MAPS

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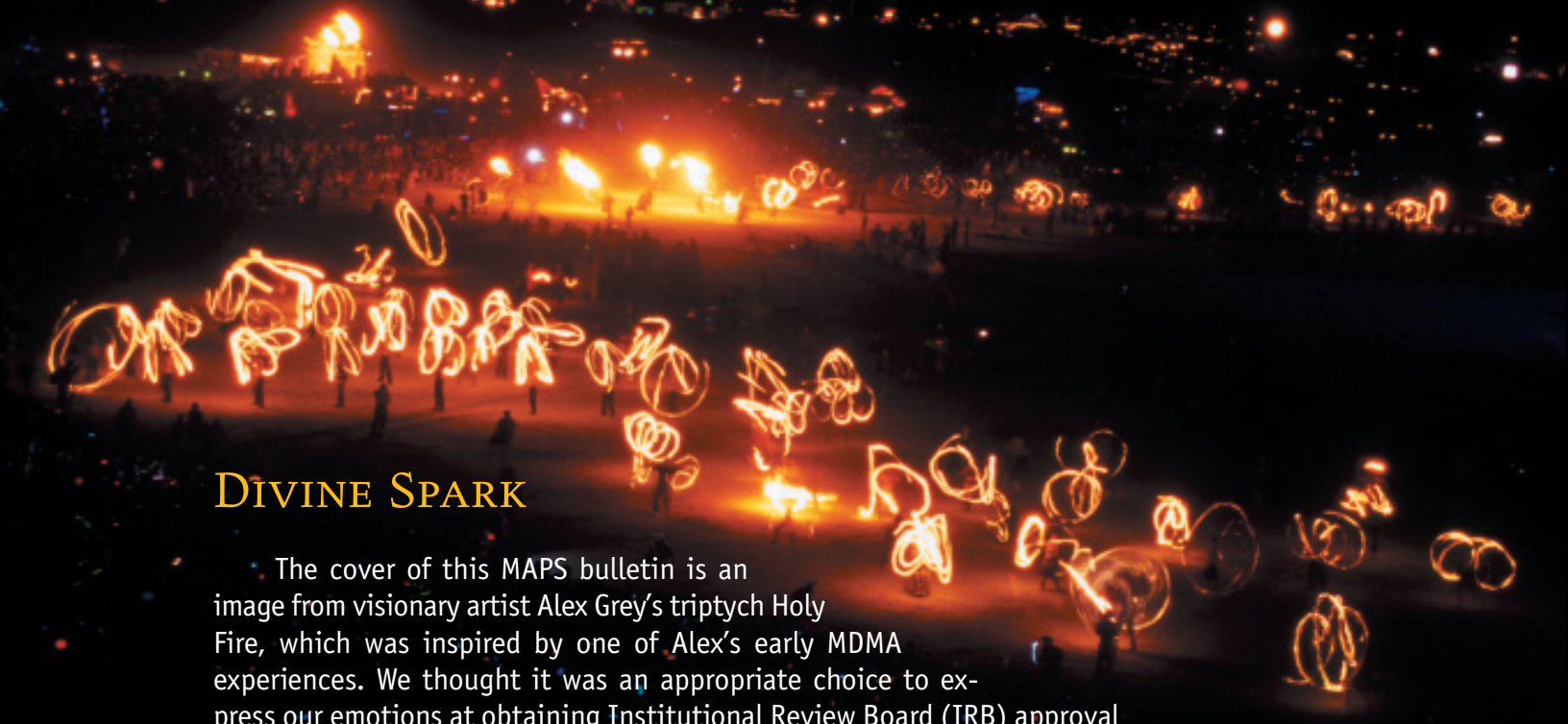

Divine Spark

The cover of this MAPS bulletin is an image from visionary artist Alex Grey's triptych Holy Fire, which was inspired by one of Alex's early MDMA experiences. We thought it was an appropriate choice to express our emotions at obtaining Institutional Review Board (IRB) approval for Dr. Mithoefer's MAPS-sponsored MDMA/PTSD study (see page 7).

The rest of the images on this page and on the back cover are from the 2003 Burning Man Festival, at which MAPS provided psychedelic emergency services. (Article on page 28). In the photo above, members of the Fire Conclave open the festivities at the Burning of the Man, the climax of the week-long festival. The photo below depicts the more somber burning of the Temple of Honor, at which Burning Man participants remember loved ones by leaving notes and tokens inside. As the temple burned, MAPS president Rick Doblin threw in the fire the original copies of the last set of documents about protocol design issues exchanged between MAPS and the IRB. This symbolized his hopes that we would finally move beyond the paperwork of the approval process to the therapeutic work of the study itself.

On September 29, 2003, we received word that Dr. Mithoefer's study won IRB approval (see page 5 for details). After almost two years of bureaucratic and political delays, we are moving to the next phase – seeking a DEA Schedule I license, and then at last beginning to treat patients.

Fire evokes creation, destruction, purification, chaos, and mystery. Its warmth keeps hope alive during the darkness and cold of winter – as celebrated in the candlelit festivals of Christmas, Hanukkah, and other winter celebrations throughout history. As we persevere through what has been a dark season for psychedelic research, we thank you for your continued support as together we keep the light of compassion and reason burning.

Winter 2003

MAPS (Multidisciplinary Association for Psychedelic Studies) is a membership-based organization working to assist psychedelic researchers around the world design, obtain governmental approval, fund, conduct and report on psychedelic research in humans. Founded in 1986, MAPS is an IRS approved 501 (c)(3) non-profit corporation funded by tax-deductible donations. MAPS is now focused primarily on assisting scientists to conduct human studies to generate essential information about the risks and psychotherapeutic benefits of MDMA, other psychedelics, and marijuana, with the goal of eventually gaining government approval for their medical uses. Interested parties wishing to copy any portion of this publication are encouraged to do so and are kindly requested to credit MAPS including name and address. The MAPS Bulletin is produced by a small group of dedicated staff and volunteers. Your participation, financial or otherwise, is welcome.

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Cover – "Holy Fire (Panel 1)" by Alex Grey, from his art book *Sacred Mirrors*. For signed books and posters visit http://www.alexgrey.com

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Exhilarating, astonishing, hard-earned, and transformative. All of those words are necessary to describe the remarkable developments of the past several months. MAPS is now poised tantalizingly close to initiating realistic drug development research programs with MDMA (see page 7) and marijuana (see page 9), with the goal of transforming them into FDA-approved prescription medicines. One reflection of MAPS' progress and growing maturation as an organization is my selection by the Drug Policy Alliance (www.drugpolicy.org) as the 2003 recipient of the Norman E. Zinberg Award for Achievement in the Field of Medicine. This award belongs to MAPS and all its members and staff since MAPS was founded in 1986, for our efforts struggling together to obtain permission to conduct medical research with Schedule I drugs.

Foremost among the recent developments is that on September 23, 2003, MAPS was finally able to obtain Institutional Review Board (IRB) approval for Dr. Michael Mithoefer's MAPS-sponsored MDMA/PTSD protocol. MAPS previously had enormously frustrating interactions with seven other IRBs, all but two of which refused to even accept the protocol for review. Of the two that did review the protocol, one approved the study and then revoked approval several months later for political reasons. The other tabled its review after months of exhaustive negotiations saying that while a majority of its members agreed with MAPS that several fundamental changes in design proposed by the IRB were not appropriate, unanimous agreement was now going to be required. MAPS almost started its own IRB, as we feared we would be unable to find an IRB that would prioritize science over politics. Yet once again persistence paid off, as the latest IRB did an excellent job of evaluating the protocol, in the process suggesting several important changes that significantly improved the design.

"This award belongs to MAPS and all its members...for our efforts struggling together to obtain permission to conduct medical research with Schedule I drugs."

As the IRB's evaluation of the protocol was in its final stages, a fortuitously-timed event took place exactly one year after the September 6, 2002, decision of the Western IRB to revoke its initial approval of the study for political reasons. On September 6, 2003, to the scientific world's astonishment, Drs. George Ricaurte and Una McCann formally retracted their National Institute on Drug Abuse (NIDA)-funded study, published in September 2002 in *Science*. The study claimed that even a "common recreational dose regimen" of MDMA could cause "severe dopaminergic neurotoxicity" resulting in MDMA users developing Parkinson's disease. In their retraction, they explained that instead of injecting MDMA into the primates used in the *Science* paper, they mistakenly had injected mislabeled methamphetamine, and when they finally injected accurately labeled MDMA into new primates, there was no dopaminergic neurotoxicity!

MAPS had advance notice of the impending retraction and was able to contribute to the content of its substantial media coverage, resulting in a tremendous opportunity for public education about the

exaggerated nature of the risks of MDMA and a temporary tripling of Internet traffic to MAPS' website. MAPS offers on its website numerous documents, both by MAPS and others, relating to Ricaurte el al.'s original study, MAPS' June 6, 2003, critical letter published in *Science* and Ricaurte et al.'s response: the retraction, MAPS' Freedom of Information Act (FOIA) request to NIDA, and its letters to NIDA Director Nora Volkow and NIDA's National Advisory Coucil on Drug Abuse seeking additional data about Ricaurte et al.'s research. Also included are challenges to Dr. Ricaurte and McCann's previous reports of substantial reductions in serotonin in human Ecstasy users, which have also not been replicated and are now generally considered methodologically flawed (http://www.maps.org/mdma/studyresponse.html). To its credit, NIDA is revising what it says about MDMA on its website and has withdrawn an educational campaign based on Ricaurte/McCann's serotonin PET scan data.

Even DEA is acting responsibly! On October 28, 2003, DEA agents finally inspected Dr. Mithoefer's facility as part of DEA's long-delayed review of his June 2002 application for a Schedule I license to handle the 3.5 grams of MDMA to be used in the study. Dr. Mithoefer's DEA Schedule I license is the last regulatory requirement we need before the study can begin. The DEA agents seemed to approve of the safe, alarm system and forms and procedures for tracking and administering the MDMA, and spoke to Dr. Mithoefer about *when* – not *if* – his license would arrive, not if. Still, we shouldn't start celebrating the successful fulfillment of MAPS' 17+ year effort to start FDA-approved MDMA psychotherapy research until Dr. Mithoefer actually receives his Schedule I license.

Once Dr. Mithoefer's Schedule I license is in hand, MAPS' Israeli MDMA/PTSD pilot study will begin its final design and approval process, we may be able to reopen MAPS' Spain MDMA/PTSD project (halted for political reasons), and MAPS and Dr. John Halpern will begin in earnest to start research at Harvard Medical School into the use of MDMA in the treatment of depression, anxiety and pain in end-stage cancer patients (more information about all these projects can be found at: http://www.maps.org/research/mdma/).

MAPS' medical marijuana research efforts have also made dramatic progress toward achieving the two necessary prerequisites for a serious medical marijuana drug development effort: an independent source of marijuana for clinical use as an alternative to the monopoly on supply currently held by NIDA, and FDA approval of the use of a vaporizer in clinical research that heats but doesn't burn the marijuana plant (in order to eliminate combustion products and reduce particulate matter).

On October 20, 2003, Senators Kennedy and Kerry wrote a powerful letter to DEA Administrator Karen Tandy urging her to approve the application from Professor Lyle Craker, UMass Amherst, for a license to establish a facility to produce marijuana for federally-approved research (http://www.maps.org/mmj/mmjfacility.html). Prof. Craker's facility would be funded by grants from MAPS. The support of both Senators from Massachusetts substantially raises the stakes for DEA and the Office of National Drug Control Policy (ONDCP), which can now expect significant political pres-

"MAPS had advance notice of the impending retraction and was able to contribute to the content of its substantial media coverage, resulting in a tremendous opportunity for public education about the exaggerated nature of the risks of MDMA and a temporary tripling of traffic to the MAPS website."

sure, unfavorable publicity and a major lawsuit if DEA continues to call for more medical marijuana research on the one hand while blocking it on the other by refusing to license a privately-funded production facility. Encouragingly, I've had a series of candid and remarkably reasonable discussions about the UMass Amherst facility with David Murray, special assistant to ONDCP Director John Walters.

"If anywhere near 1.8 million new people are trying Ecstasy for the first time each year, surely MAPS can raise $1 million a year over 5 years for our Clinical Plan to develop MDMA into a prescription medicine."

In vaporizer research, preliminary news from FDA is favorable regarding Dr. Donald Abrams' proposed study of cannabinoid blood levels, carbon monoxide levels and subjective effects in subjects who will be tested after smoking marijuana cigarettes and also after inhaling marijuana vapors from a vaporizer (Volcano, www.vapermed.de). MAPS and CA NORML have funded a sustained research program into the constituents of the vapors produced by the Volcano vaporizer and have given the data to Dr. Abrams to submit to FDA as part of his IND (Investigational New Drug) application for permission to conduct his smoked vs. vaporized comparative study.

While it's true that MAPS is primarily focused on scientific research for specific patient populations that is of limited relevance to non-medical users of psychedelics and to the larger social debates about drug legalization (see MAPS member Fred Grab's letter on page 39), MAPS has been active recently in the field of harm reduction, providing psychedelic emergency services at the Burning Man festival (see page 28). Our MAPS team offered the option of working therapeutically with difficult psychedelic states to people whose initial intentions had not included a visit to the Sanctuary tent. Personally, my main MAPS work involves years and even decades-long efforts to obtain permission and funding for psychedelic psychotherapy research that will be conducted by others. In contrast, the opportunity to provide direct assistance to people in crisis was tremendously satisfying, both despite and because of the emotional pain with which people were struggling. We found that most people were willing to work therapeutically once they felt safe, supported in their emotional process and unthreatened by arrest.

Not surprisingly, all has not been roses. In late October 2003, the Comcast cable company announced that it had pledged $51 million of ad space over three years to the Partnership for a Drug-Free America for anti-Ecstasy ads. Comcast is responding, in part, to recently released survey data from the National Survey on Drug Use and Health showing that 1.8 million Americans tried Ecstasy for the first time in 2001, more than cocaine (1.2 million), and second only to marijuana (2.6 million). Aside from the gloomy prospect of watching loads of distorted Partnership anti-Ecstasy ads, there's some hopeful implications. If anti-Ecstasy ads can be funded to the tune of $17 million a year for three years, and if anywhere near 1.8 million new people are trying Ecstasy for the first time each year, surely MAPS can raise $1 million a year over five years for our Clinical Plan to develop MDMA into a prescription medicine.

Meanwhile, we wait expectantly on DEA's decisions regarding Dr. Mithoefer's Schedule I researcher's license and Dr. Craker's Schedule I manufacturer's license, and FDA's decision regarding Dr. Abrams' vaporizer protocol. Your continued support is crucial to MAPS' ability to sustain our efforts and to respond to new opportunities as they arise. Best wishes from all of us at MAPS as we approach the celestial solstice and perhaps also a similar cultural turning point, marking the beginning of the gradual return of light after even the darkest days!

— Rick Doblin, Ph.D. MAPS President

MDMA-Assisted Psychotherapy in the Treatment of Posttraumatic Stress Disorder (PTSD): A Third Update on the Approval Process

Michael Mithoefer, M.D. (mmit@bellsouth.net)

I have several encouraging developments to report, including the exciting news that we just received Institutional Review Board (IRB) approval for the study on September 23, 2003! I will start with a very brief summary of events that I have described in more detail in previous Bulletin updates.

October 1, 2001	Protocol submitted to FDA
November 2, 2001	FDA approved study to be conducted in inpatient setting
June 14, 2002	FDA approved protocol change to allow study to be conducted in office setting, allowing us to proceed with seeking IRB approval and my DEA Schedule I license
June 19, 2002	Application submitted to Western Institutional Review Board (WIRB)
July 8, 2002	Application for Schedule I research license submitted to DEA
July 10, 2002	Approval by WIRB
September 5, 2002	WIRB withdrew approval citing safety concerns, which we responded to in writing and by scheduling a meeting with the board
November 19, 2002	WIRB notified us they had made an administrative decision to terminate involvement with our study rather than hold the previously scheduled meeting to discuss our response to safety concerns
December 17, 2002	Application submitted to Independent Review Consultants (IRC), another independent IRB which agreed to review our protocol

In my last Bulletin update I reported that we'd had extensive correspondence and discussions (including a meeting Rick Doblin and I had with them in person) with the IRC IRB. As I also reported, our dealings with them seemed very promising for some time, but to our surprise they suddenly came up with a number of new demands that we did not feel were reasonable. On March 25, 2003 we notified them that we no longer desired their services because of the impasse created by their unusual demands. Interestingly, we later learned that the IRC had been receiving a lot of pressure (from a source they would not name) not to approve our protocol. This was reminiscent of the sudden reversal we'd experienced from the WIRB. While we still don't have an explanation for the unconventional behavior of the WIRB, in light of recent events it is interesting to look back at the sequence of events surrounding their decisions. The WIRB told us that one of the scientists who had raised safety concerns to them was Dr. Una McCann from Johns Hopkins. She and her husband George Ricaurte are both authors of a paper that came out in *Science* on September 25, 2002, claiming that MDMA caused dopamine toxicity and death in primates. This was six days after the WIRB had terminated working with us. As Rick Doblin discusses in detail elsewhere in this issue, Ricaurte and McCann have recently retracted this paper because it turns out they mistakenly administered methamphetamine, not MDMA, to the primates in

this and apparently in some other studies.

For a couple of months after the IRC IRB didn't work out, Rick continued to search for an IRB that would be willing to take on this controversial project. We submitted extensive information to an IRB in Canada and another in the US who indicated they might be interested, but both ultimately declined to formally review the protocol. In May and June of 2003 we began to seriously explore the possibility of forming a MAPS IRB. Rick had extensive talks with the FDA and learned that there are many precedents for doing so, and it would be perfectly acceptable for MAPS to have its own IRB. We were gratified to find a panel of very experienced and distinguished scientists and lay people who agreed to volunteer their time to serve on a MAPS IRB.

"The DEA agents were interested in helping us understand and follow their rules, and were quite reasonable."

During this time we also heard from one more independent IRB in the US, to which Rick had previously sent an inquiry. They said they would accept the protocol for review. Although we felt confident that the MAPS IRB would certainly have the expertise to evaluate and oversee our research, and that the reputations of the individuals on the board would make their objectivity difficult for anyone to question, we decided that it was worth one more try to work with an independent IRB.

This final IRB, which prefers to remain anonymous in the media, has proved to be very thorough and exacting, but is also thoughtful and reasonable. We submitted our initial application to them on June 17, 2003. Over the next three months they held three meetings to review the protocol, and we responded to the various questions, suggestions and revisions that arose from our extensive correspondence and phone discussions with them. In addition to their own board members, they hired an independent posttraumatic stress disorder expert to advise them. All this resulted in a successful collaborative process that led to improvements in the protocol and to IRB approval of the study on September 23, 2003. A complete list of the protocol changes that resulted is posted on the MAPS website. The most significant of these is that now subjects will stay in the clinic overnight following each MDMA or placebo session. A registered nurse of the same gender as the subject will be hired to stay with them from the time Annie and I (the co-therapists for the study) leave in the evening until we return for the follow-up therapy session the next morning. We will give these nurses specific training about how to be present with subjects after an MDMA session in a supportive but non-intrusive manner. Using an RN rather than a less highly paid attendant is a compromise we agreed upon to satisfy the board. Requiring subjects to spend the night, however, is a change we are enthusiastic about. This will provide the advantage of a longer period of integration in a quiet, supportive setting without the distractions of the outside world.

The only remaining regulatory hurdle is my DEA Schedule I license. On October 28, agents from both the regional DEA office and the South Carolina Bureau of Drug Control inspected my office. The inspection, which is a routine step in the processing of a Schedule I license, went very well. The inspectors focused on issues of diversion control and checked out the safe, the alarm system and the forms and procedures that will be used to track all of the MDMA and placebo capsules. The DEA agents were interested in helping us understand and follow their rules, and were quite reasonable. I expect to receive my license in several weeks to several months. If so, we should be able to start recruiting subjects in early 2004. I realize I've made overoptimistic predictions before about when we'll start, but one of these times I'm going to be right. ■

Obtaining an Independent Supply of Research Marijuana: The First of Two Prerequisites to a Realistic Medical Marijuana Research Effort

Rick Doblin, Ph.D. (rick@maps.org)

Obtaining MAPS' own supply of marijuana that can be used in FDA-approved research studies is one of the two developments that I consider necessary to justify the expense (roughly $5 million in donations would be required over 5 years) of a realistic, non-profit, privately-funded, FDA-approved medical marijuana drug development research program. Such a program would be designed to gather sufficient information about the safety and efficacy of marijuana for one specific medical condition, with the data to be submitted to FDA as part of a New Drug Application (NDA) seeking FDA approval for the prescription use of marijuana for that condition. If successful, MAPS would use the income from the sale of prescription marijuana to patients to fund additional research into other uses of marijuana.

"The letter from Senators Kerry and Kennedy supporting the UMass Amherst DEA license application has changed the political dynamics considerably."

The other necessary development is FDA acceptance of the use of a vaporizer in clinical research. My strategic view is that medical marijuana research protocols should be designed to compare safety and efficacy in at least three groups of subjects: 1) subjects who smoke marijuana, and 2) subjects who inhale marijuana vapors from a vaporizer, and 3) subjects who receive the best currently available prescription medicine for the condition being studied. MAPS and CA NORML's prior research has shown that vaporizers deliver substantial amounts of cannabinoids while eliminating combustion products and substantially reducing the amounts of undesirable particulate matter. As a result, vaporizers enable us to address the recommendation of the Institute of Medicine (IOM) for the development of non-smoking delivery systems, with the vaporizer being the only such system that works with the plant itself rather than an isolated extract. My working hypothesis is that smoking high-potency marijuana isn't likely to pose a significant risk of lung problems. Nevertheless, for both scientific and political reasons, I think it's wise to hedge our bets and design research studies with both smoked and vaporizer groups.

It now looks quite likely that FDA will approve the first human protocol in which a marijuana vaporizer will be used. The study is to be conducted by Dr. Donald Abrams, UC San Francisco, and to be funded by California's Center for Medicinal Cannabis Research (CMCR). The study will compare cannabinoid blood levels, carbon monoxide levels and subjective effects in subjects who at different times consume similar amounts of marijuana, by smoking or through the use of the vaporizer.

Status of UMass Amherst DEA License Application

MAPS has for the last four years been seeking to sponsor a privately-funded marijuana production facility at UMass Amherst, under the direction of Professor Lyle Craker, Director of the Laboratories for Natural Products, Medicinal and Aromatic Plants, Department of Plant and Soil Sciences. The goal of the UMass Amherst facility is to create an independent source of supply of high-potency material for use exclusively in federally-approved research. The UMass Amherst facility would provide an alternative to the monopoly on supply held for the last 39 years by the National Institute on Drug Abuse (NIDA), which has marijuana grown under contract at the University of Mississippi. Problematically, NIDA provides researchers with low potency material, and only if NIDA and the Department of Health and Human Services (HHS) approve the protocol as well as FDA. NIDA has twice refused to provide marijuana to MAPS-sponsored and FDA-approved protocols. MAPS already has independent sources of MDMA and psilocybin for use in MAPS-sponsored, FDA-approved clinical research studies. There seems to be no reason, other than to obstruct research, why marijuana is currently treated differently than all other Schedule I drugs.

"I'm proud to report that over 2000 letters and faxes were sent urging ONDCP to recommend that DEA approve the UMass Amherst application."

Dr. Craker initially submitted his application to DEA for a license to establish a growing facility on June 25, 2001. On July 24, 2003, after stonewalling for over two years, DEA finally posted a *Federal Register* notice about Prof. Craker's application, with the public comment period ending September 22, 2003. A decision from DEA about Prof.Craker's application is expected within the next month or two.

On October 20, 2003, Senators Kennedy and Kerry (a Democratic presidential candidate) wrote a strong letter to DEA Administrator Karen Tandy urging DEA to license the UMass Amherst application (http://www.maps.org/mmj/kkletter102003.html). While it's got to be conceded that DEA is more likely to reject the UMass Amherst application than approve it, I'm not convinced yet that the situation is heading for yet another lawsuit before a DEA Administrative Law Judge.

Dr. Russo speaks at UMass Amherst

On September 29, 2003, MAPS arranged for Dr. Ethan Russo to speak at UMass Amherst about the production of marijuana for pharmaceutical research, the history of marijuana's medical uses, and recent clinical research with marijuana and its extracts. Dr. Russo is the editor of the *Journal of Cannabis Therapeutics* and is one of the two researchers MAPS worked with who obtained FDA approval for a medical marijuana protocol (but were then denied marijuana by NIDA, effectively preventing the study from taking place). (For more details on MAPS and Dr. Russo's struggles to conduct FDA-approved research into the use of marijuana in subjects with treatment-resistant migraines, see: http://www.maps.org/mmj/). Dr. Russo's talks were quite well received by some previously skeptical faculty members in the Department of Plant and Soil Sciences, and by quite a few previously supportive but now better informed students. Dr. Russo did an excellent job of presenting the serious and science-based approach that MAPS is seeking to implement.

Public comments in support of UMass Amherst license

According to the DEA, its public comment period wasn't actually open to comments from the public. The only people that DEA invited to comment were potential competitors of Prof. Craker, people who either already hold a similar license or are in the process of applying for one. We've been able to learn from DEA that only one comment was submitted, though we were required to file a Freedom of Information Act (FOIA) request to obtain a copy of that comment. MAPS' FOIA request was submitted on October 7, 2003. We expect to receive a copy of the comment submitted sometime in the next several months.

"As far as we know, we are the first group seeking to import marijuana for research into the United States from the Dutch Office of Medicinal Cannabis."

It doesn't seem likely that DEA will make a decision on such a controversial issue as whether to break NIDA's 39- year monopoly on the supply of marijuana that can be used in federally-approved research without taking direction from Drug Czar John Walters, Director of the Office of National Drug Control Policy (ONDCP). Since DEA didn't welcome comments from the public, MAPS worked closely with the Drug Policy Alliance, NORML, DrugSense, DRC-NET, and Americans for Safe Access (ASA) on an action alert/letter-writing campaign directed at Dr. Andrea Barthwell, the official in the Drug Czar's office who has spoken out most forcefully against the medical use of marijuana. I'm proud to report that over 2000 letters and faxes were sent to Dr. Barthwell. These faxes and letters urged ONDCP to recommend that DEA approve the UMass Amherst application in order to help resolve the controversy over the medical uses of marijuana through FDA-approved research. Perhaps in part as a result of the letters, I was able to have cordial and thorough discussions about the UMass Amherst project with David Murray, special assistant to Director Walters. As a result of these conversations, Murray invited me to write a short memo for his use expressing my view of the obstacles in the way of medical marijuana research and my analysis on why DEA licensing of the UMass Amherst facility is part of the solution. I hope to hear back from him on this shortly (see http://maps.org/mmj/mmjfacility.html, for the memo and latest news).

In a humorous moment that I'm probably reading way too much into, David Murray showed me that he had done his homework when he asked me near the end of an initial conversation what I thought of Burning Man, from which I had just returned. I was surprised and then realized that he must have read the August 29, 2003 *Boston Globe* article on the UMass Amherst DEA license application (http://www.maps.org/mmj/bglobe8.29.03.html). The article concluded by reporting that MAPS was the organization seeking to sponsor the project and that its president was unavailable for comment since he was away at Burning Man! I took the question to be, in part, a challenge to determine whether I was actually a hippie burnout stuck in the 60s (Burning Man is definitely not stuck in the 60s!). I told David Murray that Burning Man was amazing (see article on page 28), and followed up quickly by explaining that MAPS provided psychedelic emergency services there, offering support to people going through difficult experiences. That seemed to return me in his eyes to the realm of the professional, and left me pondering whether the news that the psychedelic community was providing services to take care of its own would make ONDCP more comfortable with Burning Man, or less. I don't know, but I think the effort to reduce problems shows that

the event doesn't cry out for government action.

In any case, ONDCP's rhetoric is that marijuana can't be a medicine unless more research demonstrates, to the satisfaction of the FDA, that marijuana is safe and efficacious for specific medical conditions. The UMass Amherst application is an effort to facilitate research, giving ONDCP a chance to live up to its rhetoric, or be shown in a transparent manner to be urging more research on the one hand yet blocking that research with the other.

ONDCP's New England Governor's Summit, October 8

Dr. Barthwell's comments on the medical marijuana panel at ONDCP's New England Governor's Summit, held in Boston on October 8, were not encouraging. ONDCP is fearful that acceptance of the medical use of marijuana will send a mixed message about marijuana to kids. This is despite survey evidence to the contrary paid for by ONDCP itself showing that kids in California, which is awash in messages about the medical use of marijuana, don't use marijuana at a greater rate than kids in states that haven't passed medical marijuana initiatives. ONDCP seems to prefer blatant denials of the obvious to the intellectually challenging, but ultimately rewarding, hard work that would be required to develop nuanced but credible (and therefore more effective) drug abuse prevention and education messages. On October 14, 2003, the US Supreme Court has let stand the Ninth Circuit Court of Appeals ruling that prevents the DEA from revoking the medical licenses of doctors who recommend marijuana, and on October 20, 2003, Senators Kennedy and Kerry sent their letter to DEA. ONDCP may be beginning to realize that the medical marijuana issue is spiraling out of federal control and may, in response, decide to remove the obstacles in the way of the FDA drug development process.

Encouragingly, the comments of Massachusetts Governor Mitt Romney at ONDCP's New England Governor's Summit were eminently reasonable and suggest that his work as a venture capitalist has made him justifiably suspicious of government monopolies. Gov. Romney asked Dr. Barthwell if marijuana could be treated like any other drug and evaluated through the FDA drug development process. It was all I could do to restrain myself from yelling out (no public comments were permitted at ONDCP's meeting) that the private non-profit sector was eager and willing to sponsor medical marijuana research if ONDCP and DEA would get out of the way and treat marijuana like any other drug by licensing a private producer. On November 10, I was able to discuss the project with Governor Romney's senior policy advisor in a meeting facilitated by the Drug Policy Forum of Massachusetts. This was arranged, and attended, by Leo Kahn, a major Republican supporter of Governor Romney. We hope to hear the governor's position on the project soon (An October 17 article from the *Boston Phoenix* about ONDCP's Governor's Summit can be found at: http://www.maps.org/media/bp101703a.html).

In the Wings

NIDA's National Advisory Council on Drug Abuse

MAPS has also sent a letter to all the members of NIDA's National Advisory Council on Drug Abuse (NACDA). In January 1998, the NACDA issued a report, "Provision of Marijuana and Other Compounds For Scientific Research - Recommendations of The National Institute on Drug Abuse National Advisory Council," in which the NACDA proposed most of the procedures for the provision of marijuana for research that are currently in place. MAPS' letter explained the goals of the UMass Amherst project and requested that the NACDA recommend that NIDA support the UMass Amherst project.

"It now looks at least remotely possible that NIDA's monopoly on the supply of marijuana that can be used in FDA-approved clinical trials will eventually come to an end."

Purchasing marijuana from NIDA, importing marijuana from the Dutch Office of Medicinal Cannabis

In a related effort, the laboratory that is conducting vaporizer research for MAPS and CA NORML has submitted an application to DEA for a license to import ten grams of marijuana from the Dutch Office of Medicinal Cannabis, and has submitted an application to NIDA to purchase ten grams of marijuana. The material would be used for further vaporizer research in a protocol submitted for review as part of the applications. The study is designed to measure the release of various cannabinoids, THC, CBD and CBN. On October 10, I received copies of letters to the research lab from the senior drug policy advisor to the Secretary of Health and Human Services (HHS) and from DEA, responding to the applications. Basically, HHS is requesting additional information about previous vaporizer research conducted prior to the specific protocol that was submitted for review, along with more information about the staff, facilities and equipment involved in the research. The information requested by HHS seems reasonable and won't be that difficult or time-consuming to prepare. DEA said that it won't move forward with its review unless the scientific merit of the protocol is approved by HHS. We anticipate another month or two before final decisions are made by HHS and DEA.

As far as we know, we are the first group seeking to import marijuana for research into the United States from the Dutch Office of Medicinal Cannabis. If DEA ultimately decides to approve the import permit, NIDA's monopoly on supply will have been ended but there might still remain a cumbersome process for obtaining marijuana for research that could continue to involve both HHS and DEA.

Working towards unobstructed research

Ideally, marijuana should be treated like any other drug, with the scientific design of research protocols needing to be approved by FDA, with the protection of human subjects requiring approval for the protocol and informed consent form by an Institutional Review Board (IRB), and with DEA reviewing the study from the perspective of diversion control, to ensure that material approved for medical research isn't diverted to non-medical uses. As long as protocols are privately-funded and do not involve any support from government grants, there is no need for additional protocol reviews to be conducted by NIDA/HHS, especially since the institutional mission of NIDA does not include, and is considered by some officials (I believe mistakenly so) to conflict with, the development of the beneficial medical uses of marijuana.

It seems probable that FDA will approve the first human protocol in which a marijuana vaporizer will be used, and it looks at least remotely possible that NIDA's monopoly on the supply of marijuana that can be used in FDA-approved clinical trials will eventually come to an end. If these two developments do come to pass, then the necessary prerequisites will have been achieved for a realistic, drug development program designed to obtain FDA-approval for the prescription use of marijuana. MAPS would then be eager and ready to embark on the massive effort of obtaining funding and implementing a 5-year, $5 million medical marijuana clinical research plan. ■

The Struggle to Resume Ketamine Psychotherapy Studies in St. Petersburg

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In April 2002, the studies of ketamine-assisted psychotherapy we had been conducting since 1985 were halted, for two reasons. The first reason was that the room where we kept the ketamine did not meet new regulations for the storage of scheduled drugs (These include two iron doors with two locks each, brick or concrete walls, concrete floor, a special alarm system, etc.). More seriously, several months earlier, ketamine was moved from Schedule III into Schedule II. This was part of Russia's own "War on Drugs," and was probably related to the increased prevalence of ketamine abuse among youth. The rescheduling is an important distinction, since under the recently accepted Russian federal "Law on Narcotics," it is forbidden to use Schedule II drugs to treat addictions. That law was mainly aimed against substitution therapy for heroin addiction (I should probably mention here that both methadone and buprenorphine maintenance have always been prohibited in Russia). However, with the reclassification of ketamine into Schedule II (where it joins methadone, buprenorphine, and some other drugs of addiction), this law turned out to target ketamine psychotherapy as well.

Since our ketamine studies have been on hold, we have taken active steps to obtain permission to continue our work. First of all, our hospital built a new room for ketamine storage, meeting all requirements of the new regulations (the cost of the renovation was approximately $2,000). The hospital then received an official license for keeping ketamine in that room from the local authorities of the Ministry of the Interior.

We also initiated paperwork to obtain a permit from the Ministry of Health Care. First of all, we submitted a set of documents to the Control Committee on Narcotics at the Ministry of Health Care, which usually gives permission for any work with controlled substances. In several months, we received a reply saying that for this sort of permit, we should apply to the Ministry of Health Care's Pharmacological Committee (Russian analogue of US FDA), which issues permission for clinical trials. We submitted a package of the documents to the Pharmacological Committee, and in another several months received an answer. They cannot issue a permit, because under the new narcotics law, ketamine cannot be officially registered for treatment of addictions, and they are give permission only for the clinical trials of medicines that will be registered in Russia (pre-registration trials). When we asked where we should seek permission to do scientific studies without the intent of registering ketamine for a new indication (e.g. for heroin addiction), they recommended that we apply to the Scientific Department of the Ministry of Health.

We then submitted a package of documents to the Scientific Department, and received an answer stating that it is not possible to include this study in the Federal Research Program without having it first approved by the Control Committee on Narcotics at

"In one year, we turned out at the same place where we started."

"We would treat secondary psychiatric diagnosis in heroin addicts, which is not forbidden – the law prohibits using Schedule II drugs to treat *addictions,* but not addicts."

the Ministry of Health Care.

Thus, the circle was completed. In one year, we turned out at the same place where we started.

We later re-submitted our documents to the Control Committee on Narcotics at the Ministry of Health Care. As expected, we were denied a permit under the new federal narcotics law. This means that our multiple vs. single ketamine psychotherapy (KPT) session study in heroin addicts is now completed. I am completing statistical analysis for 59 randomized patients, and will draft a paper within a few months.

I do think we might have two possibilities for the future: (1) We could apply for permission to do ketamine studies in alcoholics, or (2) We could ask for permission to treat PTSD or personality disorders in heroin addicts with dual diagnosis. In that case, we would treat secondary psychiatric diagnosis in heroin addicts, which is not forbidden – the law prohibits using Schedule II drugs to treat *addictions,* but not *addicts*. For now, we wait for the response from the Control Committee on Narcotics at the Ministry of Health Care, and if it is negative, we will initiate a new round of paperwork to get permission for alcoholics or dual diagnosis patients. This will take months, or maybe even years, since there is a strong prejudice against ketamine psychotherapy among conservative Moscow authorities. However, we still hope that at the end of this long road, we will start doing ketamine studies again! ■

Update from Lisa: A sexual assault survivor who benefited from MDMA

Last summer, I published a testimonial in the MAPS Bulletin about how MDMA helped me heal on a deeper level from lingering trauma many years after a sexual assault. Several months later, I was diagnosed with Post Traumatic Stress Disorder (PTSD) after I'd already begun to recover from it. Ironically, I was making an appeal in my testimonial in support of clinical testing for a disorder that I didn't even know I had.

Without a doubt, MDMA was the catalyst that began and accelerated my healing. It made me more aware on a conscious level of the fundamental problems I was facing. It helped facilitate effective communication with my therapist. And, most significantly for me, it gave me a goal. I wanted to feel connected to others and accepting of myself as much and as often as I possibly could.

It's remarkable how calm and happy I am now. The recurring nightmares have not come back. I sleep and eat better. I'm not constantly focused on negative thoughts or replaying events from the past in my mind. And, for the record, I have not had a desire to take the drug again. Although, it would be reassuring to know that I could safely and legally if I ever wanted that kind of healing again.

MDMA is certainly not a panacea, but it is inhumane to deny its therapeutic benefits to people who could have their lives restored if they had safe, clinical access to it.

Many blessings to those of you who are working to modify the current fear-based policy.

Lisa

To read Lisa's original account in the Summer 2002 MAPS bulletin, go to http://maps.org/news-letters/v12n2/12207rc.html

Ibogaine: Treatment Outcomes and Observations

Two ibogaine treatment providers (transcendence@mindvox.com)

Background

Ibogaine is a naturally-occurring psychoactive indole alkaloid derived from the roots of the African rainforest shrub *Tabernanthe iboga*. Ibogaine is traditionally used by indigenous peoples of Western Africa in low doses to combat fatigue, hunger and thirst, and in higher doses as a sacrament in spiritual initiation ceremonies.

T. iboga

The pharmacological properties of ibogaine have been researched for over 100 years. In fact, ibogaine was marketed in France under the trade name Lambarene until 1970 and used for its generalized effects on the body and for promoting a sense of well being.

The efficacy of ibogaine for treatment of drug dependence was first discovered by Howard Lotsof in 1962. In 1985 he was awarded a series of patents related to ibogaine's apparent ability to "interrupt" a wide range of substance abuse disorders, including those associated with opiates (heroin), opioids (methadone), stimulants (cocaine, methamphetamine), as well as alcohol, nicotine and poly-substance abuse.

This data was originally based on anecdotal reports from groups of American and European self-treating drug addicts, which indicated that ibogaine completely blocked opiate withdrawal and significantly reduced craving for alcohol, opiates/opioids, cocaine and a variety of other addictive drugs for extended periods of time.

The early to mid-90s saw a flurry of activity and interest in ibogaine. The FDA granted an "Investigational New Drug" (IND) license to Deborah Mash, Ph.D., at the University of Miami School of Medicine, to conduct ibogaine treatment in human drug-dependent volunteers. Unfortunately, due to a lack of funding there has been extremely limited progress. In 2003 establishment acceptance of ibogaine appears no closer than a decade ago.

At the present time — within the United States — ibogaine is Schedule I. It is also a controlled substance in Sweden, Belgium and Switzerland. Ibogaine's legal status in the rest of the world is that of an unlicensed, experimental medication.

Underground

The poverty of clinical data stands in sharp contrast to the wealth of personal claims made about ibogaine's efficacy in curbing substance abuse. The Internet abounds with stories of miraculous recoveries and life-changing experiences as a result of ingesting ibogaine.

Ibogaine's legal status within the US and a small handful of additional countries has effectively

placed it in limbo. However, medically supervised, government-licensed ibogaine treatment is currently available at the Healing Visions clinic, located in St. Kitts, West Indies, where Dr. Deborah Mash is the Director of Research. Unlicensed treatment is also offered at centers in Mexico, Canada, and Italy.

"In response to the growing mountain of anecdotal evidence attesting to its efficacy, an informal underground treatment network has risen, with a variety of individuals offering ibogaine for treatment of drug dependence."

In response to the growing mountain of anecdotal evidence attesting to its efficacy, an informal underground treatment network has risen, with a variety of individuals offering ibogaine itself (HCl, extract, whole root, and pretty much everything in between), to treatment of drug dependence using ibogaine.

The use of ibogaine as an entheogen — for attaining greater self knowledge and/or union with the divine — is also on the rise, with an actual religion (Sacrament of Transition) recently been established in Slovenia.

Worldwide awareness and availability of ibogaine have continued to steadily increase, with a significant burst of exposure in the mass media over the last year. Articles on ibogaine have appeared in the *New York Times,* the *Journal of the American Medical Association* and other publications.

Treatment

The following paper describes a series of ibogaine treatments that were facilitated in 2001 and 2002. The program took place in the tranquil surroundings of The Farm, West Sussex, U.K. The facility used was a converted soundproof studio — formerly a recording studio — separate from the main house.

Exceptions were made for two individuals, who were treated in their own homes. It is our opinion that the results achieved were enhanced when done outside of the client's residence. The opportunity to have several days divorced from the demands and surroundings of daily life offers a better opportunity to process and integrate the ibogaine experience.

The process began with an initial introduction and consultation, during which the possible risks and potential benefits associated with ibogaine treatment were discussed. If the outcome resulted in the subject feeling that this was a suitable treatment modality, he or she was required to submit to a liver function test and an ECG. Once an informed decision had been made, and the reports of the liver and heart tests returned acceptable results, a session was scheduled.

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Inclusion criteria

- Subject participation must be voluntary and informed.
- Subject must sign an informed consent indicating their understanding of the possible risks and potential benefits of ibogaine.
- Subject must have done some research and investigation into ibogaine and given some thought to the process.
- Subject must obtain an ECG and report.
- Subject must provide reports from a liver function test and blood work.
- Subject must sign a form stating that they have not taken any narcotic analgesics, cocaine, amphetamines or alcohol for the last 12 hours before arriving and that they have none of these substances in their possession.
- Subject must provide a next of kin in case of emergency.

Exclusion criteria

- Significantly impaired liver function.
- Any signs of abnormalities on the ECG or any previous heart problems.
- Severe mental health problems such as schizophrenia or bipolar disorder. (While it is unlikely that ibogaine could cause possible adverse reactions with bipolar disorder, the choice was made not to bear the responsibility in the majority of cases.)
- Anyone who is HIV positive or HEP C symptomatic.
- Anyone presently taking antipsychotic medication (i.e., neuroleptics, or certain antidepressants).
- Anyone on any long-term medication for which there is no prior data available regarding possible interactions with ibogaine or psychoactive compounds.

The above criteria were on occasion negotiated and compromises were made. Most individuals who were treated were not in good health. Over 90% had been diagnosed with depression, and several clients suffered from compulsive disorders.

Dosage

The form of ibogaine administered was hydrochloride (ibogaine HCl). The dose range was from 15-20mg/kg of body weight for those wishing to detox and interrupt addiction. 10-12mg/kg was given to individuals who were taking ibogaine for purposes of self-exploration or spiritual insight.

The dose range for addiction interruption that appeared to be the most effective was between 17mg/kg to 19mg/kg. The slightly higher dosage seems to have been more effective. However, for subjects that had poor liver function, we chose not to exceed the 17mg/kg ceiling.

Outcomes

Over the course of a one-year period, 24 sessions were facilitated. Of these, 18 took place with the specific intent of breaking a pattern of drug dependence.

As of this writing — some two years later — six of these 18 individuals are still clean, and have remained so for the duration.

Two people remained clean for the better part of a year, and then returned to drug use when their health declined. They claim they are self-medicating for pain, and are presently awaiting treatment at a government-funded rehabilitation center.

Two individuals maintained abstinence for 3-6 month periods after initial ingestion of ibogaine, and then returned to intermittent drug use. At the present time they are still struggling to maintain longer periods of sobriety. One person died of a heroin overdose after remaining clean for six months. Five people relapsed within one month of treatment. Two persons have not maintained contact, but remained clean for at least one week.

Observations

Ibogaine is extremely effective in providing a painless detoxification from opiates and opioids. In nearly all cases objective and subjective symptoms of withdrawal were either eliminated or seriously attenuated with a single-dose administration of ibogaine.

The physical dependency was no longer there. However, the complex series of psychobiological interactions that caused someone to become addicted in the first place were still present. Ibogaine is not a "cure" for drug addiction.

"As of this writing – some two years later – six of these 18 individuals are still clean, and have remained so for the duration."

"Typically, what someone feels after taking ibogaine is described as 'hitting a reset'."

Typically, what someone feels after taking ibogaine is described as "hitting a reset." Ibogaine returns one's state to a pre-addiction modality, and provides a window of opportunity during which the chance to establish or re-establish control is once again present. People are making choices, not following compulsions.

Approximately half of the subjects gained an impressive level of introspection and insight into their behavior during the "visionary phase" of their experience. For the other half, the most typical ibogaine experience — memory recall — was completely absent. While they were grateful for their lack of physical dependency, they expressed overall dissatisfaction with the level of insight obtained, lack of visionary experiences, or the seemingly abstract hallucinations which had no relevance to their lives.

Most subjects had a high level of openness and showed the desire and ability to communicate about emotional topics following their ibogaine experience. There was a single exception to this rule, a person who subsequently used opiates immediately upon leaving the facility.

Bad trips

Taking any psychoactive molecule can lead into relatively unexplored areas of the mind. Accounts of people who have done ibogaine and compared it to "acid times a million!" are probably heartfelt and reflect an accurate representation of the individual's opinion.

However, this doesn't necessarily make it "true." For anyone who has experience with altered states and familiarity with psychoactive compounds, an ibogaine trip will not present much of a problem. Ibogaine is an extremely mild entheogen, ego death does not occur, and if the experience becomes unpleasant, one can make the visions recede by simply opening one's eyes or turning on the light.

Additionally, many persons experience no visions whatsoever. However, it has been our experience that many — if not most — drug-dependent individuals dislike "tripping." In some cases, "dislike" is a severe understatement. The single greatest fear expressed usually amounts to, "I can't think of anything worse than tripping while I'm going through withdrawal!"

People who are physically dependent on opiates or opioids, and dose with ibogaine, are not "going through withdrawal" while tripping. The physical symptoms of withdrawal are lifted within roughly 30-45 minutes after ingesting ibogaine, before the visionary phase of the experience begins.

As with any molecule that produces altered states of consciousness, a variety of distressing situations can arise. These can be addressed with the help of an experienced sitter or guide. It is important that the sitter remain calm, and reassure the subject that they are okay. A sitter can reassure the subject by holding his or her hand and staying close by. One would also make sure that the subject is not in any physical danger by checking all the vital signs. The most important thing to stress is that the experience will pass and encourage them to relax into it rather than fight it. It is the fighting that intensifies such emotions.

Aftercare

Probably the single most important question in ibogaine treatment is the question of aftercare. Nearly all treatment providers stress the importance of post-ibogaine treatment and follow-up care in order to maintain sobriety. Yet the question of what exactly that treatment should be is difficult to answer. There is no single solution available which is optimal for all — or

even most — individuals.

This problem is worsened by a lack of funding and cohesion among ibogaine treatment providers. Data is usually not available to the public, nor is it shared between providers. Different criteria and protocols are used, and often valuable information is overlooked. Without adequate funding, treatment providers find it time-consuming and difficult — or impossible — to maintain contact and cooperation with clients; therefore keeping progress reports is extremely problematic.

In addition to the host of problems mentioned, most individuals who seek help for drug-dependence can barely afford ibogaine treatment, let alone aftercare. Many who seek ibogaine treatment have been through the entire spectrum of more standard treatment options. They are disillusioned with the 12-step programs, tired of therapy, and generally burnt out on the entire concept of "drug treatment."

Yet some sort of aftercare is essential. Many individuals are self-medicating a variety of comorbid conditions. When they cease taking their drug of choice, the underlying disorders come to the surface and need to be addressed, quite often with a combination of medication, therapy, and other forms of treatment.

A significant amount of emotional baggage is often brought to the surface after using ibogaine, and without the support of a therapist, and some kind of safety net, there is usually very little the client can do with this material. In many cases, core issues such as abuse are revealed, and the emotional impact can be overwhelming.

In our experience, post-treatment bodywork can be extremely beneficial — and in some cases, absolutely essential — as it helps facilitate a positive transformation and provides a deeper understanding and release mechanism for years of psychological or physical abuse.

To conclude, no two- or three-day recovery program can alone correct years of substance abuse. The six individuals who remained clean were all people who checked themselves into an aftercare program or sought therapy on a regular basis, post-ibogaine. The ibogaine experience can be very life-changing and leave people open and enthusiastic about creating change in their lives. While no single treatment option or modality is optimal for everyone, it is extremely important to plan ahead and make use of this window of opportunity, by whatever means are available to the client.

"Without adequate funding, treatment providers find it time-consuming and difficult – or impossible – to maintain contact and cooperation with clients; therefore keeping progress reports is extremely problematic."

Conclusions: The future of ibogaine

Ibogaine is not a maintenance drug, and no pharmaceutical house appears to have much interest in developing a medication which is only ingested once or twice. Even more importantly, the patents on using ibogaine to treat opiate/opioid addiction have expired. This amounts to a complete lack of interest from the medical community. Aside from helping those who are addicted to drugs become un-addicted, there seems to be little incentive in developing ibogaine. With no dollar signs at the end of the rainbow, development of ibogaine as a for-profit medication simply will not happen.

We know that many substance-addicted

individuals are experimenting with ibogaine on their own. Unfortunately, as with any substance which obtained through "the underground," you run a variety of risks, since you don't know the purity, origins, or authenticity of the materials you're trying to obtain.

Our advice has always been relatively consistent and straightforward. If you cannot afford to dose with ibogaine in a medically supervised setting: do as much research as you can about the materials you are attempting to obtain, about the reputation of the person(s) making them available to you, and *especially* obtain dosing guidelines from people who have used those same materials in the past.

None of this is a guarantee; it's more like a very basic prerequisite. If an individual has no idea what materials he or she is actually taking or where they came from — and if those materials turn out to be real and that individual miscalculates, the mistake can be fatal. Ibogaine CAN kill. It is not a recreational drug.

Of course there are many things that can kill, and if you're drug-dependent, this includes the heroin and crack you're doing and the lifestyle that comes with it. Nobody listens to warnings anyway — but we ask people to please try to educate themselves to the best of their ability to do so. Everyone's going to do whatever they're going do, but it doesn't hurt to take action with at least some knowledge backing it up.

Obviously, the best way to minimize these risks would be to make ibogaine treatment legally and cheaply available. However, whether it will ever be accepted as a treatment modality for drug addiction — especially within the United States — is highly debatable. The lack of financial incentive for pharmaceutical companies, the costs involved in development, and ibogaine's unusual mechanism of action are all hurdles to its acceptance.

But none of this has changed the fact that for many people in need of help, ibogaine continues to "work."

Further information

An ibogaine e-mail list has been established. Participants include pretty much everyone in the ibogaine universe, ranging from all the major — and minor — ibogaine treatment providers, a variety of Ph.D.s and M.D.s, heartwarming success stories, complete disasters, psychonauts, junkies, crackheads, disenfranchised nutjobs, and the Ghost of Saint Cobain.

To subscribe, send email (with any subject) to ibogaine-subscribe@mindvox.com or visit http://www.ibogaine.org. ■

Tsogo people, Gabon
Female Figure from a Bwiti Shrine, 20th century
Wood, nails
135.9 x 24.1 x 24.1 cm.

New MDMA Research at the 65th Annual Meeting of the College on Problems of Drug Dependence (CPDD) – June 14-19, 2003, Sheraton Bal Harbour, Miami, Florida

Matthew Baggott (matt@baggott.net)

If you've ever been to LA and you picture it your mind, you just need to add some New York and Latin American accents and you've got Miami, Florida. As a fog-addled denizen of the San Francisco Bay Area, fond as I am of hot coffee and democracy, it took a science conference to bring me to the Sunshine State. And what a conference. The annual meeting of the College on Problems of Drug Dependence is *the* conference for seeing and showing results relating to research on illicit drug use. And this year's conference was rich with preliminary results from studies of MDMA. Choosing which of the many MDMA presentations I should summarize in this limited space was difficult. Here are just a few of the many interesting studies.

M. Tancer of Wayne State University in Detroit presented data from the first few volunteers in an ongoing study of the effects of ambient temperature on people on MDMA. Healthy volunteers were given 2.0 mg/kg MDMA (about 140 mg, probably similar to one-and-a-half or two ecstasy pills) or placebo. So far, it looks like you get similar small body temperature increases from taking 2.0 mg/MDMA in a cold (18° C, or 64° F) room as in a warmer (30° C/86° F) room. Assuming subsequent volunteers show the same pattern, this suggests moderate doses of MDMA do not produce the difficulty regulating body temperature seen in several studies of rats were given MDMA. One possible explanation is that humans are less vulnerable to body temperature changes than rats because humans can remove any fur we are wearing, can sweat, and have high surface-to-volume ratios. However, it is also possible that the dose of MDMA was too low to derange body temperature aside from a slight rise due to vasoconstriction. In a rat study, Dafters (1994) found that 2.5 mg/kg MDMA produced an apparent similar rise in temperature in either warm (29° C/84° F) or cold (11° C/52° F) settings. Higher doses of 5.0 or 7.5 mg/kg were needed to make the animals become cold in the cold setting or hot in the normal setting. The importance of all this research is that increased body temperature can strain the body, possibly increasing risk of toxicity. Many deaths and serious adverse events in ecstasy users involve high (> 38° C/100° F) body temperature and we don't really know how much these cases are due to putative risk factors like too much dancing and too little water. So far, Tancer's ongoing study seems likely to confirm that moderate doses of MDMA do not impair regulation of body temperature in most people and that humans are not more sensitive than rats to this drug effect.

"The annual meeting of the College on Problems of Drug Dependence is *the* conference for seeing and showing results relating to research on illicit drug use."

P.Y. Bello and several other col-

laborators from the French Monitoring Centre on Drugs and Drug Abuse described results from a large French drug analysis program called SINTES (Système National d'Identification des Toxiques et Substances). The program obtains samples from both social/health workers and law enforcement and analyzes them with GC/MS and HPLC techniques. Of 1369 samples obtained from social/health workers, 97% were thought by submitters to contain MDMA. In reality, 83% contained MDMA and 5% contained amphetamines or MDMA-like compounds. There was wide variability in doses with only 2% of MDMA pills containing more than 100 mg MDMA. Average dose per pill appeared to be decreasing over time. Samples contained 74 =B1 18 mg MDMA in 2000, 63 =B1 14 mg MDMA in 2001, and 58 =B1 13 mg MDMA in 2002. If this trend is true in other European countries, it may have important implications for understanding studies of ecstasy users, who often seem to be taking more tablets than appeared common several years ago. More information of the SINTES program can be found on their website: http://www.ofdt.fr/BDD/sintes.

R.V. Irvine from the University of Adelaide, Australia presented preliminary data from an ongoing study measuring MDMA concentrations, biological changes, and physical changes in 24 ecstasy users before, during, and/or after a rave. Blood samples taken after the rave showed plasma concentrations of MDMA that were often around 0.3 mg/L MDMA. However, several participants had plasma concentrations that were above 0.75 mg/L MDMA. Previously, levels this high have only been documented in emergency medicine settings. These high drug levels are even more impressive when one considers they were seen the morning after the rave and that peak plasma concentrations may have been approximately twice as high. Heart rate and blood pressure were elevated in the morning, although not to a degree that would be inherently dangerous in a healthy individual. MDMA plasma concentrations were significantly correlated with body temperature (measured using the tympanic membrane in the ear), which was at or above 38ºC in two participants during morning measurements. Obviously, exercise may have contributed to all these physiological changes. These data suggest that at least some experienced users can tolerate high MDMA concentrations without clinically significant changes in physiology and that other factors such as drug combinations, behavioral or environmental conditions may be important in precipitating the acute adverse event seen in some users.

"So far, Tancer's ongoing study seems likely to confirm that moderate doses of MDMA do not impair regulation of body temperature in most people and that humans are not more sensitive than rats to this drug effect."

R. de la Torre of the Institut Municipal d'Investigación Médica in Barcelona gave a comprehensive overview of the work he and his colleagues at the Universitat Autonoma de Barcelona have been conducting on the human pharmacology of MDMA. Recent studies have explored the effects of giving two doses of 100 mg MDMA, either four or twenty-four hours apart. Even though people notice fewer effects from the second dose than the first, the second dose is less metabolized than the first. As a result, MDMA exposures (measured as the area under the drug concentration vs. time curve) are about 20 to 30% higher after the second 100 mg MDMA dose than you would expect based on the first. There is less formation of at least one metabolite, 4-hydroxy-3-methoxy-methamphetamine,

which suggests that liver enzymes were inhibited by the first MDMA dose. Previous studies (e.g. Delaforge et al. 1999) using liver tissue have indicated that MDMA inhibits an enzyme called CYP2D6 (which is short for "cytochrome P450 isozyme 2D6"). De la Torre's presentation suggests this inhibition of CPY2D6 lasts more than 24 hrs after MDMA, which means people may have altered metabolism of some drugs (such as codeine) the day after MDMA. Because CYP2D6 is inhibited after MDMA, the enzyme appears less important in MDMA metabolism than researchers once thought. People with low CYP2D6 activity (about 10% of Caucasians are like this due to genetics) thus no longer seem likely to be at significantly increased risk of acute adverse events after MDMA (see also: Gilhooly & Daly 2002; O'Donohoe et al. 1998; Schwab et al. 1999). (How CYP2D6 activity influences risks of chronic toxicity remains difficult to assess.)

E. Tella of the Drug Enforcement Administration had a poster presentation summarizing his agency's concerns with the research chemicals AMT (alpha-methyl-tryptamine), 5-MeO-DIPT (5-methoxy-dipropyltryptamine) and the combination of BZP (benzylpiperazine) and TFMPP (3-trifluoromethylphenylpiperazine). He indicated that, in addition to emergency department visits and deaths, drug seizures are an important indicator the agency uses in assessing which research chemicals are significant problems. Because the agency generally seizes compounds in the course of fighting trafficking of scheduled drugs (like MDMA), this suggests that unscheduled compounds are more likely to become scheduled if unscrupulous people sell them as "ecstasy".

"Because DEA generally seizes compounds in the course of fighting trafficking of scheduled drugs...this suggests that unscheduled compounds are more likely to become scheduled if unscrupulous people sell them as 'ecstasy'."

All in all it was an interesting conference. Of course, like most conferences, the real action was the informal schmoozing in the halls. I heard about a lot of interesting findings and rumors. I hope that some of these data actually get presented at next year's conference. ■

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The GHB National Conference: A Visit to a Different Kind of Drug Activist Community

Valerie Mojeiko (valerie@maps.org)

"GHB is basically paint stripper mixed with drain cleaner," announced Trinka Porrata, retired LAPD detective and self-proclaimed rave and club drug expert, addressing the crowd at the first annual GHB National Conference. Porrata is the president of Project GHB, a group whose strong and emotional opposition to GHB use is perhaps as clouding to good judgement and rational decision-making as the actual use of intoxicants.

Representatives from law enforcement, judicial, medical, school, and community groups gathered at the Grand Caribe Royale Hotel in Orlando, Florida on May 9-11, 2003 to disseminate much-needed information about the dangers of GHB. The result, however, was not only a sharing of knowledge and strategy, but a heated rally against GHB use and users.

GHB, a naturally occurring substance in the human brain, produces sedative-hypnotic euphoric effects, similar to alcohol, when taken orally. Its recreational potential was discovered in the 1990s, when it was marketed as a dietary supplement and sold over the counter. The media labeled GHB "the date rape drug" after several highly publicized cases in which sexual predators used GHB as a weapon by taking advantage of the unrousable coma that it can produce when mixed with alcohol. After receiving several years of negative press, GHB was classified as a Schedule I substance in March 2000.

The conference was organized into three tracks catering to specific interests—medical, law enforcement, and community resources. Medical presentations focused on the dangers of GHB overdose, addiction, and withdrawal, as well as strategies for properly identifying its symptoms. Presentations for law enforcement, prosecution, and judicial personnel included speakers from the DEA, US Customs, and the US Attorney General's Office. The community resources presenters included organizations such as Parents of Murdered Children, GHBKills.com, Families Against Drugs, and DAMMADD (Dads and Mad Moms Against Drug Dealers).

Glen Stanley, Deputy of the Los Angeles Sheriff's Department, narcotics detective, and rave/club drug expert, delivered a mocking ethnography of rave culture, which included slides of 8-year-old children dressed in rave attire and sarcastic explanations of gift-giving rituals in raves. Stanley also expressed anti harm-reduction sentiments, including disapproval of Dancesafe's Ecstasy pill-testing program.

"Nowhere in the lectures, discussion, or video footage did I hear information about the moderate GHB users like those I have known."

Steve Collier, Special Agent of the Drug Enforcement Administration (DEA), de-

scribed a large-scale GHB bust that happened on September 18, 2002. Operation Webslinger was an "international takedown" of internet traffickers, distributors, brokers, and customers of GHB and GHB-analogues, resulting in 136 arrests in 84 cities. Arrests included major distributors in the US and Canada: Science Alliance, Miracle Cleaning Products, and Pelchat Labs, the parent company of European Cosmetics.

The conference opened and closed with Porrata's emotional diatribes, discussing senior citizen GHB addicts, pop-icon Billy Idol's GHB overdose, and good husbands who began seeking out "kinky sex" or became "chronic masturbators" after discovering GHB. The revelation eliciting the most gasps from the mostly out-of-town crowd was that airline mechanics take GHB at night while working on planes and commercial pilots use it as a sleep aid.

"The emotional bias pervading the conference was understandable considering that many attendees had been personally affected by ill-informed or irresponsible GHB use."

In contrast to the law enforcement and community panels, the third section, on GHB research, provided a promising bridge to the MAPS community. With the goal of increasing awareness through educating health care providers and the public with results of scientific research, the researchers were more able to focus clearly on the facts. Deborah Zvosec and Steve Smith of the Hennepin County Medical Center in Minneapolis are interviewing GHB addicts and former addicts for a study on the development and course of GHB addiction and withdrawal. Both advocates and dissenters can agree that well-collected information is beneficial to reducing the harms associated with any substance.

Overall, the conference thoroughly covered the symptoms of GHB addiction, overdose, and withdrawal. However, nowhere in the lectures, discussion, or video footage did I hear information about the moderate GHB users like those I have known. The presenters also failed to offer any explanation as to why people choose to ingest "paint stripper mixed with drain cleaner." This omittance led one to wonder what was being hidden.

Users report that a GHB high is similar to an alcohol high, but with more lucidity and less body-heaviness, similar to the mental clarity and euphoria that is experienced after strenuous exercise. It has a profound ability to heighten sensuality and sexuality and is used to enhance a wide array of activities including dancing, communicating, massaging, and exercising. GHB is reported to "take the edge off" an LSD experience and smooth the come-down from Ecstasy.

Responsible users are aware that the primary danger of GHB lies in its extremely narrow dosage range, and use measuring instruments to calculate each dose. Even so, accidents happen, and even the most experienced users are capable of miscalculating a dose, especially while high or when using unfamiliar instruments or concentrations. Symptoms of a GHB poisoning may include nausea, vomiting, unrousable sleep, abnormal breathing and convulsions.

Despite the risks and their exaggeration in the press, GHB was recently approved as a medicine to treat narcolepsy under the brand name Xyrem. Before this approval could take place, GHB received a unique treatment by the FDA. It was re-scheduled as both a Schedule I (no medical use, high potential for abuse) and Schedule III (accepted medical use, lower potential for abuse) substance. Orphan Medical's marketing

campaign appropriately boasts the slogan, "Bring back the laughter."

The emotional bias pervading the conference was understandable considering that many attendees had been personally affected by ill-informed or irresponsible GHB use. Some had lost loved ones to overdose or addiction; others had been victim to GHB-facilitated sexual assault. People are in need of truthful information to prevent these tragedies from happening in the future, but some are caught in an unfortunate cycle. Their personal experiences motivate them to seek out information, but at the same time prevent them from finding the impartial information that is needed.

In order for the MAPS community to fully realize its goals of honestly evaluating psychedelics as potential medicines, and educating the public about the risks and benefits of these substances, we must find a way to work with people who vary in personal and political beliefs. If advocates and dissenters of GHB and other psychedelics can work together more closely, we can exchange feedback on each other's blind spots and biases. Attending the National GHB Conference allowed me to have compassion for drug war proponents, and identify possible points of connection with the MAPS community. Hopefully, we can build on common ground and meet somewhere in the middle — before seeking out new information together. ■

The Third National Clinical Conference on Cannabis Therapeutics

May 20-22, 2004
Charlottesville, Virginia

Patients Out of Time is pleased to announce that it will serve as a co-host along with the University of Virginia School of Nursing, the Pain Clinic of the University of Virginia's Health System, the Virginia Nurses Association and the University of Virginia School of Law for The Third National Clinical Conference on Cannabis Therapeutics to be held on May 20-22, 2004, at the Charlottesville Omni Hotel in Charlottesville, VA, USA.

The conference is designed for physicians, nurses, healthcare professionals, legal professionals and patients. The conference theme, "Cannabis Use Throughout the Life Span" focuses on the current research and clinical applications involving cannabis as one of the therapeutic options for health problems that include: behavioral problems, general pediatric applications, use during pregnancy, dependence and addiction risk, pain, traumatic brain injury treatment and movement disorders. The educational sessions facilitated by researchers and clinicians from the United States, Canada, Israel and the United Kingdom provide a platform for discussion that include the pros and cons for considering cannabis as a therapeutic option, varied delivery modalities, modern clinical research, use in the hospice setting, and other medical and legal issues related to this therapy.

The conference provides AMA Category 1 credit to physicians, and CEUs to nurses and other healthcare professionals through the Office of Continuing Medical Education of the University of Virginia School of Medicine.

Lending a hand at Burning Man: Psychedelic emergency services in the Black Rock Desert

Brandy Doyle (brandy@maps.org)

For our third project in providing psychedelic emergency services, MAPS volunteers joined 30,000 other participants in the Black Rock Desert for Burning Man 2003. Burning Man is often described as an exercise in radical self-reliance: with a ban on vending, and a remote location in the harsh Nevada desert, participants are expected to provide everything from their own food and water to their own creative energy, entertainment, and bizarre costumes. The result is Black Rock City: an interactive landscape of surreal sculpture, whimsical vehicles, and spontaneous fun.

Self-reliance, however, is balanced by community support. The "city" thrives on a gift economy, with a strong ethic of helping one another on survival needs, art projects, and emotional concerns. In fact, this community support is built into the infrastructure of Burning Man, in the form of a volunteer team of non-confrontational mediators: the Black Rock Rangers. These folks patrol the city, helping people set up their tents, assisting in disputes with neighbors, and addressing safety concerns. When necessary, they work with the medical and fire teams, and coordinate with outside law enforcement.

"Even when psychedelic experiences become frightening or disturbing, medical or law enforcement intervention is often unnecessary if compassionate, experienced friends are present."

Mostly, however, the Rangers help people to solve problems themselves, gently offering help when needed and otherwise staying behind the scenes, working to create a safe environment for people to have their own experiences. It's an approach that sounds almost like psychedelic therapy. As you might imagine, the MAPS team was very happy to work with this group to offer our own volunteer efforts.

MAPS volunteers worked alongside the Black Rock Rangers in Sanctuary, a geodesic dome adjacent to the medical tent. Our group included Sandra Karpetas, who has worked with MAPS on similar projects and now helps to run the Iboga Therapy House in Vancouver; Dr. John Halpern, a psychiatrist researching psychedelics at Harvard Medical School's McLean Hospital; trauma counselor Kate Sorenson; "Sam", an underground psychedelic therapist; and from the MAPS staff, myself and Rick Doblin. Other volunteers were Mark Brennan, Suez Holland and Steven Oldridge. In order to learn the Ranger system and better understand the layout and workings of Burning Man, several of us underwent Ranger training and went out patrolling on mentor shifts. A few of us even became full-fledged Rangers, which allowed us

to use staff radios to listen for incidents and communicate with other volunteers.

One of the reasons MAPS has undertaken psychedelic emergency work is to demonstrate how the psychedelic community can care for its own. Even when experiences become frightening or disturbing, medical or law enforcement intervention is often unnecessary if compassionate, experienced friends are present. Black Rock City is an amazing model of how a community can show responsibility and compassion. And psychedelics, while not used by everyone (or even by most), are, for many, part of the festival's celebration of free expression and pushing the limits of possibility.

Of course, boundary-pushing of any kind can be overwhelming, which is why the Rangers created Sanctuary. This is a place where people can recover from, or at least sort through, the stress of obnoxious campmates, strained relationships, or failed art projects. While a professional crisis intervention team is available to handle the most serious concerns (for instance, domestic violence or tragic accidents), the Sanctuary staff provides an emotional safety net for the Burning Man community. People suffering from sleep deprivation can find a quiet place to nap, and staffers distressed by incidents on shift can find a friendly ear to listen.

As the chaotic activity of the event builds over the week, Sanctuary sees more visitors, and a number of these folks were having difficult trips. We had several very powerful opportunities to work with people in psychedelic states. Three individuals, in particular, had what seemed to be especially meaningful experiences, touching on the some of the most powerful events in life: birth, parenting, and death.

MAPS volunteer Sandra Karpetas prepares a meal at Burning Man.

Early in the week, Sandra worked with a woman who was brought in because her loud yelling disturbed her campmates. She wanted to know if she had permission to let go and feel safe, asking, "Can I do what I need to do? Can I be vulnerable?" When she felt that she could, she proceeded to have what I can't help but see as a classic Grof experience: she lived out the symbolic act of giving birth. Lying on the floor, for hours she sweated, groaned, and underwent contractions, until at dawn, she apparently gave birth…to herself. She slowly returned to normal consciousness, feeling that she had undergone a process that was important and cathartic. She explained later that earlier in life, she'd had an abortion, an issue that arose powerfully during her psychedelic experience. Far from being a psychotic episode, as her "freaking out" might have been treated in another context, this birth process was relevant and healing in her ordinary life.

"Far from being a psychotic episode, as her 'freaking out' might have been treated in another context, this birth process was relevant and healing in her ordinary life."

Peter also had an experience that turned out to be quite meaningful in his life. When he came in, he was extremely agitated and confused, complaining he felt uncomfortable and alternately too hot or too cold. He told us he believed he'd been dosed,

though as he grew more comfortable with those helping him, he said he'd taken a hit of LSD. He seemed to trust those in the room, but felt he didn't deserve their help, frequently over-thanking everyone. At one point, he worried that he was going to die, and he would never get to see his son again.

Along with one of the Rangers, the underground psychedelic therapist on our team, "Sam", helped Peter to open up to his fears, encouraging him to use movement and sound to release his anxiety. The following morning, Rick helped him think through his experience, and discovered a symbolic component to his seemingly unreasonable fears the night before. In order to come to Burning Man, Peter missed an opportunity to be with his son, of whom he does not have custody, and his guilt and anxiety over his family life led to his "bad trip." Dealing with these issues directly as he came down from the trip, he felt that the experience was enormously helpful, likening it to "five years of therapy."

Dave was another participant who initially was afraid to admit he took psychedelics. His friend brought him in, explaining that Dave was having a panic attack, a regular occurrence for him. Rick sat and talked with him, and as Dave came to feel more comfortable, he revealed that he had taken mushrooms that night. As his story unfolded, he explained that his panic attack had a serious and specific cause: he had a terminal cancer diagnosis, and did not expect to live for very long. Often, as in Peter's case, the understanding people have of their lives while on psychedelics is a symbolic one. However, after talking to Dave's friends later on, we learned that Dave's story was true. With Rick's help, he started to face his fears, even becoming calm and comfortable as he discussed the end of his life. He talked about how he hoped to end his own life when the pain became overwhelming. Accepting the inevitability of his own passing, he was even able to reflect on the needs of others, thinking of how best to say goodbye to his daughter and the rest of his family.

Lamplighters prepare to illuminate Black Rock City

Each of these people was able, with the help of an experienced guide, to turn a difficult experience into a valuable one. Even in the hectic environment of an outdoor festival, even when fearing legal or other repercussions, they were able to turn inward and use their own resources to work through hard issues. Not only does this speak to the value of psychedelic therapy, I would also argue that it reflects the capacity of individual lay people to use psychedelics beneficially. I disagree with those who feel psychedelics should only be in the hands of experts, like licensed therapists or religious practitioners. I think that despite the risks inherent in recreational use, a society with legal psychedelics would develop a body of knowledge and experience among users that would minimize harmful consequences. Burning Man's do-it-yourself ethos is a celebration of the potential of regular people. From what I've seen there and elsewhere, people do have the potential to take care of one another, and have valuable, healing experiences with psychedelics in a recreational context.

I have to admit I was a little disappointed that I personally didn't have the chance to work with anyone in a profound psychedelic state. I had a fantastic conversation with a dehydrated woman, sat with a drunken pilot who mistakenly

"Despite the risks inherent in recreational use, a society with legal psychedelics would develop a body of knowledge and experience among users that would minimize harmful consequences."

thought he was dosed (until he fell asleep), and helped a possibly tripping, but definitely drunken participant look for her purse. But even though I didn't get to learn much about how an individual can work with and integrate psychedelic states, I learned a lot about how a community can. For me, the best part of helping at Sanctuary was being part of a group that not only valued psychedelic experience, and supported individuals through difficult spaces, but also functioned as part of a community, creating a context for these experiences within a bigger whole.

Much of what takes place at Burning Man is not quite translatable to everyday life. The temporary paradise in the desert couldn't exist if people didn't work the rest of the year, saving the money for all the generators and turntables that create the electric playground for a week. High-intensity celebration and exploration can only last so long.

What's amazing, however, are the values that are expressed in this transitory city. Even though it's just a few days long, Burning Man requires an enormous amount of organization. This is both for its internal functioning (to build and maintain its structure, ensure the safety and wellbeing of participants, and protect its natural environment), and its external relations (to live harmoniously with communities nearby and interface effectively with outside law enforcement and regulatory agencies). Yet Black Rock City is run by a paradox, an almost utopian bureaucracy. This relatively non-hierarchical system honors individual personalities and experiences, living its values as it performs its functions. I believe these values include a respect for the benefits of psychedelics, and a sense of responsibility to protect individuals from the unwarranted intrusion of others' value systems or outside institutions — such as the Drug War.

I was grateful to have the opportunity to participate in such a unique organization. I think Burning Man offers a glimpse of what's possible when people work together to express their idealism in the real world, holding onto a vision in the dust and sweat and toil of reality. Which reminds me a little of MAPS. With the support of our own unique community, we can continue the struggle toward a policy on psychedelics and marijuana that's founded on solid research, common sense, and compassion. It's slow, but it's inspiring — and sometimes it's even a whole lot of fun. ■

This thank you note is from a Burning Man participant – also a therapist – who, with his girlfriend, talked with our volunteers while on MDMA. They were working through a difficult LSD experience they'd had earlier in the week:

"I wanted to thank you for the help you gave us at Sanctuary – running into you when we did was a godsend, as I can't imagine meeting my girlfriend's parents later that week with her in the state she was in. She describes feeling the 'dust settle' in her mind, and although the initial surge of wellbeing she felt immediately after the therapy has receded somewhat, leaving some anxieties to resurface, to me at least she seems back to her old self. Incredible! I never imagined I would be experiencing such psychotherapy as a patient before I did it as a doctor!"

Perspective on Burning Man

Beyond Belief — Exactly!

By "Sam", an underground psychedelic therapist

This year's Burning Man theme, Beyond Belief, asks us to enter a new and larger vision. This larger vision should address the individual, the Burning Man community, and the culture at large. I'd like to share a few of my observations regarding Burning Man, and the visions that came out of that.

I just loved Burning Man, and I have great respect and admiration for the way Burning Man was organized and the way ALL the different helpers worked, by themselves and as a group. I also see that it would be the perfect place to do more "hands on" psychedelic therapy, and to move beyond the beliefs of the larger culture. For this reason, I really think MAPS should be more visible.

I'd like to illustrate my points by sharing this story with you. When I came home from Burning Man, my son and his friends told me about a high school buddy of theirs who had been to Burning Man and had a very bad experience. This friend, who's 25 years old and a very experienced tripper, had taken liquid acid. His trip developed into a two-day, two-night nightmare. He was terrified of the Rangers, medics, cops, and other authorities. He had strange physical symptoms, hellish visions, and feelings of paranoia for 48 hours. He's now back home in North Carolina, but according to his high school buddies, he's "weird." He's not like he used to be, and still afraid for no apparent (to him and his friends) reason. Now, if he had heard of MAPS, and known that trained and experienced people were available in a very safe space, he or his friends might have searched us out. I'm absolutely certain that in this situation we could have been of great help.

Our way of working with psychedelic emergencies is, in most cases, almost the opposite of what the very talented and caring helpers are doing at Burning Man. We see a powerful, mindblowing, crazy experience as an opening, an invitation to go in and work with the material that emerges. It's not something people need to be talked out of, or assured that it's just a short episode that will fade away and be gone forever.

After over 30 years of working with psychedelics, I engage the person having the emergency, welcoming the situation as an opportunity to do needed investigations, expressions, and healings. So the situation gets turned around and we can guide people, educate them, and point them in a direction that's empowering. Then they can take this experience from Burning Man and bring it back into their lives.

At Burning Man and the other two events where I've worked with MAPS, even the promoters have tried to downplay, discount, and/or discredit the use of psychedelics. By doing that they also feed the War on Drugs. Therefore, our other goal must be a re-education towards a holistic understanding regarding the use of all psychedelics. We must educate people at these events about the ancient healing, visionary, initiatory, and ritualistic use of psychedelics. Our education would also draw on modern consciousness research and the psychedelic therapies that have been established during the last 40 years.

"Beyond Belief"' was this year's theme of Burning Man. I understand that as a call not just to re-examine our own myths, stories, and beliefs, but also to help transform the beliefs, myths, and old stories of our culture. Many of these outdated stories and beliefs are based on relentless propaganda telling us the psychedelic experience is evil or simply useless.

There is a critical need for more and better education, research, and visibility. MAPS is doing a great service in these areas, so keep up the good work. ■

Not Your Father's Revolution: Two Summer Conferences and the Next Generation of Psychedelics, Spirituality and Community-Building

Valerie Mojeiko (valerie@maps.org) and Brandy Doyle (brandy@maps.org)

Altars, group meditation, and late-night thumping dance parties — not exactly typical conference features. This summer, however, we had the opportunity to experience two conferences that shared these elements, events that integrated celebration and spiritual exploration into their occasions. They also shared another unique characteristic; both were aimed at, and organized by, people in their 20s and early 30s. It was inspiring to see how these communities re-interpreted the lessons of older psychedelic culture and spiritual wisdom into entirely new visions of the world. On a planet that grows increasingly smaller, in a country with D.A.R.E. programs and the R.A.V.E. Act, and in California, where dozens of collectives organize guerilla dance parties in warehouses and deserts, these new visions are necessary. They are the dynamic response to and catalyst for a changing reality. At the Gathering of the Tribes in Los Angeles and the Altered States and the Spiritual Awakening conference in San Francisco, young people gathered to honor these visions, as they learned, taught, and celebrated.

Hoopers practice their skills at the Gathering of the Tribes

Gathering of the Tribes

Each summer, hundreds of bright-eyed ravers, desert-heads, neo-hippies and other label-defying lovers of dance music converge upon Los Angeles for Gathering of the Tribes (GOTT), an annual five-day conference and festival that unites and supports dance music collectives from L.A. all the way up to Vancouver (and a few from elsewhere in North America and Europe).

In organizing around dance events, these collectives form communities, supporting DJs, visual artists, and performers of all kinds. They serve as hubs for sharing harm reduction information and building activist networks, and they assert a shared spiritual communion unique to all-night communal dance events. Founded by Dustianne North three years ago, GOTT is an opportunity for leaders from these collectives to trade ideas, share experiences, and strategize around the common issues facing their

"Trichter's vision for ASSA was a conference that would be affordable to young people and students...He hoped to bridge the gap between a younger generation of psychonauts and spiritual explorers and the psychedelic elders they would otherwise not have the chance to meet."

communities. It's also a chance to celebrate. GOTT opened with a feast in an almost circus-like atmosphere, with stilt-walkers, fire eaters, and other performers moving through the delighted diners. The festivities continued all week, with late-night dancing and a show that featured amazing performances in dance, acrobatics, and drama.

This year, GOTT was held June 11-13, in Qtopia, a roomy warehouse-turned-event space on Hollywood Boulevard. Presentations, workshops, performances, and dance events were inspired by the theme "Evolution + Manifestation = Transformation."

Although most participants at GOTT were of the same generation, the event began with a strong sense of history and intergenerational connection. The GOTT "elders," mostly in their 30s, many of whom have been part of the dance community for more than a decade, told stories of their tribes' evolution to the present day. In the "Sages Circle," the conference hosted a delegation from an older tribe: the Prophets' Conference. Prophets' Conference founders Robin and Cody Johnson, visionary Barbara Marx Hubbard, and Grateful Dead lyricist and Electronic Frontier Foundation co-founder John Perry Barlow all joined GOTT to share their perspectives on a rapidly changing world.

GOTT participants sit on pillows, mats and other soft things during the opening meditation.

The conference also focused on building bridges with other activist and artistic communities, bringing representatives from hip hop culture, civil rights groups, environmental activists, and the peace movement. Within the GOTT community itself, individuals and groups presented new and ongoing projects. These included activist efforts, like the Club Safety Awareness Initiative and Dance for Peace, participatory workshops like hula hoping and trapeze lessons, and community-building projects like the Reconvergence of the Tribes in Vancouver.

Presenters also led group discussions on issues of interest to participants, such as Theo Rosenfeld and Jolayne Marsh's discussion on polyamory, and DanceSafe staffer Melissa Martin's talk on inspiration and motivation for activism in the dance community. Collective leaders, activists, and legal experts held a discussion circle on "The State of the Underground," evaluating the status of the dance community's legal situation and activist progress. MAPS staff member Brandy Doyle had the opportunity to give her first public presentation for MAPS, to a sympathetic crowd of ravers sitting on pillows. The talk, "Mak-

ing the World a Better Place with Psychedelics: Research, Politics, and Culture," discussed MAPS' research efforts, the Rites of Passage Project on families and psychedelics, and ideas for making psychedelic exploration safer and more beneficial. (I discovered I had a lot to learn from the GOTT folk. While they were mostly unfamiliar with the psychedelic therapy model, they were far more knowledgeable than I am about the therapeutic and spiritual potential of psychedelic use in a dance environment. This kind of use draws on ancient traditions of communal experience, and deserves attention in the study of therapeutic psychedelic use.)

The week ended when GOTT participants joined Moontribe, an L.A.-based dance collective, in celebrating their ten-year anniversary, at a weekend campout/dance party in a forest five hours northeast of L.A. This was the integration of all the lessons, the community-building, and the friendships formed during the event. After a day of traveling and rest, campers awoke to the sound of a single note breaking through the dawning chirps and rustles of the meadow. They forged the ice-cold stream that divided the camping grounds from the area that would soon become the dance floor. Decked out in the traditional outdoor dance party garb of layered flowing fabrics, warm fuzzy things, and eye protective goggles, they created a circle around the meadow, as each person silently joined hands with the two nearest others. When the circle was several acres wide, it suddenly collapsed on itself, into a chest-crushing group hug.

The music began.

Altered States and the Spiritual Awakening

On a chilly San Francisco summer morning, in a concrete courtyard hidden between SOMA-district warehouses and fenced parking lots, people of all ages gathered for breakfast, group meditation, and archetype-summoning to the sound of drums and didgeridoo. Thus opened Altered States and the Spiritual Awakening (ASSA), July 11-13, 2003, a conference that brought together experts from the fields of transpersonal psychology, parapsychology, entheogens, and consciousness exploration. The event was organized by Stephen Trichter of False Profit, a limited-liability corporation with the mission of emphasizing human over financial value. Trichter's vision for ASSA was a conference that would be affordable to young people and students like himself (he is a graduate student in psychology). He hoped to bridge the gap between a younger generation of psychonauts and spiritual explorers and the psychedelic elders they would otherwise not have the chance to meet.

This intergenerational meeting took place in the funky setting of the False Profit house/warehouse space, which was completely filled with couches for the occasion. Outside, in the courtyard, participants ate catered meals and browsed tables set up by Erowid and MAPS. MAPS also provided assistance prior to the conference by facilitating donation processing. Inside, participants attended lectures, panels, and smaller, interactive workshops on a host of topics.

Several talks approached spirituality from a research perspective. Frank Echenhofer, Ph.D. gave a fascinating talk on his EEG studies of Tibetan meditators and Brazilian ayahuasca users. Stanley Krippner, Ph.D.'s lecture on shamanism addressed ways in which the study of shamanism could make contributions to cognitive neuroscience, social psychology, psychological therapy, and ecological psychology. The six D's of shamanic technology — drumming, dancing, dreaming, drugs, diet, and deprivation — were of special interest to the crowd, which doubtlessly contained at least a few modern-day shamans.

There were almost twenty different speakers over the weekend. Daniel Pinchbeck, who wrote *Breaking Open the Head*, talked about the works of Austrian mystic Rudolph Steiner. Bob Jesse, of the Council on Spiritual Practices, discussed "Communities of Spirit." Luis Eduardo Luna, who leads ayahuasca retreats at Wasiwaska in Brazil, talked about ayahuasca use in a non-religious, non-shamanic ritual setting. The panels included a Q-and-A with the always popular Ann Shulgin, co-author of *Pihkal* and *Tihkal*, and Earth and Fire of

"For MAPS members whose primary associations with psychedelic culture are The Oracle or Woodstock, these communities should serve as welcome successors to the dreams of older generations."

erowid.org.

During the workshop sessions, many presenters discussed practical possibilities for spiritual development, offering technological, therapeutic, and spiritual tools to expand, change, or otherwise explore one's consciousness. For instance, Morgan Brent, Ph.D talked about preparation, navigation, and integration in tryptamine use. While several workshops related to psychedelic exploration, others focused on other kinds of consciousness change, such as dreaming, kundalini, and hypnosis.

Visual artists, as well as musicians and dancers, are celebrated and supported at dance collectives events.

One panel, moderated by Daniel Pinchbeck, addressed "Occult chaos in the 1960s and beyond." This conversation, between Magini, *Techgnosis* author Erik Davis, David Caploe, Ph.D., and Shanti, discussed the problems as well as the power of the 1960s psychedelic culture.

Generation-bridging, one of Trichter's goals for the event, was directly relevant to some of the talks. Maria Mangini, Ph.D., FNP, CNM gave her popular talk "Yes, Mom Took Acid," describing her narrative analysis study by the same name, in which she examined the sociohistorical impact of prior psychedelic use in adults. Mangini brings her expertise not only as a researcher, but also as a direct participant in the heady days of early psychedelia, a Catholic school teacher, and the chair of the Haight Ashbury Free Medical Clinic's Board of Directors. Dressed in an almost grandmotherly, and decidedly mainstream outfit, she explained that she is actively trying to change the far-out associations people have with psychedelics. "I want to make them think of me when they think of drugs," said Mangini.

Bridge to the future

For MAPS members whose primary associations with psychedelic culture are *The Oracle* or Woodstock, these communities should serve as welcome successors to the dreams of older generations. They have taken the ideals of peaceful activism, spiritual growth, and personal freedom and brought them into a 21st century context. In sharing MAPS' research and educational work at these events, we also had the chance to connect to our own community — a psychedelic culture which is alive and well. ■

A Review of *Practicing Harm Reduction Psychotherapy* by Patt Denning

Bruce Sewick, MA, LCPC (gunting@msn.com)

Having read the reviews on Tatarsky's *Harm Reduction Psychotherapy*, I was drawn to Denning's book because it looked more like a "how to" text than a collection of case studies. This proved to be right, and the book is a good reference for those who need more of a "cookbook" approach. Denning's approach, even when writing, is "client-centered". This book shows therapists how to empower their clients by validating their drug use as adaptive behavior, and using this knowledge as a basis for treatment.

Patt Denning is a successful harm reduction therapist who has been working in the field of mental health and substance abuse for 25 years. She is the Director of Clinical Services and Training at the Harm Reduction Therapy Center in San Francisco, California. She views addiction as a biopsychosocial phenomena, and her book attempts to explain addiction from this perspective. The book includes case studies illustrating the topic of each chapter, covering the principles of harm reduction, assessment and treatment design, and multidiagnosis patients. Also included are extensive appendices and a report on two of her consultation projects.

Her first chapter on harm reduction touches on the politics of drug laws, suggesting that the harsh penalties for drugs are politically or racially motivated. Denning advises clinicians to sort through their own beliefs regarding getting high to avoid a "countertransferential mire of reflected negative judgements and basic misunderstandings of our patients." This book also debunks many of the myths surrounding illicit drugs. She notes that the vast majority of drug users are actively working (71%) –- most of them full time. This data can help clinicians understand that drug use does not necessarily mean a person cannot be a productive member of society. Denning also cites data showing that even with addictive drugs (heroin and cocaine), less than one-fourth of users become dependent. Another little-known fact is that the highest use of most drugs occurs early in life, with spontaneous remission the rule rather than the exception (tobacco excluded).

Denning defines success as "any movement in the direction of positive change, any reduction in drug-related harm." She gives examples of how a rigid adherence to success defined as abstinence only caused more harm to her patients than the drugs they were using. Focusing instead on harm reduction, she explains, allows clinicians to treat addicts as people with problems, not problem people.

The adaptive model, which includes harm reduction, is contrasted to the "disease" model of addiction. The disease model views the individual as engaging in mechanically-determined behavior, whereas the adaptive model stresses the purposeful nature of the activity. In the adaptive model, drug or alcohol abuse is seen as an adaptive search for compensatory mechanisms. These mechanisms are reinforcers allowing a measure of normal functioning.

"Focusing instead on harm reduction, she explains, allows clinicians to treat addicts as people with problems, not problem people."

One of the key concepts of harm reduction is viewing addiction on a circular continuum of use, rather than a linear progression. Points on this continuum include experimentation, social/recreational use, habituation, abuse, dependence (abuse + compulsion + relapse potential), physi-

ological dependence and persistent addiction.

Illicit drug use doesn't always lead to abuse. The focus of this treatment modality is on the harm done and on the needs of the user, rather than on the drug itself; people can make changes while still using. There is an important distinction made in this text between use and abuse. It is reported that many clinicians feel that the *illegality* of a particular drug alone makes it abuse. Denning offers an example of a recovering alcoholic who smokes marijuana and thus is considered "abusing," whereas another recovering alcoholic using nicotine or caffeine is okay.

The third chapter explains how assessment is a form of treatment, in that gathering information is a necessary component to developing a therapeutic relationship. More specifically, motivational interviewing (listing costs and benefits) is a tool to enhance a client's motivation to change and is a way for clinicians to educate themselves about the clients. It is a technique more about collaboration than coercion. Denning also cautions clinicians to refrain from compiling a detailed drug history in the first few sessions as it diverts attention from the complex psychosocial aspects of drug use. She describes a multidisciplinary approach to assessment, which includes the following elements:

- client's stage of change (i.e. precontemplation, contemplation, preparation, action, maintenance (with possible relapses) and termination
- decisional balance (understanding benefits & consequences of drug use)
- types of drugs used
- level of abuse or dependence
- prescribed medication
- past treatment history (useful in planning for next phase of treatment matching)
- support system (does the client have a support system that can be utilized in time of distress?)
- self-efficacy (essential in the ability to make a change)
- psychiatric diagnosis (and how substance use affects symptoms)
- client's stated goals ("what would you like to change?") that derive from unique decisional balance worksheet
- developmental grid (outline of key events and personality traits that will guide treatment)

Harm reduction psychotherapy emphasizes the importance of a therapeutic relationship, which creates an environment fostering change. Denning suggests helping this person realize the complex positive and negative reasons for drug use by modeling curiosity and resisting premature conclusions.

When clinicians set goals, they should also be on a continuum, ranging from cutting back to abstinence. The goals should be "observable behavioral changes that are achievable within the context of the client's life." The therapist's goals should be compatible with the client's stated goals. Denning provides a thorough treatment design and emphasizes that it is not from the "all or none" school of treatment. Instead she cites "warm turkey" alternatives to abstinence, such as tapering, trial moderation, and sobriety sampling, which could include "drug-free days." She recommends providing an atmosphere in which the patient feels understood rather than judged, and in which the treatment's goal is to develop a needs hierarchy based on the client's perceptions and resources. The goals should be a combination of short and long-term goals, a more realistic approach.

In discussing treatment design, she explores the complexities inherent in drug abuse. For instance, she touches on the possibility that a client's relationship with a drug might be a substitute for intimate relationships. Indeed, most therapists offer themselves as a substitute attachment, but unlike the drug of choice are not always readily available nor are their efforts as successful.

This is a much-needed book that respects the client for his or her uniqueness and autonomy. Her philosophy is reflected in her acknowledgement of client influence: "I owe whatever wisdom I now possess to the patients who taught me that they do indeed know what they want and will allow me to help if I do not stand in their way." Well said — and a good read. ■

An Open Letter to Rick Dobin, Ph.D.

Hi, Rick. It's been a while. The Association has grown considerably since I joined ten years ago, the Bulletin seems to get better with every issue, membership grows, as does your staff and funding, and we grow older. I recall corresponding with you, talking with you over the phone and finally taking you to lunch after some conference in LA. You were always personally what you present yourself to be through the auspices of MAPS—diplomatic, serious, gentle and dedicated to the scientific advancement of psychedelia within strictly monitored and legally sanctioned protocols.

To say that we disagreed on these goals would be an understatement. But since you were the guy with the clubhouse, I asked if there was any way in which I could help out, and you set me up with a few writing assignments, none of which ever panned out, which, if I were given to irony, I might say about most of your research protocols, as highlighted in the last MAPS Bulletin (V. XIII, N. 1). This is no dig at you, Rick, but only to emphasize what I've said from the beginning: the US government will never permit consciousness expansion to be legally conducted in this country under a medical model short of armed revolution. I do not advocate the latter, mind you. I simply state the facts as I see them.

As a lawyer, indeed, as a former state prosecutor, I have watched the amazing degree to which heretofore persecuted groups have vindicated their rights through political struggle over the last 30 years. African-Americans, Women, Latinos, Gays and Lesbians, the physically and sexually abused, have—in my opinion, largely as a result of the shifting sense of empowerment arising out of the consciousness expansion movement of the 60s—won their liberation and dignity through a process of self-identification, unification, and emancipation. And yet, in that eerie irony that is so much a part of the psychedelic life, these newly freed souls haven't the faintest sense of the debt they owe to the chemists and freaks who fought the hippie wars to free them, and worse yet, we who still fight these wars deem ourselves somehow above the lower depths of "dirty" politics, legal battles and talking heads.

The "M" in MAPS stands for multidisciplinary. Up to now, that has meant anything from "neuro-bio-psychiatric" to "psycho-neuro-biological." Yes, there is something wonderfully ethereal about the biochemistry of ayahuasca and its anthropology or puzzling out the anomalies concerning the effects of certain psychedelics on particular neuroreceptors and concomitant behavioral observations. I realize that this foundation is your baby, Rick, but after so many years, and now that you've got the Ph.D. and we're not one step closer even to legal marijuana in the USA, don't you think that the crusade at MAPS ought to be expanded just a little? Your approach remains largely at the begging level: "Oh please, FDA, DEA, let us do our little study." Simply by virtue of your impeccable credentials, your submissions to government, academia and private foundations are taken seriously. But where has all this seriousness gotten us? The federal prisons are still stuffed with the victims of the policies of those who seriously consider your—hell no, I send you 35 bucks every year—our proposals, reject them and say, "there is no evidence to support"…whatever.

I say it's high time to try to recognize the reality-challenged as a legitimate minority in this country. I say, march on Selma and Montgomery because just as in 1967, I have a dream today. I'm a little older than you, I think, Rick, and I was out in the streets when the whole thing was in its prime, when it was nutso city, the real reason for it all, Elysian Fields and Strawberry Fields and the Dead and the Airplane and the New Riders and the String Band and the whole street scene—like I wonder if anybody today could imagine, but then I'm an old man now and don't get out much so who the hell

knows. But that was the reason for it all, Rick. It was about freedom. Freedom "to" and freedom "from." There were tough guys if you wanted to be a tough guy, but by and large, if you were a "flower kid" you could be as peaceful and lovely as you wanted, too. The color and the music and the generosity and the sex for the few short years that it lasted. And for those of us who were educated, and there were more than a few, oh, the talk 'til dawn and then class or bed or the park or the day's hustle. Nobody's told that story, Rick. It vanished like Camelot, the "real" one. But that was what it was all about.

I was so pleased to read the fantastic interview with Larry Hagman. He is a great soul. But more, it was a break in the biochem, like the "Creativity Issue." Perhaps the message is coming through. So here's the pitch. Please devote some space to other issue areas in the Bulletin: interviews with non-chemists, etc., stories about the days of Hippie-excess, legal and political approaches we can look at to make us free. Maybe it's time to poll your members to see what they'd like to see in the Bulletin.

Your friend,
Frederick Grab

Response from Rick Doblin:

"Fred - Thanks so much for your letter and your spirited critique of MAPS' strategy and Bulletin. We'll definitely include a wider range of articles in the Bulletin than biochem (hope you like the Burning Man article). I do feel that we're making progress toward our research agenda, it's just much slower than we all have hoped for. But there's enough progress that I'm not ready to abandon the effort to initiate scientific research to focus MAPS on general legalization. One day, MAPS may branch out to include a 501 (c) (4) to do political lobbying, but we're not quite there yet."

Congratulations on IRB Approval for the MDMA/PTSD Study

What a wondrous project! I have a poster that depicts the oceans wearing away the rocky coast, and use it as a focus for me, it says, "things take time."

But the beginning of the change in how we deal with psychiatric issues is upon us. I have many jobs and one is working in a small community hospital as a staff nurse on a mental health unit. Almost all the clients have been abused in some form as children, and are left with horrendous self-concepts.

We do little except intervene with antidepressants and mood stabilizers, and that is not enough so they self-medicate.

I know what this medicine can do for the psyche from my own experience. I am honored to be a part of your organization. Many you continue to receive many blessings.

Namaste,
Kathleen Panagiotes, RN,MA

Garuda, gold
Tibetan style
Mineral colors and liquid gold
71.5 x 42.5 cm
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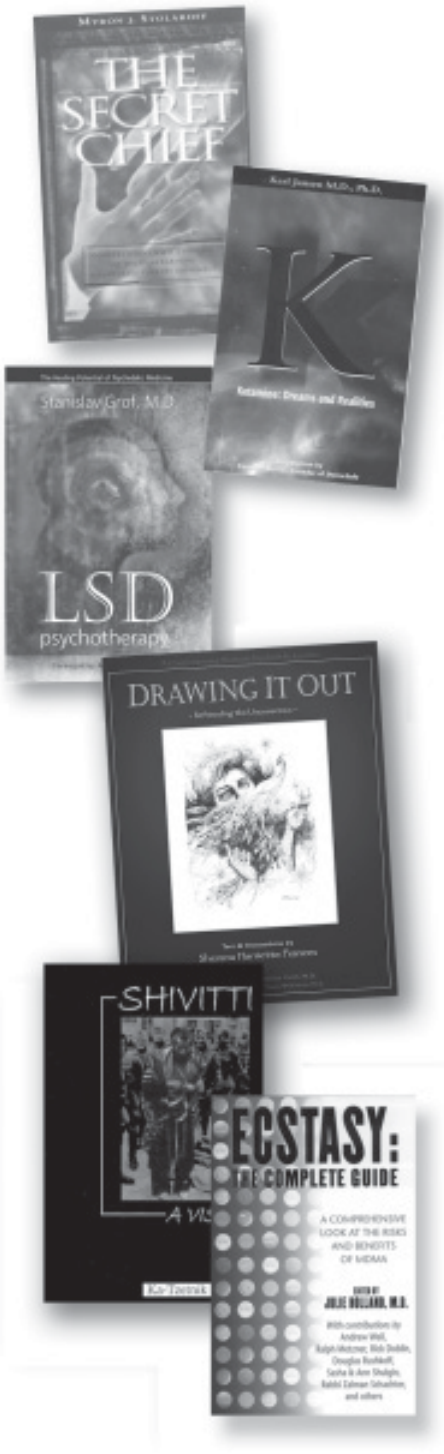

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MAPS MEMBERSHIP INFORMATION

MAPS IS A MEMBERSHIP-BASED organization working to assist psychedelic researchers around the world design, obtain governmental approval, fund, conduct and report on psychedelic research in humans.

Founded in 1986, MAPS is an IRS approved 501 (c)(3) non-profit corporation funded by tax-deductible donations from members.

MAPS has previously funded basic scientific research in both humans and animals into the safety of MDMA (3,4-methylenedioxymethamphetamine, Ecstasy) and has opened a Drug Master File for MDMA at the U.S. Food and Drug Administration. MAPS is now focused primarily on assisting scientists to conduct human studies to generate essential information about the risks and psychotherapeutic benefits of MDMA, other psychedelics, and marijuana, with the goal of eventually gaining governmental approval for their medical uses.

ALBERT EINSTEIN WROTE: "**Imagination is more important than knowledge**." If you can even faintly imagine a cultural reintegration of the use of psychedelics and the states of mind they engender, please join MAPS in supporting the expansion of scientific knowledge in this area. Progress is possible with the support of individuals who care enough to take individual and collective action.

The MAPS Bulletin

Each Bulletin will report on MAPS research in progress. In addition to reporting on research both in the United States and abroad, the Bulletin can include feature articles, reports on conferences, book reviews, Heffter Research Institute updates, and the Hofmann Report. Issues raised in letters, calls and e-mail from MAPS members may also be addressed, as may political developments that affect psychedelic research and usage.

MAPS' founder and President Rick Doblin earned his Ph.D. in Public Policy from the Kennedy School of Government at Harvard University. Doblin was also in Stan and Christina Grof's first training group to receive certification as a Holotropic Breathwork practitioner.

Nicole Tavernier, Director of Operations, has a background in various fields of business and is currently working on her degree in Business Administration.

Mercedes Paulino, Director of Electronic Media, an electro-anthro-bricolier, has become a connoisseur of Deceased Culture, weird hieroglyphs, a frequenter of forgotten systems of Mysterious Statue Chambers and Pyramids, sole witness to Polyhedral Phenomenon of alarming scale in the night sky and Sudden Unexplained Stellar Reconfiguration.

Brandy Doyle, Director of Special Projects, edits the quarterly bulletin and corresponds with MAPS members. Her work gives her the opportunity to learn about public policy, science, communication, and healing. She enjoys the way MAPS is situated at the intersection of research and action, changing the world through understanding the mind.

Valerie Mojeiko, Membership and Sales Coordinator, looks forward to corresponding with the MAPS community. Her interest in drugs and the policy surrounding them, originally sparked by a juvenile marijuana possession charge, has grown to include interests in entheogens, therapy, harm reduction, and transpersonal psychology.

"Nothing in the world can take the place of persistence.
Talent will not; nothing is more common than
unsuccessful men with talent.
Genius will not; unrewarded genius is almost a proverb.
Education will not;
the world is full of educated derelicts.
Persistence and determination alone are omnipotent."
– Israel Regardie

Rick Doblin speaks with visionary artist Alex Grey in his Brooklyn studio after the conference

Drug Policy Alliance Conference November 6-8, 2003 Newark, New Jersey

Author Daniel Pinchbeck speaks at a panel on psychedelics, which also included Rick Doblin, Alex Grey and author John Horgan

DanceSafe National Coordinator Melissa Martin gives a glowsticking lesson at the panel "Communitas: Ritual, Drugs, and Social Change."

Lynne and Rick Doblin enjoy the awards dinner at which Rick received the Norman E. Zinberg Award for Achievement in the Field of Medicine

"What is to give light must endure burning."

Viktor E. Frankl, neurologist, psychiatrist and Holocaust survivor

Burning Man 2003
See article page 28

Photo by Jim Hammer
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