in the standards and criteria taken as authoritative in assessing the admissibility and veracity of such evidence” (2641).
In an effort to broaden measurements of efficacy, different authors have discussed the need to include subjective experiences, particularly because EBM excludes the perceptions of the very people receiving treatment—the patients. The Cartesian split between mind and body, the spiritual and the material, “was erroneous and created a truncated body of science that exhibited impressive technological ability to control nature, but could not address questions of human self-understanding” (Lambert 2006:2628). This led to the “crisis in meaning” and the critical examination of biomedical standards and practices. As pointed out by Waldram (2006), “the more significant issue is the possibility that research studies are often looking for indicators of efficacy that are different from those being sought by the patient and healer” (616).

Contrary to what science would have us believe, many authors (Waldram 2006; Goldenberg 2006; Lambert 2006; Barnes 2005) argue that objectivity of positivist empirical epistemology does not in fact exist. Feminist and post-modern critics are quick to point out that science is not value free, and the constructs of “objectivity”, “universality”, and “value-free” actually serve to obscure the subjective elements that are inescapably involved in the process. The “unbiased observer” is a necessary companion, and knowledge is “indelibly shaped by its creators and attests to the specificities of their epistemic locations” (Goldenberg 2006:2624). Experience is central to the process, as we experience the world through the lenses of our categories, theories, projects and standards. The “modest witness” of the scientist was constructed so that his experiences somehow represent everyone’s and no one’s experiences. Moreover, the experience “with which empiricism works is an abstraction in which cognitive specificities are homogenized under one dominant conception of what counts as knowledge and of who qualifies as a knower” (Goldberg 2006:2625). Gender bias is also a problem in research, as women are grossly under represented. Perhaps most importantly, “in arguing that the clinical trial is the only means to assess efficacy, biomedicine is insisting on a standard that it itself fails to meet” (Waldram 2006:606). Goldberg argues we benefit from uncovering these assumptions because it allows us to address the very important socio-political question of which values ought to enter the scientific arena.

Lambert (2006) summarizes the limitations of EBM identified in 55 letters, articles and commentaries written in English since 1990 that comment on EBM. They include incommensurate nature of population evidence and individual patient profiles; bias towards individualized interventions; exclusion of clinical skills from medical
practice; production of formulaic guidelines; failure to consider patient views and narratives; and difficulties in disseminating and implementing evidence into practice (2634). Although it is not within the scope of this paper to completely deconstruct the contradictions of EBM, it the reasons outlined show that indeed EBM is not infallible.

Young (1979) argued that efficacy should be determined by at least three standards: empirical, scientific, and symbolic (Barnes 2005; Waldram 2006). Empirical “proofs” are experienced in the material world and “are confirmed by events that are explainable”; scientific proofs are those confirmed through the rigors of scientific method; and symbolic proofs, “the most ambiguously defined of the three, pertain to the ‘ordering’ of ‘events and objects’ that give meaning to, and allow people to manage, sickness episodes” (Waldram 2006:606). In the case of Ibogaine, empirical evidence could include the interruption of addiction or the removal of other psychological symptoms. The symbolic evidence come from a person’s testimony of their experience and the “waking dreams” they experienced which brought meaning to their experience. The scientific evidence includes the physical changes that occur in the brain. While Ibogaine advocates work to develop scientific evidence, the empirical and symbolic evidence could also substantiate claims of efficacy.

The question of efficacy is also dependent upon how a problem is defined. Barnes (2005) argues that systems frame problems according to the solutions they have to offer (246). Biomedicine often reduces addiction to a neurochemical disease, and consequently seeks to address it through physical approaches. Addiction can also be seen as a symptom of a larger problem, or the result of structural violence.

Time is also an important consideration in determining efficacy. As Barnes says, “the assessment is processual, in that both practitioners and patients insert a timeline into their evaluation of a therapeutic intervention, and judge accordingly whether or not it is working as they anticipated” (2005: 256). Healing is fluid, and can happen immediately or may be a lifelong process. Waldram (2006) quotes Etkin (1988) who distinguishes between proximate and ultimate effects (611). Proximate effects refer to some physical sign that indicates the curing or healing process is under way, whereas ultimate effect is more oriented towards the restoration of health. Healing can be understood as “incremental efficacy”, whereby assessments of efficacy are shifting and build upon one another, and are therefore fluid (Waldram 2006:611). According to Barnes, individual acts of healing over the course of a lifetime can be seen as subsets to some ultimate goal (2005:242). Thus one can be
cured of symptoms without being healed, or healed while physical symptoms linger.
In the context of Ibogaine for drug use therapy, proximate effects are the “removal” of withdrawal symptoms and cravings for substances. Ultimate effects could refer to the meaning found or restored in a person’s life. This may or may not be manifested in their subsequent behavior of returning to drug use or not, but the experience remains.

In many Western countries, Ibogaine is illegal or is considered an unlicensed medicine. This is because the state and biomedicine are intimately supportive of one another. Biomedicine supports the health of the population, while “strong professional organizations representing biomedicine and acting through the publication of scientific journals maintain the hegemony, in part by actively investigating the claims of alternative medicine” (Waldram 2006:617). Moreover, private pharmaceutical interests wield incredible power in determining both domestic and international policies. The state offers legal protection to the standards biomedicine defines, and violating those standards becomes punishable. The positivistic elimination of culture, contexts, and the “subjects of knowledge production from consideration” is a “move that permits the use of evidence as a political instrument where power interests can be obscured by seemingly neutral technical resolve” (Goldenberg 2006:2622). Waldram (2006) quotes Kleinman (1995) in saying, “thus, in the postmodern state, biomedicine has come to serve a major political mission…[It] has outstripped its own professional autonomy and become inseparable from the state” (618). Waldram goes one step further in suggesting that anthropologists are therefore serving the interests of the state and of biomedical systems by examining the efficacy of traditional treatments through biomedical concepts and measurements (618).

According to Foucault, the technologies of human sciences emerged during the nineteenth century “as part and parcel of the development of an extensive system of moral regulation of populations, which has involved making human beings the objects of the exercise of power” (Petersen & Lupta 1996:14). The knowledge required of experts was part of the expansion of control, discipline and regulation that encouraged individuals to conform to morals of society, turning power from an political and economic force to “a form of rule based on ‘the administration of bodies and the calculated management of life’” (14). Petersen and Lupta (1996) continue to explain that in order for people to be governable, life needed to be “renderable in to a calculable form”, such as numbers, forms, charts, and statistics (15). The “production and applications of ‘impartial’ scientific knowledge”…reflects the “emergence of a
new conception of the domain of expert practice, encompassing ‘political’ action (for example, lobbying politicians, involvement in local action groups)”, thus creating the illusion of a single correct solution, namely biomedical options.

Moreover, these experts expand their scope of expertise through the identification and elimination of “risks” which pervade human life. Petersen & Lupta (1996) quote Mary Douglas (1992) who identifies risk as sociocultural constructs that “are always political in their construction, use and effects; and inevitably include moral judgments of blame” (18). Although these authors acknowledge that risks do exist, their point is to emphasize that the selection of risk and our understanding of what constitutes a risk is constructed through social, cultural and political processes (18). Peterson & Lupta cite Castel (1991) as identifying the importance of risk discourse for social regulation in contemporary societies, where “regulation has moved from a dependence on corrective or therapeutic interventions to the probabilistic calculation of risks and the development of risk profiles” (18-19). These calculations allow for experts to intervene on the basis of their expert assessment of a probabilistic risk instead of the presence of an actual, real danger. Therefore, “one need not manifest symptoms of dangerousness or abnormality, but rather need simply display the characteristic that experts responsible for the prevention policy have identified as a risk factor” (19).

This has great implications for a treatment such as Ibogaine, where biomedical experts can reasonably disregard its efficacy because of the lack of “expert” evidence gathered by underground treatments, and blame practitioners for not adhering to biomedically-defined standards. Not only does this disregard existing empirical evidence illustrating the efficacy and safety of Ibogaine; it also serves to highlight the widespread faith in clinical expertise. Efforts by Ibogaine providers to utilize medical screening and emergency response equipment illustrate their awareness of this construction of risk. Moreover, many people are quick to disregard the very real risks (side-effects) associated with the majority of synthetic pharmaceuticals. Thus the power of EBM can be seen as a tool for controlling people’s choices of health-care seeking behavior, and the ease with which Ibogaine is disregarded as a deviant or morally reprehensible option, propagated by a socially deviant group of people.

These concepts will be used throughout the thesis to situate the data presented. The final chapter will return to this theoretical framework to reflect upon their usefulness and how this research contributed to or challenged these concepts.
Chapter 3:
Description of Research Method

3.1. Introduction

This study is qualitative in design. The core of this research depends upon data produced from in-depth interviews and discourse analysis of websites offering Ibogaine treatments in Western contexts and a documentary called “Rites of Passage” (2004). Language is central in a qualitative study, as a method and as data, “for language is fundamental to human understanding, to how we make sense of and shape the world around us; it is the most important sign system of human society” (Green & Thorogood 2004:81). Language is produced and reproduced in a reciprocal manner, with meanings continuously produced and reproduced. It is through language that we see how the interview respondents and authors of texts see the world.

3.2. Study Location

Several websites exist listing international locations for Iboga and Ibogaine treatments. Due to the limited time frame of the study, I chose to conduct in-person interviews in the Netherlands, Germany, and England. These providers have been recommended on several websites, as well as through a key informant. They have different histories and applications of ibogaine. In this way I hope to gain a fairly rounded representation of how providers frame Ibogaine. I ensured to maintain confidentiality, and as such have avoided using pronouns as much as possible in the discussion of their interviews or tying their backgrounds to where they practice.

The websites and the documentary were used to analyze the discourse offered by treatment providers and advocates. Due to language restriction, I had to focus on websites offered in English, although the majority of information on the web appears to be in English. The topics included information about Ibogaine, how it works, provider instructions, safety precautions, and treatment clinic websites. All of this information is provided in a certain way, informed by different notions of health and illness (cosmologies). Moreover, these websites are used to market their services to potential clients. The analysis of these websites netted very clear themes and is presented alongside the provider interview data. I often distinguish between
providers and advocates, as much of the material is posted on a provider website but is part of a larger advocacy network. When this is made clear, I pass that information along.

3.3. Research Methods and Data Analysis

3.3.1. Interview

In-depth interviews are considered the primary research method. Through our conversations the providers and I, “produce language data about beliefs, behavior, ways of classifying the world, or about how knowledge is categorized” (Green & Thorogood 2004:87). The interviews were semi-structured, and often followed a logical course of conversation. Two interviews were conducted in the homes of the providers, and one in a professional office. As I was not present to witness full treatments by the providers, I have to rely on what they said as truth without being able to verify this by their practice. (It should be noted that I did witness one person on his fifth day of an Ibogaine treatment for methadone.) However, because I seek the providers’ overall accounts of Ibogaine and not objective reports of their behavior, these interviews are an invaluable source of information (Green & Thorogood 2004:89). It is not only what they say but also how they say it.

According to Green & Thorogood (2004), “all interviewers need to be at least aware of issues of how interaction itself produces meaning within an interview” (83). Interviews were semi-structured, allowing respondents to respond fairly freely, allowing me to listen to how they “interpreted, classified and represented” their practice (82). Over the course of two to three hours, interviews turned into more of a conversation, and try as I might to keep my opinion to myself, at times I am confident I gave my opinions away. Even something as simple as a nod or an “hmmm…” could have influenced the interview and this reflexivity is essential to anthropological research. This is not necessarily a bad thing, as “the ethnographic interview here becomes more dialogic than monologic, and anthropological knowledge may be seen as something produced in human interaction, not merely “extracted” from naïve informants who are unaware of the hidden agendas coming from the outsider” (Scheper-Hughes 1992:25). Through the interview process, I feel confident that I was able to elicit categories relevant to providers of Ibogaine.

Robert Pool (2003) discusses the relations of power between interviewer and interviewee. Although he speaks in terms of being in a perceived position of power as
a representative of Western culture in a Cameroon village, the issue of power applies to this study. Pool suggests that “the exercise of power is usually two way,” which makes the anthropological exercise more of a “creative relationship between anthropologist and informants” (20). The negotiation nets a discussion that is recorded and then interpreted by me, the researcher. According to Pool (2003), “that is what ethnography is all about, and it should therefore be explicitly presented rather than shamefully effaced from the final monograph” (239). Moreover, I also agree with Pool that I “can never attain the final interpretation of what my informants ‘really’ meant because there is no final interpretation” (52).

Two interviews were conducted in English. One provider was a native speaker, the other non-native but fluent for many years. Although I am a native English speaker, I cannot assume shared meanings of the English language (particularly since the three of us is from different countries). In areas where meanings were not explicit, I would ask them to elaborate. However, this was rarely an issue.

One interview was conducted primarily in German with the help of a translator, a native Austrian with a background in Anthropology from a British university, and also a good friend of mine. The translator also transcribed the interview for me as a favor. Although I feel the core of the information was received, it stands to reason that some of the information may have been lost or interpreted through the translator. Although they are both native German speakers, certainly their dialects differed and perhaps political or historical biases may have existed, which may have further impacted the translations.

Pool’s (2003) discussion of the involvement of his translator Lawrence also applies here. My translator, with her background in Anthropology and an introductory fascination with Ibogaine, took the liberty to ask a few questions on my behalf. I did not regard this as a “necessary evil” or a negative “contamination of the data” (21). A good friend of mine, I trusted her implicitly, and in the end the questions were relevant and interesting. I believe this only added to the interview. In the spirit of Pool (2003), I agree “the interpreter should be credited with making a creative contribution to the joint product which the anthropologist ends up taking home: the interview texts” (21).

Short life histories of the providers were included to better understand how they came to know Ibogaine, and what prompted them to provide treatments. Each
provider had a different story to tell, which consequently led to their differing notions of Ibogaine and how they provide the treatments. In this way I received diverse accounts of the meaning and transactions of Ibogaine from the different providers. Moreover, I was able to hear if their experience with Iboga/Ibogaine altered their cosmologies in any way (Green & Thorogood 2004:38).

The purpose of data analysis is to “both reflect the complexity of the phenomena studied, and to present the underlying structures the ‘make sense’ of that complexity” (Green & Thorogood 2004:175). In order to achieve this, I began analysis by transcribing all of the interviews in the field, within one day of the initial interviews. This was to capture the information while it was still fresh in my head, in order to minimize any confusion that may have arisen as more time passed. The transcription in German took three weeks to receive, but as I was only marginally clear about what was spoken, not much could be lost in terms of retaining “freshness”. I then coded the data to elicit emic patterns of categories and their relationships, which I then used to shape my presentation of data in the forms of chapters. In this way I tried to explain the patterns and attach significance to the analysis (Brewer 2000:105).

3.3.2. Discourse Analysis

Discourse analysis of the websites and documentary was the secondary method employed. The aim of discourse analysis is “to reveal how language (and indeed any other sign system, such as the uniforms of staff or the architecture of a hospital) does its work, in conveying not just the superficial meaning, but also the less obvious social meanings” (Green & Thorogood 2004:163). Discourse analysis assumes that meaning can be found through language, not only through the words themselves but also through the meaning or symbols those words convey (Holslag 2010). The process of analysis is similar to that of the primary method of comparing and contrasting themes and their relationships and integrating them in to the analysis. An obvious limitation to this method was a need to rely on English-language material only. A second consideration is that the documentary especially is constructed to convey a certain message, so the language available is an interpretation of the filmmakers, further interpreted through me. A third consideration is the reliability of the information published on the websites. There is no way to validate testimonials and other information published with the intent of persuading people to utilize
Ibogaine treatments. However, as with the interviews, my primary concern is not what is said but how it is said and the themes that emerge therein.

I also kept a research journal as well as a personal journal for reflections. According to Brewer (2004), “writing is thinking, so ethnographers should not wait to write until their thoughts are clear; they will become clearer by writing and rewriting” (133). So many ideas and connections came to me following the interviews, which were a great asset in synthesizing the material, as well as producing recommendations for further research.

3.4. Biases

Recognizing that “we cannot rid ourselves of the cultural self we bring with us into the field any more than we can disown the eyes, ears, and skin through which we take in our intuitive perceptions about the new and strange world we have entered…we struggle to do the best we can with the limited resources we have at hand—our ability to listen and observe carefully, empathically, and compassionately” (Scheper-Hughes 1992:28). Anthropology as a discipline provides an arena for investigating assumptions and “speaking truth to power” (Scheper-Hughes 1992:28). As is the case with this study, this can be investigated through something viewed skeptically by the mainstream paradigm because it offers to help a socially marginalized group of society.

Caution must be exercised in placing the two in direct opposition to one another as dichotomous, bounded, “David and Goliath” entities. So, for example, Ibogaine versus biomedicine, natural versus synthetic, or good versus bad. The trick for the anthropologist is to be reflexive, to remain reflexive of her own biases whilst gathering the emic insight; and, at the same time, recognizing that boundaries are fluid and changing and these categories serve as “ideal types” for understanding assumptions. It does not reduce subjects to objects but instead attempts to assist in giving a voice by critically examining the dominant paradigm (Scheper-Hughes 1992:28).

Whether quantitative or qualitative, research carried out by humans “within specific social contexts, cannot be separate from our outside our social world (that is, research can’t be value-free)” (Green & Thorogood 2004:15). The facts that are selected for investigation here are necessarily empirical, which is the nature of anthropology. As much as I tried to present the material gathered without interjecting
my bias, the fact remains that I selected certain material and not others to present. As Scheper-Hughes said (1992), “all facts are necessarily selected and interpreted from the moment we decide to count one thing and ignore another, or attend this ritual but not another, so that the anthropological understanding is necessarily partial and is always hermeneutic” (23). While my intention is to maintain an awareness of my critical bias throughout, inevitably this thesis was conducted to “improve the social order” (according to my biases).

But this is not necessarily a bad thing, because Western commitment to “Enlightenment notions of truth” has been “characterized by a ‘refusal of engagement’ with the other or, worse, by an ‘indifference’ to the other—to alterity, to difference, to polyvocality, all of which are leveled out or pummeled into a form compatible with a discourse that promotes the Western project” (24). Because research is part of society, “it should acknowledge that it is inextricably bound up with the social order, and be striving to improve the social order (that is, research shouldn’t be value free).

3.5. Ethical Considerations

One of the most obvious ethical issues is capitalizing on people’s addiction or other psychological or spiritual treatments for the sake of my Masters thesis. These are very personal experiences, and I believe it is my ethical responsibility to keep those experiences confidential. I promised confidentiality of the information I received and as such, none of the names given in the interviews are recorded on any of the transcripts or the final thesis. This includes what may have been said about other providers and people in the Ibogaine network. I recognize these providers did me a great favor by providing me with this information, and it is not my intention to harm them personally or professionally in any way. The only names given are those which were publicly displayed, in the documentary and on any of the information gathered from the web.

A second ethical consideration was gaining access to practices that may be considered illegal at any point in time. Although all of the providers are currently operating within the law, because Ibogaine is not a wholly sanctioned practice, I was somewhat cautious of what I sought to uncover.

A last ethical consideration was monitoring my own enthusiasm about Ibogaine and the people I interviewed. As curious as I am to know first-hand what an
Ibogaine session is about, I honored my promise to maintain my objectivity during the research and write up period by refraining from a treatment. Although I think it would have been very helpful to understanding Ibogaine and the emic perspective of the providers, I agreed that it could have overwhelmingly biased my ability to answer the research question which focused on the providers’ points of view (Green & Thorogood 2004:45).
Chapter 4: Providers, Cosmologies, and Treatments

4.1. Introduction

The purpose of this research was to explore the meanings and transactions that define ibogaine according to providers in Western European contexts. Pharmaceutical anthropologists stress that transactions and meanings of medicines go hand in hand. For example, where and through whom a medical substance passes can decide its meaning for a patient. In the laboratories of pharmacological researchers and in the offices of medical policy makers the medicines are evaluated according to their chemical structure and safety profile. Although providers consistently agree upon their role in terms of providing safety and comfort, it became clear that the cosmologies informing providers can differ, demonstrating that meaning of a particular medicine such as ibogaine varies even within provider subgroups. As a result, how providers offer ibogaine and assess healing may also differ. This chapter will address the cosmologies (logics) informing the providers, the role of the provider, and how this reflects variability of meanings and transactions in medicine.

4.2. The Treatment

Although ibogaine treatments are specific to the person undergoing the treatment, I asked each of the providers to describe a general session. While the setting differs for each provider, the application and roughly thirty-six hour treatment follow a similar structure. Most sessions are with a single person, although a friend or a loved one who the person trusts may be present to help support the person or providers may have someone working along side them. With the case of addiction, the provider has to be sure the substances have finished from the person’s system. One provider offers a shower before as they will be in bed for at least the next 2 days and will not be able to move to bathe. The person is first given a test dose, which calms them down because “they feel they can handle it” (personal interview) and also serves as a diuretic. They then receive the larger dose, which is determined by weight, by need, and also through the experience of the provider in knowing if they need or can handle more. “And then they are knocked out. You just have to look that somebody’s comfortable, and that they’re not lying down too much on one side.” The provider
also helps them to go to the bathroom, and cleans up after any mess they may make. For the first 8-12 hours, the experience is very intense, “where they are really imprisoned by these visions and pictures” (personal interview). The person lies in bed for 2 to sometimes 6-10 days, only leaving to go to the toilet. They have to be supported because their motor skills are not functioning. Providers also watch to be sure the person does not vomit, and if they do, that they do not choke on the vomit. They may also prepare food for their clients. After the treatment, a person is very exhausted and may experience aches from lying down for so long. One provider compared the exhaustion to a triathlon or extreme support. Slowly they start coming back to life and the provider is there to help them with this.

The length of the treatment also varies. Some only treat people for 2-3 days, and may recommend they see a therapist for follow up sessions, or they may not. Some providers offer ibogaine as a catalyst of a larger treatment process, thus expecting follow up sessions, perhaps minimizing the actual ibogaine treatment. Other providers, however, feel that treatments require more, and as such will keep people in their care for up to ten days. Some providers dose higher than others, but all are careful to monitor the person and give them only what they can handle.

It is always highly recommended that a person be present when someone is undergoing an Iboga journey. Lotsof and colleagues developed the “Lotsof ProcedureTM” for the application of ibogaine, which includes short and long term medical, psychological, and social care of the patient (Freedlander: online). Lotsof described this as a single administration modality (SAM), and considered the primary obligations of the providers as:

“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 dependency, 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” (Freedlander: online).

Although their approaches differed, all of the providers I spoke with shared the position that their role was to provide safety and comfort to their clients. This includes providing quality medicine from a reputable, trusted source. The provider also ensures that the person drinks enough water, particularly with drug addicts who are often very dehydrated. Some providers also monitor the person’s blood pressure to
make sure it has not dropped too low. They also spoke of establishing trust and the importance of support following a treatment. The same was true of the documentaries and websites I analyzed. However, none of them utilized an exact procedure.

One provider spoke about the setting provided for treatments. As a provider,

“The tranquility and the Iboga, when you take Iboga, when you have experience Iboga, you suddenly realize the set and setting is so unimportant, you actually only need a bed. Everything else doesn’t interest you anymore. Of course you are sensitized to light and volume et cetera, but if you have a darkened room and a bed that’s enough for you, during the trip nothing else interests you, you are so captured by these images that you see, and I am just one person who provides it, it could have been I-don’t-know-who instead” (personal interview).

From the descriptions synthesized above, it is clear that the provider does play a role in the treatment process. The next section investigates the actual involvement of the provider in the session. If he or she could have been “I-don’t-know-who instead”, the question becomes where is the perceived locus of power in the treatment.

4.3. The Involvement of the Provider and the Locus of Power

A key point is what happens when the person takes the medicine, and with that, how the provider is involved. The transaction is not limited to the simple, brief exchange of medicine, with the person taking the medicine and then leaving to do with it as he or she pleases. Instead the person is rendered physically incapacitated for a period of at least eight hours, requiring the monitoring of the provider for at least another eighteen hours thereafter. The transaction involves a longer period of time than with a synthetic medicine, whereby the provider offers an experience with ibogaine with the provider in the background. The transaction is therefore very empowering for the person receiving the treatment because it is up to them to make the most out of their experience, and not the doctor or provider.

According to one provider,

“Even though there’s someone who administers, their experience excludes the administrator in a sense that the administrator is only really there to be very much in the background in providing safety or if there is any reason for the person to want to communicate with them. But they’re not really involved in whatever process that goes on” (personal interview).
The ingestion of a synthetic pharmaceutical, whether for a physical or mental disorder, may not necessarily include a conscious experience with the medicine’s effects, although a person recognizes if the medicine has worked or not. For example, if I have a headache, I may take an aspirin and then notice 45 minutes later that my headache is gone. I would not have been aware of the incremental changes occurring as my headache lessened and lessened to the point of disappearing all together. However, with ibogaine, a person is quite aware of the medicine working, as his or her consciousness shifts and the person enters a waking dream-like state. It is not just about the chemical changes, but the visions produced and “realizing what is most important” for that person (personal interview).

This provider went on to say the following about empowerment and the role of the provider:

“The doctor has the wisdom and knowledge, to prescribe, to give this thing, to make change, whereas with ibogaine, even though there’s someone who administers, the actual process beyond that is really a relationship between the person and the drug... I guess it differs from psychotherapy because there the therapist is very much more involved, in dialectic, in some kind of conversation, an interaction. And that person is coming to see the therapist and there is a two-way conversation. But with the ibogaine, it’s very much a separate thing...So it’s kind of a different position than a therapeutic relationship, or an analytic relationship or doctor-patient relationship.”

The person ingesting the ibogaine is empowered to heal, power the provider surrenders in the transaction, assuming a more care-taking role. The provider does not have the knowledge of the problem or the power to heal or fix whatever the person is suffering from, but he does have the power to provide the ibogaine. However, that power is within the person to identify the cause of his suffering and sort it out on his “Iboga journey”. This is not to say that the provider is disempowered. They still play a very important role, and are further empowered by the fact that they are providing a drug that is difficult to obtain.

This is an interesting twist of the paradox of greater and lesser power through the transaction of medicine. It requires an analysis of where the power is located. A medical doctor is empowered through the knowledge of the paradigm, and retains that power in the relationship, even when the medicine is passed. He is further empowered with a patient’s expectation of his ability to heal, to have the knowledge to identify, diagnose and prescribe medicine that will cure a person of their disease. With
ibogaine, although the provider has power in the sense of providing the medicine, he or she does not diagnose in the biomedical sense. The real locus of power is with the ibogaine itself. However, it is not the root bark or capsule itself, but the spirit or energy of the Iboga with the power to heal.

Much of the literature describing Ibogaine and its effects discuss the “spirit of Iboga” as guiding them through the encounter. One provider I spoke with said, “I can say that at the first Iboga trip I had I had childhood memories and I thought, ‘Oh I will go back to that,’ but that won’t happen. Iboga will tell you where it’s going” (personal interview). A woman in the Netherlands who used ibogaine to overcome heroin and cocaine addictions said she, “heard a voice telling her to make a choice. ‘To choose a new beginning or choose to die struggling and suffering alone’ (www.ibeginagain.org/articles/spirit.shtml). A journalist describing his Ibogaine journey also said, “While startling at the time, such an encounter with a seeming ‘spirit of Iboga’ is a typical vision produced by the Bwiti sacrament” (Pinchbeck 2003:online).

Ultimately the “spirit of Iboga” is an animated agent wherein lies the power to heal. The medicine is the Iboga root, but the perceived power comes from the spirit of the agent. The real power of Iboga is not innate to the root bark itself, although the chemical properties also play a detoxification role on a physical level. This differs from synthetic pharmaceuticals where the power is chemical, and the perceived power is innate to the chemical processes themselves. Thus the locus of power in an Iboga treatment is with the animated agent, and is, according to the providers and the testimonials of clients, infinitely more powerful than the providers who present a person with an opportunity to experience the spirit of Iboga themselves. People establish a relationship with the spirit of the Iboga in order to identify the parts of them that need restructuring. It is the spirit of the agent who is working with the patient, and not the provider. The chemical changes are not the primary mechanism of action, as the healing happens on much more than a somatic level.

Many advocates thus argue that trying to isolate the chemical derivatives of Iboga is an insufficient experience of the total drug effect. These clinicians said they did so because they recognize it is likely the only way ibogaine will ever see the market as an addiction treatment medication. The advocates in favor of the psychoactive properties would have recognized the spiritual aspects of the medicine, something which biomedicine has no room for. Conversely, clinicians who come
from a biomedical paradigm where objective, verifiable, physical changes serve as proofs would not see the need for the psychoactive properties, and may even agree those properties are more aligned with recreational substances than medicinal. Thus they may have felt justified in working towards isolating the chemical properties.

This also reflects the spiritual component of ibogaine, addressing a person’s search for meaning, through the experience in the altered state of consciousness. Many scholars predicate discussions of healing on discussions of differing notions of the self, which is ultimately linked to search for meaning. A person’s fundamental nature, according to Barnes (2005), is directly related to notions of personhood, and to their vision of some ultimate possibility or what is ultimately possible for a person to become, whether in life or after death. The meaning of “ultimate possibility” is different for each person, and in the case of Ibogaine, depends upon the relationship they establish with the spirit of the Iboga and the experience they have with the treatment.

For example, one provider spoke anonymously of a person who came with existential problems, wanting some kind of change or insight into himself, for which this person thought ibogaine would help. This person had seen many other health professionals in search of a solution or a medication to his problems, but nothing worked. By the time he reached this provider, he was at his last. The provider did not diagnose his problem, but did offer him an experience with ibogaine in order that he might gain some insight into what is going on with him.

As with many TCAM therapies, ibogaine is often sought as a last resort after biomedical approaches have not successfully addressed a person’s ailment. Many of the testimonials posted on websites also admit to approaching ibogaine as their last hope, and then coming out of it with a peace of mind, freedom from fear, a realization of an interconnectedness of life, and other realizations that leave them more content and at ease with life.

When a person seeks a treatment, the provider will frame ibogaine according to their perception of what ibogaine is. This is informed by their cosmology. The following chapter discusses this point in more detail, including three cosmologies, which presented themselves in this study. These cosmologies inform the meaning of the medicine, illustrating that meaning of medicines changes according to different actors and contexts.
4.4. Cosmologies

As mentioned above, ibogaine treatments are individual to the person. At the same time, providers of ibogaine also differ. While websites or providers may not explicitly compare themselves to others, they do so implicitly through the language they use. Providers offer treatments according to their logic of illness and healing, or cosmologies. Whilst recognizing there are no bounded categories of providers, this section discusses some of the variations within providers, presenting them as different “types” according to their informing cosmologies.

According to the providers I spoke with, ibogaine treatments differ from biomedical treatments. Biomedicine focuses on physiological processes, identifying symptoms with a diagnosis and the corresponding technical treatment available. Providers who operate as clinicians are investigating these physiological processes. However, for the purpose of this research, clinical researchers were not included due to time and location restraints. Nevertheless, from their actions, we can extrapolate they operate according to a biomedical paradigm, accepting and the need for modern pharmacology to support the acceptance of ibogaine.

None of the providers I spoke with assess problems according to physical symptoms. That action is left to the ibogaine and more specifically, to the persons themselves to experience with the ibogaine. One provider spoke of Iboga in terms of energy. According to this person, everything is energy, both positive and negative, where a healthy individual has his or her energy in balance. Therefore a person’s physical symptoms are irrelevant because their illness comes from an energy imbalance. Healing comes from restoring balance. Iboga works to bring the energy back in to balance. The provider said,

“In the beginning, it shakes it all, like this. You feel like you’re being thrown from one side of the room to another, like a roller coaster, you don’t know what’s coming to you. It’s like crawling to every cell of your body and taking all the toxins out of you, and sometimes you need to vomit. It just comes out. But then after you feel so relaxed, and so balanced. And a lot of things are disappearing, symptoms are disappearing, because you are relaxed, your body is more in balance, your brain chemistry is more in balance. And this is when the real healing comes. When you take energy which is not in balance and you just give it something and the end product is it’s more balanced. So this is healing” (personal interview).
The provider went on to say that to have healing, to gain balance, you have to start with the truth. It was described as a natural law. And some ibogaine providers, according to this provider, are more interested in putting on a performance and the power of being recognized as a provider, and not because they are working with a certain energy. Money is necessary to live, but providing treatments should never be about the money. According to this provider, so long as a person “does it right, the medicine takes care of you. You will never have too short of anything. Somehow it works like that.” (Personal interview).

This provider is informed by the notion of energy and balance, and the use of words like “truth” and “natural law” suggest a belief in a verifiable order and a balanced whole. It is part of a New Age notion of healing, according to Kirmayer (2004). The metaphoric logic is that of a restorable whole of balanced energy. Ibogaine is the medicine which is ingested to restore that balance. Iboga is “an energy like everything else. So the energy of the Iboga will take care of itself… If you work with your heart and with positive energy, it will work with you” (personal interview).

For this provider, the experience with the Iboga provides truth which can be embraced in a person’s life, empowering them to overcome addiction, see the other dimensions, and recognize that “everything is connection, and that you can choose sides, you can work for good, and you can work for evil. You decide what is good is not only about money” (personal interview).

This provider elaborated on the notion of good and bad providers. This very ethical language, positioned as dichotomous and clearly with this provider falling in the “good” category. According to this provider, a good provider is someone who gives ample attention to the person they are treating, and is not concerned with getting them out in 3 days. A good provider is not interested in making the money, and will treat the person regardless, because money will come in another way. A good provider uses their heart and monitors the dosage and works with the person for as long as it takes.

Bad providers are those who are not really interested in doing the work, of dedicating themselves to more than three days for a person’s treatment. They are essentially in it for the money, for the power. Anyone can be a provider and can lie about their qualifications or intentions. This provider felt very strongly that people should be wary of providers who used ibogaine to overcome addiction and
immediately turn around and became providers themselves. They need time to heal because,

“Their lives are a mess because they were drug addicts. Emotionally they are still like children. If someone started using drugs when they were seventeen, and then they are in their 40’s, and all the way they are using drugs, emotionally they are like 17 years old. So you cannot tell me that a 17 year old can be a good guide to someone else with 20, 30 years an addict, because they neglected themselves! That’s the big difference” (personal interview).

This provider went on to tell of stories of people claiming to be providers but tricking people with placebos, robbing people, and providers using heroin or crack during treatments. Anybody can say they are a treatment provider, “and it’s a weird market, you don’t know who’s who. And junkies know how to lie” (personal interview). In order to overcome these considerations, this provider said a person interested in ibogaine has to contact many providers, tell them of their needs (i.e., addiction) and see how much the provider asks for in compensation. You will be able to distinguish a “good” provider from a “bad” provider.

The language this provider uses is very dichotomous: good/evil, positive/negative, single/multiple dimensions, and placing Iboga in opposition with biomedicine. This may have been done for my sake, to clarify in order for me to understand. Regardless, this provider suggests healing occurs as a restoration of dichotomous imbalances, through a cleansing of energies in the form of memories in order to arrive at truth. These dichotomies are also normative, framed in an ethical discourse. Below is a table outlining the dichotomous language of the provider:

<table>
<thead>
<tr>
<th>Language Utilized by Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conventional Medicine/Pharmaceutical Industry</strong></td>
</tr>
<tr>
<td>Evil</td>
</tr>
<tr>
<td>Symptoms/Diagnose/Medicine</td>
</tr>
<tr>
<td>One Dimension</td>
</tr>
<tr>
<td>Material</td>
</tr>
<tr>
<td>Negative Energy</td>
</tr>
<tr>
<td>Only Chemistry</td>
</tr>
<tr>
<td>Greed/Ego</td>
</tr>
</tbody>
</table>

Another cosmology presented in this study was that of psychotherapy. Many providers utilize ibogaine as part of a long-term psychoanalytic strategy. Ibogaine is
said to “allow someone to see their true self and to re-experience past events and repressed memories in a detached way without the emotional pain often associated with these memories” (www.ibeginagain.org/faqs.shtml). This statement not only assumes the existence of a reachable true self, but also that uncovering repressed memories is essential for healing.

This site then goes on to say that, “modern theories of dreaming often relate that dreams appear to be pseudo-sensory experiences that serve to diffuse the stresses resulting from unresolved emotional conflicts of the day before. In a similar way, it seems to be that ibogaine induces dreams that serve to try and reduces stresses whose origin is much earlier. Ibogaine visions frequently lend themselves well to the principles of dream analysis derived from Jung and others” (www.ibogaine.co.uk/ibogain6.htm#six). This website warns of using ibogaine as a “magic bullet” instead of undergoing therapy, suggesting it may seem attractive because it “avoids the formal behavior with the ego perspective relatively intact” (www.ibogaine.co.uk/ibogaine6.htm#six).

According to Kirmayer (2004), the notion of healing in psychotherapy is a corrective relationship of a psychological conflict or maladaptive learning (behavioral or cognitive) by “re-learning through exposure, and cognitive or behavior modification, and insight” (35). Ibogaine works here by bringing “repressed material to light—to make conscious what is unconscious” (www.ibogaine.co.uk). According to Lotsof, this is because “it allows a complete review by the individual of the issues they consider most important to themselves. We all know the questions we have to ask, and we all know the answers. And ibogaine precipitates that discussion” (Rite of Passage). The latter part of this statement also illustrates the empowering nature of ibogaine, whereby the person has the answers within, and not the doctor or psychoanalyst. Ibogaine is presented as a tool, with an understanding that psychoanalysis is the appropriate paradigm for framing and addressing problems.

The psychoanalytic cosmology differs from the West African cosmology where Iboga originates. As discussed in much of the literature, Iboga trips involve communication with spirits which are generally the source of maladies. These spirits are very real as they produce very real problems for people. However, the indigenization of Iboga into Western European, psychoanalytical contexts does not recognize spirits as the source of maladies, but instead the subconscious. The discourse used reflects psychoanalytic cosmology, such as “repressed material” and
“unconscious” and “conscious”. In accordance with this cosmology, the therapeutic settings, involvement with the provider, and treatments are very different from their African counterparts. Interestingly, both spirits and the subconscious are immaterial things, but both are very real forces people have to deal with. As such, the meaning of Ibogaine also changes.

The provider I spoke with who integrates ibogaine in to his psychoanalytic psychotherapy practice says that ibogaine therapy, “involves the use of the fast-acting insightful detoxifying effects of ibogaine with the long and slow acting conversation of psychoanalysis. It is individualized therapy, placing the subject at the center of the treatment” (provider unpublished document). He suggests combination of therapy differs from mainstream approaches to drug treatment because it focuses on the individual and not just the drug, which is “more personal than a uniform and objectified approach of most drug treatment programs” (provider unpublished document).

This provider spoke of utilizing his medical background to protect oneself, and the difficulty of using ibogaine under those auspices. While discussing the patient/doctor power structure, the provider said,

“Seeing that work with ibogaine on one hand had to be under this umbrella for me of medicalizing, yet at the same time I was going more in to psychotherapy and started training in that. And these two different modes of operating, someone comes to you as a patient to a doctor whose meant to give you something to make you better, and you don’t, and it’s hell. There’s a sort of power structure…that’s very difficult to maintain as a doctor…So you spend all your day trying to work out how to keep it as safe as possible, so that nothing bad will happen, so that no one can make any claim against you. At the same time you’re trying to offer the best possible treatment you can” (personal interview).

This provider’s statements show the difficulty of operating in a space between contexts, so-to-speak. In the absence of an established paradigm, providers are forced to make choices about how they explain and provide ibogaine. This also includes choosing to whom they provide. This is not to say it is impossible, but it certainly illustrates the challenges of operating within two—if not more—cosmologies, particularly when the dominant paradigm is skeptical of its use and a person can be held legally accountable for any problems.
4.5. Conclusion

Through the example of ibogaine, it is clear that the meaning of a medicine changes along with actors and their settings. Although none of the providers I met with is wholly informed by a single cosmology, through their discourse it was possible to see which logic primarily informs their practices. It also demonstrates the challenges associated with the indigenization of medicines informed by different cosmologies.

The multi-level perspective stresses meanings and transactions are inseparable. Ibogaine is a very interesting example of the “charm” of medicine because empowerment of the person undergoing treatment occurs through the experience of the relationship between the animated spirit of the medicine and the person. Even though the idea of a medicine’s spirit may seem very foreign in Western European contexts, it nevertheless seems to cross cultures by establishing individual relationships with the people it treats and providing healing in culturally-relevant symbols. It is through the psychoactive journey that a person experiences changes, which providers interpret according to their cosmologies. Although biomedicine does not yet recognize the healing properties of such an experience, many people attest to the meaning their experience provides.

The following chapter looks at the notion of efficacy, as presented by the providers interviewed, websites of other providers who offer treatments, and from the documentary. The cosmologies presented here continue to inform their notions of efficacy, which is expressed through their discourse of how ibogaine works, as well as through their definitions of issues they treat and the solutions they offer. It concludes with a political-economic discussion of efficacy in terms of pharmaceutical development.
Chapter 5:
The Efficacy Discourse: Cultural, Political and Economic Constructions of Ibogaine’s Effects

5.1. Introduction

Ibogaine providers offer treatments in spite of legal uncertainty or clinical validation. Generally they say they do so because of the radical changes it can make in a person’s life, changes they witness repeatedly, and which many people attest to. Thousands of anecdotal accounts of Ibogaine’s efficacy exist, yet these accounts are essentially irrelevant to its biomedical development. Clinical development has been an uphill battle, with “lost opportunities to confirm a positive benefit risk balance, during both preclinical and clinical developments as well as losses of financial supports” (Mačiulaitis et al 2008:181). Skepticism from governments and pharmaceutical lobbyists further challenge ibogaine’s medical development.

This chapter will look at the issue of efficacy, recognizing the hegemonic position of EBM and the role stigma of substance abusers play in hindering ibogaine’s development. It looks at how providers frame ibogaine in lieu of biomedical validation, and how this relates to their framing of the problems they address. A deeper discussion of addiction will demonstrate this point, along with the cultural distinction of acceptable drug use, using the example of methadone to illustrate this point. It concludes with a discussion of the political economy of ibogaine development.

5.2. How Ibogaine Works

To date, no one I spoke with nor any of the literature could exactly define the chemical mechanism of action. What is known is that ibogaine is that “the mechanism of action of ibogaine in the treatment of drug addiction appears to be distinct from other existing pharmacotherapeutic approaches” (Mačiulaitis et al 2008:181). There is a significant body of case studies and anecdotal reports supporting ibogaine’s efficacy in the treatment of substance addition disorders. Both human and non-human clinical trials have validated this. Although there are different theories, ibogaine “seems to hit
neuroreceptor reset and blocks opiate withdrawal cravings. Nothing else does” (Patrick Kroupa, Right of Passage).

All three of the providers I spoke with said ibogaine’s popularity is growing, and with it the number of providers offering treatments. The potential for unsafe conditions emerges, threatening the credibility of ibogaine all together. At the same time, clinical researchers continue to gather evidence of ibogaine’s efficacy. Dr. Glick admits, “It’s been a continuous battle for respect. Ibogaine has really become notorious because it didn’t originate in a lab, but in the counterculture” (Vastag 2002:3099). Moreover, Dr. Mash has admitted she is concerned her clinical efforts will be compromised because of the “burgeoning unsanctioned use.” She said, “We’ve got this explosion of underground clinics, and I’m scared that everything I work for is going to go right down the toilet” (Vastag 2002:3099). Dr. Frank Vocci, head of anti-addiction drug development at NIDA, said the underground use of ibogaine is “basically one big uncontrolled experiment” (Vastag 2002:3099). These clinicians’ statements, informed by the biomedical paradigm, demonstrate the status of scientific efficacy, the supremacy of EBM, and the recognized stigma associated with drug users.

In lieu of clinical language, many providers describe how ibogaine works in terms of three stages. First is a symbolic, visionary stage. The first stage is said to be characterized by the retrieval of memories, closed eye visual imagery, and a ‘waking dream’ state. Anecdotal reports suggest memories are “relived in a sense, primarily in a visual modality, but without the emotional weight they carried when the events occurred, allowing the individual to view them with greater insight” (Freedlander:Online). Lostsof (1995) characterized the experience as “as a movie run at high speed, or a slide show” (Online). These images “are easy to manipulate by both the subjects and the clinician, and therefore this phenomenon has been sighted as a potentially valuable tool in psychotherapy” (Naranjo, 1967, 1974; Freedlander: Online).

The second stage is a longer, reflective stage “filled with insight into one’s life and patterns”; and the third and final stage is a residual stimulation phase, where “ordinary consciousness returns even while the spirit of the journey continues to supply personal insight and opportunities for psychological integration. At the very ‘least’, addict who have taken ibogaine to test to its power to greatly diminish, if not completely dissolve, the
suffering of withdrawal, leaving them with the optimism that often accompanies deep cleansing” (www.ibeginagain.org/articles/spirit.shtml). These experiences and empirical evidence are what many providers offer as efficacy.

Below is a table summarizing the clinical pharmacodynamic effects in substance abuse treatment as outlined in the three stages:

**Figure 2: Table of Clinical Pharmacodynamic Effects in Substance Abuse Treatment**

<table>
<thead>
<tr>
<th>Opiate withdrawal</th>
<th>Reduction of drug craving</th>
<th>Reduction of drug withdrawal</th>
<th>Reduction of depression and drug craving (up to one month)</th>
<th>Reported cessation of drug use (up to more than 1 year)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal new experience</td>
<td><strong>Acute</strong> phase with &quot;onicoric&quot; experiences (onset: 1-3 h, duration: 4-8 h)</td>
<td><strong>Evaluator</strong> phase with &quot;neutral&quot; and &quot;reflective&quot; emotional tone (onset: 4-8 h, duration: 8-20 h)</td>
<td><strong>Residual Stimulation</strong> phase with return of normal allocation of attention (onset: 12-24 h, duration: 24-72 h)</td>
<td></td>
</tr>
</tbody>
</table>

* Reported cessation from the sample of 41 individuals: nine individuals were treated twice and one was treated three times for a total of 52 treatments. Fifteen (29%) of the treatments were reportedly followed by cessation drug use for less than 2 months, 15 (29%) for at least 2 months and less than 6 months, 7 (13%) for at least 6 months and less than one year, 10 (19%) for a period of greater than one year (8, 89, 93).

(Mačiulaitis et al 2008:190)

Many providers also use symbolic language to describe how ibogaine works. All healers utilize symbols in the forms of metaphors to describe how their methods work. For example, biomedical doctors often use the metaphor of a machine or of plumbing when describing the human body. One provider I spoke with used the following metaphor:

“I always take the example of the computer because people are busy with computers today. So you have a lot of files which are useless, you save them and really they are not functioning anymore, they are just blocking the space, taking space for nothing. So what the Iboga does is come in and pushes resent. And then all those files and all these things, like random, vision from this one and vision from that one… But you don’t know how it got into the memory of this person. And anyway it’s not functional anymore, so it goes away. And then something, when you finish so many days, you get space in your memory, in your databank, and you can fill it in with any information you want” (personal interview).
This provider uses symbols to describe the treatment of very real problems. Another provider at a clinic in Mexico said,

“Ibogaine is a doorway that you walk through and on the other side you’re clean, but the problem is when you get to the other side of the doorway, there’s a vacuum behind you. And that vacuum is trying to suck you back to addiction. So if you don’t get up and get moving away from the doorway, you’re going to get sucked back in to your addiction” (RK, Rite of Passage documentary).

Here again symbolic language is used to describe the healing process, which is understood as a process and not disease for which a single cure exists. In order for providers to frame how ibogaine works, they often spoke in terms of what they were treating. The following section looks at the language used to describe the issues they use ibogaine to treat, and how they define a “successful” treatment.

These descriptions demonstrate the usefulness of Young’s (1979) suggestion for symbolic and empirical along with scientific forms of efficacy. Both the empirical and scientific forms of efficacy are grounded in the phenomenological world, where science has the distinction of standardized structure of empirics. The high status and large infrastructure afforded to science give it more validity, but essentially it is still empirics. The symbolic world is a world of ideas, but it is also very strong and, as discussed by Kirmayer (2004), also can influence the world of things (i.e., through physiological changes). By utilizing the empirical and symbolic aspects of efficacy, providers demonstrate that scientific efficacy and they are better able to address the multiple levels of action where ibogaine works. Science is incapable of isolating those points, but the status of science is so great that it is able to discount ibogaine all together when the method does not work.

One person working at the University of Miami pointed out, “What exactly does it do? We don’t know. Of course that same answer can be applied to many of the things in the PDR [Physician’s Desk Reference] right now.” (Patrick Kroupa, Rite of Passage documentary). His comment speaks to the limitations of EBM. If clinical tests do not always guarantee efficacy and safety, the paradigm is not absolute or flawless. However, the hegemonic position of biomedicine is so strong that those flaws are rarely discussed. As such, it is able to hold other treatment modalities to a
standard that it does not itself adhere to. Clearly there are limitations to using lack of clinical evidence of efficacy as a viable objection to ibogaine’s development.

5.3. Defining Problems, Offering Solutions

Barnes (2005) and Kirmayer (2004) argue that healing systems frame problems according to the solutions they have to offer. Part of defining success involves how the problem is framed. Iboga is often put in relation to drug addiction, although the general discussion of symptoms and treatment can be applied to psychological disorders as well. One provider talked of the sadness and pain people carry with them, which may or may not be expressed or addressed through addiction, utilizing symbolic language to frame the problem. This provider said,

“I am convinced that all the misery in the world, all the sadness people carry, that is an invisible ribbon that is passed on from generation to generation, and this is how people carry problems with them. Often it is not conscious, maybe you become conscious of it with the help of Iboga, but many don’t even know what they carry inside of them. It’s the sadness that has been handed down from one generation to the next” (personal interview).

This provider went on to say that addiction is,

“Only one possibility of how you can spare yourself pain. There’s the classic story of being with the wrong people at the wrong time and then becoming addicted. But most of the time what happens is that many drug users use the drug as self-medication unconsciously, because this pain, they would otherwise maybe break because of the pain they carry within them, and they don’t want that, and then they help themselves through this way” (personal interview).

This statement considers addiction as a means of self-medication, where people seek medicine to mute their pain, regardless of social categorization. The distinction between legal and illegal medication is culturally constructed, leaving the determining factors to some outside force (i.e., governments, pharmaceutical companies, et cetera). Many Ibogaine treatment providers offer addiction interruption to prescription medications. This relates to Helman’s (2001) discussion of the normalization of drug use in Western society whereby the “chemical road to success” encourages the use of either legal or illegal chemical comforts to bring about mental, physical, social, sexual or economic “success”. According to Helman, self-medication
also includes removal of anxiety, guilt, worry, grief or anger. The ibogaine treatment allows a person to uncover and face the source of the pain instead of muting it with a chemical. As there are no addictive properties in ibogaine, providers and advocates are quick to state that ibogaine is not another attempt at muting pain, but a tool for healing.

Howard Lotsof spoke of “addiction syndrome”, with a treatment “literally turning an addict in to a non-addict over a two to three day period” (Rite of Passage). The word syndrome refers to “a group of symptoms which consistently occur together, or a condition characterized by a set of associated symptoms” (Oxford dictionary: online). According to this definition, addiction can be one symptom of many. In this way ibogaine is an important tool in addressing unconscious issues, which can manifest as part of the larger syndrome. The use of psychoanalytic work can be helpful in understanding how all of the issues relate, for example.

One provider discussed the notion of ibogaine addressing the symptom of addiction, saying, “I assume that this drug addiction is only one symptom, and it could also be psychological problems that people have (and there Iboga is just as effective…) People get a completely different attitude to life, and if in their heads the goal manifests itself to become clean one day, and they work towards it for many years because they have taken Iboga once, then they will also make it one day” (personal interview). Here ibogaine works by offering insight that change a person’s attitude towards himself, and empowering them to work towards a long-term goal. Thus establishing a direct cause-and-effect relationship between the treatment and the outcome is not possible, but the effects manifest over time to changes a person’s perception of himself and his place in the world.

Regarding addiction as a symptom differs from popular notions of addiction as an incurable disease, which necessitates a person identifying himself as “an addict” for the rest of his life. A person can never get away from their disease, but must learn to live with it and rise above it. None of the providers I spoke with saw addiction as a disease. The psychoanalyst I spoke further added that the problem with the disease model of addiction is a,

“High level of objectification, and a lack of space for the subject. There is a merging of the object of one’s desires (opiates) and the ideals of the institutions. There is no space in this for a subjective instead of objectified form of therapy. This can leave the addict feeling
alienated if they are not completely accepting of the ideal offered” (provider’s unpublished document).

All of these providers recognize the subject in the treatment, the person, whereby addiction is a symptom of something within a person, and not a disease attacking from the outside. The problem is framed in a way which ibogaine can address. The psychoanalyst provider said that substitution therapy, or Cognitive Behavioral Therapy (CBT), or “creating some sort of merging of object idealization in the form of a 12-step program” do not work for everyone. With treatments like CBT, he says you may be able to treat a symptom, but it is only part of it. He also says psychoanalysis and exploring cause or oneself has always thought to be difficult with addicts, “which it is if they are addicted, but I don’t think it’s impossible if they are not.” He goes on to explain,

“There is a big fear in stopping addiction. They’ve found something that fine tunes them so well, takes away any unease, any impossibility or any feeling overwhelming that they can’t handle or deal with. They have something just to keep them in a certain place, and it works really well. The problem is if they often start wanting to get out of that box they put them in. And it’s a very highly obsessional box. There’s no room for maneuvering and squeezes out life I the sense that you kind of end up dead, in a sense. It’s also a way to try to stop death, to put off the life process, the life and death process, to come to some static place” (personal interview).

Ibogaine helps a person accept the reality of death, making it real, and providing the “potential for an authentic being-towards-death instead of being bound by the death drive” (provider unpublished document). Ibogaine therapy helps the addicts enter in to an authentic life, where they realize the desire for complete satisfaction does not exist, so when treatment feels unsatisfying in comparison (which he suggests is a lifeless, death-like state), the person will be less likely to drop out of therapy. Through the ibogaine, the person is able to communicate with a symbolic Other, but in therapy the psychoanalyst acts as a sort of agent to the Other.

Howard Lotsof distinguished the Lotsof Procedure from conventional addiction treatment because,

“It stresses most is the level and nature of the rapport between the clinicians and the patient. As Lotsof (1994) describes, ‘… the sense of conflict seen in most treatment modalities between the doctor and
patient over the immediate ceasing of drug use does not exist’. Treatment is approached with a ‘pro-choice attitude’ by the caregivers, where abstinence is not demanded. Rather, the patient is allowed to continue using drugs until a certain time before the procedure, based on the amount of time needed for the given drug to clear the body. The position of the treatment team is ‘that ibogaine will either work to interrupt chemical dependence or it will not’ (Freedlander: Online).

Moreover, the symptom-free window of opportunity provided by a treatment leaves a person in a “receptive psychological state earlier in the course of therapy…therefore they will require faster intervention to learn societal skills and to overcome and objectively understand various traumas experienced during their lives” (Lotsof, 1994, quoted in Freedlander: online). This statement also includes the subject in terms of assessing “explainable” changes in themselves, and working with them.

One woman who used ibogaine to overcome crack, heroin and alcohol addictions gave the following testimonial, which speaks to the difference in treatment paradigms:

“There’s a lot more to the story than people are learning at treatment centers and at 12 step meetings. And there’s nothing wrong with those institutions, but their message is that drug addicts have a disease, they’re going to have it for the rest of their lives, and there’s only one approach to healing that disease, which is going to these meetings and doing the 12 steps. And I certainly think those things are helpful, but they never get you past the place where you’re identified as a person which a sickness that sort of always has to be a consideration in your life. And, I feel like ibogaine has introduced me to this whole parallel universe of realizing that my mind is not all there is. And, while my drug problem was very real, it doesn’t have to ever happen again because I can choose for it to not happen again” (Rite of Passage documentary).

Ibogaine is distinct from current pharmacological treatments for substance abuse. According to the literature I reviewed, current pharmacological treatments generally fall in to two categories: replacement therapy and aversion therapy. Replacement therapy theoretically replaces the drug of abuse with a safer one, although they can be just as addictive. Methadone is an example of replacement therapy, and is often used to reduce the risk or harm associated with injecting equipment (such as contracting Hepatitis C and HIV). Aversion therapy is the use of drugs that interact with the drug of abuse and cause unpleasant side effects, and as such “often show high incidences of patient-non-compliance, and subsequent relapse”
Whereas both of these treatments are long-term strategies, ibogaine differs in that it is a short, intense intervention and is not addictive in itself.

Although methadone has helped many people, it is nevertheless highly addictive and hard on the body. Ibogaine is often used in the treatment of methadone addictions. One provider said, “Methadone is a terrible drug. Drug addicts somehow are happy to have it anyway, because they have something. Better than nothing. On the other hand it’s better to have nothing because you quit” (personal interview). Lotsof himself entered a methadone maintenance program in 1973, which he considered life saving. However, “the system of administering methadone was becoming more restrictive to patient life styles,’ and so with the knowledge he had gained from his experiences with ibogaine, Lotsof endeavored to wean himself off methadone” (Freedlander: Online). These restrictions were what Bourgois (2000) documented, which he argued were overlooked in favor of biomedical discourse and dosage considerations only.

One provider said, “There are many doctors who don’t even know about Iboga, and that will probably just stay like that. It’s known there have been deaths so then it’s considered dangerous, but it’s not of interest how many people die of methadone every year. That is unimportant” (personal interview). The hundreds of people who have used ibogaine to overcome methadone are the first to stress the benefits of ibogaine, but opinions of addicts are generally irrelevant to the policy decision-making process.

Different literature says ibogaine can “reverse” or “interrupt addiction” while facilitating “a painless detox period for drug addicts”, to remove “the effects of conditioning in addicts” (Rite of Passage documentary). It is also said “that ibogaine is not a magic bullet, it’s not a cure for addiction, it’s an addiction interrupter. It gives people a chance they would not have otherwise. I like to say ibogaine is a catalyst for change” (Randy Hencken, Rite of Passage documentary). For these providers and advocates, the word “cure” was never used to describe what ibogaine does. Patrick Kroupa, who himself used ibogaine to overcome heroin addiction, said, “Cure is a strange word. Cure implies something outside of yourself will completely rewire you. It will not. You are still whoever you are…The question is, what are you other than drug dependent?” (Rite of Passage). One provider said,
“Cure is for meat.” Addiction can be seen as a symptom of something greater, “so ‘curing’ or success in drug treatment, what are you talking about, they’re not using the drug? Yet they’re doing something else, or their life is crap, they’re howling at the moon, beating up their partner. I don’t know. But it’s a bit hard to measure what success is and what cure is. I think life is an ongoing problem that cure is maybe for physical illness, and even then it’s debatable what cure is” (personal interview).

These statements highlights the healing/curing distinction discussed in Medical Anthropology, where a person may be “cured” of symptoms but still require healing on a different level. It also relates to the discussion of when to measure success. This provider states that curing is often referenced in terms of physical or biological symptoms, and even then it may be an inadequate assessment. Healing in this sense refers to the “broader psychosocial processes of repairing the affective, social, and spiritual dimensions of ill health or illness” (Waldram 2006:604). This also shows how problems are framed according to the solutions they have to offer. When addiction is defined as a symptom, healing on a broader level takes place; if addiction were considered a disease, only the physical changes might be considered, and in that light providers might be inclined to speak in terms of curing.

This discussion also illustrates Waldram’s (2006) discussion of proximate and ultimate goals. When a person experiences ibogaine, the healing happens both proximately and ultimately. Ultimate effects may occur at a later date which cannot necessarily be attributed directly to the ibogaine treatment and which are individual to each person, but providers recognize it continues to work for a person for several weeks following a treatment. Healing is processual, and as discussed by Barnes (2005), the issue becomes when to measure the “success” or “failure” of a treatment. The ibogaine treatment may be part of a processual healing where a person seeks “ultimate healing”. Thus clinical tests which seek direct, verifiable cause-and-effect proofs are incompatible measures of ibogaine’s efficacy. Moreover, the inclusion of the patient in determining when and where changes occur is also lacking in clinical measures of efficacy.

Providers stressed the importance of the intention of the person undergoing treatment in order for a treatment to work. One provider stated plainly, “Ok not everyone is coming clean, because not everyone is having the right intention to start with. They do it to say to other people, ‘See, I’ve tried. Nothing works for me.’ And
some people say, ‘I don’t want to be dumb again, I know what it does, it’s not really interesting anymore’” (personal interview). Another provider said,

“I think Iboga is a great help for humanity, on the other hand I think it doesn’t help everyone. There are people who feel the Iboga trip, they realize it, they see it, but afterwards they close their eyes to it because problems are really dealt with. Others open themselves to what they are experiencing and are so thankful for it…” (Personal interview).

These statements reflect the importance of intention, and with it the empowering principle of ibogaine, as a person is empowered to through their choice. It also reflects the uniqueness of ibogaine, whereby a window of peace, clarity and absence of symptoms provide a person with a great opportunity to change.

All of the providers I spoke with provide ibogaine because of the satisfaction they receive from the results. For example, “There’s something really good in this, and when you see it work with people, a day later they can’t quite believe they’re not craving smack, and they feel good. It’s a very difficult thing to not want to provide for people” (personal interview). Another provider said, “If this is what’s going to help people, I’m gonna do it” (personal interview). The third provider said, “When they call me two to three days later and say with pride, ‘I’ve been clean for three days,’ and I am happy for them. Of course I have met many people through Iboga, people who are standing at the edge of society, but have such lovely souls and are extremely friendly. I find that beautiful, that especially those people who are often forgotten carry so much warmth inside. And that gives you a nice feeling of course” (personal interview).

These providers frame how ibogaine works outside of clinical language, and accept the empirical results they witness as proof for ibogaine’s efficacy. They include the patient’s perspective in assessing efficacy. It also shows that clinicians may be looking for indicators which differ from those being sought by the patient and client. Because these treatments occur outside of legally approved clinical laboratories, the results are not considered valid. The next section discusses providers’ view of pharmaceutical industry resistance to ibogaine, and the implications this may have for the future of ibogaine.
5.4. Pharmaceutical Development

Providers accept that ibogaine is an effective treatment option. All providers and literature reviewed believe the pharmaceutical industry will continue to block its development for economic, political and moral reasons. Because ibogaine is not a maintenance drug, there is no profit incentive for private companies to invest in its development. Because drug users are stigmatized, the development of an addiction treatment medication could reflect poorly on the companies which develop it. Many political bodies also consider the moral component of drug use, preferring policies which punish drug users instead of appearing to cater to weak behavior. Furthermore, political figures and organizations are often tied to powerful economic interests, further blocking the development of competing treatment options.

Howard Lotsof plainly summarized the politico-economic logic of the pharmaceutical industry: “The pharmaceutical industry is not there to develop medication to cure disease. It’s there to develop medication to increase the profits of shareholders” (Rite of Passage documentary). Lotsof’s company, NDA International, attempted to work with several pharmaceutical companies (such as Lilly and Dupont), as well as other smaller companies. He received similar response from all of them:

“The first issue was the fatality rate in the population in drug users. Drug users are dying at a rate of three to seven times the rate of the normal population, which means that the associated with the companies is that much grater so immediately there is a deficit of liability to the development of drugs to treat that disorder. Also I was reminded that the companies have to spend their money in the best way to demonstrate profits to their shareholders, not in their best way to treat various diseases. Additionally, the companies did not wish to get involved with the treatment of drug addiction because of the stigma associated with the field. You would think if a company developed a cure for addiction it would be very good for them, but the stigma is so great that even to provide effective medication in that field is viewed as problematical by the companies” (Rite of Passage documentary).

Lotsof’s comments speak not only to the lack of profit incentive and obligation to the shareholders, but to the moral judgments associated with stigma. The Neoliberal market economy rewards this thinking. The issue of stigma can go unaddressed and is fairly excusable in the mainstream. Government policies (particularly the US) generally mirror the position of large corporations whose lobbyists actively influence political will. It highlights how the drug policies of the U.S. (which many other countries mirror) are characterized by the Protestant ethic.
linked with the rise of capitalism. Drug use is seen a morally bankrupt practice, and despite the potential to create a viable treatment option, the stigma is too great. In this way, health policies do seem to resemble missionary work than public policy.

Moreover, clinicians and pharmaceutical companies seem to dislike the waking visions ibogaine produces. While discussing the pharmaceutical development of ibogaine, one provider talked of attempts to isolate the chemical properties and remove the “psychedelic effect”. That “is what the pharmaceutical industry doesn’t want, but I think that exactly this visionary stuff, these psychedelic pictures if you like, are the reason for why Iboga can help so well” (personal interview). Dr. Glick, who is working to isolate the derivative, along with Dr. Voci at NIDA, see this as the only hope of getting ibogaine into the market as a therapeutic drug. Both also recognize ibogaine’s “social history” is a concern for the US FDA (Voltag 2002:3101). This also demonstrates how informing cosmologies change the meaning of ibogaine. Biomedically informed clinicians see the visions as unnecessary, but other providers, informed by different cosmologies, see them as essential.

Ibogaine development also threatens profits of existing replacement therapies, such as methadone. They are able to utilize biomedical discourse to further their economic agenda. The “addiction-as-disease” model dominates biomedical discourse in terms of methadone, which is considered medication, but as a maintenance drug guarantees long-term profits for the companies that produce it. It is also why one provider said, “the pharma industry is a real bunch of bandits for me sometimes, really. That’s how I see it” (personal interview). By pushing for clinical efficacy of ibogaine, we see how power permeates truth and knowledge. Furthermore, as already discussed, not all of the synthetic medications produced adhere to these clinical standards of efficacy, but are marketed anyway.

In November 2009 the government of New Zealand supported classifying ibogaine as a prescription drug for the treatment of opiate addictions on the grounds that it is less harmful than methadone (http://www.medsafe.govt.nz/Profs/class/mccMin03Nov2009.htm). New Zealand is the first to integrate ibogaine into law based on clinical evidence. Indeed it is a landmark achievement for advocates. The majority of other Western governments maintain a lack of “scientific rigor” as their reasoning. Perhaps this is an example of lawmakers and clinicians considering “what combination of drugs, laws and
medical/health discourses might produce less social suffering on the street” (Bourgois 2000:188).

Despite the increasing global awareness and interest in ibogaine, many advocates admit that it is unlikely ibogaine will ever be developed as a viable option for drug dependence or as a tool in psychotherapy. As one researcher said, “I see a few very small sort of aborted efforts that haven’t gone anywhere. Unfortunately I think ibogaine will simply continue to exist, expand and grow as the awareness of it grows so people who are in a position who need it at least know that it’s out there. And if you know that it’s out there you have the opportunity to make choices and get however it is you do so” (Rite of Passage documentary).

5.5. Conclusion

Clinical efficacy is the only acceptable means for establishing mainstream efficacy. Despite laboratory work to establish this, as of yet no exact mechanism of action has been determined. The experience of the Iboga journey is very much part of the healing process, and is included in providers’ constructions of how ibogaine works. The manipulation of symbols is a very important part of the healing process, which is why symbolic aspects of efficacy are so important. In the absence of clinical proofs, empirical proofs are offered. Clinicians working to validate ibogaine are weary of these accounts, for safety issues but also for the credibility of their work. This further shows how the meaning of ibogaine changes with actors informed by different cosmologies—whether biomedical, psychoanalytic, New Age, or another.

These cosmologies also inform how the providers frame the problems they address. As none of them considered addiction a disease for which there is a cure, so too did none of them frame ibogaine as a cure for addiction. Instead the journey ibogaine takes a person on allows them to explore the root of their problems, of which addiction is a symptom that ibogaine addresses chemically as well as symbolically. The person undergoing treatment is the subject of healing, not the disease or addiction. This also explains why the intention of the person is always stressed, because they are actively involved in the healing process.

If addiction is a disease, then it can be medicated, but here we have seen through the example of methadone how power can permeate knowledge so as to secure economic interests. Ibogaine potentially threatens this power, not only financially but also paradigmatically. But if a Western country like New Zealand is
taking the bold stance that ibogaine can also be a government sanctioned therapeutic tool, despite the lack of pharmacological “proof”, then perhaps there is room for a third type of pharmacological method of treating addiction.

So long as providers believe they are helping people, and people believe they are being helped, then it is likely the availability of underground treatments will continue to grow. As one provider said to me, “Why I do this is just the reason that I am convinced that this plant, or rather this root, can really help many people and has already helped. Iboga doesn’t have to provide any proof anymore. They have been provided a long time ago” (personal interview).

The next chapter looks at how providers frame risk, also informed by their cosmologies and expressed through their discourse. It discusses what is at stake for each of the providers interviewed, and how this may influence notions of risk.
Chapter 6:  
The Risk Discourse: Safety, Medicalization, and Implications

6.1. Introduction

Increasing anecdotal evidence of Ibogaine’s effectiveness is said to be responsible for increased awareness and availability of ibogaine. The issue of risk presented itself early on in this study of Ibogaine. Safety is always a concern, although the perceived level of risk may vary among providers. With increased information comes differing opinions, and in the absence of regulated standards—whether biomedical or other—comes the potential for misinformation. The question becomes whose information is correct, and according to what values.

Several websites discuss basic safety considerations of taking Ibogaine. The primary consideration listed is often ensuring the proper dosage and avoiding simultaneous use of opiates, which all of the providers I interviewed also said. Some websites warn that Ibogaine is an inherently risky and as such, assistance from an experienced provider with medical safeguards in a clinical setting is highly recommended. However, others say Ibogaine is not risky if you know how to dose properly and ensure a person is not mixing any substances during their treatment.

Some websites stress the importance of “proper clinical testing of heart and liver function” before taking Ibogaine (www.Ibogaine.co.uk/Ibogaine6.htm#six). Other sites also recommend a psychiatric review beforehand, further recommending that a person be involved in proper therapy “where there’s an open admission by the individual of the presence of emotional issues” to make sure that “Ibogaine doesn’t make things worse” (www.Ibogaine.co.uk/Ibogaine6.htm#six).

Clinical tests have shown that Ibogaine is safe in animals, enough to warrant the approval of Phase 1 and 2 clinical trials. This chapter will explore the language used in the construction and nullification of risk and safety, drawing on websites, materials for providers available on several websites, the documentary, and interviews with providers. It will also include a discussion of what is at stake for the providers, how this is expressed in their language and their practices, including their construction of risk.
6.2. Safety

According to the materials reviewed and providers interviewed, the two most important safety concerns with Ibogaine are determining the correct dosage and making sure a person is not mixing Ibogaine with any other substance (i.e., opiates). Materials exist which give a weight ratio for determining dosage according to the reason for treatment (less for spiritual, more for addictions). All of the providers said determining dosage also involves a feeling or intuition about what the person needs. One provider said,

“When I see the person in front of me I can always tell pretty well, ‘This dosage will work well’, and most of the time, I’m right. If I am not right I still have the possibility through Ibogaine to add another dosage within a few hours. There is a specific border I cannot cross, because then it becomes dangerous, I am aware of that” (personal interview).

Howard Lotsof developed a providers’ manual, which includes “inclusion and exclusion criteria, Ibogaine regimen and doses, and considerations for post-treatment care. A naïve physician would likely accept it as a standard medical protocol” (Voltag 2002:3100). The presence and open availability of a safety manual suggests some attempt to mitigate risk. He said that it was “intended for lay-healers who have little or no medical experience, but who are nevertheless concerned with patient safety and the outcome of Ibogaine treatments” (Voltag 2002:3100). Presumably this was put in place in the absence of an official professional body which might provide standardized training and administering guidelines along with some sort of regulatory structure. Without such a regulatory body, providers must depend on their network and experience to dose properly. This attempt at standardization is the closest thing to written regulations on the web.

None of the providers I spoke with talked of using the manual. One provider suggested they are rules for the sake of rules, and are in place to reinforce the fear associated with Ibogaine and a marketing tool to attract people to their medically-oriented clinics. Instead providers utilize their experience and websites of other providers, along with their own personal network to share information.

According to several sources, at least 12 people have died in connection with Ibogaine, but this number may be higher as many treatments go unrecorded. One website guesstimated “a ballpark figure for deaths during treatment is probably of the order of 1 in 300” (www.Ibogaine.co.uk). These deaths are often attributed to
combined use of opiates during and shortly after an Ibogaine treatment and pre-existing heart problems which cannot be detected by an EKG (www.Ibogaine.co.uk). These deaths are often sited when providers and advocates say ibogaine is inherently risky.

6.3. The Construction of Risk

Ibogaine was presented as either inherently risky, safe so long as the provider knows what they are doing, and not risky at all. When this risk is presented, it is recommended that a person undergo treatment a in a clinical setting with medical (heart) monitoring so as to ensure constant safe supervision.

One website says, “While Ibogaine may represent a major medical breakthrough, there is an inherent level of risk with Ibogaine treatment. Ingesting too much of the substance, being excessively thin, or suffering from liver or heart problems are dangers associated with this type of treatment.” They recommend gathering advice from many providers, and state that “any treatment provided by an experienced and knowledgeable Ibogaine therapist will include a medical and psychiatric review for the patient’s safety” (www.ibogaine.co.uk).

In the documentary “Rite of Passage”, the Program Coordinator for a treatment clinic in Mexico, said the following:

“Ibogaine administration needs to be done in a safe situation. Ibogaine is not inherently safe as people have found out time and time again, and for us the two most important things are the safety and the comfort of the patient…So we try to administer our Ibogaine in a safe situation. We use a hospital, we put our patients on a heart monitor, we have nurses and people available with emergency plans.”

By labeling Ibogaine inherently risky, it suggests a need for a qualified person or group with the capacity to nullify that risk. It speaks to the notion of “experts” whereby a person with certain qualifications is acceptable but one without is not. One provider recognized that despite the hundreds of people he or she treated, he or she recognized that because he or she lacks a PhD, “what I say is not taken seriously until other people come out and say, ‘Hey, it worked for me’” (personal interview). The question becomes who decides which qualifications are best, and what benefits a person receives for aligning themselves with that institution.
The words “medical”, “clinical” or “scientific” were often used to convey safety on websites that stress the importance of medical monitoring during Ibogaine treatments. For example, “studies taken by leading research and academic facilities have shown that Ibogaine is invaluable in treating physical dependency and the associated withdrawal symptoms of heroin, methadone, and prescription opiates. It alleviates 90% of opiate withdrawal symptoms and can address cravings for two to six months” (Awakening the Dream House: online). However, with this and similar references to clinical studies, there is no reference to the actual studies or information on how these figures were established.

By aligning themselves with a biomedical model, this type of provider also attempts to show drug regulators that Ibogaine can be a viable, medical treatment option. It draws on the status and authority of the biomedical paradigm to bolster the reliability of Ibogaine. The use of medical equipment also draws on this power, aligning the providers with modern, technological knowledge. While this advice could protect people from utilizing charlatans, it also serves to dissuade people from using experienced providers who do not see the need for medical monitoring or testing. Moreover it serves as a marketing tool, for someone coming from a Western, biomedically-dominant society will likely find comfort in the presence of medical equipment.

A second type of provider are those who offer treatments outside of a clinical setting, for example in a home or office, and suggest people get heart and/or liver tests beforehand. They likely have emergency medical equipment on site. Two of the providers I spoke with have a defibrillator, though neither of them have or ever expect to have to use it. These providers do not consider Ibogaine to be inherently risky, but recognize things can go wrong if the clients have not been entirely truthful with them about the test results or conditions, or should anything else go wrong. They inform the person of the risks associated with Ibogaine. They also recognize these measures aid in legal protection, demonstrating if necessary that they were as responsible as they could be, according to biomedical protocol. As one provider said to me, “Often we communicate for several weeks from the moment they contact me to when they are finally with me…we exchange ideas and some of them ask very explicit questions…and I enlighten them as much as I can beforehand about the risks and what can happen in terms of dangers. Ibogaine is not a children’s toy, definitely not” (personal interview).
One of these providers said,

“And there you are, giving something really quite harmless and safe, and monitoring them this whole time, to the point where I ended up buying a defibrillator and a patient monitor like you find in the hospital because I was absolutely paranoid about anything bad happening. And they were all good things to have, to show I was doing good clinical practice” (personal interview).

At the same time, this provider recognized that he or she could also be blamed for overmedicalizing Ibogaine, so “it’s an impossible situation” (personal interview).

Putting the notion of inherent risk into context, one provider pointed out that psychiatrists are prescribing medicine all the time with side different side effects that they likely don’t fully disclose. Some drugs “are horrendous, life threatening, but you don’t tell them that, and I don’t’ get you to sign something to say you’re taking this at your own risk. You send them out the door and say take it at home and good luck” (personal interview). Many drugs that have been cleared as safe by regulatory bodies have been done so without full understanding of their mechanisms of action, and yet the risk associated with these medications is considered safe because regulatory bodies have weighed the concerns and approved them for consumption. Rarely though does anyone know what goes on behind the scenes of a clinical study or the political economy of approving a medicine. The faith in biomedicine and the legal framework that supports it is so strong that side effects are considered tolerable and safe.

A third type of provider sees no risk with Ibogaine and thinks the idea of medical equipment unnecessary. One provider I spoke with felt this way, suggesting that so long as you know how to dose properly, there is nothing to worry about. Of course, this was said under the assumption that the way he or she provides treatments is safe and correct. This provider felt other providers “make a whole scare thing around it so people will be afraid to take it” (personal interview).

The major reason this provider felt it was safe was because Ibogaine is naturally occurring. This provider does not take an EKG from everyone or have medical response equipment on site, “because Ibogaine is not a killing plant. You don’t take an EKG when you do mushrooms do you? So why do you do it when you take Ibogaine? They don’t do it in the jungle, when they take Ibogaine” (personal interview). This provider borrows from the legitimacy of the traditional or the origin of Iboga, and is the same provider who informed by the notion of energy, balance.
The idea that natural is inherently better or safer than synthetic medicines is one of the reasons often cited for people choosing TCAM therapies. All of the providers admit that Ibogaine can be dangerous if the dose is administered incorrectly or in combination with other drugs. This of course is true with many substances. As one provider said, “I was apprehensive in the beginning, but I knew the dosage makes the poison, that is always like this everywhere. I informed myself for a long time in advance” (personal interview). This provider operates knowing that just because something is naturally occurring substance, too much of it can be harmful. This provider also said, “I think when people say, ‘it’s better for me to have a doctor for the Iboga trip’, I say it’s ok, but the natural thing of Ibogaine, you see in Gabon, it’s not a doctor, it’s a shaman. I know Ibogaine and I have the Ibogaine feeling and I know what this root can do, so I say I don’t need a doctor” (personal interview).

One provider was further adamant that the presence of a manual or an international federation of providers will not guarantee safety, as there is nothing enforcing people to follow those standards and nothing for them to do if something does in fact happen. Generally speaking, protocols serve as a safety net. If a person can show they followed protocol properly, they may not be held responsible if problems arise. This statement by the provider further demonstrates the position that Ibogaine itself is not risky, but the person responsible for administering it may be unsafe and therefore a person should exercise extreme caution when selecting a provider. Moreover, the person undergoing treatment is also responsible for their safety, to not mix Ibogaine with other substances. To this provider, medical equipment or training does not guarantee safety, but what does is an experienced provider with honest intentions.

6.4. What is at stake?

Although all three of the provider I spoke with are professional providers (in that they charge money for the treatments), they differed on the degree to which Ibogaine contributed to their livelihood strategies. It is the sole source of income for one provider; another integrates it in to a larger psychoanalytic practice; and another has a career entirely outside of Ibogaine. Nevertheless, each had something at stake by providing Ibogaine. The first provider made it very clear that income was most at stake. Agreements with government and tax authorities allows this provider to circumvent tax and legal restrictions, a sort of “don’t ask, don’t tell” policy. This
provider also felt somewhat threatened, for financial reasons and not reputation reasons, by other providers establishing themselves too close to where his or her practice is established. Presumably this is why much of the language of this conversation was centered on validating his or her practice as the best. This provider also said ibogaine is not risky, which also suggests the possibility that the medical integration of ibogaine could threaten his or her livelihood. This may also be why this provider twice stated the lack of professional credentials or a PhD is why he or she is not always taken seriously. Reputation is everything, so it is in his or her best interest to be honest and provide the best treatments possible.

A second provider spoke mostly of his medical license at stake. Of course the loss of his medical license would lead to a loss of livelihood. In the absence of established Ibogaine protocol biomedical protocol is used. Medical doctors are held accountable to this protocol, which means his medical license could be revoked if the doctor does not demonstrate “best practice”. A person’s expectations of safety and medical regulation put the burden of responsibility on the doctor, and not on the person undergoing treatment—even if they sign a waiver stating they understand the risks associated with an Ibogaine treatment. But he was also critical of EBM methods, and his practice seemed caught between his own understanding of risk and dissatisfaction with having to take measures to appease legal regulations that come with the responsibility of being a doctor.

A third provider with another career outside of Ibogaine said that he or she would continue to provide it so long as it helped people, but didn’t see doing it forever. It was not a fundamental source of income, but the one thing this provider worried about was the legality of the practice. To circumvent the illegality of Ibogaine, this provider offers “Ibogaine initiations” instead of “treatments”, but admits that it is likely only a matter of time before the legal system cracks down on the providers of Ibogaine in that country. The interests of his or her family were of principle importance to this provider. This provider took measures such as having emergency medical equipment on site, as well as having people sign liability waivers, but admitted that were something ever to happen, neither of those would likely protect them from the law. This provider trusted the spirit of Iboga would take care to ensure the family’s safety.

It could also be said that clinics, as presented in the documentary and websites, show the acceptance or medical development of Ibogaine as an issue at
stake. These providers and advocates align themselves with medical establishments, and being seen as non-medical could potentially threaten their acceptance as a viable medical tool (and potentially be shut down). Livelihood could also be a consideration for these practitioners, particularly if they stand to gain anything from pharmaceutical development.

6.5. Conclusion

Issues of safety and risk regarding Ibogaine clearly are not absolute. All providers I spoke with agree there is a potential for danger if care is not exercised. The issue becomes who according to which values determine “experienced” and “knowledgeable”, particularly in an environment lacking consensus. Advocates working towards the medical acceptance of Ibogaine emphasize the need for medical safeguards, borrowing from the safety of medicalization and attempting to legitimize themselves that way. They suggest only reputable providers offer treatments this way. Other providers may recognize a certain level of risk but do not consider Ibogaine to be inherently risky. Rather, it is the provider who is responsible for the risk and subsequent safety measures by determining the dose and screening the person they treat. Some go further, suggesting that because it is natural, it is safe, borrowing from the traditional application of Iboga for legitimacy.

Risk may be constructed differently for different reasons, influenced by interests (what is at stake) and cosmologies. In the absence of internationally agreed upon protocols, the defining qualities of an “expert” ibogaine provider varies, despite Lotsof and colleagues’ attempts to standardize (and legitimize) risk and safety protocol. It is interesting that the notion of expert is often discussed in terms of ability to mitigate risk, further illustrating the need for the ibogaine movement to validate itself within the biomedical community. It is also interesting that the same biomedical paradigm allows for drugs that are quite risky (i.e., may cause death) and yet they pass to the market freely.

It seems the most vocal providers and advocates are doing their best to work within the biomedical paradigm to develop ibogaine. Concerns about “overmedicalizing” ibogaine indicate that it can only be indigenized so far. Perhaps medical equipment and safeguards alongside clinical efficacy are all it would take to establish legitimacy. Ultimately it remains to be seen just how far moral and
economic interests can go to impede ibogaine’s development. So long as people continue to fund research, the movement will likely continue, however slow.

Chapter 7:
Conclusion and Discussion

7.1. Introduction
The purpose of this study was to explore how the meanings and transactions of medicine vary, through the example of ibogaine. Although not the primary interest of this research, clearly meanings and transactions change when ibogaine is reworked into a medicine for treating addiction or as a tool in psychotherapy in the West. Within Western European contexts, we have seen how the meanings and transactions can change within the providers. It also investigated meaning through the construction of efficacy and risk by analyzing the discourse of the different actors involved. This included a disentanglement of social categorizations and assumptions related to medicines, drugs, addiction and treatment, which includes discussions of power. It sought to do this through an analysis of the horizontal and vertical linkages between the different “levels” of social organization, with the provider as the primary focus. This analysis provided the space for power struggles to surface, to see how the meanings change according to different actors, and how hegemonic notions of meaning are integrated and challenged.

The research questions used to reach this objective were:

What are the meanings and transactions that define Ibogaine from the perspective of providers in Western European contexts?

The main question is divided into the following sub questions:

- What cosmology informs the Ibogaine treatments, and how do providers frame ibogaine to clients?
- Do advocates inherently accept the need for modern pharmacology to support the acceptance of Ibogaine?
- How do the providers construct and address risk?
o What is at stake for the providers, including legal, livelihood and self-image considerations?

7.2. Discussion

Ibogaine is clearly a distinct medicine. Without scientific explanations of the exact chemical mechanism(s) of action, it is lost somewhere in the gray zone between medicine and drug. Through the empirical data and the theoretical concepts utilized, I have shown that the biomedical cosmology alone is inadequate to explain how and why ibogaine works. Each of the three providers framed ibogaine differently, according to their informing cosmology, although their framing of problems and solutions did overlap at times. Not all providers accept the need for modern pharmacology to explain the effects of ibogaine, or to promote the acceptance of ibogaine. Perhaps ibogaine’s distinctiveness is threatening not only for economic reasons, but also for paradigmatic reasons. If something cannot conform to hegemonic standards, it is natural for the hegemony to discount its credibility all together.

But perhaps ibogaine has something paradigmatic to offer instead. The application of Young’s (1979) three aspects of medical effectiveness better suits a medicine like ibogaine, where more is needed to understand it and as such we gain a better understanding. Perhaps this can be applied to other medicines as well. What biomedicine calls efficacy is just one aspect of evidence. Both empirical and scientific aspects are grounded in the world of material, the difference being that scientific evidence includes a structured method of data collecting, processing and reporting that comes with a very high status. The latter part is particularly relevant to ibogaine, when empirical evidence is partially gathered by a highly stigmatized group. The symbolic explanations are everything that people use to convey meaning. This study uncovered New Age or psychoanalytic cosmologies also provide explanations of how ibogaine works, whether by restoring balance or by making the unconscious conscious. A final reason why these aspects of effectiveness should be considered is that they are the patient’s perspective, something many critics argue is lacking from scientific measures of efficacy.

Ibogaine is often discussed in terms of addiction, which I mainly focused on in this study. Providers never framed addiction as an incurable disease, but instead see it as a symptom of a greater problem, whether an imbalance or repressed memories, for example. Thus they never framed the effects of ibogaine as “curing” any problems,
but instead healing, restoring balance, or providing insight into deeper issues or recovering repressed memories. This study has also shown that ibogaine doesn’t always work and is not always safe. All three providers agreed some risk exists with ibogaine, but it is related to the dose and making sure a person is in the right place to undergo a treatment (i.e., in early withdrawal, not suffering from severe psychiatric issues). But the same can be said of many synthetic pharmaceuticals, suggesting the “gold standard” of EBM does not always live up to its title. Thus it seems invalid to hold ibogaine to a standard that biomedicine does not always hold itself to.

There is indeed a lack of interest and financial capital on the part of pharmaceutical companies to develop ibogaine. Providers and advocates agree that the Neoliberal, capitalist (profit-driven) paradigm, informed by EBM which in turn informs lawmakers and secures the market for interests of pharmaceutical companies, will inhibit the mainstream integration of ibogaine as a treatment option. This study used the example of methadone to illustrate the inconsistency of a drug treatment option produced under this paradigm. Although the use of methadone reduces harm in terms of social and associated health risks, the drug itself is very harmful on the body. Many people utilize ibogaine to overcome methadone addictions.

Bourgois (2000) discussed how in the 1970s, methadone went from being a “drug” to a “medicine” under the direction of pharmaceutical development supported by the addiction-as-disease model, allowing for biomedical discourse to dominate political and legal methadone discussions. He further discussed how addicts are at the mercy of the state in terms of how and when their medicine is dispensed, although dosage levels and mechanisms of action are discussed and not the structural violence against addicts. By continuing to label ibogaine an illicit, deviant substance, the state (encouraged by pharmaceutical lobbyists) is able to utilize the biomedical discourse of efficacy and risk under the direction of clinical “experts” to inhibit the development of ibogaine as a medical tool. I also suggested that addicts who utilize ibogaine in spite of legal restrictions exercise agency against the structural violence, regaining some power by refusing to submit to the discourse and directive of the dominant interests.

Through the discussion of the role of the provider, this study showed that the locus of power for healing is not with the provider, but through the experience of the relationship between the Iboga and the person undergoing treatment. The intention of the person is essential in order to make the most of the relationship, to choose what
they will make of the symbolic journey. The provider is important because he or she not only makes the Iboga available, but also because of the care-taking and support role they play throughout the lengthy treatment process. However, it is the animated spirit of the Iboga which people attribute the healing power to.

This example puts an interesting twist on the theoretical concepts of pharmaceutical anthropology. Empowerment of a patient comes from making the most of the relationship with the animated spirit of the medicine, which is ingested in a capsule form. The provider is still required to make the medicine available, but individual agency is still exercised through the experience of the Iboga journey. The empowerment principle still holds in this example. I suggest that “Westerners” who have come to rely on the “chemical road to success”, through an unconscious chemical mechanism of action, are again empowered through this experience where they are forced to consciously experience the effects of the medicine, and have to want to change (i.e., the importance of intention). It is an active relationship with the medicine which is in itself empowering because we have become so dependent on “checking out”—something especially true for addicts. The paradox of the greater/lesser reliance on the provider also exists, because many people still utilize providers to obtain ibogaine but the role of the provider is essentially reduced to supplier/caretaker. Moreover, the authority of the medical doctor does not always exist with providers, so the responsibility is further handed over to person undergoing treatment.

Of course exceptions can easily be made to this, such as a person suing a provider regardless of whether they are medically licensed or not. Nevertheless, it is clear the providers utilized in this study recognize their role is important but limited in terms of healing. But each of them has something at stake by providing ibogaine, whether it is their livelihood, medical license, or overall welfare through legal ramifications. Despite this, they continue to make ibogaine available. They say they do it because they see it work, over and over again. That empirical evidence is enough to continue making treatments available.

Ultimately people will likely continue providing treatments. When lawmakers disregard ibogaine, they may potentially put more people in harm because anyone can call himself or herself a provider. The issue of “qualified” providers came up again and again throughout this study. If ibogaine’s popularity does indeed continue to grow, in the absence of biomedical legitimization, more effort will need to made to
establish internal monitoring or safety procedures to identify what is meant by “qualified”. This will keep people safe from insincere providers and will ensure the most effective treatments possible. The question still remains as to who will decide upon those guidelines and according to what values. If New Zealand moves forward with medicalizing ibogaine, it may set a precedent for other countries to follow.

7.3. Recommendations for Further Research

More qualitative studies supporting clinical studies would be important for people to get a broader sense of how ibogaine works, and who is utilizing it. This may even serve to restore some legitimacy on the part of advocates.

I do think an investigation should be made into the unintended consequences in Gabon and other West African communities as people travel there to experience a Bwiti initiation. I read several accounts, mostly on websites but in some books as well, of people traveling to Gabon to experience “the real thing”. What happens to the local communities where Iboga originates, or is offered? As with a lot of post-colonial development, tourism becomes a principle source of revenue. But how sustainable is this, and who does this benefit, and what are the consequences? The commercialization of sacred medicines and practices will surely impact their traditions, as they have surely done so already. Recognizing that Gabon is by many standards a very modern place, surely this medicine are an important part of their traditions, and the potential for compromise seems great.

On the flip side of this, more should be researched on why people seek “Iboga holidays”. This study cited that “return” to the mystical as one of the reasons for the rising popularity of TCAM therapies. This was the same thing I witnessed with the ayahuasca in Peru, and was horrified by the neediness of Westerners to belong to some ancient tradition. They took very expensive courses to train to become shamans, citing a global expansion of consciousness as their birthright for entering the lineage of shamans. It would be an interesting exercise to research the motivations and perceived outcomes of people who seek such experiences. I can’t help but wonder if turning to more romantic treatments in search of belonging to some ancient society in this time, which is becoming increasingly technically isolating. Surely there are many other reasons why people embark on such journeys.

Continuing with the global political economy of Iboga, it would be so interesting to track the global flow of ibogaine, along with where the money goes,
who it benefits, what it is used for, and why. In a time when global health is a very popular issue, where access to essential medicines is a leading topic, it would be very interesting to see how a “traditional” medicine like Iboga is impacted by the global flow of pharmaceuticals.

Finally, I would be most interested in following the development of ibogaine in response to methadone treatment. The New Zealand example is just the first, as all providers agree that methadone is not the only option for treatment. Methadone puts ibogaine in a very interesting position, as it is no longer in response to “the machine”, but to a part of the machine. It will be so interesting to see how this develops not only in New Zealand, but also in the rest of the world. It would be interesting to develop the power/knowledge nexus and biopower discussions further, in the context of ibogaine.

Ultimately I think interest in this subject will continue, and I am happy to have contributed to it in some way. I am so grateful to the participants of this study, and wish them the best in their futures.
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Annex 1

Provider Profiles

Below is a brief explanation of the three providers interviewed.

Provider 1 has been operating in the Netherlands for over ten years and has provided over 600 Iboga and Ibogaine sessions. She began in 1999, but started treating people more regularly in 2000. Now she treats ten people a month, on average. They travel from all over the world to come to her, hearing about her through word of mouth or reading about her on the Internet. She offers treatments in her home, with one room used specifically for treatments, although other rooms can be used if more than one person is there receiving treatment at a time. The room has two beds, one for the person undergoing treatment, and one for her to monitor the person. She is in the process of building an outdoor house for people to use while the weather is nice, and to accommodate more people. There is also an outdoor garden area. She got started to help the brother of her ex-husband who was an addict. Since she began in 2000, she has treated people for addiction to benzos, tranquilizers, heroin, methadone, alcohol, tobacco, as well as for a range of psychological issues and for people seeking spiritual exploration. She also discovered that ibogaine treats Hepatitis C. She gets the Iboga from South Africa. She charges on a sliding scale between €500 and 2000 euro, but has provided for less when a person absolutely could not afford it.

Provider 2 operates in Germany and has been providing since 2006, and has treated about 40 people. He has the only German language Iboga website. He offers treatments in his family’s “old, nostalgic house”, but is planning to acquire a new house in a neighboring town to better accommodate travelers. He has treated people ages 21 to 55, the latter a man who was addicted to heroin for nearly 40 years. He became a provider after he used Iboga to overcome a “crisis of sense”, or a life crisis. He admits his life changed drastically, and through is enthusiasm for it he decided to help friends of his with drug problems. He expanded as responses were only positive, and through word of mouth his practice grew. Ibogaine is legal in Germany but it is not considered a medicine, so he officially offers initiations, as he is not a doctor or a therapist. He has treated people for addiction, as well as anorexia and other
psychological issues. He gets the Iboga from Africa, but did not say which country specifically. He charges between €1000-1400, but will provide for less if people cannot afford it.

Provider 3 operates in the United Kingdom and became interested in 2002, experiencing ibogaine himself for the first time in 2003. He heard about it through a friend and was working in drug and alcohol addiction and became fascinated about it. He is a medical doctor and worked as a psychiatrist for 15 years. He no longer practices psychiatry but does work in psychoanalytic psychotherapy. He also earned an integrative medicine diploma. He provides treatments in a comfortable office with a bed in the corner. He gets his ibogaine through a contact with a laboratory in Europe, who brings the root bark over and extracts the ibogaine. He also operates on a sliding scale, charging between £2000 and 2750 for the treatment, but also charges for pre- and post-treatment sessions. Sometimes he will provide the treatment in a person’s home to save them the cost of the room.
Annex 2

Interview Schedule

Place: The session

- How do people get to know about you and Iboga
- Where does the session happen; what is the best locality for the sessions; how long should they last; how many sessions should one take; how does one prepare for your sessions
- What is the appropriate dose; how do you know; what happens if you give too much or too less
- Please describe the going-ons of a session
- What kind of persons do participate (sex, age, education, occupation, ethos)
- Efficacy: spiritual (bwiti) and pharmacological (the laboratory) aspects
- Describe a successful and an unsuccessful session

The provider: The session’s leader (therapist)

- Your own encounters with Iboga as a participant (short life-history focused on encounters with ibogaine, spirituality, psychiatry)
- How did you become a ‘therapist’ (is this the right term?)
- The personality and life of Iboga-therapists in general
- Curing and healing: taking away symptoms and/or personal growth
- Do you know about clinical trials which investigate Iboga’s safety and efficacy; does the paradigm of modern pharmacology justice to Iboga

The State, Society and Colleagues: Policy, Safety, Media Representations, Ethics

- Network of colleagues: controlling quality and safety
- How do you ‘market’ your sessions
- Are you involved in advocacy
- How do you get Iboga
- How do you deal with legal rules and law enforcers