

THE AGENCY OF IBOGAININE: EMIC UNDERSTANDINGS
OF A GRASSROOTS PSYCHIATRY
IN MEXICO

by

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ABSTRACT

As opiate addiction rates rise, many individuals find conventional biomedical and 12-step-based treatment programs insufficient in their attempts to overcome addiction. In response to this unmet need, a grassroots community has developed a novel approach to treatment based on a unique cultural model of addiction. Operating with the belief that conventional treatment models are intentionally designed to not to work, this community aims for the mitigation of problematic drug use, rather than complete sobriety. Its mode of treatment is a psychedelic-like plant alkaloid, ibogaine. Perhaps in part due to the recent scientific attention classic psychedelics have received and in part due to the rise of opiate addiction rates, ibogaine therapy has become the subject of an increasing body of scientific literature. But, small clinics around the world have practiced ibogaine therapy for opiate addiction consistently since the mid 20th century.

This paper: (1) contextualizes the scientific work that has been done in these clinics by providing an ethnographic account of the ibogaine therapy community and its understanding of addiction, (2) situates ibogaine therapy within the larger scope of psychedelic-assisted treatments for addiction, and (3) explores the emic understanding of how ibogaine therapy works. Drawing on Eduardo Kohn's framework for an "anthropology beyond the human" and theoretical concepts from cognitive anthropology, I put forth the argument that ibogaine therapy is grassroots psychiatry, centered on the healing power of ibogaine, which is itself a social agent capable of healing through conversational interaction with patients.

DEDICATION

This thesis is dedicated to the ibogaine therapy community for opening its doors to a curious outsider, and to my wife for her constant support throughout this journey.

LIST OF ABBREVIATIONS AND SYMBOLS

MEQ	Mystical Experience Questionnaire
LSD	d-lysergic acid diethylamide
DOC	Drug of choice
NA	Narcotics Anonymous
AA	Alcoholics Anonymous
SR	Smart Recovery
ORT	Opioid replacement therapy
FDA	United States Food and Drug Administration
IV	Intravenous
DSM-V	Diagnostic and Statistical Manual of Mental Disorders (fifth edition)
sp.	Any one of a particular group of species within a genus
U.S.	United States
p	Probability of results more extreme than those observed under the null hypothesis
std.	Standard deviation
IBM	International Business Machines
SPSS	Statistical Package for Social Science

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INTRODUCTION

I was starting to get huge visuals and it was very much like a movie screen playing out, when my eyes were closed. I could see several different story lines going at the same time. I did hear things too. I was hearing the voices. But then I would open my eyes and everything would go away. But then I would be maybe hallucinating a little bit and seeing things in the room. But then as soon as I would shut my eyes the movie would start back playing from where it left off. I can't articulate. I feel like some of the people I was seeing... I don't know if it was in a past life or in a future life. There weren't many faces that I recognized, but it seemed like everyone knew me, if that makes sense. I don't know. It was weird. It was almost like four different scenes going on at once. One of them was more cartoonish like. The only thing I can say is it felt like a big movie screen of like all this information coming at me at once. And it was hard to sift through. Again, it's just hard to articulate it. It was definitely the most, um, the biggest trip I've ever been on... Then the following day I got up and the cravings [for opiates] were gone. (Jessica, Interview 2019)

Jessica traveled from her home in the Eastern United States to an ibogaine therapy clinic in Baja California, Mexico during the summer of 2019 to receive treatment for opiate addiction.

In a post-treatment interview she described her experience to me as a visionary quest for sobriety, filled with profound insights into her life and the issues underlying her addiction.

As she struggled to describe the immense detail of her movie-like reel of visions, she pondered her ability to mediate the onslaught of information by opening her eyes, taking respite from cacophony and chaos. Though she had difficulty sorting through all she saw and heard, this overwhelming experience is precisely what she expected, what she wanted.

Somehow these visions are tied to her final statement. Somehow four separate movie scenes playing at once in her mind are directly connected to the cessation of cravings that plagued Jessica for more than a decade prior. For Jessica, the most important takeaway is that she no

longer craves opiates, but what is it about her experience with ibogaine that so abruptly changed the course of her life?

Ibogaine is an oneiric alkaloid found in a few Apocynaceous shrub species native to West Africa, most commonly *Tabernanthe iboga* (Alper 2001; Brown, Noller, and Denenberg 2019). Ibogaine is most concentrated in the second layer of root bark, between the wood and outer bark. Despite its relative unfamiliarity in both popular culture and academic literature, ibogaine is gaining status in the United States for its therapeutic value in the treatment of opiate addiction. Nonetheless, the alkaloid and plants containing it are banned under the Controlled Substances Act even in the context of medicinal use. Ibogaine is commonly described as a psychedelic, though it is chemically quite different than classic psychedelics like d-lysergic acid diethylamide (LSD) and psilocybin, as are the phenomenological qualia associated with its use. Perhaps in part due to the recent scientific attention classic psychedelics have received and in part due to the rise of opiate addiction in the United States, ibogaine therapy has become the subject of an increasing body of scientific literature (e.g., Alper 2001; Brown 2013; Brown and Alper 2018; Brown, Noller, and Denenberg 2019; Noller et al. 2018; Rodger 2018). But, ibogaine therapy for opiate addiction has been practiced consistently since the mid-20th century in small clinics around the world (Alper 2001). This paper (1) contextualizes the scientific work that has been done in these clinics by providing an ethnographic account of the ibogaine therapy community and its understanding of addiction, (2) situates ibogaine therapy within the larger scope of psychedelic-assisted treatments for addiction, and (3) explores the emic understanding of how ibogaine therapy works. Drawing on Eduardo Kohn's (2013) framework for an "anthropology beyond the human" and theoretical concepts from cognitive anthropology, I argue that ibogaine therapy is

grassroots psychiatry, centered on the healing power of ibogaine, which is itself a social agent, capable of healing through conversational interaction with patients.

--A Brief History of Iboga(ine)--

First, it is important to understand the history of iboga(ine) and ibogaine therapy. Ritual use of ibogaine has been documented across multiple people groups in the endemic region of *Tabernanthe sp.*, in which the bark is dried and ground into a coarse powder called *iboga*. While ibogaine makes up roughly 5% of dried iboga, there are many other psychoactive compounds of which the very little is known (Fernandez 1972). The most comprehensive and authoritative ethnographic account of iboga use in West Africa comes from James Fernandez's work in the 1950s (see Fernandez 1982). Since Fernandez's work focused primarily on Bwiti among the Fang in Gabon, little is known about the role of iboga in other traditions (Rodger 2018). The Fang and virtually all other Bwiti practitioners credit the Bongo (or "pygmies") with the discovery of iboga, which grows naturally in the rainforests they dwell in. According to the origin myth espoused by the *Asumege Ening* branch of Bwiti, the last creator god, Zame ye Mebege, first gave the Bongo iboga as a means of relieving "the misery in which blackman was living" (Fernandez 1972, 245). Bwiti is thus classified as a revitalization movement brought about in an effort to reconcile traditional beliefs with Christian doctrine imposed during colonial periods. And the very essence of Bwiti lies in the consumption of iboga, which has enabled a healing process to begin within cultural groups that have been severely damaged by contact with imperial European societies.

Unlike most other cases involving indigenous uses of psychotropics, 19th century colonial powers actually encouraged the consumption of iboga. The stimulating effects seen in lower doses held much appeal during projects such as the construction of the Douala-Yaounde railroad

in what is now Gabon. Just as Bwitists favor low doses for extended hunting trips, both German and French explorers took note of the valuable stimulant during demanding expeditions in the area. One explorer, Griffon du Bellay, returned to France with specimens that would ultimately undergo scientific investigation, yielding greater European interest (Fernandez 1972, 243). These initial specimens led to the first published description of the *Tabernanthe iboga* (Lecomte 1864). Between 1901 and 1905 French researchers isolated ibogaine and performed the first pharmacodynamic studies of the alkaloid, ultimately recommending its use as a treatment for “asthenia” or chronic fatigue. During the mid 20th century the drug was sold in low dose 8mg tablets and marketed as a mild stimulant to combat a multitude of medical maladies (Alper 2001; Goutarel et al. 1993).

Towards the end of this period in 1962, a young man by the name of Howard Lotsof ingested a relatively high dose of ibogaine, serendipitously discovering the drug’s therapeutic value. Having struggled with heroin addiction for years, Lotsof awoke to find himself undergoing no opiate withdrawal and devoid of his typical cravings. This was evidently the end of his struggles with heroin. As the founding member of L&S Laboratories, 19-year-old Lotsof was already experimenting with a wide variety of hallucinogens when he first took ibogaine. During the following year L&S documented the administration of ibogaine to seven heroin-dependent individuals, five of whom remained opiate-free for at least six months thereafter. In 1963 the FDA cut off L&S Labs’ supply of hallucinogens, abruptly halting their ibogaine investigations (Alper et al. 2001). Shortly after closing L&S Labs, the FDA classified ibogaine as a “Schedule 1 hallucinogen” with the passing of the Controlled Substances Act of 1970, effectively ending any legal exploration of the drug’s therapeutic value in the United States. Despite ibogaine’s criminal status in the United States, Lotsof and others continued detoxing

opiate addicts, eventually moving abroad to countries where ibogaine was either legal or unregulated. And in 1985, Lotsof received a patent for the administration of ibogaine during opiate detox (Alper 2001).

--Psychedelic Therapy--

Of course, ibogaine was not the only new (to Western Euro-American societies) psychedelic examined for therapeutic potential around the 1960s. Albert Hofmann first synthesized LSD in 1938. Five years later, in 1943, he became the first person to experience its hallucinogenic effects (Hofmann 1980). Less than a decade later, amid honeymoon travels entirely removed from Hofmann's pharmacology, Valentina P. Wasson and R. Gordon Wasson discovered the use of psilocybin-containing mushrooms during Mazatec healing ceremonies in a small Oaxacan town (Wasson 1963). Meanwhile in the 1950s, Canadian psychiatrist Humphry Osmond and famed novelist Aldous Huxley collaborated on projects involving mescaline and LSD, generating the term "psychedelic" and ultimately the humanist-scientific blend that is psychedelic-assisted psychotherapy (Dyck and Farrell 2018). One of Osmond's primary foci was the use of psychedelic-assisted psychotherapy for the treatment of addiction. Many papers coming out of his lab in Saskatchewan during this period reported unprecedented success rates from trials targeting alcoholism. As a result, Bill Wilson, the founder of Alcoholics Anonymous, and the organization itself actually endorsed LSD-assisted psychotherapy at the time (Dyck 2006). Thus, the therapeutic value of psychedelics was widely recognized in Western psychiatry during the 1950s and 1960s.

In fact, between the time Hofmann discovered LSD and the passing of the Controlled Substances Act, a major focus of psychological research was understanding how psychedelics work in therapeutic settings. Alongside this effort, there was also a great effort to understand the

psychedelic experience. If we could understand the phenomenological characteristics of the psychedelic experience, perhaps we could in turn understand how psychedelics work in therapeutic settings. While this research transpired in many locations, the most prominent location for inquiries surrounding the psychedelic experience in the mid 1960s was Harvard University. There, Timothy Leary oversaw the (in)famous Harvard Psilocybin Project within the Department of Psychology. Though a scandal in which Leary and his colleague Richard Alpert were fired for giving psilocybin to undergraduates led to dismantlement of the Harvard Psilocybin Project soon after its inception, its contributions to psychedelic science are still relevant and widely discussed today. Perhaps the most notable of these contributions is concept of a psychedelic-induced mystical experience.

In 1963, one of Leary's graduate students, Walter Pahnke, conducted "The Good Friday Experiment" in which ten Harvard Divinity School students received 30mg of psilocybin while ten received a placebo. The conclusion of that experiment was that "persons who received psilocybin experienced to a greater extent than did controls the phenomena described by our typology of mysticism" (Pahnke 1963). Pahnke conceptualized "mystical experience" as an aggregate of 7 domains: internal unity (becoming one with ultimate reality), external unity (the sense that all is one, all is connected), transcendence of time and space (loss of temporal and spatial awareness), ineffability and paradoxically (difficulty describing the experience to others), sense of sacredness (spiritual quality), noetic quality (profound insight into ultimate reality), and positive mood (peace, love, joy) (Pahnke 1969; Griffiths et al. 2006). Pahnke used this concept as the framework for developing a scale capable of measuring mystical experiences during psychedelic sessions; the scientific community largely adopted Pahnke's "Mystical Experience Questionnaire" (MEQ) as a standard measurement of psychedelic-induced mystical experience.

That was until 1970 when, with the passing of the Controlled Substances Act, psychedelic research came to an abrupt halt under prohibition in the United States.

Hands tied, psychedelic researchers moved on to other areas of interest. Psychedelic science ceased to be a valid academic endeavor. Then, after decades of silence, the U.S. Food and Drug Administration gave a team of researchers led by Roland Griffiths permission to conduct the first (legal) scientific experiment with psychedelics in the U.S. since 1970. The team administered the Pahnke-Richards MEQ to 36 participants during a double-blind placebo-controlled experiment that sought to measure psilocybin's ability to "occasion mystical experience" (Griffiths et al. 2006). Like Pahnke's Good Friday Experiment, this hallmark study concluded that psilocybin does in fact induce mystical experiences as defined by Pahnke's typology; 61% of the participants met the criteria for a "complete mystical experience." Since 2006, scientific interest in psychedelics has steadily risen; the United States and many other state-level governments have continued to permit clinical experiments with psychedelics. Many of these projects also employ Pahnke's typology of mysticism by using the MEQ, which is commonly embedded in the larger States of Consciousness Questionnaire (e.g., Brown, Noller, and Denenberg 2019; Griffiths et al. 2006).

Following suit, when the Multidisciplinary Association for Psychedelic Studies (MAPS) funded an effectiveness study of ibogaine therapy for opiate addiction, the MEQ was included. Tom Kingsley Brown began collecting data for this project in 2009. Though the initial papers did not discuss mystical experience, Brown combined his data with those collected by Geoffrey Noller and colleagues, who administered the MEQ in another MAPS-funded ibogaine study in New Zealand. Together they published a paper on ibogaine's ability to occasion mystical experiences in 2019. Twenty-four percent of the 42 participants in those two studies achieved a

“complete mystical experience,” defined as scoring 60% or higher in six or more of the seven domains laid out in the MEQ (Brown, Noller, and Denenberg 2019). However, Brown and Noller’s findings suggest that ibogaine either does not induce mystical experiences as frequently as psilocybin does or that Pahnke’s typology of mysticism does not adequately capture the profound and meaningful experiences ibogaine induces.

I lay aside the question of whether or not ibogaine induces mystical experiences as often as psilocybin for now. This question ultimately demands an analysis of the MEQ’s ability to accurately measure mystical experience broadly across drugs and across cultures. Instead, in this paper I focus on addressing the second underlying question: Does Pahnke’s typology of mysticism adequately capture the nature of the ibogaine experience in a way that is analytically capable of explaining why an ibogaine session is so meaningful and so therapeutic for patients undergoing ibogaine therapy for opiate addiction?

To address this question, I examine the MEQ’s ability to measure the personally meaningful phenomenological qualia experienced during ibogaine sessions by statistically comparing MEQ results from this study, Brown and Noller’s study, and Griffiths and colleagues’ study. I use the MEQ alongside qualitative data to explore how the meaningful phenomenological qualia associated with ibogaine are similar or different than those associated with classic psychedelics and Pahnke’s typology of mysticism. From there I explore ethnographic data that suggest the therapeutic value of ibogaine is centered in the social interaction between patient and alkaloid. That is, I examine how the emic understanding of ibogaine therapy is characterized by an explicit recognition of ibogaine’s position as an agent interlocutor that assumes the role of “healer” in therapy sessions. I draw on Eduardo Kohn’s (2013) theoretical framework for an “anthropology beyond the human” to investigate this

phenomenon further, revealing a multispecies milieu in which a plant alkaloid, ibogaine, heals human patients through intimate interaction. And finally, I employ theoretical concepts from cognitive anthropology to show that the emic understanding of ibogaine therapy derives from a cultural model of addiction that is fundamentally separate from the model driving conventional biomedical and 12-step-based treatments.

THEORETICAL FRAMEWORK

Eduardo Kohn's framework for an "anthropology beyond the human" is largely based on Charles Peirce's work on semiotics, or representation through signs (Kohn 2013, 7-8). Kohn builds on the application of Peircian semiotics in biology, or biosemiotics, to establish a new way of approaching ethnographic contexts in which humans and nonhumans co-create the living world. Kohn enables us to move beyond merely explaining human phenomena by way of situating them in their respective contexts, to a place where we can empirically analyze the contexts themselves. He does this by pointing out the insufficient tendency in anthropology to reduce signs to symbolic representation, offering an alternative "open whole" in which signs are representations, not just symbolic, but also iconic and indexical. Moreover, representation of the world is not an exclusively human trait, but one that is shared by all life, human and otherwise. And if nonhuman species represent the world, albeit differently than humans, semeiosis – representation of the world through signs – is a fundamental characteristic of all life. Kohn therefore relies on the term "ontologies" not as a way of talking about worldviews, but as a way of talking about worlds, that is, the immense array of realities inhabited by the plethora of living beings on Earth. A single ontology is therefore understood as one individual's reality.

Though these ontologies are different, they are not entirely separate. Thus is the foundational premise of an anthropology beyond the human. As Kohn puts it, humans emerge from and are embedded in a semiotic world comprised of myriad beings. We constantly interact with nonhumans. We represent them, and in turn, they represent us. The dualist view of human and environment breaks down here. Instead Kohn's framework offers a monistic view of life,

which is by definition meaningful. Meaning is not something simply imposed on the world by humans; rather, as Kohn puts it, “meaning is a constitutive feature of the world.” Life is thus a product of representation, of thought. Thoughts make up the world; they are alive. Just as human-human interaction shapes the ontology of an individual, a self, so too does human-nonhuman interaction. This multispecies milieu, what Kohn calls “the ecology of selves,” is a complex dynamic situation in which all life resides. Drawing on the biological concept of ecology, this framing allows us to conceptualize the social world as a space filled by interactions within and across species boundaries. Since humans are fundamentally woven into the fabric of this ecology, we cannot understand the entirety of the human experience outside the context of the whole ecology of selves. In other words, if we want to understand human ontologies, we must examine their relationship to nonhuman ontologies.

I use these concepts in analyzing emic understandings of ibogaine sessions as conversations in which the patient and ibogaine are interlocutors. Further, to fully understand how meaning is created in the interaction between patient and alkaloid, I draw on John Austin’s (1962) concept of “performativity.” Austin defines performativity as speech behaviors that count as social acts. Flemming and Lempert (2014) outline how the concept of performativity is embedded in John Searl’s (1969) “speech act theory” and explain how the notion of speech as action produces and reproduces culturally significant meaning in interaction. I use concepts from Searl’s framework here to examine the production of meaning during patient-ibogaine interaction. Alongside this I explore the extent to which patients afford ibogaine agency in these interactions.

Finally, I explore how the emic understanding of ibogaine therapy stems from a distinct cultural model of addiction within the ibogaine therapy community. A cultural model is an

“internalized version of socially transmitted knowledge [that] individuals use to interpret the world and act within it” (Gatewood 2012, 366). In other words, individuals use cultural models to understand the way things work in the world and to make decisions about how to behave. The concept of cultural models is rooted in a cognitive approach to culture, which is fundamentally based on Ward Goodenough’s (1956) definition of culture as “that which one must know to function in society.”

Individuals within the ibogaine therapy community employ a cultural model of addiction that yields a unique understanding of how addiction works. This emic understanding of addiction is ultimately incompatible with what I call “conventional” biomedical and 12-step-based approaches to treatment. In turn, the ibogaine therapy community has developed its own grassroots psychiatry rooted in a unique cultural model of addiction. By extension, members of the ibogaine therapy community must employ a culturally constructed “schema” or script for “how ibogaine therapy works.” Claudia Strauss (1990) argues that “culturally formed cognitive schemas not only determine our interpretation of the world but also direct our actions in it, often serving as goals” (pg. 197). Strauss uses Ronald Casson’s (1983) definition of schemas as “cognitive abstractions,” which essentially serve as culturally constructed maps for individuals. These maps enable individuals to interpret particular stimuli in the world and respond in culturally appropriate ways.

In this paper, I draw on Kohn’s framework for an anthropology beyond the human and Strauss’ framework for analyzing schemas to elucidate the emic understanding of how ibogaine therapy works. I show that ibogaine therapy follows a shared schema for treatment that stems from a unique model of addiction. Furthermore, I use this framework to contrast the ibogaine therapy schema with that employed in conventional treatment. Using semantic network analysis,

I show that these separate treatment scripts yield different motives, which in turn influence an individual's behavior surrounding opiate use. Strauss is known for her use of "personal semantic network" analysis. This system examines idiosyncratic "webs of significance" that are unique to individuals, yet based on shared schemas. Personal semantic networks direct "goals and styles of behavior" (Strauss 1990, 211). While this kind of analysis is valuable for investigating the role of individual psychology and life experience in shaping idiosyncratic goals and behavior, I conduct a semantic network analysis at the group level here. My goal in doing so is to provide an understanding of the shared emic understanding of how ibogaine therapy works.

METHODS

--The Field Site--

I conducted this study at a clinic located roughly 30 miles south of the US-Mexico border, just outside Tijuana. Patients typically fly or drive to San Diego, where a driver employed by the clinic picks them up. The driver shuttles them to Tijuana, at which point they change vehicles. From here the clinic director and his partner drive the patients to the clinic. My wife and I visited the clinic in the summer of 2019 and were escorted from the San Diego airport in this manner, alongside a patient seeking treatment for his opiate addiction. Patients are welcomed upon arrival by staff members and the clinic's therapy dog, Humphrey. Though the exact location varies, when we arrived the campus consisted of three large houses lined along a cliff-side vista overlooking the Pacific Ocean. These are all connected by a shared path and outdoor common space, complete with spa-like amenities. The house on the south side of the campus is currently considered the "treatment house," though while there I witnessed treatments take place in one of the other buildings too. The house furthest north was being rented temporarily during our stay due to an overflow of patients – the clinic offered a price reduction to patients who participated in this study, which led to a larger-than-normal population (seven individuals at its peak). The central house contains bedrooms like the other two, but also acts as the primary common area. There is a large open space downstairs consisting of a living room with comfortable seating, games and a television as well as a dining area and a kitchen.

The clinic employs two chefs, one who works weekdays and one who works weekends. They each make three meals per day, and offer a wide variety of snacks at the request of

individual patients. Perhaps the most agreeable sentiment among staff and patients alike is that the clinic offers world-class food – an opinion I can personally attest to. The only point of contention is in regards to which chef and dish are superior. Among the relaxed eating schedule, patients generally spend most of their time in this central space, or just outside on the porch where they smoke cigarettes and socialize. While I was there, there was only one patient who spent considerably more time in her room than in common areas. I never saw her smoke, but all the other patients certainly maintained a high rate of tobacco consumption. Only one of them expressed interest in quitting the habit, despite the overwhelming focus on overcoming addiction in the group.

As these daily activities transpire, nurses and other medical staff constantly check in with patients, providing medications, changing IV fluids, and checking vital signs. Most of this work is done in preparation for treatment. Given recent concerns regarding ibogaine's ability to induce cardiac arrhythmias (e.g., Koenig and Hilber 2015) and other complications deriving from interactions with various drugs, medical staff are highly concerned with monitoring heart conditions and “flushing” a plethora of problematic drugs from the body in the days leading up to treatment. During this time, the clinic prevents withdrawal with immediate-release morphine. Though it may seem counter-intuitive to provide morphine to those seeking detox from opiates, the purpose of ibogaine therapy is largely to mitigate withdrawal symptoms. The rationale is thus to provide a maintenance dose as all other preparations are made. And so, the compounding result is a very intimate setting in which patients and staff members (and the occasional researcher) spend the majority of their waking hours in close communion.

Because ibogaine therapy is unregulated in many countries and illegal in others, the settings and practices of each ibogaine therapy clinic are unique. Comparisons of clinics were the

subject of much conversation while I was in the field, both among patients and staff. Some practitioners may integrate elements of Bwiti or even neo-shamanic paraphernalia one might expect to find in a New Age ayahuasca ceremony, while dosing patients with root bark containing myriad psychoactive compounds, not just ibogaine. Others, like the one I visited, adopt a more clinical approach with medical doctors and carefully regulated ibogaine hydrochloride dosage protocols. Most participants in this study reported carefully selecting a clinic based on treatment philosophy and factors like price and location.

The community at the clinic, constantly shifting with an ever-changing pool of patients, is largely maintained by a consistent staff and connections to the larger ibogaine community via internet platforms and personal connections to other members outside the clinic. The physical location, set apart from the few neighbors in the area and even farther from the homes of its patients, offers a space in which patients can ground themselves in a community of individuals experiencing similar situations as they set out on a journey of healing. Though they often leave within a week of their arrival, the clinic represents a place created and maintained specifically for addicts seeking a new way of life. This is perhaps most evident in the cordial nature of the constant interaction between patients and staff. (Note: I use the term “addict” only to the extent that it is commonly used within the community. As such it is used only to refer to individuals currently struggling with addiction.)

The clinic has moved locations many times within the same geographic area and is comprised mostly of staff members who have worked in ibogaine therapy for a period far longer than the clinic has been in operation. It has operated under its current name for approximately eight years. The clinic is owned and directed by an American who has lived in Mexico since his own successful ibogaine treatment for opiate addiction in the area. Though Mexican medical

personnel make up the majority of the remaining staff, most of the clinic's patients are also Americans seeking legal treatment outside the jurisdiction of U.S. law.

--Procedures--

This article is the product of a summer research project that took place at an ibogaine therapy clinic in Baja California, Mexico. I conducted ethnographic participant observation at the clinic during the summer of 2019. My wife and I arrived at the San Diego airport midmorning before receiving a ride over the border with the clinic's driver in the same manner that most patients come in. Picking up a new patient on route, the small sedan was full of passengers and a heap of large baggage as we cruised effortlessly in the opposite direction of long lines awaiting entrance to the U.S. Upon arrival we settled in to a bedroom inside a small house situated on the crest of a hill overlooking the Pacific Ocean. This would be our home as we lived on site alongside patients as they came and went every few days. Living on site allowed me to participate in and observe daily activities and hours of seaside conversations. The laid back nature of the small group permitted detailed note taking throughout the day.

Alongside participant observation, I interviewed participants at their convenience and often worked with medical personnel to document dosage information and verify each patient's treatment regimen. I conducted semistructured interviews with open-ended questions allowing for participant-led conversations situated around key topics, namely: previous treatment experiences, pre-treatment expectations of ibogaine, and post-treatment accounts of ibogaine experiences. I also administered two brief electronic pre- and post-treatment surveys via Qualtrics. The pre-treatment questionnaire queried data on demographics as well as drug abuse and treatment history. The post-treatment questionnaire contained the 43-item MEQ.

Roughly half of the interviews took place on site during my visit. The other half, I conducted via phone with participants who received treatment after my departure. Clinic staff informed all patients of the study prior to their interaction with me, either in person or via phone, and facilitated researcher-participant introductions with those who expressed interest. I then conducted pre- and post-treatment interviews with each participant, and 1-month follow-up interviews via phone with those I was able to get in contact with. All interviews were one-on-one, taking place after participants agreed and consented to the protocol.

The University of Alabama's Institutional Review Board and the clinic's medical staff approved this protocol.

--Analysis--

Upon returning from the field, I categorized my field notes by date. I then transcribed all interviews from audio records. Once all the qualitative data were organized in text, I coded for themes emergent in observational and interview data. I employ both deductive and inductive processes in my analysis of these themes. A deductive process enables me to focus on themes surrounding the phenomenological qualia commonly experienced during ibogaine sessions. I knew prior to entering the field that the ibogaine experience differs significantly from other psychedelics. This insight mostly came from co-constructing a research plan with the clinic's director prior to conducting this study.

Within this area of interest, an inductive approach allows me to keep this focus broad enough to realize an inherent connection between the phenomenological experience during these sessions and the community's understanding of how ibogaine therapy works. Ultimately, I am then able to make inferences about the cultural model of addiction that shapes this emic understanding of treatment. This requires an unanticipated analysis of data surrounding the

community's understanding of addiction, especially in contrast to alternative models of addiction. I employ a semantic network analysis of these data to generate an outline of the emic understanding of how ibogaine therapy works alongside an emic understanding of how conventional treatment works. In this analysis I employ Strauss' concepts of contiguity and significant terms. Following Strauss, I consider there to be contiguity between terms if "in the absence of interruptions that change the topic of conversation, idea B follows idea A in a person's discourse" and an association of terms based on significant terms "if a person talks about ideas A and B using the same significant terms."

Exporting demographic and quantitative data from questionnaires, I analyze descriptive statistics, sample makeup, and MEQ scores in IBM SPSS version 26. Consistent with prior usage of the MEQ (e.g., Brown, Noller, and Denenberg 2019; Griffiths et al. 2006; Pahnke 1969), I define a "complete mystical experience" as scores of 0.6 or higher on at least 6 of the 7 domains: unity (either internal or external), transcendence of time and space, ineffability, sense of sacredness, noetic quality, and positive mood. I then compare MEQ scores to Brown and Noller's (2019) ibogaine results and Griffiths and colleagues' (2006) psilocybin results. Because the MEQ defines a "complete mystical experience" as attaining certain scores on separate domains (and not as a single aggregate score) the most meaningful way to talk about MEQ scores is in terms of proportions (i.e., what proportion of the sample met the criteria for a "complete mystical experience"). Therefore, to compare proportions from this study and the other two, I conduct a 3x2 chi-square to test the hypothesis that ibogaine will occasion mystical experiences less often than psilocybin based on Pahnke's typology of mysticism. I set alpha to .05 for a 95% confidence interval. Finally, I analyze the results from the MEQ comparison in the context of qualitative findings.

RESULTS

A total of 15 patients participated in this study (5 women, 10 men). The age range of this group was 21-60, with a mean age of 41. Education levels ranged from high school to graduate studies, with the majority (61%) of participants having completed high school diplomas but not college degrees. Over half (53%) self-identified as middle or upper-middle class socioeconomically; the largest concentration was six participants identifying as upper-middle class. Eight participants identified as white/Caucasian, three as Hispanic/Latino, two as Black/African American, one as Native American, and one opted not to answer.

Participants also provided data on their personal histories with addiction and prior treatment attempts. Eighty-six percent reported opiates as their drug of choice (DOC). The remaining 14% (2) reported alcohol as their DOC; both of these participants were women. Ninety-seven percent of participants said their DOC had been a problem for more than 3 years, and 50% said it had been a problem for 9 years or more. Eighty-six percent tried some form of treatment prior to arriving at the clinic; none tried ibogaine therapy before participating in this study. Six participants selected the highest category provided, “5 or more” treatment attempts. Thirteen of the total 15 participants provided data on prior psychedelic use. Of those, 85% had experience with a psychedelic other than ibogaine; none had prior experience with ibogaine. Table 1 displays demographic and drug history data.

Age	Gender	Education	DOC	Length of Problem (yrs)	# Of Prior Treatments	# Of Prior Psych. Uses
60	Woman	--	Opiates	10+	2	--
59	Woman	4yr Degree	Alcohol	7 to 8	1	1
55	Woman	Grad Degree	Alcohol	10+	5+	5+
42	Woman	Some College	Opiates	7 to 8	3	0
25	Man	HS Diploma	Opiates	7 to 8	5+	5+
24	Man	Some College	Opiates	10+	5+	3
38	Man	Some College	Opiates	5 to 6	0	3
21	Man	Some College	Opiates	3 to 4	1	5+
47	Man	Some College	Opiates	10+	3	5+
50	Man	4yr Degree	Opiates	10+	5+	4
57	Man	Grad Degree	Opiates	9 to 10	5+	0
42	Man	HS Diploma	Opiates	10+	5+	5+
23	Man	HS Diploma	Opiates	1 to 2	0	1
44	Woman	2yr Degree	Opiates	10+	1	2
--	Man	--	Opiates	--	--	--

Table 1: Demographic and Drug History Information on 15 Participants

Thirteen participants completed the MEQ post-treatment: two opted not to complete the second survey. Three of those 13 (23%) met the criteria for a “complete mystical experience.” The mean number of domains in which participants scored .6 or higher is 3.92 (std.=2.02). The mean scores for each individual domain are as follows: internal unity = .67, external unity = .57, transcendence of time and space = .56, ineffability and paradoxically = .75, sense of sacredness = .68, noetic quality = .68, positive mood = .51. Figure 1 displays mean MEQ scores by domain.

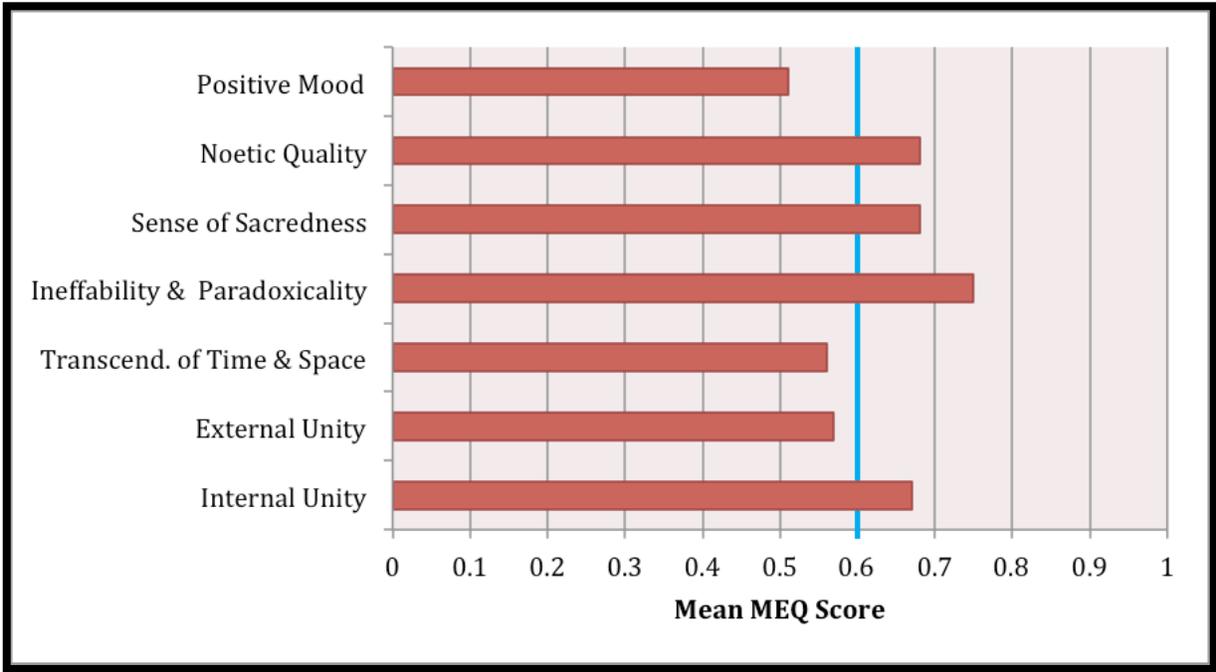


Figure 1: Mean MEQ Scores by Domain

Proportions of participants who achieved a “complete mystical experience” from the two ibogaine studies are almost identical; 23% of participants in this study met the criteria while 24% met the criteria in Brown and Noller’s (2019) study. These results are notably lower than the 61% reported in Griffiths and colleagues’ (2006) psilocybin study. The chi square test supported the research hypothesis, confirming that while there is no significant difference between MEQ scores from this study and those of Brown and Noller’s (2019) ibogaine study, there is a significant difference between both ibogaine studies and Griffiths and colleagues’ (2006) psilocybin study ($\chi^2=12.912$, $p=.002$). Table 2 outlines the comparison of MEQ results from these three studies. I discuss possible explanations for these differences, and considerations regarding the use of the MEQ in future ibogaine research below.

Complete Mystical Exp.	This Study (Ibogaine)	Brown-Noller (Ibogaine)	Griffiths et al. (Psilocybin)	TOTAL
YES	3 (23%)	10 (24%)	22 (61%)	36
NO	10 (77%)	32 (76%)	14 (39%)	55
TOTAL	13	42	36	91

Table 2: MEQ Results, Comparison of Proportions from 3 Studies

Qualitative data from participant observation and interviews reveal a distinct cultural model of addiction within the ibogaine community. Though patients only spend a few days at the clinic for treatment, they are connected to the larger ibogaine therapy community through internet forums and websites, friends and family with prior ibogaine therapy experiences, and pre-treatment interaction with clinics (usually via phone or email). This cultural model of addiction is characterized first by a rejection of the broad categorization of “drugs.” The community distinguishes between psychotropic substances based on their potential to yield problematic use and their potential therapeutic value. That is, there is no overarching domain of “drugs” used to classify all psychotropic substances. Therefore, chronic substance use that would be considered addictive behavior in conventional biomedical and 12-step programs (e.g., daily cannabis consumption) may contrarily be seen as therapeutic in this cultural model. It may in fact aid in recovery from opiate addiction. Second, this model is fundamentally more lenient than the conventional model in that complete sobriety is not expected; mistakes are tolerated.

These qualitative data also elucidate an emic understanding of the way in which ibogaine therapy works. Ibogaine is not seen merely as a drug intervention but rather as an agent healer. Providers and patients both spoke of ibogaine as possessing knowledge surrounding each individual’s personal needs regarding treatment. Participants spoke of ibogaine as having the

ability to speak to these needs on an individual level in ways that ultimately assist patients in their fight to overcome addiction. In this sense, patients and providers view ibogaine less as a treatment for addiction and more as the healer who treats issues underlying a patient's addiction. While a medical doctor monitors the entire treatment session, their role in the intervention is primarily to maintain the safety and comfort of the patient. They bring ibogaine-filled capsules to the patient initially, but then removes themselves physically from the treatment room and socially from the healing conversation that occurs within that space. Once they do so, the patient is left in the care of an agent plant alkaloid that will now curate the treatment protocol according to its knowledge of the patient's individual needs. Three primary themes emerged from these data regarding the nature of how ibogaine therapy works: (1) traveling and interacting with ibogaine, (2) ibogaine as a social agent, and (3) reoccurring phenomenological qualia (e.g., reel-like visions and familiar faces). The emic understanding of how ibogaine therapy works and these three themes are outlined in the discussion below and in Figure 2.

EMIC UNDERSTANDINGS OF ADDICTION AND TREATMENT

From an anthropological perspective, addiction must be conceptualized, at least in part, as a dysfunctional social disorder. For example, Fernandez and Fernandez (2001) point out that outsiders such as missionaries have labeled Bwitiists as “addicts” citing their regular consumption of extremely high iboga doses during rituals. Of course, Bwitiists do not see themselves as addicts, but rather justified in the use of a divine gift to commune with dead ancestors capable of bestowing valuable knowledge upon them (Fernandez 1972). This controversy highlights the role of culture in defining addiction. A certain behavior such as drug use may be dysfunctional in one group but not in another. The distinction depends entirely on how the behavior is perceived within the group. It is therefore necessary to elucidate the emic understanding of addiction within the ibogaine therapy community to fully address the emic understanding of ibogaine therapy works.

The DSM-V outlines criteria by which “substance abuse” may or may not be classified as a “disorder.” Like those of other psychological disorders, the diagnostic criteria for substance abuse disorder require an individual’s substance use to cause “impairment in function.” But what is functional or dysfunctional is dependent on cultural context. That is, “impairment in function” is a good standard for classifying disorders only to the extent that “function” is defined relative to the group within which an individual is operating. To determine whether or not one’s drug use causes impairment in function, we must first ask, what is the standard of function? This is a question of culture.

Functioning within society is the essence of Ward Goodenough’s seminal definition of culture. “Culture is that which one must know in order to *function in society*” (1956, emphasis

added). Functional behavior in one society may impair function in another. For example, Bwitists consider iboga use sacred and necessary; it is a functional behavior. To European missionaries, iboga use appears as a social problem, and likely a threat to the Christian doctrine they preach; it is an impairment in function.

Returning to the question of opiate addiction, from an anthropological perspective we can only really define addiction according to the definitions employed by the groups we study. That is, we must rely on emic understandings. Within the ibogaine therapy community addiction is defined largely as “problematic drug use.” This may be juxtaposed with non-problematic drug use – that is, particular drugs and ways of using that are not representative of addiction. Without taking such emic understandings into account, we risk projecting our own definitions of “success” and “failure” onto the community.

Most patients at the clinic reported having prior negative experiences with 12-step programs like Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) because of the hyper-focus on complete sobriety. The clinic acknowledges the distaste for this model within its client base by advocating instead for a program called Smart Recovery (SR). While I was there, I had the opportunity to attend a few SR meetings and learn of the group’s opinions surrounding the concept of “relapse” in 12-step. Their understanding of relapse is that an individual reverts themselves back to the beginning of the recovery process simply by using a drug, any drug, once. Someone at one of these meetings even reported being asked to forfeit his sobriety “chips,” previously awarded for “clean” time, after relapsing once before returning to NA. The idea behind this notion is that a person struggling with addiction is either actively using drugs or in recovery. One pill or puff of cannabis renders them “not sober,” and therefore unclean, not in recovery.

Smart Recovery espouses a more lenient perspective, offering the concept of “lapse” as a replacement for “relapse.” A lapse is viewed as a reconcilable mistake. For example, suppose an individual struggling with addiction has not used heroin for 5 years. If that person were to smoke a half-gram of heroin over a two-day period to, say, cope with the death of a loved one, the act would be considered a lapse in SR and a relapse in 12-step. The distinction is that a lapse is a relatively minor offense that can be easily overcome. When one lapses they are able to pick up where they left off – 5 years heroin-free in this case – without having to undergo the whole process again from day one. From the perspective of ibogaine therapy patients, relapse requires one to give up their clean time and “pick up a white chip” signifying to the community one’s standing as newly sober.

Though SR was not developed specifically for ibogaine therapy, this sort of thinking is much more in line with the model of addiction maintained within the community. Just as the boundaries between sobriety and active addiction are not as rigid as they are in conventional treatment circles, the ibogaine therapy community does not take as hard of a stance on which drugs are and are not appropriate. In fact, the term “drug” is quite problematic in ibogaine therapy. Ibogaine, after all, is classified by the United States federal government as a “Schedule 1 controlled substance,” which is defined precisely as “having no medicinal value and a high potential for abuse.” As such, the American public is meant to understand ibogaine and heroin as being in the very same category. The notion of using one to overcome addiction to the other is therefore absurdly contradictory. Thus, the very essence of ibogaine therapy challenges the conventional understandings of drugs within American culture at large.

From this basis, the ibogaine therapy community rejects conventional models of addiction and treatment. Not only does the method of treatment involve a psychoactive drug, but

the community is also largely tolerant of substance use post-treatment. Cannabis and other psychedelics are viewed as perfectly acceptable, and even useful in long-term recovery maintenance. In fact, these drugs are understood to have immense therapeutic value. Many participants reported regular use of LSD, psilocybin-containing mushrooms, ayahuasca, ketamine-assisted psychotherapy, and cannabis in the weeks directly following treatment. Often, such use is credited in part with helping patients avoid their problem drug after treatment. These substances are seen as valuable tools in the task of addressing core issues underlying addiction, such as depression or anxiety.

Another important point of contention is the ibogaine therapy community's rejection of the "once an addict, always an addict" philosophy espoused in conventional treatment. During the first SR meeting I attended at the clinic, the group discussed their shared belief that one can fully overcome the snare of opiates, even to the point that maintenance methods like meetings or therapy are no longer necessary. In other words, addiction is not a life long facet of one's identity.

This notion stands in stark contrast to the biomedicalization of addiction as a "disease" or "disorder." Such contrast is found throughout the cultural models of addiction maintained in the clinic and its respective community. One pattern in the data I collected is a general distrust of government, pharmaceutical industry, and the biomedical community, all of which are thought of as maliciously working together – even to the point of intentionally creating and maintaining the "Opioid Crisis" in the United States. When I asked him about his post-treatment goals, one participant told me he wanted "others to avoid this trap that is set by the government for them to take advantage of the people in order to make money." Another participant, John, more explicitly blamed the government for propagating the concept of "drugs" explaining:

I hate the word “drugs” [be]cause it puts heroin in the same box as stuff like acid [LSD] and DMT, and they don’t belong in the same box at all. And fuck the government for doing that to people and fucking with their heads...Opiates [are] really not good for your spirit, and ibogaine helps you understand how much stronger your spirit is than that. (Interview 2019)

There is a perception among patients at the clinic that the government operates in favor of pharmaceutical companies and biomedical professionals seeking financial gain at the expense of those addicted to opiates. Of the 15 participants in this study, only 14% tried no other form of treatment prior to ibogaine – none had tried ibogaine therapy previously. Of the 86% who had previously attempted treatment, 50% had tried 5 or more other forms of treatment. Twelve of the 13 participants seeking treatment primarily for opiate addiction tried methadone, buprenorphine, or both at least once before participating in this study. Their presence at the clinic of course indicates a lack of effectiveness in such treatments, at least with this particular population. But more importantly, their lack of success with opioid replacement therapy (ORT) and 12-step has, at least in part, inspired a profound distrust of the entire system of addiction care in the United States.

Patients believe that organizations of power want to maintain and even grow American opiate addiction in pursuit of economic gain. Moreover, patients do not believe the biomedical system within the United States is capable of treating addiction in any tangible sense. ORT is seen simply as an alternate addiction. While ORT is generally thought of as a safe and effective way to allow patients to slowly wean off opiate dependence (e.g., Mattick et al. 2009; Ward et al. 1999), the patients I interviewed reported having worse cravings and withdrawal symptoms during ORT than those experienced with prescription opiates and heroin. Again, this is not just seen as the current state of knowledge in the field but rather malicious intention on the part of medical personnel and the pharmaceutical industry. One participant explained:

[Physicians] give [opiates] to you very easily. You say you're in pain and they give it to you, but to get off they treat you badly... I don't trust the United States... They won't give us something to help us. So, it's very likely that [ibogaine] will help because we can't get it at home... I really don't think they want us off drugs. (Interview 2019)

These areas of contention between ibogaine therapy and conventional treatment help explain who goes to ibogaine therapy and why, but they also point to the presence of two separate cultural models for addiction. Goodenough's definition of culture provides a framework for understanding the ways in which the cultural model of addiction in the ibogaine therapy community drives behavior and beliefs surrounding treatment that are contrary those associated with conventional biomedical and 12-step approaches. If addiction is conceptualized as an impairment in function, it is fundamentally tied to cultural contexts. "Impairment in function" is really a matter of an individual's behavior not aligning with cultural expectations.

So of course we must ask, what is expected? In order to do so, we must examine the rules that make up a cultural model. In cognitive anthropology, these are commonly known as constitutive rules. John Searle defines constitutive rules as those following the formula: "x counts as y in context c" (1969, 35). Roy D'Andrade explains that these rules make up "culturally created entities," which are "entit[ies] created by the social agreement that something counts as an entity" (1984, 90-91). Operating under this assumption, we are able to see how ibogaine might attain its social agency. It is an agent healer because there is social agreement that it is an agent healer.

Moreover, applying this framework to the question of cultural models of addiction, we can make sense of disagreements in treatment models such as that of a lapse versus a relapse. In the case of both a lapse and a relapse we find the same observer-independent facts. Continuing with the example above, a person who has self-identified as suffering from heroin addiction has

used after a 5-year period of abstinence. Heroin use is our x variable. The context (c) in which the individual used heroin is addiction recovery. The act of using heroin, however, “counts as” something different (y) depending on the cultural model of addiction. In the model employed by the ibogaine therapy community, heroin use (x_1) counts as a lapse (y_1) during addiction recovery (c_1). In the model employed by conventional biomedical treatment and 12-step communities, heroin use (x_2) counts as a relapse (y_2) during addiction recovery (c_2). In other words, while using heroin is an observer-independent fact, the acts of lapsing and relapsing are observer-dependent facts, dependent on the cultural context in which heroin use takes place. By extension, treatment models utilizing these concepts only make sense within their respective cultural contexts. Thus, treatment models are inherently based on cultural models of addiction.

Another important constitutive rule that renders conventional treatments incompatible with the ibogaine therapy community’s model of addiction is that which John alluded to in the quote above. Conventional treatments rely on the taxonomic category “drugs” as an overarching domain for all psychotropic substances (e.g., alcohol, cannabis, heroin, ibogaine). In other words, a substance (x_3) counts as a drug (y_3) if it is psychotropic (c_3). Within this model, any psychotropic “drug” is potentially addictive. The ibogaine therapy community recognizes and rejects this model. Instead they employ a model based on two constitutive rules that distinguish between problematic and therapeutic use of psychotropic substances: substance use (x_4) counts as a problem (y_4) if it the substance harms one’s spirit (c_4); and substance use (x_5) counts as therapeutic (y_5) if the substance heals one’s spirit (c_5). Within this model, a substance’s psychotropic properties have no bearing on its addictive potential. A substance’s psychotropic properties are observer-independent, but their classification as “problematic” or “addictive” or “therapeutic” is observer-dependent.

From this framework, a distinct cultural model of addiction appears within the ibogaine therapy community. Working from a different model of addiction, the ibogaine community has developed a model of treatment that better suits its needs than conventional biomedical and 12-step approaches. In this model, ibogaine is not seen merely as a drug with medicinal properties. Rather ibogaine is seen as a healer capable of interacting with each patient on an individual level according to their unique needs, guiding them on a meaningful journey towards a better life.

Strauss' framework relies on the precept that "human motivation has to be understood as the product of interaction between events and things in the social world and interpretations of those events and things in people's psyches" (1992, 1). Ibogaine is a thing in the social world as ibogaine therapy is an event in the social world. This principle explains why interactions with ibogaine are so significant. Patients afford ibogaine agency to heal them. Ibogaine does so by acting in meaningful ways during conversational interactions with patients; though ibogaine does not audibly speak in the same way human interlocutors do, it conveys meaning through visions and other phenomenological experiences. Ibogaine sessions are literally social interactions shaping the motivations of individuals, often in the direction of recovery.

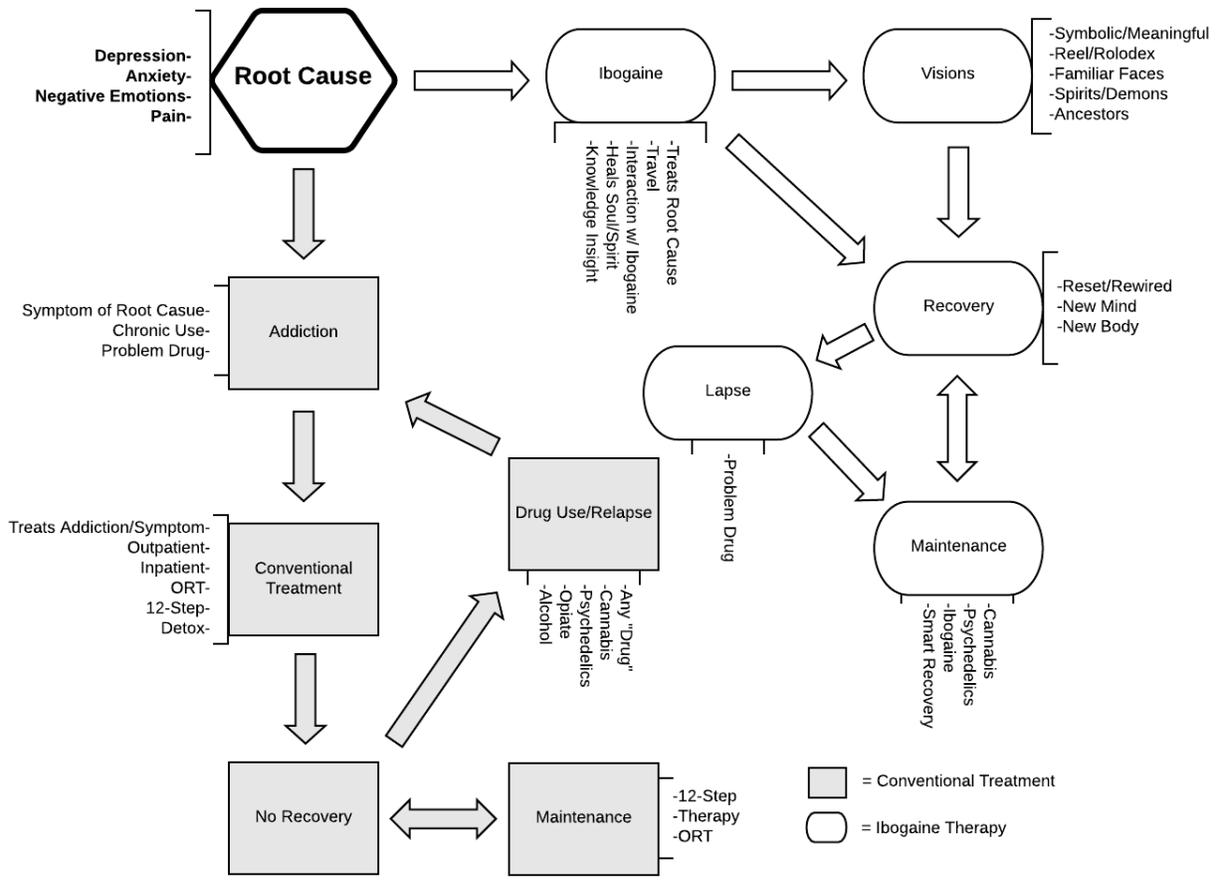


Figure 2: This community employs a distinct model of addiction to understand how ibogaine therapy works. In this model, ibogaine therapy is understood to treat root causes of addiction directly through patient-alkaloid interaction, while conventional treatment is understood only to treat addiction as a symptom of underlying issues.

TRAVELING AND INTERACTING WITH IBOGAINE

And then I ate the first flood dose, um, about 10, 20 minutes after that I kind of started to see like random negative things like, like, uh, like demons and things like that. But they would just pop up and I'll close my eyes. But as soon as I would say, you know, leave, get out, they would vanish, they'd be gone... [Then] I just had this feeling that psychologically everything has been wiped away in terms of negative cravings and emotions. It's almost like all my, like, anger just kind of vanished. Like I feel like I'm in a new body basically. I feel like my soul just, I still have the same soul, but I feel like I just transferred into a different mind. Yeah. Like a new mind. Okay. And I wonder if this is how I would feel if I would have never touched drugs. (Ted, Interview 2019)

Most anthropologists can appreciate the profound impact of travel on one's worldview. The interactions we have as we move through time and space forever shape our understanding of what it means to be human. This is perhaps the foundation of participant observation. Given our definitional focus on humans, anthropologists simultaneously recognize how human interactions, filled with knowledge and emotion, create the world in which we all live yet often fall short of giving enough attention to those between people and place, and even more so people and nonhuman beings. With the bulk of anthropological inquiry dedicated to person-person interaction, we are equipped only to elucidate the essence of society to the extent that society is comprised only of humans. But, humans interact with more than just other humans. Perhaps these interactions are not all characterized by verbal conversation (though many are). Nonetheless, people constantly engage with their surroundings, human and nonhuman, through the natural course of life. These interactions contribute to the ways in which one perceives the world, in effect shaping one's ontology, one's own reality.

When anthropologists conduct fieldwork abroad, when we look at a foreign culture ethnographically, we experience different ontologies and thereby expand our understandings of what it means to be human. This experience is made possible through interaction, interactions we have with our host communities and interactions we observe. It is therefore necessary to look at all these interactions, not just human-human, but also human-nonhuman interaction to paint a complete ethnographic picture. We are not isolated organisms merely making use of the objects around us; we are social beings engaged in constant dialogue with the world around us, human and otherwise.

Applying this perspective to ibogaine therapy, I argue that ibogaine acts both as a vehicle for travel, and as an agent entity that patients engage and learn from. Ibogaine takes patients to another place outside their bodies, and acts as a tour guide as they journey together. Keeping with the imagery of flight commonly adopted in discussions of psychedelics, we may think of ibogaine as both a helicopter and its pilot. Ibogaine functions like the helicopter in that it is the means by which travel is possible. At the same time it acts as the pilot in that it determines the appropriate route and destinations along the way. Just as passengers on a helicopter, ibogaine therapy patients are along for the ride, having submitted ultimate trust in the pilot's ability to meet the travel expectations laid out before taking off. But, the metaphor breaks down here. Unlike most helicopter passengers, patients have expectations for what they will gain from the trip more so than where ibogaine will take them or how it will take them there. They expect an ontological shift that will ultimately enable them to change their personal desires and behaviors. Much like ethnographers, ibogaine patients travel abroad expecting to experience new ways of thinking and being in the world, through interaction with the alkaloid and the visions it conjures.

Ted examined this phenomenon as he relayed his ibogaine experience to me the day after treatment. Ibogaine literally “transferred” his soul to a new mind and a new body. This of course is the end result of a twelve-hour-long journey. Along the way ibogaine revealed Ted’s negative cravings and emotions, his anger, in the form of demons. Through my conversations with Ted, it became apparent that he understood the negative emotions to underlie his cravings for opiates. Heroin in particular was a means of coping with emotional turmoil. But, while these visionary demons are iconic symbols of Ted’s emotional struggles, they are also real entities with whom he interacts. Notice that ibogaine takes Ted on this journey towards a new mind, but it is Ted who takes on agency saying to the demons, “you, leave, get out of here.” Ibogaine conducts Ted’s tailored healing journey by taking him through these processes and empowering him to overcome the root causes of his addiction.

While the anthropologist may seek to understand a specific cultural facet with the goal of making a contribution to a larger body of academic literature, the ibogaine patient aims to understand something about themselves so that they may address the root cause of their addiction. For many who participated in this study, that aim took the shape of redefining a problem drug. That is, whereas opiates or alcohol previously represented a means of escape from stress, depression or anxiety, ibogaine may teach patients instead that problematic drugs represent a rather ineffective and detrimental way of dealing with such issues. In effect, ibogaine utilizes the “trip” phenomenon to take patients on a healing journey during which it may teach them to overcome their addiction and the problems underlying it.

IBOGAINE, AN AGENT HEALER

I think [ibogaine] reset. Like I think that something, even though I didn't have that great big vision and stuff like that, it feels, it just feels better inside. Like I don't feel like I have to do everything myself. Like I, it's sort of like letting go. And then also too, I was thinking about the actual experience, and I think I'll be thinking about that for a while. And yeah, I honestly think that the one face I saw was my father. Like it became a little bit clearer yesterday. Like last night I really sat out on the balcony and thought about it and I thought, you know what? I thought, when everything started to get a little weird that black sheet pulled itself over me. I think [ibogaine] was kind of like 'this is all you can handle right now.' Right? 'You don't need to go there.' And it was like being protective and not being bad. And so I think it takes a few days to kind of process what's happened to you, but the feeling is very hard to explain. It's like somebody came down and just put, you know, just kind of enveloped you and said, 'you know what, you're going to be okay.' And that was partly the staff here too, cause they talked me through, and the support that you get. And I think it's the little bit of understanding. I don't think I really understood it and now I do. (Charlotte, Interview 2019)

Patients speak of ibogaine as a social agent that acts as a healer rather than a passive tool used for healing. Because Charlotte's experience differs quite a bit from the typical vision-filled "trip," it is interesting to compare her account to a more common example like Jessica's description at the beginning of this paper. While Jessica reported hours of vivid visionary experience, Charlotte fell asleep for the majority of her ibogaine session and remembered few visions – she recalled a brief display of a blank film reel, the face of her father, and then just blackness. Jessica's description is far more in line with what is typically reported, but Charlotte's experience points to an important distinction. Though patients look for meaning in their visions, the visions themselves are not responsible for healing. Rather, ibogaine is itself an agent healer capable of transforming, through interaction, the mind and body of patients seeking relief from psychological and physical cravings for the drugs upon which the patients are dependent.

Charlotte revealed the agent nature of ibogaine and its visionary healing methods as she reflected on ibogaine's decision to end her visionary experience with the darkness of a bed sheet. Despite her initial frustration with this lackluster session, Charlotte concluded that ibogaine only gave her what she could handle at the time. That is to say, ibogaine, having knowledge of Charlotte's psychological state, implemented a tailored program specific to her needs. She simply had to let go and allow ibogaine to take control of the healing process. Though this program lacked visionary qualia, ibogaine nonetheless accomplished the goal of "resetting" Charlotte's mind, preparing her for recovery from addiction.

Proponents of multispecies ethnography point to the intimate, inseparable attachment humans have with the nonhuman world in which they live (Kirksey and Helmreich 2010). From this perspective the interactions humans have are not limited to the social boundaries of our own species, but rather "interaction[s] of the phenomenal worlds... that are particular to the perceptual and bodily dispositions, motivations, and intentions of different kinds of beings" (Kohn 2007, 4-5). In other words, interactions between humans and nonhumans are mediated through the agent forces of all parties involved. It is therefore necessary to expand, and simultaneously reduce, Ahearn's (1999) definition of agency from "the human capacity to act" to "the capacity to act." To be more precise though, it is necessary to include Sherry Ortner's (2006, 134-137) position that this action must be intentional; we might say "the capacity to act intentionally."

Discussions about psychological mechanisms of actions and pharmacokinetics are far removed from the discourse surrounding "how ibogaine works" that takes place within the ibogaine therapy community. Ibogaine is not seen as an inanimate alkaloid with unintended therapeutic value. Rather, patients and providers within the community view ibogaine as an

agent actor capable of healing the body and mind. One patient captured the essence of this idea stating in agreement with Charlotte, “ibogaine will only show you what you need to see, and only what you can handle at the time.” And, many patients expressed an auxiliary belief in ibogaine’s ability to “reset” or “rewire” the brain.

While the mitigation of physical withdrawal is certainly recognized, relatively pleasant detox is at most considered a nice addition to the true power of the treatment. Nearly all those who participated in this study had previously detoxed completely. All but 2 participants had tried other forms of treatment prior to ibogaine, typically involving some period of detox. In turn, one of the most salient themes in pre-treatment interviews was the distrust of and disbelief in conventional treatment methods. That is, patients who had already overcome the hurdles of detox, no longer experiencing physical withdrawal, returned to problematic drug use because the treatment they received failed to address the core cause of their addiction. Patients view their addiction first and foremost as a psychological problem. Ibogaine is therefore understood to work on a psychological level, addressing issues like depression and anxiety, which are understood to underlie the outward expression of addiction.

In one unique case, an elderly woman who had used heroin daily for the majority of a 30-year period experienced horrific withdrawal after treatment with symptoms persisting even into the third week. During her 1-month follow-up interview, she told me she felt the ibogaine and difficult detox experience were equally responsible for her newfound ability to resist the urge to use heroin. Having been through traditional detox multiple times, she reported worse-than-ever withdrawal symptoms (quite contrary to the typical ibogaine experience) that worked in unison with ibogaine to heal her psyche. Like many others, she believes ibogaine “reset” her brain in a way that “won’t allow” her to use heroin even when she desires to do so. But with that, she also

attributes her desire to stay clean in part to the desire not to go through withdrawal again.

Though the sentiment regarding psychological healing is prevalent throughout the data I collected in this study, this particular case emphasizes the belief that ibogaine works not because of its ability to mitigate withdrawal but rather its ability to heal the mind. That healing, though, is not seen as a one-time occurrence. Instead patients believe ibogaine to be *intentionally acting* on their minds long after acute effects subside. Ibogaine, intentionally acting in a manner dependent on the psychological preparedness and needs of each individual patient, can therefore be conceptualized as an agent actor in interaction, in conversation, between patient and alkaloid.

REEL VISIONS AND FAMILIAR FACES

Though visions are not necessary for a successful treatment session, Rodger (2018) provides evidence supporting the argument that the visionary experience associated with ibogaine consumption is a significant facet of the alkaloid's therapeutic value. Participants in this study relayed vivid descriptions of visionary experiences in post-treatment interviews, often pondering the innate meanings of particular visions. While such meanings may not be readily available immediately after treatment – many patients require a fair amount of time to process their experiences – there is an overwhelming consensus in the community that visions are meaningful and intricately tied to ibogaine's therapeutic potential. Visions are generally personal and unique, but there are striking similarities between individual accounts. The two most common themes that emerged from participant descriptions were (1) vaguely familiar human or humanoid faces and figures and (2) visions displayed in a continuous rotating manner, such as on a film reel.

The first theme is particularly interesting in that it reveals a deeper connection between ibogaine therapy and Bwiti. According to the Fang Bwiti origin myth, ibogaine was a divine gift meant to connect living practitioners with deceased ancestors. Ancestors frequently appear to Bwiti initiates after the consumption of extremely high iboga doses, often in the form of faces (Fernandez 1972). Most post-treatment accounts did not refer to visionary faces as ancestors – though one did – but rather as vaguely familiar “faces” “heads” or “spirits.” Participants described seeing floating faces and human or humanoid figures that appeared to be familiar, despite the frustrating inability to identify them. Like Bwitists, ibogaine therapy patients spoke

of these faces and figures as entities holding valuable knowledge related to the underlying causes of their addictions.

The second theme describes the way in which most participants experience visions during their ibogaine sessions. Visions are perceived as moving scenes on a film reel comprised of individual frames. The content of these film-like visions is thought of as far more significant than the way in which they are displayed, but the presence of this imagery in completely separate ibogaine sessions begs the question: To what extent is the visionary experience influenced by cultural expectations, reproduced in patient-patient interaction? On the surface the answer seems quite evident; surely patients are sharing their experiences with those who have not yet gone through treatment, instilling self-fulfilling expectations. But, we must question this assumption in light of the theme of familiar faces. The fact that Fang Bwitists were reporting similar visionary experiences in the 1950s to those reported by contemporary ibogaine therapy patients means that if we are to assert the role of expectations in determining visions, we must first explain how those expectations crossed substantial amounts of time and space. At this point, however, it seems that visionary qualia like familiar faces are an innate property of the ibogaine experience regardless of context.

What we can say with more confidence though, is that visionary experiences are, as Rodger argues, immensely important to the ibogaine therapy community. One participant was distraught when she told me she saw a film reel, but that all the frames were blank. She was convinced that without insightful visions her treatment would end in utter failure. She later came to believe that what she had seen was sufficient and that “the ibogaine did work,” but her initial concern points to the emic understand of how ibogaine works. Ibogaine is not thought of as simply a pill that through pharmacologic mechanisms can cure a biopsychological addiction.

Instead, this patient shared in the understanding that ibogaine is a teacher and a healer. Visions are viewed as mechanisms through which ibogaine conveys information to patients that will aid them in the process of overcoming addiction. As such, visions serve as an indication that ibogaine is working as intended. A lack of visions is a lack of evidence that the healing process has taken place – though it is not evidence to the contrary.

DISCUSSION

Patients expect ibogaine to act in certain ways; as an agent healer, if ibogaine fails to fulfill these expectations, a patient may become deeply concerned about the effectiveness of the treatment. There are, therefore, certain qualia that evidence an effective ibogaine session. Visions are perhaps chief among these. Patients expect visions and are concerned if they cannot remember having them or the details of specific visions after their sessions. Moreover, patients find meaning in visions, relevant to their addiction and the larger issues underlying it. So, on the surface visions can and do provide therapeutic value, but visions are not the source of that therapeutic value themselves. Rather visions are one tool the healer, ibogaine, uses to heal.

Another way of knowing ibogaine has worked is the sensation of feeling “reset” or “rewired” after completing an ibogaine session. Patients often describe this feeling as extremely difficult to explain, but nonetheless unmistakably present. Like visions though, this feeling is evidence of the work ibogaine has done and a method by which ibogaine heals. However, it is not necessary for effective treatment. Just as a surgeon may often use a scalpel, ibogaine may often use visions. But neither always uses the same tool, and when they use a certain tool, they do not always do so in the same way. Each case is different and thus requires different procedures. Ibogaine, like any healer, assesses the needs of each individual patient and employs the appropriate procedures, wielding the proper tools.

Returning the question of an emic understanding of how ibogaine works, it is important to remember that ibogaine therapy is a grassroots movement inspired and driven by (previous) addicts for addicts. Despite the United States’ ban on ibogaine and irrespective of clinical

affirmation, the ibogaine therapy community has continued to treat those in need since Howard Lotsof discovered ibogaine's therapeutic potential in 1962. Ibogaine therapy is the product of a community seeking to address its own health needs in a response to a hegemonic system that is incapable of doing so. That system is, in fact, viewed as actively preventing effective treatment, if not intentionally creating the problem in the first place.

Ibogaine therapy is thus a grassroots movement of resistance against systems of care perceived to be broken and even malicious. Much like the psychedelic-fuelled counter-culture of the 1960s, this movement is driven by marginalized people taking charge of their own minds. And yet again, psychedelics and cannabis represent a path to that freedom. In this movement however, the mechanism of control has been pinpointed in a much more precise way. While the hippies rebelled against formal education, capitalist economics, and social institutions like monogamy, the ibogaine therapy community is rebelling against the drug epidemic they believe to be incited by hegemonic industry. Members understand addiction to be an intentional product of corporate interests. Ibogaine therapy patients and staff believe powerful industry players gain financially first from their addiction to opiates and second from repeated treatment attempts that are designed to fail. To the extent that the community represents a sub- or even counter-culture, we may consider ibogaine therapy a grassroots psychiatry developed as an alternative to the biomedical model that has failed the community.

The inclination to administer ibogaine in controlled clinical trials examining efficacy and mechanisms of action – and even develop similar drugs without psychoactive properties (e.g., Glick et al. 2001) – is entirely misplaced. The ibogaine therapy community is as dependent on the psychoactive properties of ibogaine as it is independent of the Western biomedical model of psychiatry. The visionary experience is largely what generates and affirms notions of ibogaine's

agency. Ibogaine is not viewed as merely as a drug but as a healer and teacher. This understanding stands in contrast to that of Western biomedical psychiatry and derives from a fundamentally different cultural model of addiction. Moreover, the ibogaine therapy community's treatment model is grounded in the understanding that ibogaine is an agent healer; patients afford ibogaine agency in one-on-one interactions during which ibogaine tailors treatment to each individual patient. Members interact with and learn from ibogaine during their treatment sessions. Ibogaine is therefore not a passive treatment tool but rather an agent interlocutor in the development of the social ontology upon which this cultural model is built.

Drawing on Kohn's (2013) framework for an anthropology beyond the human, I argue that the social ontology of the ibogaine therapy community is negotiated by its constitutive members. Ibogaine is one such member. The knowledge of how ibogaine works derives from personal interactions with the alkaloid rather than scientific investigations of its mechanisms of action. Beginning with Howard Lotsof's initial treatment sessions in the 1960s, there is a rich tradition in the ibogaine therapy community of treatment providers who have themselves gone through the experience of overcoming opiate addiction with ibogaine. The clinic I worked at operates within this tradition. The founder and director of this clinic overcame opiate addiction after a single transformative ibogaine session. Likewise, most of the clinic's staff members have sought ibogaine's assistance through their own challenges in life. Like patients, they rely on their own experiences with ibogaine as they develop an understanding of how ibogaine therapy works. In other words, the community's understanding of ibogaine therapy derives primarily from one-on-one interactions with ibogaine, which is itself, in effect, a member of the community. As such, ibogaine engages in interpersonal interaction with all other community members, impacting along the way the social ontology of the group.

Ibogaine takes on agency in interaction, guiding patients on a journey capable of changing their minds forever. Scientific efforts to understand ibogaine therapy must first understand the movement, the people, and the culture behind it. Failure to do so will result in misinterpretations at best, and hegemonic co-opting at worst. The relatively low MEQ scores in this study and Brown and Noller's (2019) paper suggest the need for an ibogaine-specific measure. Again, I lay aside the question of whether or not ibogaine induces mystical experiences as often as psilocybin does. However, it is evident that Pahnke's typology of mysticism does not capture the nature of the ibogaine experience in a way that is analytically capable of explaining why an ibogaine session is so meaningful and so therapeutic for patients undergoing ibogaine therapy for opiate addiction. There are spiritual elements within the clinic population I work with, and certainly in the ibogaine therapy community at large. But, Pahnke's mystical experience typology does not fit well within the broad scope of ibogaine's phenomenological qualia.

Even from an etic perspective, this comes as no surprise as ibogaine's chemical structure differs substantially from that of classic serotonergic psychedelics. Moreover, despite its 1960s origins, ibogaine therapy has remained quite removed from the larger psychedelic community in that it has been used primarily in one very specific context, opiate detox. Should future researchers want to measure spiritual qualia in ibogaine therapy sessions, it would likely be most effective to create an ibogaine-specific scale in collaboration with members of the ibogaine therapy community. Again, ibogaine therapy is a grassroots movement stemming from deeply rooted distrust of a hegemonic medical system. As such, it deserves collaborative approaches to research that utilize tools suited to the unique needs of the community. That is not to say there is

anything wrong with using the MEQ in ibogaine research, but simply that the MEQ is ill-fitted to the profound and meaningful phenomenological qualia experienced during ibogaine sessions.

That is, the idea of a mystical experience is largely misplaced in the context of ibogaine therapy. While patients will sometimes report gaining some spiritual insight or visionary interactions with supernatural beings, such descriptions are far less prevalent than themes surrounding a more mundane social interaction with ibogaine. An ibogaine session is generally thought of as more akin to a surgical procedure (in which ibogaine is the surgeon) than sacred communion with the divine. That is not to say the interaction is not extremely important and valued in the lives of patients. It most certainly is. My point is simply that the interactions patients have with ibogaine are seen as social encounters, interactions between patient and healer, between patient and ibogaine. They are not, however, generally viewed as spiritual encounters laced in mysticism.

Situating ibogaine therapy in this way, as a grassroots psychiatry based in a distinct cultural model of addiction, enables scientific inquiry to work from a new starting point. We must ground our research in an emic understanding of ibogaine. Ibogaine therapy is built on a unique cultural model of addiction, which is incompatible with conventional treatment methods and the understandings of addiction they stem from. Interactions with ibogaine and ensuing visionary experiences are central to the emic understanding of how ibogaine therapy works. As outsiders peaking in, it is necessary for researchers to contextualize their work within the cultural framework of the community, such that it holds value to those involved. Ultimately “effectiveness” is subjectively defined. Only after we understand the goals of the community and the emic perspective, can we begin to address more complicated questions like those surrounding broader applications of *their* knowledge.

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APPENDIX A: IRB APPROVAL LETTER

See the following page.

July 29, 2019

Dillon Patterson
Department of Anthropology
College of Arts & Sciences
The University of Alabama
Box 870210

Re: IRB Protocol # 19-008-ME
"Ibogaine and Experience at "Experience Ibogaine": Exploring the Relationship between Culture,
Mystical Experience, and Opioid Treatment Outcomes"

Mr. Patterson:

The University of Alabama Medical Institutional Review Board has granted approval for your proposed research. You have also been granted the requested waiver of documentation of informed consent. Your application has been given full board approval according to 45 CFR part 46.

The approval for your application will lapse on July 10, 2020. If your research will continue beyond this date, please submit a continuing review to the IRB as required by University policy before the lapse. Please note, any modifications made in research design, methodology, or procedures must be submitted to and approved by the IRB before implementation. Please submit a final report form when the study is complete.

Please use reproductions of the IRB approved stamped consent form to obtain consent from your participants.

Good luck with your research.

Sincerely,



J. Grier Stewart, MD, FACP
Medical IRB Chair

Informed Consent

Please read this informed consent carefully before you decide to be in the study.

Consent Form Key Information:

- Participate in a 1.5-hour study about ibogaine therapy during opioid detox
- Fill out in one survey 1 day before treatment
- Fill out in one survey 1 day after treatment
- Fill out in one survey 30 days after treatment
- Allow notes to be made about your treatment at Experience Ibogaine
- Your identity will remain confidential
- Minimal risks beyond those of everyday life

Purpose of the research study: The purpose of this study is to examine the relationship between culture and treatment outcomes at Experience Ibogaine. The researchers conducting this study will survey participants who are registered for treatment at Experience Ibogaine. This process will help us better understand what factors impact treatment outcomes. The researchers conducting this study will not make decisions about your treatment. Experience Ibogaine medical staff will make these decisions. Your treatment will not be influenced by your participation in this study.

What you will do in the study: You will take part in three 30-minute-long surveys before and after your treatment at Experience Ibogaine. These surveys will collect information on how culture shapes your overall treatment. You may skip any survey questions that make you feel uncomfortable. You may stop the survey at any time.

Time required: The study will take about 1.5 hours of your time. Each survey will take about 30 minutes.

Risks: The only risk associated with being in this study is a potential breach of confidentiality. To reduce this risk as much as possible, we will make protecting your confidentiality our top priority. (See the "Confidentiality" section below.)

Benefits: This study will not directly benefit you. Your treatment will be the same as if you were not in the study. An indirect benefit that may come out of this study is a better understanding of ibogaine therapy in general.

Confidentiality: The information you give in this study will never be linked to you. Your information will be assigned a code number. The list connecting your name to this code will be kept in a locked file. Your name will be removed from this list when the study is complete unless you consent to be contacted for a later study. (See "Participating in Future Research Studies" below.) If you do participate in future studies, the information you give in this study will be linked to the information you give in future studies. Your name will be removed from the list once those studies are complete. If you choose to quit this study your name will be removed from the list right away. Your name will not be used in any reports or shared with anyone outside the research team.

Project Title: Ibogaine and Experience at Experience Ibogaine: Exploring the Relationship between Culture, Mystical Experience, and Opioid Treatment Outcomes

Voluntary participation: Being in this study is completely voluntary. Your treatment at Experience Ibogaine will not be affected by your being in this study. Should you choose to quit being in this study, your treatment will not change.

Right to withdraw from the study: You have the right to quit being in this study at any time without penalty. If you choose to quit the study all your survey responses will be destroyed. There is no penalty for quitting. You will still receive full compensation (5% discount) for the study.

How to withdraw from the study: If you want to quit being in this study, tell the researcher and exit the survey. If you want to quit after your materials have been submitted, please contact Mr. Patterson.

Compensation: You will receive a 5% discount off the total cost of treatment at Experience Ibogaine for participating in this study.

If you have questions about the study or need to report a study related issue please contact:

Mr. Dillon Patterson
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Box 870210
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If you have questions about your rights as a participant in a research study, would like to make suggestions or file complaints and concerns about the research study, please contact:

Ms. Tanta Myles, the University of Alabama Research Compliance Officer at (205)-348-8461 or toll-free at 1-877-820-3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach Website at <http://ovpred.ua.edu/research-compliance/prco/>. You may email the Office for Research Compliance at rscompliance@research.ua.edu.

Agreement:

I agree to participate in the research study described above.

I do not agree to participate in the research study described above.

Participating in Future Research Studies: We would like to contact you in the future to see if you would be interested in being in another research study (or for more information about the current study).

Please indicate below if you are willing to be contacted about any future research studies.

Yes, I agree to be contacted about future research studies.

Project Title: Ibogaine and Experience at Experience Ibogaine: Exploring the Relationship between Culture, Mystical Experience, and Opioid Treatment Outcomes

No, I do not want to be contacted about future research studies.

Informed Consent

Please read this informed consent carefully before you decide to be in the study.

Consent Form Key Information:

- Take part in a 3-hour study about ibogaine therapy during opioid detox
- Take part in 2 in-person interviews at Experience Ibogaine.
- Take part in 1 follow-up interview and 1 follow-up survey 30 days after treatment
- Allow notes to be made about your treatment at Experience Ibogaine
- Your identity will remain confidential
- Minimal risks beyond those of everyday life

Purpose of the research study: The purpose of this study is to examine the relationship between culture and treatment outcomes at Experience Ibogaine. The researchers conducting this study will take notes about treatment. They will also interview participants who are registered for treatment at Experience Ibogaine. This process will help us better understand what factors impact treatment outcomes. The researchers conducting this study will not make decisions about your treatment. Experience Ibogaine medical staff will make these decisions. Your treatment will not be influenced by your participation in this study.

What you will do in the study: You will take part in two 1-hour-long interviews at Experience Ibogaine. You will take part in one 15-minute-long follow up interview on the phone and complete a 20-minute-long survey 30 days after you leave Experience Ibogaine. A researcher will take notes about your treatment. These interviews and notes will collect information on how culture shapes your overall treatment. Your interview responses will be audio-recorded. You may skip any interview questions that make you feel uncomfortable. You may stop the interview at any time.

Time required: The study will take about 3 hours of your time. The first two interviews will take about 1 hour each. The third interview will take about 15 minutes. The follow-up survey will take about 20 minutes.

Risks: The only risk associated with being in this study is a potential breach of confidentiality. To reduce this risk as much as possible, we will make protecting your confidentiality our top priority. (See the "Confidentiality" section below.)

Benefits: This study will not directly benefit you. Your treatment will be the same as if you were not in the study. An indirect benefit that may come out of this study is a better understanding of ibogaine therapy in general.

Confidentiality: The information you give in this study will never be linked to you. Your information will be assigned a code number. The list connecting your name to this code will be kept in a locked file. Your name will be removed from this list when the study is complete unless you consent to be contacted for a later study. (See "Participating in Future Research Studies" below.) If you do participate in future

Project Title: Ibogaine and Experience at Experience Ibogaine: Exploring the Relationship between Culture, Mystical Experience, and Opioid Treatment Outcomes

studies, the information you give in this study will be linked to the information you give in future studies. Your name will be removed from the list once those studies are complete. If you choose to quit this study your name will be removed from the list right away. Your name will not be used in any reports or shared with anyone outside the research team. Audio-recordings of interviews will be written out exactly. Written records will be stored in a secure file and audio-records will be destroyed.

Voluntary participation: Being in this study is completely voluntary. Your treatment at Experience Ibogaine will not be affected by your being in this study. Should you choose to quit being in this study, your treatment will not change.

Right to withdraw from the study: You have the right to quit being in this study at any time without penalty. If you choose to quit the study all audio-recordings, notes, and survey responses will be destroyed. There is no penalty for quitting. You will still receive full compensation (5% discount) for the study.

How to withdraw from the study: If you want to quit being in this study, tell the researcher and leave the room. If you want to quit after your materials have been submitted, please contact Mr. Patterson.

Compensation: You will receive a 5% discount off the total cost of treatment at Experience Ibogaine for participating in this study.

If you have questions about the study or need to report a study related issue please contact:

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Agreement:

_____! agree to participate in the research study described above.

Project Title: Ibogaine and Experience at Experience Ibogaine: Exploring the Relationship between Culture, Mystical Experience, and Opioid Treatment Outcomes

I do not agree to participate in the research study described above.

AUDIO RECORDING CONSENT:

I understand that interviews in this research study will be audio-recorded. I give my permission to the research team to record my interviews.

Yes, my interviews can be audio recorded.

Participating in Future Research Studies: We would like to contact you in the future to see if you would be interested in being in another research study (or for more information about the current study).

Please indicate below if you are willing to be contacted about any future research studies.

Yes, I agree to be contacted about future research studies.

No, I do not want to be contacted about future research studies.

Signature of Research Participant

Date

Print Name of Research Participant

Signature of Investigator or other Person Obtaining Consent

Date

Print Name of Investigator or other Person Obtaining Consent