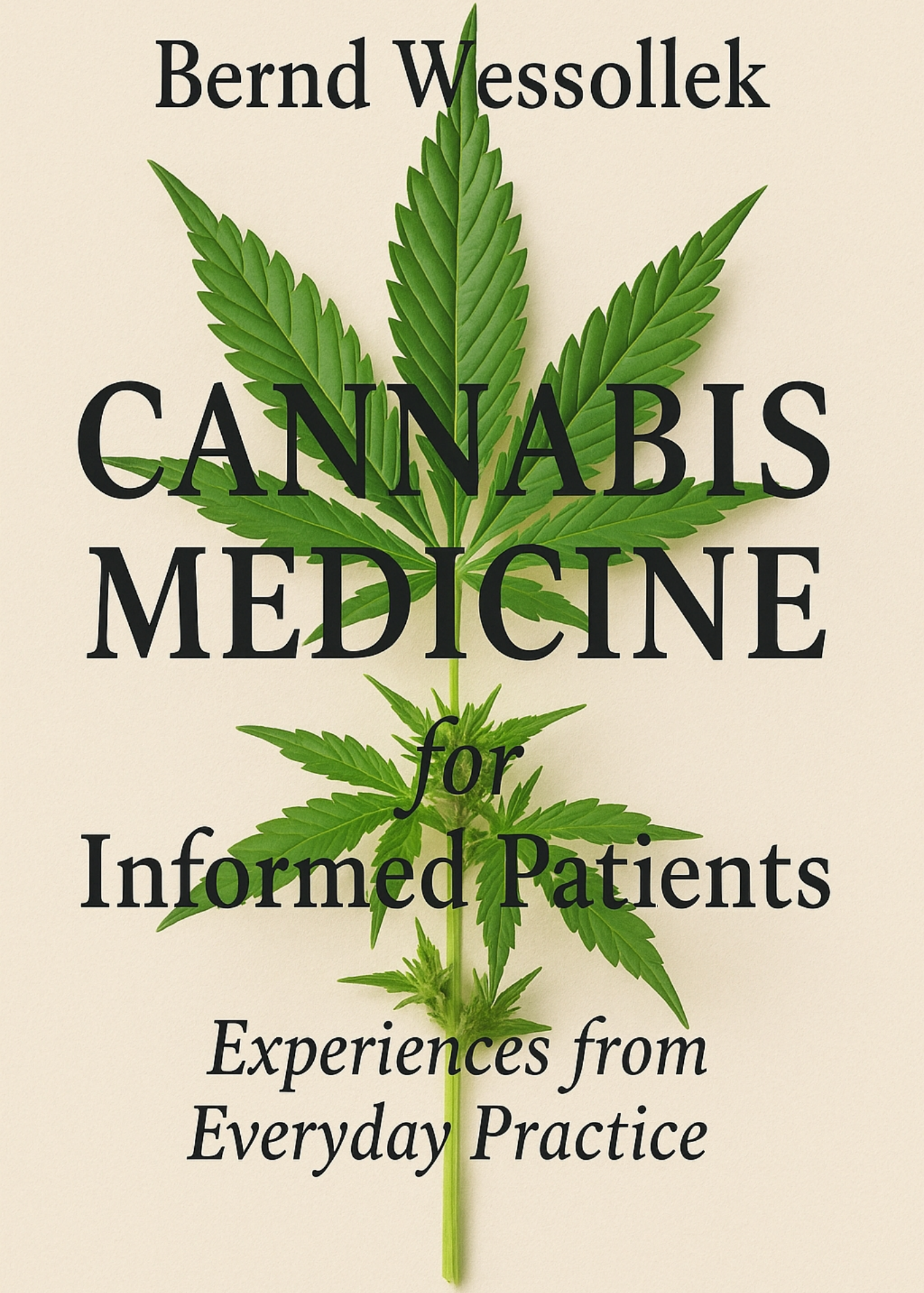
Bernd Wessollek



CANNABIS MEDICINE

for Informed Patients

Experiences from Everyday Practice

Bernd Wessollek

Cannabis medicine for responsible patients

Experiences from real-life practice

Foreword

This book was published in print in spring 2024 by Nachtschatten-Verlag Solothurn. With the help of friends, I have decided to offer it free of charge as an e-book in German, English, Thai and Estonian. It can also be supplied in Polish, Spanish, Turkish and Italian on request. However, it is easy to translate the edited German edition into the desired language yourself using AI. Anyone who has been suffering from chronic illness for a long time without having found a viable path to recovery/health may come to the conclusion after reading my experience report: I'll give it a try! Great, get in touch with us! We look forward to hearing from you. Reading the (short!) book requires some concentration. Read it with a little childlike trust. I haven't lied. cbd-thaimassage-berlin has now become a peaceful, beautiful place with a campsite, guest rooms, a holiday apartment and much more. It is located in the middle of Isaan, about halfway between Udon Thani and Sakon Nakhon, both of which are larger cities with airports. The flight time from Bangkok is 1 hour. We live here together with the locals. No resort, no reservations. We learn from each other. The Thai people are friendly, honest and lovable. The goal is to create permanent jobs for masseurs, movement therapists, gardeners, service staff, nurses, etc. Your help in building an ashram where people can lay the foundation for lasting recovery in a few days/weeks/months is indispensable. You bring the millennia-old Thai culture into every encounter with patients. We accompany cancer patients to the nearby Wat Khampramong, which is unique worldwide and, in my opinion, a leader in therapy. Arokhayasala Khampramong Temple. 100 km away. Some of this is in the book. About cancer in general and Khampramong in particular. We take care of daily nursing, as is customary in all Thai hospitals, if the patient's family is unable or unwilling to do so. This is rare. But it is common in Europe. When I wrote the book 22/23, I still had hope that collective cultivation in cannabis social clubs would prevail. Once again, I had underestimated the extent of their networks, possibilities, but also their inhibitions and unscrupulousness: I am referring to the global conglomerate of the pharmaceutical industry, pharmacists, health authorities and politicians. After meticulous and presumably corrupt preparatory work following the last step towards legalisation in Germany**, the pharmaceutical lobby has managed to grab about 50% of the German cannabis trade. This needs to be improved urgently and sustainably. Pharmacies are by no means synonymous with drug safety when it comes to cannabis. On the contrary, as explained in more detail in the book .**

Dr Bernd

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Chapter 1 – "My" cannabis medicine

In this handbook, I present my way of using cannabis as medicine. I started in 2015, at the age of 66. First as a member of the patient group that used to meet regularly in the offices of the German Hemp Association in Berlin-Prenzlauer Berg. Then as an early member of the CSC (**Cannabis Social Club)** Berlin. Here I worked on a voluntary basis until 2017 as the only doctor.

In spring 2018, I worked for one of the cannabis companies that have been springing up like mushrooms and temporarily managed their "first practice for cannabinoid medicine" in Berlin-Schöneberg. I ended this work very quickly after ten weeks because the operators of the practice had no interest in cannabis as a medicine, but only in profit. I will come back to this later. Today, I work on a voluntary basis, providing advice and support.

My background

I am writing this little book for people who want to learn about cannabis medicine as I have practised it and, as long as I remain healthy, will continue to practise it. After completing my state examinations and doctorate, I completed five years of surgical training and then worked as a general practitioner for almost ten years. I then undertook another five years of clinical training and most recently worked as a senior physician in a psychosomatic clinic. Until 2009, I was then established as a medical psychotherapist and psychoanalyst in Bavaria. In 2011, I had a serious accident, spent three months in hospital and was classified as needing nursing care for almost four years. This is my medical and a small part of my personal background, against which I began to learn from cannabis patients as a cannabis patient myself and to pass on what I had learned at the same time. Learning by doing. As a doctor, I was used to this.

My form of cannabis medicine is simple and practical in terms of how the plant is used. I use it based on my SO years of experience as a doctor. My form of cannabis medicine includes nutrition, basic psychotherapeutic techniques, meditation, [TCM1] **yoga and physiotherapy.**

As physiotherapy**,** I recommend **traditional Thai massage (TTM),** which fascinated me back in the early 90s. At that time, the famous Wat Pho massage school in Bangkok ( ) was still open on the temple grounds, and I made ample use of this offer. Until I met my wife, I had never once had a TTM in Europe. I met my wife in Berlin in 2016. We were both surprised

to discover that we had independently developed an enthusiasm for TTM. There are competent and experienced masseuses in this country, but no one can be sure that the decadent development of TTM has not found its way into the massage studio of their choice. For the goal of TTM is certainly not the rapid sexual dissipation of life energy (chi). Unfortunately, it is fitting for today's world to sully a very old technique rooted in Buddhist tradition such as TTM with the desire for masturbation by a kind of body slave or serf (prostitution). Therefore: take a close look at the massage parlour where you are seeking help, or consciously remain in the dirty segment, but then do not expect relief from your complaints or even a cure.

Cannabis medicine is not a quick fix

Cannabis medicine, as I describe it here, holds no secrets and no dangers, provided that everything is done openly and honestly. By this I mean, above all, the cultivation of the plants for the extraction of the flowers and the production of other dosage forms, i.e. mainly concentrates of the two main active ingredients THC (tetrahydrocannabinol) and CBD (cannabidiol), individually and in combination.

This is deliberately a guide for people who are free and confident enough to familiarise themselves with the subject matter. Warning: **cannabis medicine is not for the faint-hearted or complacent consumers. It definitely does not satisfy the desire for quick fixes or 'instant' medicine.** For chronic conditions**,** there is almost never 'the' medicine! **For those who are searching, however, cannabis, when used competently as a medicine, offers considerable independence from established medicine,** which is increasingly degenerating into a technological monster. Of course, it offers precise diagnostics and a number of irreplaceable therapeutic advances in minimally invasive surgery and in the prevention of colon cancer, for example, but at what price? As a patient, you usually receive less attention than the computer monitors and the equipment used.

The cannabis offered by German pharmacies now consists predominantly of flowers with a THC content of over 20%. Doctors, if they are willing to work with cannabis at all, only need a fraction of this. Basically, the supply of highly concentrated flowers is aimed at the consumer market. The range offered by some pharmacies with a licence to sell cannabis is certainly comparable to that of large Dutch coffee shops. If you really want to buy from a pharmacy, you need a doctor who is not afraid to issue a BTM prescription [narcotics prescription] for the desired flower to a healthy person. Then you need a pharmacist or their assistant who specialises in cannabis flowers for well-heeled consumers who have given the prescribing doctor a disease from the long list of indications for cannabinoids as the reason for their desire to consume. These are mostly courtesy prescriptions. The pharmacist keeps an oversupply of cannabis flowers available during business hours that meet the requirements of the

Cannabis Agency. These deal with hygiene and safety requirements at the production facility, variety consistency and dealing with pests and mould.

There are no special medical cannabis varieties.

There are reports suggesting that certain types of flowers are particularly effective in treating specific illnesses. An example can be found in the chapter entitled "Jacob". However, it is still difficult to have an objective discussion on this topic. When, in spring 2017, doctors were legally permitted to prescribe flowers approved for use in pharmacies – in addition to products that were already available on prescription, such as Sativex and Dronabinol – the vocabulary changed abruptly: people were no longer 'stoned' or 'high', they were suddenly 'medicated'. There was a certain self-irony in this, which would not have bothered anyone, but also a considerable amount of presumption.

The trick with the pain

Anyone who, for whatever reason, wanted to obtain supplies from the pharmacy would diagnose themselves from the long list of indications for cannabinoids and, of course, would not choose multiple sclerosis or Parkinson's disease, but chronic neuropathic pain. With this self-diagnosis, it was relatively easy to find a doctor who would at least issue a prescription for the desired flower. Germany's elite potheads, including many rappers, suddenly had "back problems". The more intelligent ones brought an X-ray or MRI image with them to the initial consultation with the prescribing doctor. As is well known, an unremarkable or slightly pathological finding does not rule out pain syndrome. But the doctor was more likely to believe the patient's history of pain (or so the patient thought) if they had already undergone radiological examination, and so they took advantage of the fact that cannabis is evidence-based effective for chronic neuropathic pain (see page 67; a randomised, prospective study has shown that the relief of neuropathic pain through cannabis can be significantly attributed to the use of cannabis).. In defence of the rap musicians, it should be mentioned that critical voices such as that of King Keil soon emerged from their ranks, advocating self-production and independence.

Control power of health insurance companies

The consultation in the pharmacy is no different in content from the sales pitch in a coffee shop. How strong (THC), how expensive? Does it help with pain, does it help you sleep better afterwards? Experiences, rumours and wishful thinking are exchanged on the one hand, and competence, conviction and commitment on the other. The only difference is that Dutch coffee shop operators have been selling illegally, whereas German pharmacists have not. They sell the varieties approved by the Cannabis

Agency, which are of course legal. However, unlike their Dutch neighbours, they and many of their colleagues were still railing against potheads and green-left legalisation advocates at their local CDU regulars' table just a few years ago. What was that about Saul becoming Paul? To my knowledge, this did not happen for financial reasons. Or perhaps the pharmacist attended the SPD regulars' table. There, they simply waited to see which stance was best suited to remaining in power. First against cannabis, then in favour of it when a new coalition presented itself. The main thing is power.
Of course, in the near future there will be cannabinoid-based medicines with a narrowly defined focus, i.e. a specific area of application. There are already flower varieties (hybrids) such as Trainwreck or LA Confidential, which are said to be more effective than others in treating migraines and migraine-like headaches. These are empirical values. Evidence-based recommendations are still pending. I myself get by therapeutically with a few 20% flowers: half Indica and half Sativa or Indica- or Sativa-dominant hybrids. I also need larger quantities of 99.9% CBD isolate for mono or combination therapy. In addition: 0.25-0.5% THC drops, mainly for pain and tumour therapy.

Sooner or later, cannabis will no longer be classified as a narcotic. It never was one; this will become clear when reading this book. Since the beginning of 2017, cultivation has been practically permitted for medical purposes in Germany. There are several higher court rulings, mainly in North Rhine-Westphalia, that expressly allow this. At the same time (March 2017), doctors were allowed to prescribe cannabis on a BTM prescription. This coincidence could give rise to the suspicion that this was intended to take the wind out of the sails of the higher court rulings of the Federal Medical Association ( ): Patients thus remain within the realm of established medicine and are therefore visible and controllable – mainly through health insurance companies and their auxiliary organisation MdK (Medical Service of Health Insurance Companies). This is because although prescribing cannabis on a BTM prescription has been possible since spring 2017, it is subject to application. To this day, patients must submit a lengthy questionnaire completed by their health insurance doctor, which in recent years has mostly remained blank because contracted doctors lack the necessary knowledge. To date, there are no mandatory training courses offered by medical associations. This is hardly surprising after decades of prohibition, discrimination against consumers and ideologisation of the issue.
As a therapeutic measure, especially for chronic and acute pain, I prefer the combination of TTM with cannabis. Since 2017, my wife and I have

been combining traditional Thai massage with CBD oil as a matter of course. All patients (with one exception) also wanted the follow-up massage with CBD oil. Many people now know that cannabis is evidence-based2 and effective for neuropathic pain with little to no side effects. In combination with CBD oil, a two-hour traditional Thai massage is by far the most effective physiotherapy I know.

Which doctor still makes house calls?

As of the turn of the year 2022/23, Germany will have a shortage of more than 4,000 general practitioners, mainly in rural areas and socially deprived areas. Added to this is the growing specialisation of medicine. Most medical students decide early on to train as specialists and take care of the economic aspects of their planned practice in good time. Radiologists and orthopaedic surgeons, for example, have to invest heavily when setting up their practices, but are then among the top earners. General medicine has also become a specialist discipline.

Specialists in general medicine refer patients to other specialists. "Family doctor care" is also listed on the signs of some internists.

But who still makes house calls? There are quite a few young general practitioners who see the long-term care of their patients as their life's work and bravely uphold their ideals in their everyday professional lives, despite all adversities. Everything has to be documented and the health insurance budget has to be kept in mind at all times. Continuing education is mandatory. Participation in events organised by medical associations and associations of panel doctors ( ) must be certified. Points are collected and counted so that the doctor can bill for "basic psychosomatic care", for example – translation from medical jargon: Just to be able to bill for a few longer and "deeper" conversations with patients, the doctor has to comply with guidelines; he is dependent on the health insurance companies, he has to be well-behaved. Due to his many years as an assistant in a hospital, he is used to the classic hierarchy, even though people like to talk about flat hierarchies. Criticism of the chief physician and/or senior physician can lead to not being considered for the allocation of therapeutic or diagnostic procedures in the clinic (e.g. colonoscopy). However, the trainee doctor must demonstrate a defined number of defined procedures in order to be able to take the specialist examination.

Head physician joke: The young doctor opens the door to the patient's room from the inside, holding a tray with a tourniquet and tubes for blood samples, and hits the head physician, who is rushing past in the corridor, on the arm with the door handle. Startled, he exclaims, "Oh my God!" The chief stops briefly (and with him the senior physician, ward physician, ward

nurse and ten students) and says, "Good morning, Chief Physician!" That would have been enough.

Established medicine, alternative medicine and self-help

Until the summer semester of 1970, there was no central admissions office for medical studies in Germany. Any high school graduate could apply to any medical school. I was admitted to Kiel in the winter semester of 1969/70. The anatomy professor responsible for this was Alkmar von Kügelgen, who later examined me in anatomy in the Physikum. He believed that future doctors should be empathetic and able to listen and improvise. Even in extreme situations, doctors should be able to save face and reassure their patients. He rejected women in the majority of cases because of the possibility of pregnancy. Medical studies cost taxpayers a lot of money, and a prolonged absence from work was not justifiable.

In short: after the winter semester of 69/70, there was a central admissions office and those with top grades in their school-leaving exams were given places at university. People like me now had to wait a long time. Did you know that Ferdinand Sauerbruch, the great German surgeon, was almost not admitted to medical school? He had to prove that he had passed the Graecum, a degree in Greek that was required at the time, similar to the Latinum later on. In his autobiography *Auf des Messers Schneide* (On the Razor's Edge), he describes how he "improvised" to get the Graecum. (His examiner's daughter played a role in this.)

I don't want to compare myself to Sauerbruch in any way, but I also had to pull out all the stops to pass my mathematics A-levels with a "sufficient" grade after attending a modern language grammar school. I had mastered basic arithmetic and the rule of three, but I didn't have the faintest idea about higher mathematics. I had to go so far as to have surgery on my sinuses on the day of the written exam and declare that this procedure was urgent and without alternative. Since I had survived severe meningitis a few months earlier, the source of which was suspected to be my chronic sinusitis, the maths teacher had no chance. I got a "four" and was able to take my Abitur exams two years later. The maths teacher never spoke to me again.

Originally, I wanted to become a journalist or an actor. I also played in a rock band after school. My father had heart disease and died in 1968 after several heart attacks. The helplessness I felt at his bedside finally convinced me to study medicine. Even as a small child, I had suffered from serious illnesses and lived in constant fear of the doctors my mother dragged me to see. When I later turned to psychoanalysis, I recognised myself in the description of 'identification with the aggressor', a defence mechanism

(against existential fear) in early psychological developmental disorders. Before falling asleep, I regularly entered operating theatres in my imagination, opened abdominal cavities and conducted rounds, as in the doctor's joke above.
I do not want to devalue today's doctors with their first-class school-leaving certificates. However, medicine, which has become globalised as a result of digitalisation, is being driven forward by these representatives of the meritocracy. Technologically, the advances are undeniably breathtaking. Examples include imaging techniques, minimally invasive surgery and, in some cases, surgical joint replacement. But where has the art of healing gone? Healing as the interplay of knowledge, empathy, courage and creativity. Therapy means serving, caring, healing. Therapeutics can be translated as the art of healing. Over the course of my life, I have come to the conclusion that it is essential to look over the shoulders of shamans and to study, for example, traditional Chinese medicine (TCM), traditional Thai massage (TTM), medicinal botany and dietetics. Otherwise, we run the risk of standing still and becoming complacent. Nor should we leave the field to the half-informed. In the current populist protest and denigration campaign against elites, it is often said that "those at the top" are to blame for everything. How much does a person need to know in order to realise how little they know ( ): that would be the mindset that could remedy the situation. In the past, it was called humility.

The system is already collapsing. We are stocking up on batteries, non-perishable food, water, camping stoves, etc. to be prepared for prolonged power outages. Hospital ambulances are already overcrowded. Have you ever waited for hours on a stretcher in an emergency room to be treated? Or try to get an appointment with a specialist as a statutory health insurance patient! The associations of statutory health insurance physicians have set up special referral agencies. As a privately insured patient, you can get an appointment within a few days, often even on the same day.
Lauterbach's plan to set up a thousand health kiosks in areas with poor medical care and to promote cannabis clubs is a step in the right direction: helping people to help themselves and promoting networking. Common diseases such as hypertension, diabetes, obesity, etc. can be treated here, as can the increasing number of depressive and psychosomatic disorders. The legislator will require the involvement of a doctor or medical professional. However, it should also allow for flexibility. The principle of self-help is proving increasingly successful. Alcoholics Anonymous would say, "Help yourself, then God will help you!" Nutritional counselling, yoga, basic meditation techniques, etc. should be included in the health kiosk's offerings. Above all, however, I see an opportunity here **to offer cannabis**

medicine to everyone. Experienced growers and patients could contribute their knowledge and thus break the monopoly of pharmacies. The many existing cannabis social clubs (CSCs) would have the opportunity to make their resources available to the public – for the benefit of all involved.

A practical example: a young man develops severe joint pain in his fingers, wrist, knee and ankle within a few days. He feels generally unwell and has a high temperature in the evening. His GP is no longer available after 5 p.m. At the emergency room of the nearest hospital, he is given a few diclofenac tablets and instructed to see his GP. It is Friday. It is now 10.30 p.m. The wait at the emergency room was four hours. On Monday, he is given an appointment with his GP for a blood test on Thursday. The laboratory tests show no evidence of acute rheumatic fever. The patient learns this the following Monday during a telephone consultation. He still has joint pain. The diclofenac alleviates the joint pain somewhat, but quickly causes the young man to develop irritation of the stomach lining: he has acid reflux and no longer has any appetite.
At the health kiosk or shop, we would have given him a high dose of CBD from the outset, recommended a vegetarian diet for at least 14 days and helped him with the practical implementation (it is very easy to enrich dietary fats (rapeseed oil, for example) with 99.9% CBD crystals).

Conventional medicine emphasises the need for prospective *randomised* double-blind studies, the largest possible groups of patients with comparable symptoms. For example, group 1 would be treated with a placebo, group 2 with cannabis, and group 3 with low-dose diclofenac. The person administering the medication (doctor/family member/nurse) must not know whether they are giving a placebo or the active ingredient. If cannabis proves to be statistically significantly superior, the study would have to be discontinued for ethical reasons and the patients in the placebo and diclofenac groups would have to be treated with cannabis. The larger the groups, the more meaningful the study will be. However, the organisational effort required for such a study is considerable.
The pharmaceutical industry sponsors such studies if a relevant profit can be expected. I can easily imagine that the industry will develop some combination of CBD/THC/terpenes in drop or capsule form as a specific remedy for joint and muscle pain, prove its statistically significant effectiveness in a study (after 1-2 years) and obtain approval for it. The drug will then be launched on the market at astronomical starting prices. Believe me, I'm not making this up!

In Thailand, basic healthcare for the rural population has always been provided in small state or Buddhist clinics for traditional medicine. Most patients are poor and pay only a small contribution towards costs. An individual combination of TTM and traditional herbal medicine is largely offered. I saw this for myself in several clinics in the spring of 2023: since Buddhism stopped classifying cannabis as a "drug" in 2018 and began recommending it as a remedy, it has taken on a central role in herbal medicine and is added to most established herbal mixtures as a kind of "enhancer". The doctors and masseurs work with a CBD/THC ratio that is familiar to most patients. THC is dosed as highly as CBD for serious illnesses. The medicine is specially prepared for each patient and, if possible, given to them immediately. Usually in capsule form. The results are excellent.
"My" cannabis medicine works in a similar way. I try to compensate for the fact that TTM is not accepted by insurance companies in this country and that we have a comparatively meagre range of herbal remedies to offer by optimising TTM with CBD oil and through the targeted use of basic psychotherapeutic techniques. You will find examples in the case studies.
Since 2010, I have been recommending home cultivation myself, recommending it to others since 2015/16, and trying to encourage patients to join cannabis social clubs or to found new ones. Immediately after the change in the law in March 2017, according to which cannabis can be prescribed as a medicine on a BTM prescription, there were products from a total of four companies in pharmacies, including two that offered flowers. There are now a huge number of flowers from various producers in specialised pharmacies. It is not the norm, but it does happen time and again that customers open the professionally sealed tin and notice a slight smell of mould. Mass production has to be fast; it's all about profit and market presence. There is often no time for fermentation after rapid drying.

Patient safety is therefore by no means guaranteed by the cannabis agency and the pharmaceutical industry. Even if the industry is called Tilray and the former foreign minister sits on the (broad) board of directors. Patients gain safety by taking matters into their own hands. This brings joy, strengthens their attitude towards life and their self-confidence, and **provides them with one of the oldest medicinal plants at low prices.** It belongs to no one, and certainly not to the pharmaceutical industry! The latter is already working on the product lines of the future: THC nasal sprays and a huge range of capsules and drops with THC or CBD dominance and "balanced" products (THC and CBD in roughly equal concentrations). **With every single step towards autonomy, you are working for your health. Buy a modern, inexpensive grow tent!**

Organise a bulk purchase! Join a CSC and learn how to grow cannabis! You will quickly achieve the quality of mass production, and you will no longer be annoyed by the undesirable developments that have long been apparent in German pharmacies and doctors' surgeries. When you are less annoyed, you release less adrenaline and cortisol. This significantly reduces your risk of having a heart attack or stroke. It's that simple!

I have anonymised the patients described in the case studies (chapters 2 to 8) as far as possible. I have changed names and biographical details so that no conclusions can be drawn about the patients' true identities. I consider the illnesses that led these people to seek treatment with cannabis to be typical. I have omitted examples of MS, Parkinson's and Tourette's patients because they are usually competently treated with cannabis by established neurologists and this fact is quite well known among the general public.

Chapter 2 – Birgit – *Real migraine*

She went from pillar to post. Not from pillar to post, but from one internist to the next, then to a neurologist, then to another, and finally to a luminary, a very renowned neurologist in a German university town. He had long headed the university's neurology clinic and was considered an international expert on headaches of all kinds, especially genuine migraine (nine subtypes are distinguished today).
Birgit stopped running. For a while, she believed she had reached her goal and no longer needed to search. She was exhausted. After various attempts at treatment, she had almost given up hope that her suffering would end. Now she invested what little hope she had left entirely in Professor N. He had published articles in specialist journals and written books, mainly about true migraine. If he couldn't help, who could?
He gave her new medication and prescribed behavioural therapy. She kept a migraine diary, avoided certain foods such as cheese and red wine, started jogging and learned yoga exercises. She received physiotherapy, mainly massages of the neck and shoulder girdle muscles.
But nothing helped. The attacks did not become stronger, but slightly more frequent. When she was asked to rate the intensity of the pain on a scale of 1 to 10, she burst into tears. She had spontaneously said 11 because she had thought of the peak of the attack, the so-called climax.

Birgit's symptoms were typical and would have been suitable for a textbook. The attacks are preceded by a so-called aura, a complex change in perception: the objects in her field of vision are surrounded by a kind of faint glow. Her surroundings seemed strange and unreal, and the pain was not long in coming. It began as a dull rumbling in her temples and neck, then spread to the entire left side of her skull and intensified into a stabbing staccato of pain. Every ray of light hurt. She was now incapable of doing anything but lying still in a darkened room.

Only at the climax can she vomit violently and convulsively, and the attack slowly subsides. Working is out of the question for at least a day, often two. The diagnosis was complete, including modern imaging procedures such as CTG and MRI. It was clear: Birgit suffered from genuine migraine, which could be clearly distinguished from various other types of headache such as tension and cluster headaches. Birgit is an educated young woman. She grew up in a sheltered middle-class environment, studied business administration and currently runs a boutique in Austria. In her circle of friends, red wine is the drink of choice for "winding down" in the evening.

Potheads are considered weak, fickle and lazy. Nevertheless, her friends suggested that she at least give cannabis a try. At this point, she was already being treated by the professor and, on closer inspection, presented
– on closer inspection – the image of a good girl who wanted to please her father in order to be praised and loved. Of course, she complied with his instructions, including abstaining from red wine and taking the new medication, a triptan.

Cannabis vs. conventional pharmaceuticals

Triptans came onto the market in the late 1980s as a revolutionary new development in migraine treatment. Sufficient money had been invested in research and clinical trials because the companies expected high profits. People are happy to invest in common diseases. In the case of rare diseases, however, the coffers remain closed: no relevant profits are to be expected. Chemically, triptans are derivatives of serotonin and should be taken as early as possible to prevent the attack from fully developing. There are now more than seven commonly used triptans. Birgit was given the latest one by the professor, which had just come onto the market: one tablet per day and an additional one when the aura is first noticed. The side effects were considerable: Birgit experienced tightness in her upper chest, dizziness and an unpleasant tingling sensation in her hands, sometimes throughout her whole body. But they helped only slightly, if at all, against the pain. Novaminsulfon (metamizole) had at least provided her with some relief. She had tried ergotamine-containing medications and immediately stopped taking them: they had increased her pain and, above all, her nausea. Ergotamines are found in ergot, a native fungus that grows parasitically on grain and causes severe
can cause poisoning. Ergotamine is also used to produce LSD.
Birgit kept going. She didn't give up, even though she was bummed that the professor couldn't cure her. The next stop on her journey was a Chinese doctor who used TCM, especially acupuncture.

Moderate success. On the pain scale, Birgit was now between 6 and 9, relative to a full-blown attack. It could be described as relief, but nothing more, and this was certainly not enough to make a migraine attack acceptable. A suggestion from her circle of friends to try cannabis led her to me: an elegant dark-haired woman in her mid-thirties, healthy at first glance. Well-circulated, normal weight, flowing movements, friendly demeanour. She was well informed about what was available in German pharmacies. At that time, the range was limited. I suggested to Birgit that she try a treatment combining traditional Thai massage and cannabis, step by step, patiently. Alternatively, she was considering inpatient treatment in

Kiel, which was already a centre for migraine research and treatment in Germany at that time.

She didn't need the alternative. At first, she rarely told me about her journey, then regularly and frequently for a while. She said she couldn't understand herself and couldn't forgive herself for not using cannabis for her migraines earlier. She had started with 99% CBD granules, initially adding 250 milligrams daily to her dietary fats, then 500 milligrams, then 1 to 2 grams. She had also received TTM with CBD oil twice for an hour. However, she was constantly waiting for the next migraine attack until it actually came. Not as severe as before, but painful enough. This was the signal for her, as agreed, to now also use THC. **She bought a mobile vaporiser and began inhaling first a quarter, then half a gram of cannabis flowers with about 20% THC in the evenings.** Again, she waited for the next attack, which, however, did not come until about three weeks later. She had previously had an average of two seizures per week. This one developed as usual, but she perceived the symptoms in a fundamentally different way: she was able to view them from a distance and was also able to keep the third part of our agreement: increasing the THC dose at the onset of the seizure. She inhaled 250 milligrams twice within an hour and was able to greatly shorten and weaken the seizure. Pain scale: 3, maximum 5. No vomiting, hardly any sensitivity to light. She said she would do the same thing the next time she had a seizure. She now has no more than two seizures a month, which are bearable and no longer confine her to bed in a darkened room. She allows herself the freedom to decide whether to continue working or not. She never thought that would be possible.

About six months after starting this combined treatment with TTM and cannabis, Birgit developed a strong desire to share her new experience with others, i.e. to pass on her knowledge. She went to unusual lengths to do so, making a passionate plea for cannabis as medicine at a festive reception attended by members of the Bavarian and Austrian governments. I cannot rule out the possibility that she was threatening to harm herself in the sense of a phase of manic after-effects following depressing treatment experiences. If so, it can only have been a temporary, manifest reaction. She now describes herself as an almost cured migraine sufferer or migraine patient. She sells CBD products online, campaigns for the legalisation of cannabis, grows her own medicine in Austria and, together with fellow sufferers, is searching for the ideal flower to combat migraines. The Californian hybrid Trainwreck was considered the ideal strain among growers in 2018 and 2019. Wishful thinking was probably the father of the idea. Birgit's medical history is also an example of how illnesses have

complex causes and their treatment must be equally multi-layered and individually tailored. It would be nice, but it's too simplistic: a single flower for every migraine sufferer. This one flower may have a completely different effect than desired on the next patient.

While we are on the subject of developing remedies for migraine: a researcher once worked on finding a headache remedy that would expand the existing range or, better still, replace it. His name was Albert Hofmann and he was commissioned by the Sandoz company to develop an optimal headache remedy from the aforementioned ergotamine (in ergot extract). He discovered lysergic acid diethylamide, or LSD for short, accidentally took about five times the recommended dose during a self-experiment and had a powerful psychedelic experience on his way home from the laboratory.
Birgit did not fly that high. Accordingly, her fall was also low. As she reports, the then Austrian Chancellor also attended the reception mentioned above. She particularly recommended cannabis and TTM as a fixed combination to him. She was not completely taken aback, but she was very disappointed when she realised that his interest was feigned: he did not call her, and the telephone number he had left her was incorrect.
Fundamentally, the impulse not to keep a new, enriching experience to oneself, but to share it with others, is a beautiful human trait. At its core, it serves to preserve the species. Knowledge should not be lost; it should be preserved for the species or the group. It is also an expression of affection and trust.

I base my approach to cannabis medicine on this impulse and the friendly bond that consumers and patients often develop with each other when they venture out of their hiding places and open up – in cannabis social clubs, self-help groups, at trade fairs and other events.
We should not wait until profit-oriented industry representatives decide to invest in lucrative research projects. These will focus on diseases and disorders that are numerous and for which existing treatment strategies are not convincing. The expected profit must be high, otherwise investments are not worthwhile. At the end of the research project, there is almost always one supposedly optimal drug, e.g. the one unbeatable flower for migraines. Its name is then mercilessly pushed into people's minds using modern marketing techniques. Distress and helplessness are exploited, all under the guise of research, which is also used to justify the abnormally high prices of new drugs when they are launched.

Pharmaceutical managers and free spirits

To make it perfectly clear to pharmaceutical executives and health policymakers: the plant does not belong to you! For decades, you have discriminated against it and us, labelling cannabis users as failures. Now you are stealing everything that free and creative minds have developed in this era – including modern indoor production with LED lighting and hydroponics, which are powered entirely by solar energy. The feminised hybrids, the crossbreeding of natural species (*Cannabis ruderalis)* for "automatic" outdoor production, the modern extraction of individual cannabinoids from good harvests, etc. – you are appropriating all of this. All of this was created illegally.

Ödön von Horvath wrote about the eternal philistine: "The philistine is known to be a hypochondriac egoist, and so he strives to conform cowardly everywhere and to distort every new formulation of an idea by appropriating it." He was concerned with the philistine. Nowadays, we can better speak of (petty) bourgeois thinking. Let's all use our imagination to picture what the collaboration between Dutch and Californian breeders might have looked like in the late 1970s and early 1980s, when they achieved the stroke of genius that was the creation of sinsemilla! Sinsemilla, the seedless cannabis plant, is a clone of a good mother plant and the basis of all modern cannabis products. Creative free spirits achieved this. Far removed from paralysing and fearful bourgeoisie.
In comparison, it doesn't take much imagination to picture modern managers in their white coats and protective helmets striding through the non-sterile corridors of their production facilities , while in the sterile wing, modern slave labourers, completely encased in sterile protective clothing, inflame their tendon sheaths as they cut and trim the flowers. This impresses the good citizen. Everything seems to be in order. I enjoy talking to growers, and sooner or later the conversation usually turns to the topic: How do you treat your plants? Most of them talk to them and, in addition to providing them with optimised growing conditions, also play them music.
I remember a grow where I played half of my AK47 plants The Beatles (Revolver, White Album) during the flowering phase and the other half Mozart and Vivaldi. My AK47 plants clearly preferred The Beatles. But most cannabis plants prefer classical music. They are living beings! About four weeks before harvest, I start telling them that I will soon have to kill them. I promise them that I will dry and ferment them carefully and that their lives were meaningful because they will soon help sick people and bring joy to healthy people. (To all senior and junior prosecutors: I am now 73 and have not grown anything myself for a long time. But as soon as I retire, I will buy myself a good grow tent. A wonderful hobby for old

people!)
A different spirit can also enter modern mass production. For example, it can be combined with modern fish farming to save energy and nutrients. Farmers in Uganda or Thailand who grow 200 to 600 plants will not know each and every one of them, but they will treat them with love or at least respect. Under certain circumstances, this enables them to provide a better education for their children. Cannabis and opium are natural remedies: the opium pipe is still a blessing for pain-stricken elders among the mountain tribes of Thailand, and cannabis is finding its way into standard everyday medical practice. Nature provides us with these remedies; I believe that the natural human response should be gratitude. Birgit no longer runs from one expert to another. She has found her way.

Chapter 3 – Jacob – *Migraine-like headaches, child of divorce*

Jacob has two famous parents. His mother is famous, his father very famous. After his parents separated, Jacob grew up with his mother, who has the same dark skin colour as him. His father used to be straw-blond, but today his hair is more grey to white.

Jacob arrives on time. The appointment was made by his solicitor. I treated him a few months ago. A "cannabis solicitor" at
"cannabis doctor". The son of prominent parents, previously known only to insiders, is tall and curly-haired. 187 cm, athletic build. So I'm not surprised when he reports that he has "only been seriously ill once". He looks like the picture of health.

He hasn't been living in Berlin for long, is preparing an exhibition of his paintings and was sitting in the passenger seat of his girlfriend's car when they were stopped for a routine traffic check. He tested positive for cannabinoids. Two weeks later, he received a letter summoning him to an MPU (medical-psychological examination).

In medicine, medical history is one of the most important sources of information. Jacob does indeed have a serious health problem. On closer inspection, he had suffered from a severe acute illness at the age of seven, and a chronic illness had developed at the onset of puberty. However, he had been symptom-free for about two years.
That was when he started using cannabis as medicine.
His parents separated when he was seven years old. Jacob has been sitting in my treatment room for about ten minutes now. He swallows, searches for words, remains silent. Gradually, he finds the words. When his father left the family estate in Southern California with a small wheeled suitcase, he developed a fever, watery bloody diarrhoea and colic.
That same evening, his mother took him to the hospital. He was diagnosed with salmonellosis, treated in intensive care, and discharged after three weeks as cured.
At the age of 15, Jacob's chronic suffering began: headaches that occurred in attacks, mostly on one side, often in the back of the head, nausea, vomiting, sensitivity to light. His father, who kept in touch with Jacob and his brother, took him to renowned neurologists in Europe and the USA. His mother consulted a doctor specialising in traditional Chinese medicine, then a shaman. No improvement! Painkillers brought only minor relief to , as did triptans. One neurologist diagnosed migraine, another psychosomatic tension headache.

It was only treatment with cannabinoids that brought about the

breakthrough. In California, it was easy to find an experienced doctor and obtain a medical card for inexpensive treatment with medical cannabis. LA Confidential was the first strain prescribed and helped immediately. I have already written a little about chronic headaches and their treatment with cannabinoids in the chapter "Birgit". My encounter with Jacob gives me the opportunity to elaborate on the medical basis of cannabis medicine on the one hand and to draw attention to the phenomenon of children of divorce on the other.

Basic principles of my cannabis medicine

1. Learn as much as you can about the endocannabinoid system. I highly recommend Franjo Grotenhermen's books. Grotenhermen is *the* pioneer of cannabis medicine in Germany. His open letter to Rick Simpson at the end of his book *"Cannabis Against Cancer"* is a good example of professional competence combined with tolerance. Simpson had assumed that cancer could be effectively treated with maximum concentrations of cannabis and had quickly gathered a kind of cult following around him.

2. **Don't be afraid!** Pharmacologically, cannabis is less dangerous than acetylsalicylic acid (aspirin). An overdose of aspirin can cause inflammation of the stomach lining, whereas an overdose of cannabis will, at worst, cause you to sleep deeply with your breathing completely intact. This is also a clinically important difference from opiates, which must **always** be prescribed and monitored by a doctor.

3. **Face the fact that cannabis medicine and smoking** (inhaling burnt plant components, mainly tobacco or cannabis pure or mixed with tobacco) **do not go together at all.** A valuable remedy should not be burned; it should be swallowed or inhaled, and the motto should be: **as little as possible, as much as necessary.** *Start low, stay low* – this often works. **Don't skimp on the vaporiser.** The inexpensive devices are the most expensive in the long run, as they don't last long and need to be replaced. Most cannabis patients inhale their medication two to three times a day and are therefore best served with a portable vaporiser. The Mighty is portable, almost indestructible, and has a long battery life. You can also control the vaporisation temperature digitally, which often proves useful during therapy.

4. **In the case of acute pain or cardiovascular disease, please refrain**

from self-treatment with cannabis. Cannabis has neither a beneficial nor an adverse effect on arteriosclerosis. New users may experience a slight increase in heart rate. If, as in the case of Birgit and Jacob, pain syndrome (chronic pain) has already been diagnosed, it is advisable to try vaporised cannabis. If possible, use flowers from a 100% Indica (such as L.A. Confidential) or an Indica-dominant hybrid. This applies to all pain patients and all pain locations.

5. **The gods have placed diagnosis before every therapy. Under no circumstances should you make this diagnosis yourself!** If your doctor has diagnosed a chronic illness, the prognosis must be carefully assessed. Accordingly, if cannabis treatment is chosen, it will be necessary over longer periods of time (chronic pain syndromes). For other illnesses (e.g. depressive and autoaggressive disorders), treatment is carried out until the symptoms disappear or at least until there is significant relief.

6. **When administered orally (drops, capsules, mouth sprays), cannabis takes effect later, lasts longer and has a more intense effect.** However, the current state of affairs is that oral treatment has so far inevitably focused on the administration and serum concentrations of CBD and THC. Pain patients in particular should also look at the terpene composition of the flowers used. It is not the norm, but the number of patients who are successfully treated with isolated terpenes is growing! One of my patients has an extremely keen sense of smell: he can identify the dominant terpenes in a flower with considerable accuracy. Since strain descriptions, for example on Leafly, specify the terpenes contained, I have been able to verify this several times: he is usually right!

7. **If you are primarily looking for anaesthesia or just sedation, cannabis is the wrong remedy!** Cannabis expands consciousness (mostly) in a very mild form when used sensibly. This is especially true for *Cannabis sativa.* The effects of sativa include a slight increase in drive and mood elevation. For this reason, it can be used by experienced doctors to treat depression. **A precise medical diagnosis is always necessary for depressive disorders!**

Let's return to Jacob: he first came to see me in spring 2019. The range available in licensed pharmacies had already grown somewhat. However, there was still no pure Indica available. I could only prescribe him a hybrid, which did not help him as reliably and sustainably as the flowers he was familiar with from the USA. LA Confidential is now also available in German pharmacies under a different name. It has always been widely

available on the black market. But Jacob knew how to help himself. Experienced growers met regularly in Berlin to exchange experiences and breeding results. He now sourced his flowers there and confirmed my experience that the mass production of the industry lagged significantly behind the results of experienced growers from Spain, Switzerland, the Czech Republic, Estonia, Poland (and increasingly from Germany) in terms of quality. In the meantime, pharmacy cannabis has improved.

I know some of these pioneers and respect their attitude: they do not want to be enslaved by the pharmaceutical industry, which cultivates according to regulations with the aim of maximising profits. A friend from Estonia has been growing cannabis for two decades and selling grow equipment for 18 years. Now he has to watch as the pharmaceutical industry's specialists, backed by seemingly unlimited funds, shamelessly copy everything that has been developed illegally. To name just a few: sinsemilla, the female, i.e. seedless cannabis plant (a collaboration between Dutch and Californian breeders in the 1980s), LED lighting with long "teething problems" in cannabis cultivation, hydroponics combined with fish farming (ecological cycle), supply of renewable energy sources, mostly solar energy, and crossbreeding with the natural species *Cannabis ruderalis* ("automatic" varieties). The latter makes it possible to grow high-quality cannabis outdoors, an important step in breaking the power of the pharmaceutical industry. Important crosses such as Headband and Fire Tire (both Indica) have been developed among the old breeders, and they calmly accept the fact that they are currently being overtaken, figuratively speaking, by the employees of the pharmaceutical industry. By this I mean that the financial resources of the industry are enormous and a great deal of money is being pumped mainly into indoor production.

Amongst the old breeders, I heard the saying: "To live outside the law, you have to be honest." An attempt at interpretation: illegal breeders have to be able to rely on each other, otherwise the industry will eat them alive. Jacob got in touch with me from time to time. He got his driving licence back. Last year, there was sometimes a photo of him in the newspaper, and he was mentioned in other media. Exhibitions, vernissages. He wears his hair shorter, looks more serious. He is now 29.

Children of divorce

Every second marriage in Germany ends in divorce – and in the vast majority of cases leaves at least one unhappy child behind. Jacob reacted to his father's departure with an acute bacterial infection. For a few days, he hovered between life and death. I don't think it's an exaggeration to understand the physical symptoms as an expression of his despair. His parents still live in more than comfortable economic circumstances. This

mitigated the experience of being abandoned, but by no means completely.

For a seven-year-old who idealises his father, his father's permanent departure from the family home is a catastrophe. The standard phrases don't get through at all: We're both still here for you. And
- as in Jacob's case - from the father: I'm not gone forever! For the child, his world falls apart. Pain, fear and anger overwhelm his still fragile ego and, in most cases, find no other expression than the development of symptoms. Jacob probably had a brief immunological weakness, which opened the door to the spread of salmonellosis and thus to a life-threatening situation due to fluid loss and a shift in the salts in his blood serum. In the long term, most children of divorce will blame themselves for their parents' separation. If they remain alone with this sense of guilt, they will discover more and more repulsive and negative aspects of themselves and become strangers to themselves.

Jacob's case also serves to highlight the risk to the doctor himself when prescribing cannabis. Jacob is an honest person; he sought help and found it. There are others who want
"Just the prescription and the ID card." This refers to the **blue opioid ID card issued by the DGS** (German Society for Pain Medicine), on which the doctor confirms that the medication is necessary and must be taken regularly. Substituted heroin addicts (methadone, buprenorphine) and high-dose pain patients (often cancer patients) have been familiar with this ID card for a long time. In spring 2017, I decided to provide my patients with this card. At that time, pharmacies were already issuing a *green cannabis card*. This is not a medical document, but an advertising measure to promote customer loyalty.

The right to reimbursement

In March 2017, I had already been treating patients with cannabis for about two years (special exemptions for cancer patients and quadriplegics from the Federal Opium Agency) and was eager to see whether the government would allow cannabis to be prescribed as a medicine on a new special prescription form, as announced, or whether it would still have to be prescribed on the usual BTM form. I thought it made a lot of sense and was necessary to take cannabis off the list of narcotics, but I didn't really expect it to happen. Still, it was outrage that made me decide to give my cannabis patients the same help and support that every pain patient who needs opiates and every opioid addict on substitution therapy gets as a matter of course.

Word quickly spread that the card, when correctly and completely filled out by the doctor, allows patients to carry their monthly supply of prescribed medication with them once a month, even in their car or on public transport. With a daily dose of 5 grams of flowers containing about

20% THC, that's 150 grams. A daily dose of 5 grams is undoubtedly a high dose, but not unusual for pain patients.

Not everyone was as honest as Jacob. Some fed me stories that anyone with common sense would have recognised as pure fantasy, or they tried to bribe me. There are now online doctor portals that offer a fixed price for the initial consultation (with a guaranteed prescription for controlled substances!) and a fixed fee for repeat prescriptions. These are private services that are billed in accordance with the German Scale of Medical Fees (GOÄ). However, if a patient with a serious illness and unsuccessful standard therapy wants to exercise their **legal right** to have the costs of their cannabis treatment reimbursed by their statutory health insurance, the situation immediately looks very different .

Even pain patients whose treatment with cannabis is evidence-based often fail to find a doctor registered with the National Health Service (NHS) who is willing to fill out the NHS questionnaire and approve the application. Mostly, they lack the time or courage, or both. This seems to be gradually changing, but until now, doctors who work with cannabis have been the black sheep among their colleagues. Fear of recourse claims from health insurance companies is often cited, but this is merely an excuse used by the doctors in question. Payment for cannabis therapy is subject to application and approval and is not covered by the colleague's budget. In my experience, the way statutory health insurance companies and many panel doctors treat cannabis patients is still far too often characterised by latent, habitual discrimination – a consequence of prohibition, which has been in place for almost a hundred years.

Note: Cannabis is both **a medicine and a recreational drug.** Whether the statement "Cannabis is not a drug, but a natural remedy" is made by someone who is simply repeating something that suits them, or by someone who has resolved their spiritual conflict in this way, is up to the individual. For many Hindu sadhus and all Rastafarians, cannabis is sacred.

However, it is important to note that **before you submit an application to your health insurance provider for alternative treatment with medical cannabis, you should read the legal text carefully.** You will be amazed at how far the legislator goes and what options you have. Visit an advice centre and do not be afraid to seek legal assistance. Health insurance companies often play for time. Many patients withdraw their claims when faced with sufficient bureaucracy.

Incidentally, **there is basically no difference between medical and "normal" cannabis.** This question is asked time and time again. It is easy to answer yourself once you have studied the requirements of different

countries, e.g. the current glossy brochure for Italy: in order to be allowed to call a cannabis plant "medical", the manufacturer must primarily ensure safety requirements at the production site, hygiene standards and reproducibility of the variety.

I recommend that at the beginning of any cannabis treatment – or in the course of successful self-treatment – a detailed medical report be prepared as early as possible: medical history, findings, diagnosis, differential diagnosis, prognosis and therapy. This will protect you (and itself). In the field of cannabis medicine, it is to be expected that some laypeople will feel compelled to interfere and add their two cents. To this day, the story of the neighbour's child who started using cannabis and ended up in the toilet with a needle in his arm is still told. Save your energy! Debating with ignoramuses, fanatics and populists is almost always pointless. One of my favourite patients, a Munich judge who has since passed away, once said something wonderful:
"You can't talk about the ocean with frogs in a well."

Chapter 4 – Bodo – *Chronic inflammatory bowel diseases: irritable bowel syndrome, Crohn's disease, ulcerative colitis*

When I started offering consultations after the change in the law, I was surprised that about one in seven patients came to me with one of these three diagnoses: irritable bowel syndrome, Crohn's disease or ulcerative colitis. All three diagnoses are caused by chronic inflammation of the intestinal mucosa. The histological and optical findings differ between the three diseases, and the symptoms vary in severity. Severe diarrhoea and cramp-like pain are mandatory, accompanied by non-specific complaints such as sweating, fatigue, loss of appetite and weight loss.

Blood in the stool is a warning sign. Untreated ulcerative colitis or Crohn's disease can perforate, i.e. the crater-like areas of inflammation can break through, allowing intestinal contents to enter the abdominal cavity, or the inflammation can be so severe that it leads to intestinal obstruction. In both cases, surgery is required. In most cases, the affected parts of the intestine are removed and watertight connections between the remaining parts of the intestine are created using special suture techniques. The mortality rate is high in such cases.

A colonoscopy is essential for diagnosing Crohn's disease and ulcerative colitis. During this procedure, polyps are removed and tissue samples are taken from areas of severe inflammation. The rightly feared colon cancer almost always develops from initially benign growths on the mucous membrane, medically known as adenomas, commonly referred to as polyps. The diagnosis of irritable bowel syndrome is therefore usually a diagnosis of exclusion if the colonoscopy showed "nothing unusual" or if no colonoscopy has (yet) been performed but the patient continues to have symptoms.

Bodo is 24 years young, somewhat corpulent and very intelligent. He studies computer science and quickly notices that I have a troubled relationship with IT. He is the only child of a single mother who has worked as a nurse in the endoscopy department of a hospital for many years. She seems to have never stopped trying to persuade him to have an endoscopy. Like all patients with chronic diarrhoea, he lives in fear of losing control of his bowels, i.e. soiling himself. During our first conversation, I have difficulty silencing my smartphone . It rings and rings. Bodo immediately seizes the opportunity to leave his uncertainty and possibly fear behind and

sit down on a higher chair – in every sense – so that we can negotiate at eye level: "Your mobile phone has seen better days, hasn't it?" I always have a small selection of seating options in my consulting room, including a very comfortable couch and a recliner. The tall, hard chairs are actually intended for patients with spinal problems. Bodo is currently choosing one.

Fear of the dentist

One press of his finger, and my mobile phone falls silent. I am reminded of the huge black telephone that stood on my grandfather's desk and which neighbours and relatives who did not yet own one (in the post-war period) were allowed to use. I am reminded of the loudspeaker of our radio, in front of which the whole family gathered when Germany won the World Cup against Hungary in 1954. Bodo thinks of the dentist. Not a specific one, but dentists in general. He has been suffering from both for quite some time: toothache and a panic fear of the dentist. Only when I point out the possibility of dental treatment under hypnosis or nitrous oxide does he come to the real reason for his visit to me: he is trying to escape his mother. He told her he was looking for a specialist. The specialist was older and had a long waiting list. This achieved what he wanted: peace from her and her diets, therapy suggestions involving aminosalicylates and corticoids, her admonitions and advice. And endoscopy appointments, which she kept arranging and he kept cancelling.

Bodo suffers from severe diarrhoea: watery, slimy, rarely less than ten times a day, and his fear of colonoscopy is at least as great as his fear of the dentist. Six months ago, he joined a self-help group for cannabis patients in the Rhine-Main area, where mainly "intestinal patients" meet regularly. Since then, he has been virtually symptom-free. **Several times a day**, **he inhales cannabis flowers** grown organically by a friend. It is a **hybrid with about 18% THC and less than 1% CBD**. He is very happy that he can now control his diarrhoea and will continue on this path. His friend is also a student and gives him a fair price for the flowers. He has now also helped him to set up a grow tent at home. He has just sent four Sativa plants "into flowering" (, i.e. changed the day/night rhythm accordingly (set the timer on his LED lamp to twelve hours of sunlight).

But as much as he relies on cannabis treatment for his intestinal problems (severe gas and cramp-like abdominal pain in addition to diarrhoea), he cannot ignore the fact that his toothache is getting worse every day. He contacted me to optimise and legitimise his cannabis treatment. **The** toothache is now getting in his way.

The next day, a dentist in Berlin-Mitte who specialises in treating

anxious patients removes a completely defective and abscessed molar under nitrous oxide. In the following weeks, as he tells me on the phone, Bodo quickly implements my suggestion **to massively increase** the **CBD dose** and carefully determine the necessary THC dose. He is now growing his own **strain with a balanced CBD/THC content (8% each**), which appears to be becoming the main component of his therapy. He has given up smoking (joints) and bought a tried-and-tested mobile vaporiser second-hand.

Immune and endocannabinoid systems

In my experience, the success of cannabis treatment for chronic inflammatory bowel disease can be assessed and predicted optimistically. The intestine has a particularly high density of cannabis receptors and is a central component of the endocannabinoid system. We are increasingly understanding this in connection with the human immune response. If we could spread out the entire intestine, including all its villi and crypts, we would have a huge area in front of us on which a microscopic world war is constantly raging. Pathogenic5 germs (disease-causing agents), once they have penetrated the mucosal barrier, are identified with certainty and destroyed by lymphocytes, killer cells and antibodies, as are the individual malignant degenerated cells that arise at least once a day somewhere in the organism through spontaneous mutation, very often in the large intestine. This usually occurs in cases of chronic inflammation. The immune response can be completely exaggerated (allergy) and destroy the body's own tissue (autoimmune disease) or suppressed and weak (malignant growth).

The interaction between the immune and endocannabinoid systems is being researched worldwide. For years, the term "dysfunctional endocannabinoid system" has been appearing in scientific publications, mainly in connection with fibromyalgia and in migraine headaches. However, chronic inflammatory bowel diseases should also be increasingly considered from this perspective. **It has proven effective to replenish a potential CBD deficiency or to substitute CBD at the beginning of cannabis treatment.** If there is no deficiency, additional administration does not endanger the patient: CBD does not cause any change in consciousness. There are no known side effects. Most patients feel more relaxed. The anti-inflammatory effect is an added bonus. In patients who received TTM and cannabis at the same time, I observed increased muscle relaxation and faster regression of symptoms. It requires talent, good training and a little courage on the part of the masseuse to include the abdomen in the traditional Thai massage routine. If all three conditions are not met – and this is usually the

case – the abdomen should be left out. However, if it is treated under the conditions mentioned above, the effect is usually profound.
The muscular relaxation achieved by combining CBD with TTM is impressive, which is not surprising: the target organ of the treatment is the musculature. Like the diaphragm, the abdominal wall consists almost exclusively of striated muscles and tendons, while the middle layer of the hollow organs (stomach, gallbladder, duodenum, small intestine and large intestine) consists of smooth muscles. We can influence the fine adjustment of muscular tension, the immunological and metabolic processes in the intestinal wall, and the activity of the higher central nervous structures (mainly in the brain) with cannabis, and even more so with the combination of cannabis and TTM. There are no known relevant side effects. The quality of the massage is crucial.

The removal of the chronically inflamed tooth probably played a significant role in Bodo's recovery. Advanced caries affects the entire tooth root and spreads to the jawbone when the immune system can no longer fight off the pathogens that have penetrated deep into the tooth. This defensive battle costs energy, and the patient is under chronic stress. Bodo's dentist had, of course, taken an X-ray and saw no possibility of saving the tooth with root canal treatment because the bone substance around the neck of the tooth had already begun to dissolve.

The diarrhoea became less frequent, and Bodo was quite satisfied. His mother was less so. She continued to urge him to undergo a colonoscopy – for her, as an endoscopy nurse, this was literally an everyday occurrence. Bodo was interested in my opinion, and I had no choice but to agree with his mother. I tried to take the pressure off him, assuring him that it was a very effective preventive measure against cancer. Polyps can be removed with an electric snare, along with precancerous lesions or areas that have already degenerated. But above all, it enables a precise diagnosis, because it makes a difference to the prognosis whether the patient has irritable bowel syndrome, Crohn's disease, ulcerative colitis or colon cancer.

Despite, or perhaps because of, his mother's insistence, Bodo did not undergo an endoscopic examination. A stool test had not revealed any occult blood, and Bodo was satisfied with the treatment results. Diarrhoea was rare. He still suffered from bloating, and his stools were not yet formed, but overall he was satisfied with his stomach.

Dominated by fear

Young doctors should be taught this mantra: diagnosis – prognosis – therapy. Based on his symptoms and medical history, and after the physical examination, I was fairly certain that he had irritable bowel syndrome. But

the line between experience and overconfidence is a fine one. The exact diagnosis is made jointly by the internist and the pathologist. During the endoscopy, the internist takes tissue samples, documents, describes and interprets the findings visible to the naked eye, while the pathologist fixes, cuts, stains and examines the tissue sample under a microscope.

In terms of content, I had to agree with his mother, but I avoided putting pressure on Bodo. He kept in touch with me, complaining on the phone that he was feeling worse after an initial improvement, and asked about increasing his cannabis dose. We agreed **on six to eight times 250 milligrams of his usual flowers with a balanced THC/CBD content of 8% each** and adjusted the cannabinoid medication to his symptoms over the next two years. Most recently, Bodo added **2 grams of CBD crystals (99.9%)** to his dietary fats (vegetable margarine without palm and rapeseed oil and virgin olive oil for salads) **every day**. In addition, he inhaled up to 500 milligrams **of one of the many new flower varieties, whose THC content is stated by the producer as 23%,** four times a day**.**

The deeper problems of a patient are not usually apparent immediately. However, they gradually come to light. Bodo was dominated by the fear of losing the attention of his (over)protective mother if he became independent and moved freely in life . He projected his longing for a strong father who could have slowed his mother down onto me. For example, in impossible situations, he would (sometimes unconsciously) demand impossible certificates to test whether I would disappoint him like his father had. Of course, I did. But by then, we had focused enough awareness on his deeper conflict together that he was able to endure the frustration. To my knowledge, six years later, he is doing well today.

Chronic inflammatory bowel diseases provide a good example of how cannabis medicine, as I understand and practise it, works with cannabis, but the emphasis is not on cannabis, but on medicine. I will summarise "the secret of healing" again at the end of this handbook, but at this point it is worth pointing out the importance of nutrition and digestion.

Supportive diet

Fundamentally, the **bipolarity of our autonomic nervous system** reveals our evolutionary past. We rest, sleep and digest, and the parasympathetic nervous system is active. The heart beats calmly in the lower pulse range, blood pressure is low and the intestines are working. Peristalsis has begun. The pupils are narrow.

The opposite is true during the **"hunting phase":** the pupils are dilated because many mammals hunt at night, blood pressure rises and the intestines rest. The **sympathetic nervous system** is now active. When we are ill, we intervene in this system by taking long breaks from eating at defined times, thereby supporting the rhythmic functioning of the gastrointestinal system and relieving it at the same time.

Instead of putting additional strain on the system with probiotic yoghurts, fibre and more or less gentle laxatives or with peristalsis-inhibiting agents (loperamide), it is better to take a long rest period during which we **only** drink **water or tea** and limit our intake of proteins, fats and carbohydrates to a maximum of eight to ten hours. **For severe symptoms, a single meal a day works well, or even better, a short fast of three to seven days.**

Most patients with chronic inflammatory bowel disease need two meals, which should be eaten at roughly the same times . Breakfast at around 10 a.m. and the main meal at 6 p.m. has proven to be an effective measure. I have had good experiences with chronic inflammatory bowel disease with a **diet of coconut water (at least 1 litre daily, alternating with one to two litres of tea or water) and ripe papaya.** A maximum of half a large papaya sometimes works wonders. However, the length of time such a diet is followed depends on the general condition of the patient and, not least, on their body weight. Papayas are currently so expensive in this country that they can only be considered as a therapeutic measure for people who are better off financially. Instead, I recommend blueberry juice (no skins!) and old apple varieties.

Chapter 5 – Enrico – *ADHD*

Slim and tall. His nose, his fingers, his whole physique. Enrico was the second son of what was then the last generation of an old Neapolitan family. His parents ran a restaurant in Bavaria, now in its second generation. Like him, his three brothers had attended a private secondary school. At the time, his parents had decided that it would be best for their five children to obtain their school-leaving certificates, speak at least three languages and go on to university. Because knowledge is power, and power enables a comfortable life. Houses and flats. Boats, cars and motorbikes. The family spent their holidays together, often with relatives in Naples and Sicily, sometimes in the Caribbean and Thailand. His mother was both a smart businesswoman and an Italian mama who made pasta and kept the family together. He sometimes didn't see his father for weeks because he was away on business: sometimes in Rome or Milan, then again in Frankfurt.

Diagnosis: concentration disorder

Enrico's suffering began when he started school. He was required to sit on a chair in front of a desk for a full hour, together with around 30 other children, and concentrate on a topic. He couldn't do it. It was impossible to overlook him as he slid back and forth on his seat – long and thin as he was – repeatedly standing up briefly and quickly sitting back down when the teacher's disapproving gaze fell on him. He was yelled at and beaten, dragged to paediatricians and psychologists, and finally to a renowned psychiatrist. He was driven inside and out. His strong urge to move would not let him rest, it drove him on. Thoughts, emotions and fantasies flowed incessantly. When he came across something that captivated him, he liked to linger and did so willingly. Until it drove him on.

The psychiatrist diagnosed a concentration disorder because the patient could only concentrate selectively on things that were exciting or fascinating. The hyperactivity was impossible to overlook. The selective concentration disorder appears in the usual diagnosis as attention deficit: attention deficit hyperactivity disorder. **ADHD.** Nowadays, this diagnosis is often confirmed by psychological testing. An intelligence test is usually included. Enrico's IQ was 140!

For conventional medicine, methylphenidate was and is the "drug of choice" for ADHD, a stimulant (often euphemistically called a psychotonic) that falls under the Narcotics Act and virtually forces patients

to concentrate. Internationally, however, the treatment of ADHD consists of psycho (mostly behavioural) therapy and methylphenidate. In that order. Most patients receive only methylphenidate and are treated with
"Follow-up examinations" check whether they have internalised the performance requirements for their age group. The value system of our performance-oriented society knows no mercy and reveals its hypocrisy: six-year-old children are treated with a "psychotonic" that is quite rightly subject to the Narcotics Act. Methylphenidate is approved for patients aged six and above. To ensure that children "perform", they are exposed to a drug that has more side effects than benefits: their heart rate increases and their sleep is almost always disturbed. The children lose their appetite. Hyperactivity is replaced by increased muscle tension, very often in the masticatory muscles. In short: schoolchildren on speed. Teeth-grinding, muscularly sedated minors who are all too often exposed to the harsh discipline of their parents and professional educators without protection.

The first joint

Enrico's mother is intelligent, educated and empathetic. She had observed her son's peers who were being treated with Ritalin (methylphenidate) and decided to spare her son this measure. When doctors, psychologists and educators urged her to give her son the medication, she remained firm. Normally, parents give in when professionals appeal to their superego: your son is suffering unnecessarily. Make it easier for him! But Enrico's mother relied on her senses and her experience. She did not allow the methylphenidate treatment. When the teachers increased the pressure, for example at parents' evening, she deliberately brought her husband into the conversation. She would contact him now, and he would be present at the next parents' evening. Enrico's father was more than just a respected figure in the community. Rumour had it that he was part of an international organisation that it was better not to have anything to do with.

Enrico remained unmolested. He grew taller and thinner, and devoted himself (voluntarily and with great concentration!) to the visual arts and music.

At the age of 12, he suffered so much from his restlessness and anxiety that he sought help on his own initiative. His mood changed within seconds from cheerful curiosity and a joy of discovery to complete despondency. Life seemed meaningless to him. A friend of his older brother suggested he try cannabis. So, a few days before his 13th birthday, Enrico smoked his first joint. Today, at 24, he can remember the exact day, hour and place.

And the effect: "The first thing I noticed was my shoulders. They literally dropped down. My shoulders dropped at least ten centimetres. My fists also opened. I felt so calm and relaxed that I thought: Why on earth didn't anyone tell me about this before?!"

Vaping instead of smoking

When he first came to see me, Enrico (aged 24) had been treating himself with cannabis for twelve years. He smoked one joint in the morning with tobacco and about 250 mg of organically grown cannabis flowers with about 18 to 20% THC, a second in the late afternoon and possibly a third at night. His **daily dose of good quality cannabis flowers with 18 to 20% THC was therefore less than or just under one gram.** Sometimes he took a break for a few days. Overall, his daily dose was constant. A few years ago, he needed more. He had graduated from high school and started studying art. He was now aiming to become a teacher. He enjoyed passing on knowledge and sharing his enthusiasm (especially for Caravaggio and Picasso). He sought me out to legitimise the treatment. He had been living with a woman for several months and would like to start a family with her.

I examined Enrico and focused on **explaining to** him **the need to switch from joints to a vaporiser.** No combustion takes place in a vaporiser. Once the condensation point of the substance to be inhaled has been reached (157°C for THC), it is inhaled. **All oxidation products, and especially nicotine itself, have no place in medical treatment.** I issued Enrico with an opioid ID and prescribed Pedanios 22/1 cannabis flowers to enable him to continue treating himself within the legal framework.

Many people struggle with compulsions that rob them of their freedom to make decisions and act. It starts with compulsively returning home because they have forgotten whether they turned off the stove or a monitor. It ends with principles, ideologies, clubbiness and dogmatism. The dynamic is always the same. It starts with fear. **If cannabis is medically indicated and inhalation is chosen as the form of administration, it is necessary to vaporise it instead of burning it.** Burning and smoking it not only places a constant toxic strain on the lung tissue, it is also fatally reminiscent of the intravenous administration of opiates, especially heroin: the effect is immediate and powerful, and wears off just as quickly.

Digression: Basically, I can report good experiences with *cannabis monotherapy7* in heroin addicts. If these patients were to smoke their individual cannabis/tobacco mixtures in joints or bongs, I would consider

them unnecessarily at risk of relapse. Because the flash is followed by disappointment. The lifelong longing for that first shot of heroin (provided it was of good quality) remains anyway. *Even the second time around, it won't be the same as the first.* Cannabis is not heroin, and even at high doses there is no risk of respiratory arrest. But the sudden onset of the drug's effects is unnecessarily reminiscent of the first shot. For cannabis monotherapy in opiate addicts, the vaporiser (Volcano, Mighty, Crafty) is indispensable!

Enrico was the first in a long line of young male ADHD patients among my patients, including other highly intelligent individuals, most of whom had experience with methylphenidate. Most had taken it for a while and then switched to cannabis on their own initiative. I am aware that people from the cannabis community seek me out because word of mouth is likely to have spread there rather than at the CDU party conference. This circumstance naturally limits the significance of the following statement and must be taken into account: all ADHD patients who came to me had started self-treatment with cannabis. All were under 40 years of age, male and self-employed or at the end of their studies. Almost all had founded start-ups – in Germany, the Czech Republic, Austria, Spain, Switzerland and Malta. Almost all were successful. **In all cases, cannabis flowers with 18 to 22% THC were inhaled.** Almost all obtained their medicine from a grower they trusted. Many were now growing their own. **Maintenance doses ranged from 0.5 to 3 grams per day.**

All patients were "adapted" to their maintenance dose, i.e. adjusted: reaction speed and orientation are not impaired, and the test subject can respond adequately to complex challenges.

Cannabis vs. methylphenidate

Child and adolescent psychiatrists, led by Professor Thomasius from Hamburg, are fighting against the German government's efforts to legalise cannabis. Their latest argument, after "drug deaths" were identified as victims of individually excessive heroin use or (far more commonly) as victims of mixed consumption of illegal and legal substances, is inhibited brain growth. Anyone who smokes cannabis before the age of 23 to 24 must expect to develop up to 30% less brain mass in certain functionally defined areas of the brain. The result is learning disorders. Of course, we are talking here about cannabis as a recreational drug.

In practical cannabis medicine, on the other hand, we see people like Enrico. He was not yet 13 when he used cannabis for the first time. About

20 per cent of my patients have ADHD. All of them have benefited from early self-treatment with cannabis.

The effects of cannabinoids on brain development and function have not yet been sufficiently researched. Conventional psychiatry, on the other hand, does not hesitate to use methylphenidate and various other "indispensable" psychotropic drugs. However, there are many psychiatrists who are searching for and open to viable ways out of suffering. Not every remedy is suitable, and cannabis is not for everyone. However, it is clear that in most cases, ADHD symptoms exist before school age and brain growth is not yet complete when young patients use cannabis. Often instead of methylphenidate.

My ADHD patients all describe – each in their own way, but essentially in agreement – that a new life began for them when they started cannabis treatment. Many felt comfortable in their bodies for the first time. To quote one patient: "When I first used cannabis**,** I thought to myself that **this must be the state that healthy people call normal."**

In the other large patient groups, mainly pain patients and cancer patients, in which cannabis is administered as a medicine, the patients are predominantly much older than 24. My ADHD patients were largely self-employed as artists or entrepreneurs.

Digression: I enjoy listening to all kinds of music. I still remember Grandmaster Flash and the Furious Five, Lauryn Hill, the beginnings of hip hop, on vinyl, but then work started to get the better of me. Since I started using cannabis as medicine, I've also become familiar with rap. I liked Eminem; then, for a while, various rappers turned up at my surgery, some very well-known, some well-known and some unknown. One of them had heard about me from a German-Russian and was interested in becoming a patient, probably imagining that in the event of a police check, he would be able to wave a kind of free pass at the officers from his convertible. The German-Russian had visited me in 2018 during my three months as acting head of the "first German practice for cannabinoid medicine". At the time, I had been stupid enough to let a company put me on display and take advantage of me. One of the managers occasionally smoked weed at home, another played the model hippie because he had worked on a Californian cannabis farm for a while. Everyone else drank alcohol and despised potheads. They clearly preferred profit. I wouldn't have let the German-Russian get close to me if I had organised the setting (practice) myself.

If someone repeatedly tells you with conviction, "I am a good person," then

the opposite is most likely to be true. In short: he collected a considerable commission from the rapper, which the rapper demanded back from me when he realised that I couldn't immediately keep my promise to find a successor. I was ill for a long time in 2020 and received serious threats. I'll spare us the details. I've learned my lesson.

I still like Eminem. I've forgotten the names of the others, whether they were patients or not.

Healing is always free

I am 73 and reserve the right to choose the people I allow to approach me. I see patients seeking help via video call. I try to help those who are seriously ill. Whether a rice farmer in Thailand serves me a meal as payment for a house call (on an electric tricycle with a top speed of 30 km/h) or a comparatively wealthy businessman pays me "out of petty cash" is ultimately irrelevant to me . *I don't keep the money anyway.9* As a rule, I will avoid the businessman with the petty cash.

Healing is always free. Anyone who values my work can donate to children, adults in need, fair trade, war victims, etc., or sometimes to our livelihood: my wife's and mine. We don't have a car, expensive watches or designer clothes. The DHV collection box is on my desk and next to my wife's treatment area. We have paid our taxes. Our place in today's democratic meritocracy is comparable to that of individual critical members of a dysfunctional family: adult children of addicted parents founded their own self-help groups decades ago and can share similar experiences from their environment to those we have had with prosecutors, authorities and neighbours.

Chapter 6 – Pavel – *Psychosomatic Medicine*

Most patients who visit their doctor, usually their family doctor, because of a health problem are, **according to the current definition**, **suffering from a "psychosomatic" illness.** Modern medicine understands psychosomatics to be the interaction between the body (soma) and the psyche. Even illnesses that at first glance appear to affect only the body, such as fractures and infections, have their own psychological dynamics when viewed more closely. By this I mean not only pain, but the entire spectrum of perceptions and sensations that would not have occurred without the physical illness. Despair, hopelessness, existential fear, panic, to name but a few. In most cases, shame plays a central role. Conversely, even illnesses that appear to be purely psychological have a strong physical side: a patient suffering from depression, for example, often has no appetite and usually suffers from insomnia.

The proportion of psychosomatic patients in the cannabis doctor's surgery is likely to be just as high as in GP practices. One day, Pavel turned up at my surgery. My first impression: a mountain of a man. Everything about him was big: his hands, ears, torso and limbs. His head was relatively small. He had large brown eyes with reddened eyelids and conjunctiva. I had expected a small, delicate person because of his quiet, rather high-pitched voice on the phone. Quietly and evenly, as if he himself were not involved, he says something monstrous: for as long as he can think and remember, he has been unable to sleep deeply and restfully. He only falls asleep when he is completely exhausted or overtired, but then wakes up quickly, often after only half an hour. He always wakes up between four and five in the morning. He feels exhausted, drained and overly nervous. He has to force himself to do everything, both at work and in his private life. His life is pure torture. He wonders why this has happened to him. It feels as if he is being punished for a serious transgression.
It wasn't just sleep disorders. For as long as he could remember, he had had a "sensitive" stomach. Around the age of 20, he couldn't remember exactly when, it got worse. In his mid-20s, he had his first gastroscopy: an ulcer near the pylorus. Most "stomach ulcers" occur in this area. The pylorus is the gatekeeper of the stomach: on the one hand, it is the ring muscle that regulates the release of stomach contents into the duodenum, and on the other hand, it is the special mucous membrane that performs various tasks in the transport of substances. Among other things, it produces a protein to which vitamin B12 must be bound in order to enter the organism. Vitamin B12 plays a key role in blood formation, among other things. Note: A

"stomach ulcer" is often a duodenal ulcer, because part of the pylorus belongs anatomically to the stomach, while the other part, further away from the mouth, belongs to the duodenum.
The modern term is therefore: parapyloric or praepyloric or pyloric ulcer. Ulcer means ulcer, not tumour.
Ulcers do not proliferate. On the contrary, they are deep defects in the mucous membrane that appear as if they have been punched out. Since most of us do not normally look at other living beings in our stomachs and duodenums, we can imagine the lower leg ulcers associated with venous disorders or diabetes. Ulcers near the pylorus are dangerous because they can rupture (perforate) or bleed. When they rupture, extremely aggressive acidic stomach contents enter the abdominal cavity, causing peritonitis, which is a life-threatening condition.
If the ulcer extends deep into the tissue and a small or larger blood vessel is damaged, this can cause either oozing or massive arterial bleeding, depending on the situation. Here, too, the Grim Reaper is already wielding his scythe unless the surgeon intervenes in time with his knife, clamps, ligatures (needle and thread), thermocoagulator (to cauterise small bleeding vessels) and, above all, his skill. In cases of massive bleeding, patients vomit and lose litres of blood, which the anaesthetist must replace. Sometimes *erythrocyte* *concentrates10* are administered. In cases of oozing bleeding, anaemia develops gradually, with patients passing tarry stools or having "occult" blood in their stools, which can only be detected with a test (haemoccult). Chronic inflammation of the stomach lining (gastritis) can also become haemorrhagic, i.e. bleed. Just imagine lots of tiny ulcers that we cannot see with the naked eye.

On the development of ulcers: If I had answered "bacterial" to the question about the development of stomach and duodenal ulcers in the 1975 state examination in internal medicine, I would probably have had to retake the entire exam. The accepted theory at the time was clearly "psychosomatic". Today, it is assumed that a microorganism called Helicobacter pylori is the culprit: a bacterium that colonises the stomach and intestines under certain circumstances.
If the infection is not cured, ulcers usually develop or, much more rarely, a malignant tumour develops **(stomach cancer,** see chapter on cancer). Conventional medicine focuses on eradicating the bacterium using a combination of three or four drugs, including at least two antibiotics. The diagnosis is made using a special stool test or, much more commonly, a special breath analysis. If the pathogen is still detected or reappears sooner or later, the battle begins again. The pathogen must be destroyed.

Psychosomatic medicine

Back to Pavel: he is the second son of a single father and grew up as an only child in a children's home. He was in his mid-20s when he was diagnosed with a "stomach ulcer", but not with a Helicobacter infection. This spared him the ordeal of Helicobacter eradication. The language brings it to light: conventional medicine calls this procedure eradication: the complete destruction of a pathogen. The reduction of important microorganisms that live symbiotically in our intestines is accepted as a necessary side effect. The combination therapies are stressful. Most patients need weeks to recover from them, and the question of why one person becomes infected and another does not remains unanswered. What are the specific circumstances mentioned above?

Since this is an infection of the stomach and intestines, it makes sense to first address the patient's eating habits. In the broadest sense. However, that is not enough, but we will automatically make progress once we have started to take a closer look at him. We are now in the border area between psyche and soma, in the field of psychosomatic medicine. For as long as he can remember, Pavel has used food, mainly sugar, to calm and comfort himself in the absence of a caring person. His father was authoritarian and could only calm or comfort the boy by offering him baby food again and again, saying, "Eat up!" Over the years, milk substitutes and porridge were replaced by potato chips, cheeseburgers and sweets of all kinds. Dad's message: Men don't cry. Pussies cry. A chocolate bar never hurt anyone. Over the years, this also applied to alcoholic beverages and nicotine cigarettes, the pacifiers of adults. (**See chapter "Consciousness expansion in cannabis medicine"**)

Cannabis and a glimpse into the unconscious

The ulcer was treated as usual with modern gastric acid inhibitors, known as proton pump inhibitors. The best known of these is pantoprazole (up to 20 milligrams per tablet), which is available without a prescription. The ulcer disappeared, but the sleep disorder, a cardinal symptom of depression, remained. Ten years ago, after watching a television documentary, he consulted a neurologist who prescribed medication and referred him for behavioural therapy: 25 hours with a psychological psychotherapist who concluded an "anti-suicide contract" with him right at the beginning. The neurologist increased the dosage of the medication or changed it about every four weeks. Over a period of two years, he was introduced to two benzodiazepines (lorazepam and oxazepam), various antidepressants and hypnotics (sleeping pills).

He probably experienced the psychologist in a similar way to how he had experienced his father. She cannot have been particularly empathetic. In any case, Pavel felt bombarded with advice, guidelines and platitudes. The

dilemma of current psychotherapy began long before the endless series of traumas resulting from war, displacement and uprooting that it has been confronted with in recent decades. At that time, psychoanalysis was the supreme discipline of psychotherapy. The professors and heads of large clinics were required to be neurologists (psychiatrists and neurologists) with the additional title of psychoanalyst. Current status: Hardly any psychology faculty or psychiatric clinic in the Federal Republic of Germany is still headed by a medical analyst. Everywhere there are neurologists without analytical training and psychologists who offer behavioural therapy – behavioural therapy that has undoubtedly blossomed in terms of content and treatment techniques in recent decades, but which, in my opinion, increasingly ignores its limitations.

I have sometimes wondered whether doctors should still be allowed to claim that they can treat mental illness. Freud was a doctor, a brilliant pioneer and trailblazer. Psychotherapy is a medical task, and the push by psychologists to prescribe psychotropic drugs is grotesque. No one snorkels on the surface when they want to dive to the bottom. One thing remains certain to this day: there is only one method in established psychotherapy in which the therapist must have been a patient! Anyone aspiring to the "grand additional title" must undergo a long and highly frequent training analysis with an experienced training analyst. At least two to three times a week. At their own expense and in addition to extensive theoretical training and training treatments under the supervision of at least one other training analyst. Quite a few reach four-digit numbers in terms of analysis hours. Only when the prospective analyst knows themselves well (and thus their unconscious conflicts) can they use the key, as Bela Grunberger calls it: the instrument of transference and countertransference. Only when the therapist knows himself well enough can he use the impressions, feelings, scenes and associations he notices in his work with the patient for interpretation.

The prerequisite for doctors to be able to bill statutory health insurance funds for "basic psychosomatic care" services, on the other hand, is a relatively short period of further training organised by the medical associations and associations of statutory health insurance physicians. I rate this additional qualification as "better than nothing". The essential tools of analytical psychotherapy cannot be learned in a few courses and supervised therapy sessions anyway. Only transference/countertransference gives us the key to recognising the unconscious dynamics of an encounter (e.g. therapy session) and making the patient aware of them. A therapy session is not a lesson in which the behavioural therapist teaches or explains something to the patient. Despite digitalisation and globalisation, the level of knowledge of

most of our contemporaries is tantamount to a declaration of bankruptcy. It has reached the point where even educated people call on psychologists when they have mental health issues. Explanations are of no help whatsoever. It's a waste of time. I've seen it happen many times.

Cannabis reliably helps with mental illness in one respect: when used skilfully, it allows us to see more than before. **Once patients have familiarised themselves with the relaxing effects of their chosen cannabinoid, they find it easier to address their unconscious conflicts.** They are unlikely to experience enlightenment, but they may and should see a few things more clearly. Many people go round and round in circles until they realise that it is a roundabout. No one promised seekers a rose garden; it is not an easy path. The craving remains, even if they no longer consume chocolate bars. What to do? An appointment with a cannabis doctor is not the worst idea. Side note at this point: I like Lauterbach and quote him (Federal Press Conference): A good doctor must have tried everything he prescribes to his patients. I agree. Exceptions prove the rule. Pavel visited me three times in two years. He had smoked some pretty good cannabis a few times – despite his fears – and felt good when he was alone. To avoid taking an authoritarian approach, I didn't give him the usual lecture, such as: "You can't seriously be putting the combustion products of tobacco and cannabis (a 'normal' joint) into your lungs!" Instead, I told him how I came across the vaporiser in the course of my life and warned him.
As is so often the case in life, the supposedly cheap purchase is often the more expensive one in the long run. **There are a few vaporisers that have been in medical use for a long time, including in the Netherlands, Spain and the USA. They are slightly more expensive to purchase, but they last a long time.** The manufacturer (a German family business that has since been bought out) offers excellent service. The devices can therefore be purchased second-hand at a reasonable price. Whether in Bangkok or Amsterdam, good coffee shops provide customers with a Mighty or Volcano with a replaceable mouthpiece. The vaping temperature can be controlled digitally. Some have mastered the art of varying the vaporisation temperature depending on the terpene, CBD and THC content of the selected flower.

Pavel began inhaling the approximately **20% pure Indica flowers**. He gradually increased the dosage from 250 to 500 milligrams (= 1 gram = 200 milligrams of THC) per day to double that amount. He has maintained this daily dose to this day. He alternated between different strains. He prefers **a sativa during the day and sticks with indica at night.** At first, he slept like a log, night after night. I had recommended a few books to him –

among them

Among other things, a fairy tale interpretation that deals with loneliness and alienation – a reliable breathing technique – and music: listening to it, dancing to it, letting yourself be carried away emotionally. He came back after ten months, had lost weight, and was beaming. He had dropped out of a gardening apprenticeship in the Czech Republic some time ago, but remembered these basic skills when he realised that he couldn't spend his days in an office. He was a "nature lover". As luck would have it, he came across a company at a cannabis fair that develops and sells "equipment" for cannabis cultivation. Within a few months, he had specialised in organic fertilisers and nutrient solutions and was visiting growers all over Germany, advising them and learning from them.

A few months later, he casually mentioned to me that he had started his own business. He said his boss had been overcome by greed and turned out to be a slave driver. He put it a bit more harshly than that. It occurs to me:

"This time you haven't been sent to a care home." A twitch in the corner of his eye. "You're not a pussy either when the tears come." The rest is nobody's business but Pavel's and mine.

He calls me occasionally. Most recently, he offered me a refurbished Volcano, the now digitised Mercedes among the vaporisers. A power supply unit. He had discovered an ancient one in my study, without letting on. "You don't have to pay anything, it's free." Now it was my turn to twitch at the corner of my eye. I accepted the gift.

Chapter 7 – Kevin – *Chronic pain syndrome following a slipped disc and opioid dependence (tramadol)*

"How's the air up there?" I almost asked. The new patient is very tall. I'm quite short. The giant and the dwarf. The giant's name is Kevin and he made an early appointment with me because he's on day release and has to be back at the prison by around 6 p.m. My built-in censor immediately rephrased the question: "Are you over or under two metres tall?" I like to get straight to the point, but I try to do so sensitively. Kevin is 1.97 metres tall.

Like many tall people, he developed "back problems" at an early age. He was five years old when his parents immigrated from India to West Germany. Over the years, he became increasingly interested in sports. Due to his rapid growth, two basketball coaches took a special interest in him. Whether the training load was appropriate and sufficient stretching and relaxation exercises were incorporated cannot be determined with certainty in retrospect.

Tramadol for sport

Kevin's back pain began at the age of 25 and worsened suddenly within seconds: a sharp, stabbing pain in the sacrum area that spread to his right buttock and down his thigh to his knee. An MRI (magnetic resonance imaging = a modern, highly accurate diagnostic imaging procedure without harmful radiation exposure) showed a displaced disc in the spinal canal between the fourth and fifth lumbar vertebrae. Most patients refer to a similar finding as a slipped disc, but doctors call it a protrusion, Latin for "protrusion", meaning that it is not a complete herniation. In a complete herniation, the displaced disc tissue is already "sequestered", i.e. it is no longer connected to the actual disc. Such a sequester can be sharp-edged.

A complete herniation must be operated on quickly if it has caused bladder paralysis or paralysis of the foot lifters and lowerers because it mechanically irritates or even severs the corresponding nerve root (here: L4/L5). The patient is then operated on in a prone position and under general anaesthesia: the corresponding level of the spine is exposed and the pressure is taken off the nerve root.

Kevin had suffered an incomplete herniation. Treatment for this condition is usually conservative: professional physiotherapy with the aim of strengthening the back muscles to relieve pressure on the displaced disc.

As Kevin was now a key player in a successful basketball team, his coach and the club's board attached great importance to his recovery. In short, Kevin received unusually intensive physiotherapy under the guidance of a specialist in physical and rehabilitative medicine.

Perhaps he would have fared better if he had only received the "standard programme" of physiotherapy covered by statutory health insurance: normally six physiotherapy sessions in three months, which can be doubled in justified cases. The maximum amount of outpatient physiotherapy covered by health insurance: half an hour of manual treatment and movement exercises every week for three months. Sometimes in an exercise pool. However, it must be taken into account that the patient has to undress and dress again. This can take a long time for patients in pain. Then 30 minutes of treatment becomes 20.

However, if Kevin had been treated by the physiotherapist alone, the effectiveness of the treatment could have been assessed without bias. For Kevin, it was not just a matter of general pain relief, but of being able to return to his position as a key player on the basketball team as quickly as possible. So the specialist (a member of the club) pulled out all the stops and prescribed Kevin tramadol from the outset, an opioid that can still be prescribed on a normal prescription today because it is not covered by the Narcotics Act. It is very popular with athletes because it briefly eliminates the typical pain associated with overexertion, which is caused by hyperacidity in the muscles. For Kevin, it was a fatal decision.

Pharmaceutical empires on the way to a cannabis monopoly

Tramadol was launched in the 1970s as Tramal by the Grünenthal company and was heavily advertised with untenable promises: no dependence despite strong effectiveness. Reason: no euphoric effect. Such deliberately misleading advertising strategies were not uncommon at the time. In the early 1980s, for example, the company Böhringer launched the opioid buprenorphine as Temgesic with the same promises. Today we know that it is highly addictive. It is about ten times as strong as heroin and has been classified as a narcotic since the mid-1980s. Tramadol is not. However, it is also much weaker.

Digression: Several decades ago, the name Grünenthal was on everyone's lips because Contergan (thalidomide) had also been developed by Grünenthal (as an over-the-counter sedative and sleeping pill) and was part of its product range. It is still used today to treat leprosy. It caused severe malformations in the children of women who had taken it during

pregnancy. Everyone can form their own opinion about the way in which Grünenthal acknowledged its guilt and attempted to compensate an army of Contergan patients. There is plenty of material available, including a film.

I just want to emphasise that the pharmaceutical empires are powerful, often unscrupulous, and currently in the process of monopolising the production of old and new cannabis products worldwide wherever possible. With the help of the administration and established pharmacists, they are well on their way to establishing a cannabis monopoly in Germany if no resistance is offered. In my opinion, some companies have lost all right to advertise themselves and their products, as they have repeatedly endangered, harmed and even killed people with corrupt and immoral strategies.

However, it should not be forgotten that the pharmaceutical world is changing: in 2018, the first German pharmacist waived exclusive mark-ups, sold cannabis at fair prices both in his pharmacy and by mail order, and was immediately bullied by his colleagues. A resourceful colleague pointed out that he had made a careless mistake in his application for a licence to sell cannabis by forgetting to tick the box for "mail order". He was reprimanded, banned from mail order sales and fined until the matter was clarified, and lost income. There are now specialised pharmacies that are helping to improve the image of the industry with fair prices and expert, honest advice. Even more helpful, in my opinion, are the efforts of a Berlin-based pharmaceutical company to set up an academy w h e r e training courses for doctors a n d pharmacists are organised and offered. The aim is to enable experienced doctors and pharmacists to use cannabis effectively.

Kevin was prescribed tramadol, initially 100 to 150 milligrams a day, the usual dosage. After a few months, during which he became a regular player, he was taking five to ten times the initial dose. He was "like a zombie": drowsiness, balance problems, loss of appetite and insomnia, and – particularly annoying – persistent constipation, commonly known as constipation, an inevitable side effect of opiates and opioids, accompanied him.

Then, on a balmy summer evening, came the key scene. Kevin had run out of tramadol, and a friend had ordered pure brown heroin from the internet and had it delivered. "Once is never" is a dangerous misconception when it comes to heroin. For predisposed individuals (opiate-type addicts, see chapter on "Addiction"), the euphoria experienced when taking pure heroin intravenously for the first time is so overwhelming that the craving

for that first fix lasts a lifetime. Even the second fix is disappointing in comparison to the first. The price is simply too high. Pure heroin without the consumption of other substances very quickly triggers physical dependence, but unlike alcohol and nicotine, it does not cause serious physical damage. Withdrawal is unpleasant, but usually harmless. There is no risk of delirium tremens as with alcohol and benzodiazepines.

In short: Kevin was hooked on the needle, the costs for a day without *"turkey11"* were growing, he had to cut heroin and resell it. He was caught. The amount seized was considerable. There was no probation, but fortunately there was a good doctor at the prison who cooperated with us so that he could undergo *warm withdrawal*, i.e. gradually reduce the tramadol dose while increasing the cannabis dose. **Taking four 250-milligram doses of 22% Indica flowers via vaporiser inhalation**, Kevin eventually forgot about his last dose of tramadol (50 milligrams) and rated his pain intensity as 2 to 3:
"easily bearable". A fellow prisoner worked with him in the gym: strengthening the long back extensors, etc.

Substance abuse, dependence and addiction
Kevin called me a year ago. He said he was doing well. He was playing basketball again and was clean. He had left the club. Over time, it had become clear to him that behind the camaraderie and joviality of his sports friends there was nothing more than relentless mutual pressure: performance had to be delivered regardless of the risk of injury.

He sometimes consumes cannabis with friends after work, but no longer on a regular basis.

In recent years, around 30 per cent of my patients have suffered from chronic pain and had similar experiences to Kevin. For them, too, the suffering usually began with back or lower back pain, whereby "lower back" refers to the sacrum *(Os sacrum:* the
"sacred bone"). The sacrum developed from the fusion of the lower vertebrae, completes the pelvic ring and merges with the coccyx at the bottom. However, the anatomy of the spine is designed for quadrupeds. The evolutionary step towards upright walking reveals an anatomical weakness: the increased pressure load when standing upright affects not only the hip and knee joints, but also the lower nerve roots, especially those between the sacrum and lower lumbar vertebrae and those in the level above. When substance abuse, dependence and addiction play a role in the clinical picture, as is the case with a large proportion of elderly patients with

polyarthrosis [13]. **the problem of dependence is almost always the primary issue.** Addiction is fundamentally a serious chronic illness with a poor prognosis. We should try to understand it as an attempt by the individual to heal themselves in order to be able to live with personality, anxiety and depressive disorders (more on this in the chapter on "Addiction").

What is often forgotten or concealed is that **most "drug deaths" are caused by mixed consumption.** Crystal meth (methamphetamine) is the killer drug of our performance-oriented society. Luxury speed freaks afford expensive cocaine and talk the same nonsense without pause as the junkie with the crack pipe. I am convinced that cannabis will improve the social climate in the long term if we free it from its dirty image. The beer drinkers at the regulars' tables, at the shooting clubs and Oktoberfest celebrations in this country, won't like it, nor will the gourmets with their noses in their wine glasses. Let's just ignore them. They prefer a different drug that removes their inhibitions about interacting with other people.

Cannabis does not cause physical dependence and only rarely causes psychological dependence.

I could list the diagnosis here: chronic pain syndrome, advanced polyarthrosis, alcoholism, reactive depression. However, I will not write about depression, pain management and addiction again at this point, but about **Carla** – **as an example of elderly people who usually suffer from one or more chronic conditions when they visit the doctor.**

Let's start with osteoarthritis, or joint wear and tear. Experience shows that degenerative joint disease (osteoarthritis = joint wear and tear, calcification) does not directly shorten life expectancy. However, if left untreated, it very often shortens it indirectly! The more painful knee or hip osteoarthritis is, the more it restricts a person's mobility.

However, the less an elderly person moves, the faster their life expectancy decreases: superficial thrombosis, weight gain due to obesity (liver!), muscle loss, etc. Clots can break off from leg or pelvic vein thrombosis and block a large vessel in the pulmonary circulation. We call this condition pulmonary embolism. It is life-threatening and often fatal.

The doctor will therefore tailor their treatment recommendation to the extent of the osteoarthritis and the pain. Nowadays, they have access to technologically advanced diagnostic tools for this purpose. These mainly include CT, MRI and ultrasound, which can be used to objectively assess the findings. However, we are still unable to measure pain intensity. Patients are usually asked to rate their pain on a scale of 0 to 10, with 0 meaning no pain.

Similar findings, different treatment paths

Another thing that should go without saying: we treat people, not diseases. In Patient A, a hip joint whose joint space has already been partially narrowed by calcium deposits and which is already showing signs of effusion will lead to mild pain syndrome. He successfully treats this himself with physiotherapy, ibuprofen and devil's claw root as a decoction, enabling him to live largely pain-free without restricting his range of motion. The statutory health insurance pays for six half-hour treatments in three months (!) with the physiotherapist, who massages and moves his hip a little. Five minutes are needed just for the undressing.

Patient B has very similar X-ray findings. She is in a better financial position than Patient A. She has undergone a long course of acupuncture treatment with a Chinese doctor, has visited various physiotherapists, paid for the treatment herself and tried a raw food diet according to

Bruker. However, her pain continued to increase, reaching a level of 7 to 8 on the above pain scale without painkillers. She sought help from an anaesthesiologist who specialises in pain management. She now takes 200 milligrams of tilidine twice a day in a prescription combination with 16 milligrams of naloxone. Tilidine is a strong opioid that can only be prescribed with a standard prescription in combination with the antagonist naloxone. This prevents constipation and respiratory paralysis in the event of an overdose.

400 milligrams of tilidine is a high dose of a strong opioid[14]. Patient B is called Carla here.

Carla came to see me in the winter of 2017. She was a slightly overweight 65-year-old woman, athletic, dressed in subtle colours. Because we had already spoken on the phone, I already knew that she was a Protestant pastor and widowed. Her husband had the same profession. It takes her about five minutes to walk from her front door to the entrance of my practice, which is on the first floor, just under 20 steps up. She is not struggling for breath, but groans quietly in pain. She uses a walking stick to take the weight off her right leg.

The appointment was arranged with me by her only child, Bastian, one of my first patients after cannabis was legalised as a medicine in March 2017. Bastian had suffered from chronic tinnitus (ringing in the ears), which responded well to cannabis. Not long ago, photos and a few lines had arrived from Uganda. Bastian has been living and working there as a musician for quite some time. He is married to a Ugandan woman. The two have become parents for the first time.

"Are you flying to the christening, or is Bastian coming with your daughter-in-law and grandchild? You can christen it yourself!" Carla's pain seems to have subsided. She has sat down on the hard chair with the straight backrest. Patients with spinal and hip problems usually prefer it because they find it harder to get up from a comfortable armchair. She smiles.

During the physical examination, I notice a faint smell of alcohol. Deodorant? The liver is palpable about a finger's breadth below the rib cage and seems to be hardened. "I don't even know if I want to have the baby baptised. Even if the two of them really want it." Carla hesitates, then says, "I've become a bit shaky in my faith." I turn my attention to examining her hip joints and knees. She has brought X-rays and lab results from the last few months.

Alcohol and pain medication

Carla studied theology, married a fellow student and, together with

her husband, looked after a medium-sized parish in Lower Saxony. She was 36 and he was 38 when the pastor couple had Bastian. At first, she stayed at home with her son, then she shared the work in the church, the retirement home and the parish with her husband. Carla took on all the religious education classes at the comprehensive school and for the confirmation candidates, while her husband took more care of Bastian. The death of her husband five years ago took Carla by surprise. He suffered a heart attack on his way to a funeral.

Bastian left her a year later. He had found his place in an international band from Uganda and in life. After her husband's death, she herself "fell into a hole," barely able to fall asleep and unable to sleep through the night. Then came the pain. Physical pain. In her fingers and wrists, in both hips and in her right knee. Shortly afterwards, back pain set in.

The X-rays she brought with her show advanced degenerative changes in the painful joints – joint spaces narrowed by calcareous deposits and so-called marginal spurs. In the intervertebral areas, not only are the intervertebral joints affected, but the lower intervertebral discs are already moving towards the spinal canal and thus towards the respective nerve roots. "I live in fear that the disc will prolapse, squeeze the nerve and I will no longer be able to walk. I am alone. My husband is dead and my son is in Africa. I need help. This is new territory for me. I have always helped others."

I focus first on treating the pain. I don't want to ignore the faint smell of alcohol. Medically speaking, I come from a time when medical technology was nowhere near as advanced as it is today. I have learned and internalised to rely on my senses. So I have to follow up on my findings to make sure I don't overlook anything important. At the same time, I try not to offend Carla. She nods vigorously when I express my suspicion: "Could it be that the tilidine isn't relieving the pain sufficiently and you're trying to enhance its effect with alcohol?"

Carla's nod would only have confirmed the intensity of the pain if it hadn't been for the palpation findings on her right rib cage and the lab reports from the last few months that she had brought with her. The so-called transaminases were significantly elevated, usually an indication of an inflammatory reaction in the liver tissue with already beginning remodelling: first fatty liver, later connective tissue remodelling to cirrhosis (shrinking liver). The notorious hepatocellular carcinoma often develops in the shrunken liver. This is almost always caused by toxic damage to the liver from alcohol or medication.

Carla had combined both, and she had a history: at the beginning of her theology studies, she began drinking heavily. When she noticed

that she needed a constant level of alcohol to compensate for withdrawal symptoms such as excessive yawning, sweating, restlessness and tremors, she attended several Alcoholics Anonymous meetings on the advice of a friend. There she found understanding and expertise and quickly became sober. When the pain therapist and orthopaedic surgeon suggested replacing her right hip joint with a prosthesis, she started drinking again "out of shock" and set the wheel in motion once more: increased dosage, personality change, shame. In short: relapse.

Alcohol withdrawal and CBD treatment

By now, she needed at least one glass of vodka to control the withdrawal symptoms. Bastian had organised a treatment trial with cannabis in the form of space cakes, a type of pastry made with cannabis butter or hashish. She felt nauseous and her heart was racing. Bastian suspected that she could not tolerate the combination of alcohol and cannabis. I can confirm that this is the case for most people.

However, she had observed how Bastian, despite undergoing prolonged outpatient infusion treatment at the ENT specialist, had not experienced any improvement in his tinnitus, then inhaled cannabis flowers using a mini inhaler (vaporiser) and was now symptom-free. That is why she came to see me.

To summarise: after her husband's cardiac death and her son's move to Africa, Carla realised: 1. I am lonely and sad.

2. My musculoskeletal system (bones, muscles, tendons, joints and central nervous system) has aged faster than average. 3. I have severe pain in several joints and am now taking strong painkillers, which hardly help me. However, they put a strain on my entire body, mainly my liver. 4. I am an alcoholic, i.e. addicted, and relapsed after my husband's death. I am currently a mirror drinker (delta alcoholism) and am seeking pain treatment with cannabis at the expense of my health insurance company, because cannabis has a negligible effect on the liver and is considered a very safe substance pharmacologically. The treatment of neuropathic pain with cannabis is scientifically considered to be evidence-based.

The first step in treatment was therefore to become abstinent from alcohol as quickly as possible. **Unlike THC, CBD is compatible with alcohol and facilitates alcohol withdrawal.** Carla quickly reduced her daily alcohol intake and at the same time began cannabinoid treatment with increasing doses of 99.9% CBD isolate, which she added to her dietary fats. Initially half a gram, later up to three grams daily. At the same time, she had a two-hour TTM with CBD oil administered by an experienced masseuse once a week. **It took less than three weeks for her to become abstinent from alcohol.** This allowed us to slowly reduce the

tilidine and start THC at the same time – **in the form of approximately 20% flowers as vaporiser inhalation.**

Living with pain

Carla now lives in Uganda and Lower Saxony, spending six months in each place whenever possible. She spends the winter in Uganda with her son, daughter-in-law and granddaughter whenever she can. Many people in the village know them. She is no longer lonely. Her joints hurt less in the warmth. She takes cannabis every day, a hybrid that is grown in her children's village. Under the town sign it says: "You are now entering a stress-free zone. Good vibes only. Karibuni sana." Carla has found a way to live with her pain. In the summer, the shaman in her daughter-in-law's village mixes some local roots, bark, leaves and flowers into a tea that reduces fever and relieves pain. One cup three times a day. In the evenings, her daughter-in-law applies clay packs to her knees and wrists. The warmth helps a lot to loosen the blocked muscles. In addition to physiotherapy and phytotherapy, she vaporises marijuana grown in the village. She had it tested in Germany: **16% THC, almost 2% CBD, pesticide-free. She needs about one to two grams a day.**

In Germany, she misses the dry, warm climate and the warmth of family life. On the advice of her family doctor, she takes THC orally in the form of dronabinol drops. **Caution: The effect of oral administration of THC (e.g. dronabinol) in the form of drops, baked goods, sweets and drinks is usually significantly stronger than when inhaled. Older people require a significantly lower dose.**

Carla's pain level is now between 2 and 3. Sometimes she experiences pain attacks: without warning, a sharp, piercing pain is superimposed on the dull, constant pain. This happens rarely. When she can't bear it anymore, she takes 50 milligrams of tilidine (combined with naloxone).
She has not mentioned her crisis of faith again.

"Aging without cannabis is possible, but unnecessary."

In Uganda, as in other emerging countries, there are no European or American-style retirement homes. There are communities of older people, extended families and churches, mosques or temples where refuge can be sought. But hotel-like facilities, where as many people as possible are crammed in, where it smells of urine in the entrance area and where no one laughs except on command at the Christmas party: these do not exist in Uganda. Or they are so rare that they are insignificant.

However, retirement homes will be necessary in the northern hemisphere, at least until the Earth is flooded and humanity has drowned or died of thirst or starvation. But until then, operators could

at least show some respect for the elderly and create optimal living conditions for them. Bright single rooms with futons (on platforms to protect the staff's spines) and terraces, sufficient friendly, well-paid staff, and free access to the cannabis depot at all times: tea, biscuits, joints, vaporisers and various fillings. Of course, residents can visit each other at any time and stay together if they wish. So finally, normal conditions after a century of caging and torture.

At the very least, elderly people must be given the opportunity to consume cannabis at any time. Lifelong brainwashing has had its effect on the silent majority. That is why they do not allow themselves the relief that cannabis can provide, i.e. relief from the usual ailments of old age: arthritic pain, depression, insomnia and loss of appetite, etc. Could a poster campaign help? "Ageing without cannabis is possible, but unnecessary."

Cannabis as an ideal remedy

Whether old or young, consuming cannabis will make most people more aware that they need affection, closeness and tenderness. It makes sense to turn to people who have chosen the same path, and the development of dating portals for cannabis users points in this direction. Of course, the shock of reality cannot be avoided with this approach. But isn't it possible to do without displays, edited portrait photos and the shock? If we fully understand that we are in need of affection and love and not mobile phones, influencers, series and programmes, this would be tantamount to a revolution. In the end, Tommy Chong might be right: "Marijuana is the drug against war."

The female cannabis plant is sometimes idealistically called the "green goddess". It is considered sacred by Rastafarians and Hindu sadhus. On the other hand, it has been extremely devalued by the majority of people since the 1960s (gateway drug, devil's drug, expression of moral inferiority, etc.).

We are currently in a transitional phase and should be cautious and stick to the facts. The fact is that modern and therefore humane elderly care is only made possible by cannabis. **For a large proportion of elderly people, cannabis is an ideal remedy.**

A walk through a typical "neat and tidy" German retirement home is so different from a visit to an Israeli or (in some cases) Swedish home that one wonders: Why on earth are elderly people in this country still subjected to the torture of standard treatment: incapacitation in the broadest sense, forced accommodation in shared rooms, prohibitions instead of options, and staff shortages in all areas? Who wants to be constantly overwhelmed in a depressing, foul-smelling environment? Who wants to spend their last days here? Wouldn't you want to live here?

This question arouses curiosity. In the spring of 2023, I discovered a hotel complex (resort) in Isan and stayed there for a few weeks. It is currently used as a B&B guesthouse. It has a lake, beautiful old trees, pavilions that can house a bakery, a coffee shop and a good massage service, and a restaurant. Since then, I have been working to find investors and fellow campaigners to organise a place for people of good will to live and work there. It doesn't matter whether they need care or are looking for a purpose. Temples, schools and daycare centres are nearby, and a shopping centre and Pharo Khon, a thriving small town with all kinds of amenities, are 6 km away. For more information, visit our website *cbd-thaimassage.de.*

Chapter 9 – Expanding awareness in cannabis medicine

I have long wondered why cannabis is used as a medicine by pain patients on the one hand and, on the other hand, almost equally by people with ADHD, PTSD and depressive disorders (including the current trivialisations such as "burnout syndrome") and, in some cases, long COVID.

Cannabis is not a painkiller or a sedative. Nor is it an antidepressant or a psychostimulant. I am not aware of any other medicine that has such a broad spectrum of effects and no mandatory side effects. To understand this phenomenon, it is of course helpful to learn about the physiology of endocannabinoids. We then understand theoretically how externally supplied cannabinoids interfere with the metabolism of the body's own cannabinoids (endocannabinoid system).

The endocannabinoid system can now be considered to be well researched. It is somewhat more difficult to understand than the endorphin system, as it is not solely concerned with pain. Endocannabinoids are substances produced by the body that block excessive excitation in the central nervous system (CNS) (e.g. through so-called postsynaptic inhibition) and ensure balance: psychophysical equilibrium, to put it another way.

Take from the rich and give to the poor

When I started working with cannabis medicine, a Spanish colleague provided me with his bibliography, which already included around 100 publications at that time (2016). There are more and more projects at international universities dealing with cannabis in the broadest sense, and many reputable sources of information. I can wholeheartedly recommend the *DHV* and the *IACM*[16]. However, I am aware that I have been labelled a "pirate" by colleagues in the IACM. An Israeli neurologist told me this at a conference in Tallinn. I am not offended, but I would like to make a brief comment:

Pirate – the word has a nice ring to it in my ears – I mainly associate it with the fictional Captain Jack Sparrow, the legendary Klaus Störtebeker and, immediately after that, Robin Hood, although to my knowledge he did not go to sea. Take from the rich and give to the poor: I have always believed in this, and still do today, and have also been able to achieve a little balance in my professional life over the last seven years .

When I provided seriously ill patients with high-quality, organic medicinal cannabis free of charge, they were certainly not high earners, but without

exception people in precarious circumstances. As panel doctors, we were still being "sampled" with standard medications by pharmaceutical representatives in the 1990s, so that we could give patients something to take with them, either to help them quickly or as a confidence-building measure. In both cases, the patient receives the medication as a gift. In this respect, I was and am happy to be a Pirate.
For me, **empirical medicine** is just as important as **evidence-based medicine.** The latter dominates today's medical landscape, right up to the Ministry of Health. I take it seriously, but I don't fly its flag. I am also not a club person. My last membership was with *CSC Berlin17,* which I quickly terminated. I have a basic knowledge of statistics and understand the importance of prospective clinical studies, but I preferred to look over the shoulders of traditional healers (shamans) and charismatic doctors rather than voluntarily attend company-sponsored training events. My first surgical teacher was a philosopher, surgeon and neurosurgeon at the first community hospital in the Federal Republic of Germany, a charismatic woman. Her basic attitude was to leave everything to nature. But if intervention was necessary, then it had to be radical, i.e. at the root of the disease (*pathogenesis).*
Over the years, I was drawn to psychoanalysis – I owe it to her for introducing me to the phenomenon of transference and countertransference, which provides reliable access to the unconscious dynamics of a relationship or even a one-off encounter (e.g. a diagnostic consultation). In short, I am a practitioner rather than a theorist.

I will now pick up where I left off and try to explain why cannabis is an indispensable medicine for pain, depression, compulsive disorders and psychosomatic disorders, offering a comparatively wide range of treatments. If it is not actually a painkiller, anaesthetic, sedative or antidepressant, what is it then? There must be a common denominator. Legally, it is still classified as a narcotic. Pharmacologically, it is not. It does not restrict consciousness, nor does it dampen it. The opposite is often the case, and this brings us to the common denominator of its many areas of application: **cannabis alters consciousness in the sense of intensifying and deepening perception .** Music, colours, touch, sexuality, to name just a few keywords.
I have heard identical statements from several pain patients. The wording varied greatly, but they all emphasised that the pain had not changed in any way, **but** that they perceived it **much more distantly when under the influence of cannabis**. As is well known, pain cannot be objectively measured. In order to assess it, patients are asked to rate their pain on a

scale of 1 to 10, with 0 meaning no pain. On average, "my" pain patients experienced pain relief of four to five points.
It is possible that the ability to experience pain as limited is enhanced under cannabis. However, it could also be that pain perception is simply overlaid by the stimulation of various sensory stimuli under cannabis, as I have just described. **Treatment can confidently begin with CBD alone. For more severe pain, THC is added,** as I described in the chapter
"Birgit".
In sharp contrast to CBD, THC has a psychedelic effect, i.e. in high doses it dissolves familiar cognitive structures to the point of synesthesia: sounds are seen, images are heard, and normally largely separate qualities of perception merge.
As early as the 1960s, an extremely potent psychedelic, lysergic acid diethylamide (LSD), was used in treatment for psychiatric and psychotherapeutic reasons. When administered to suitable patients in an appropriate setting, the wide access to the unconscious provided by the drug can be used therapeutically. Mescaline (peyote) and psilocybin (magic mushrooms) have similar effects to LSD and are traditionally used for medicinal and/or ritual purposes.
THC is to LSD what a primer is to a dumdum bullet. It has a mild psychedelic effect depending on the dose. Many first-time users report that they perceive music with an intensity they have never experienced before, even to the point of emotional turmoil or ecstasy.

Body and soul
There are no illnesses that do not affect the whole person. A broken bone, for example, is ostensibly a purely physical event, but pain, powerlessness and helplessness must be processed emotionally , and quite a few people react with depression: they lose their drive and sleep poorly. The other extreme is primarily mental illness. Here, in the worst case, the person finds themselves in a strange world. In psychosis, they hear voices that give them orders or devalue them. In depression, they feel paralysed and exhausted, hopeless and abandoned. Here, too, the physical aspect of the illness will not remain hidden for long: difficulty falling and staying asleep, muscle loss due to lack of exercise, weakening of the immune system, etc. So it is always the whole person who falls ill: body and soul fall ill together.
When treating bone fractures, it is usually sufficient to set and immobilise the fracture and encourage the patient. However, even a delayed healing process, for example as a result of poor callus formation, requires both: correction or intensification of physical treatment and empathetic care by medical staff. Sometimes the fracture must be treated surgically (known as

osteosynthesis) using plates, screws and prostheses. Conversely, we now know very well that mental disorders are much easier to treat if the patient does sport or yoga exercises. Nothing has changed in this regard since ancient Rome – and (much later) since Turnvater Jahn. A healthy body has always been assumed to mean a healthy mind. In the 1970s, people started jogging. Before that, they called the same activity endurance running. Today, we stand out if we don't go to the gym several times a week.

Help for self-help

If we are willing and able to open the treasure chest of empirical medicine, we learn that cannabis is one of the longest-used medicinal plants. Of course, there is also a herb to treat pain. In fact, there are two: opium poppy for physical pain and hemp (cannabis) for mental pain. We find them as grave goods in the oldest human tombs.

At the same time, both substance groups have been undergoing a "rejuvenation". First, opiates and opioids were released from the taboo zone, and now cannabis medicine is fighting to prove its effectiveness and establish its importance in society. As one of the pioneers in this field in this country, I can only urge people to take a close look, inform themselves and take courage.

We need courage to free ourselves from the consequences of decades of discrimination and criminalisation of cannabis (prohibition) when we are asked for the first or repeated time: Why don't you try cannabis? We need courage when we decide to give it a try. I am under no illusions: even those who read this handbook will probably not be able to ignore the old background noise: narcotic, gateway drug, neglect, etc. Fortunately, however, time has not stood still. Sometimes it needs to be repeated like a mantra: cannabis is one of the safest substances there is. It very rarely causes addiction. Even if it is overdosed, breathing remains unchanged. The patient then usually sleeps soundly.

The proven principle is **helping people to help themselves:** the responsible patient.

is in demand. It could be that medical capacities will be disproportionately tied up in military operations in the future. In the worst case, there will be increasing demand for war surgery. However, for the fields of internal medicine, neurology and geriatrics, highly effective medicine with few side effects that has proven itself in everyday therapeutic use, such as cannabis medicine already is today, will become very interesting. The boom times are over anyway, and cannabis medicine meets the criteria that are currently necessary: sustainability, low $CO_{(2)}$emissions, socially and ecologically progressive concepts in production and marketing, etc.

Academic medicine is highly specialised these days. However, the future of medicine will require passion, improvisation and experience from staff and patients alike. Otherwise, our liberal society will not be able to withstand the stress test that autocrats are mercilessly demanding of it. Practical cannabis medicine should be able to make a contribution to this.
The concept of **the responsible patient** will only exist until we have met them in person. I had a key experience in this regard in 2017, when a group of cancer patients from the new federal states visited me to discuss their treatment regimens and experiences with me. The patients had been growing their own flowers for many years, producing their own medication. Over the years, they had tried various strains for their (serious) conditions, discarding some, crossing others, etc. They all live in rural areas, are well connected with each other and can be described without hesitation as responsible patients.
I learned as much as I could from these responsible patients. In my experience, helping people to help themselves is an essential element of cannabis medicine. Growers and patients should exchange information. Cooperation instead of the eternal competition of our performance-oriented society: everyone against everyone else and only for themselves. Let's take a look inside the vaults of pharmacies: medical cannabis – the range offered by German pharmacies now consists predominantly of flowers with a THC content of over 22%. Doctors, if they are willing to prescribe cannabis at all, only need a fraction of this. Basically, the range of highly concentrated flowers is aimed at the consumer market. However, pain patients in particular need cannabis for oral use, usually in the form of drops, which pharmacies offer them in the form of extracts. These are now offered by licensed companies (so far mainly Canadian and American companies) at high prices. They are manufactured using the rosin process, which requires little equipment. In self-help groups, comparable extracts are available at a tenth of the pharmacy price, often even significantly cheaper.

Finding the remedy itself

The range of products offered by some pharmacies that have obtained a licence to sell cannabis can easily compete with that of large Dutch coffee shops. The trend is towards online trade. The prices of pharmacy and black market products are becoming increasingly similar, and with the usual time lag, we in Europe are likely to soon find ourselves in the same situation as, for example, in Southern California: legal and illegal (outdoor) cultivation exist side by side in almost equal proportions. The plant does not care whether the grower obeys the law or not. It needs light, CO_2, nutrients and care. Its therapeutic value goes far beyond the administration of

cannabinoids through oral intake or inhalation.
For some people, therapy begins with the selection of seeds and the cultivation of suitable mother plants and ends with the reproduction of the most suitable flowers. We should think of this process as a collective action and make one thing clear: we can find the remedy ourselves; we do not have to submit to government regulations. If a company can invest enough in safety (explosion-proof walls, security personnel), hygiene (two-room technology) and logistics, it is allowed to sell any cannabis strain as "medical cannabis". In Germany, the Canna- bis Agency was created at the BfArM, primarily with the aim of controlling every single step of production and punishing violations by refusing or withdrawing the respective licence. If we leave it at that for the moment that such an institution is, on the one hand, powerful and therefore susceptible to corruption, but on the other hand protects consumers or patients from quality losses and contamination of the cannabis on offer, we could turn our attention to the fact that behind many arguments against cannabis lies **a fear of psychedelic consciousness alteration**. This is not entirely identical to the fear of intimacy and devotion, but it is along the same lines. Essentially, THC is an amplifier; it can intensify any sensory perception. If someone is very tense, this state persists and sooner or later becomes unpleasant, then unbearable, cannabis, depending on the THC content, will only help if the consumer is able to calm their mind and release muscular tension ("let go"). If they are unable to do so, have no previous pleasant experience and no one at their side to calm them down if necessary, THC will intensify their state of tension. Anxiety hormones are released, the adrenergic part of the autonomic nervous system (fight-or-flight mode) is activated, and a panic attack is not far off. This applies explicitly only to unreasonable use.
Overall, cannabis is a very safe medicine, comparatively more pharmacologically safe than aspirin. However, if your **heart** starts **racing**, please remember that **THC and CBD** have **antagonistic** effects: it is usually sufficient to take CBD; **the best and fastest way to do this is to inhale CBD flowers (**with a negligible THC content) **using a vaporiser**, which you can buy for little money at any late-night shop. You will pay considerably more at the chemist's. Computer-savvy people compare prices and order online. It doesn't have to come to you being taken to the emergency room of the nearest hospital, where you will be reprimanded and bombarded with benzodiazepines.
Combining cannabis with alcohol has only indirectly to do with cannabis medicine. Unfortunately, however, it is not uncommon in the luxury food sector, and it is mostly young people who follow the motto: when the

donkey gets too comfortable, it goes out on thin ice. Alcohol and cannabis: vomiting with "circulatory collapse" in the emergency room. Rule of thumb number one for anyone who uses cannabis: there are people who can tolerate anything and more. But for the majority, **THC and alcohol do not mix. This is especially true when consumed at the same time.** There is no question that Muslims drink alcohol and Christians eat or smoke hashish, but this observation alone is not enough. I strongly recommend Baudelaire's wonderful essays on hashish and wine. Take a sip of red wine or , inhale a few puffs of cannabis or calm your mind using another method, and treat yourself to this reading!
But you can also make it easier for yourself: think of a reggae open-air concert and then the Munich Oktoberfest. You could also take St. Peter's Basilica and a Hindu temple. Western culture has literally instrumentalised alcohol: a glass of sparkling wine to get up and perk up, beer to loosen inhibitions, red wine to relax and for the Christian sacrificial ritual (Eucharist), white wine with fish. Sweet wine for dessert.

The East is much more discreet when it comes to cannabis. But see for yourself! Ideally, there will be a shift in society over the next few years, initially discreet, then more pronounced, from alcohol to cannabis, and things will become a little more peaceful in our part of the world. However, scepticism is warranted. (Many people understand freedom mainly as filling the engines of their vehicles with fossil fuels so that they can endanger themselves and others without speed limits, and at the same time filling their stomachs with ethanol so that they don't have to admit that they mostly use the vehicle alone.) With a little optimism, we can expect cannabis to contribute to improving the (social) climate. What kind of contribution this will be remains to be seen.

Chapter 10 – Cannabis and sexuality

Various experts could comment on this topic: endocrinologists, urologists, gynaecologists, psychologists and psychotherapists (not to be confused!) – and nowadays also an army of coaches, influencers, tantra teachers and sex addicts. One will deal with hormone metabolism, the next will unconsciously try to convey their ideas of ecstasy, devotion and satisfaction to you. The third may give you advice with an emphasis on "blows". Here is my creed on the subject:

1. The sex drive is the strongest force that moves and drives us living beings. Consciously and unconsciously. Eastern philosophies speak of chi, the life force that circulates in the body in temporally and spatially defined pathways (meridians, chakras). The most important pathway, surrounded by two others, is the Kundalini Shakti, which runs mainly in the centre of the spine from the first chakra (tip of the coccyx) via the forehead chakra to the seventh chakra (crown chakra). There is only this one life energy, which moves either towards pleasure/procreation or towards knowledge/enlightenment. To do this, it must be guided from its usual vegetative pathways to the higher centres. At the end of the 19th century, Freud laid the foundation for all modern psychotherapy in the West and attributed the same central importance to the sex drive. Gautama Buddha attained enlightenment under a tree about 2600 years ago. He had previously lived an ascetic life for a very long time.

2. **Cannabis is not an aphrodisiac**.[19] Yohimbine (an indole alkaloid from the bark of the yohimbe tree) is said to be one. Asparagus, chilli, ginger, ginseng, as well as some seafood (oysters) and eggs are said to have aphrodisiac effects.
3. Vascular agents such as sildenafil (Viagra) and tadalafil (Cialis) are potency drugs for men with erectile dysfunction and only work if a key sexual stimulus can unfold in the man's imagination to such an extent that he forgets his limp penis at least until genital union occurs. At this point, at the latest, a large proportion of men realise that they have been mistaken: the hard penis changes nothing. These men cannot let themselves go and relax, they do not reach orgasm, they remain alone with their stiff penises, regardless of whether someone is with them or not. They cannot give anyone pleasure and lust , nor can they feel it themselves, because something is missing: a loving and warm-hearted relationship with another person, without which sexuality consists only of functioning and

performance. What a terrible thought!

Three decades ago, a prostitute said: "The worst thing that could have been done to us was the invention of Viagra. Old men can now hump like crazy, but they can't reach orgasm. Every now and then, one of them tries too hard and dies of a heart attack in bed." That's the crude, tabloid version. But it allows us to recognise the fundamental conflict.

Ask yourself what you understand by happiness.

Six numbers in the lottery? A cosy home in the form of a semi-detached house with ten years' worth of electricity and heating bills paid? Your favourite football team winning some kind of final? A powerful orgasm with yourself or someone you love/desire/admire? Redirecting your life energy through practice (meditation) to the upper energy centres and gaining insight/enlightenment? How else can the suffering of living beings be reduced or alleviated? Would it make you happy to follow this path?

We belong to the primates, the upright mammals with fairly large brains. Unlike our closest relatives (great apes), we have deliberately and mercilessly destroyed the planet over the last 50 years (Club of Rome: early 70s, clear message that no one wanted to hear). We will die in unbearable heat, drought, hunger and dehydration, or drown in the next flood, because we were unable to limit CO_2emissions. Global industry, motorists (including ourselves) and, above all, our overwhelming stupidity and greed have ensured that time has run out. The children (*Fridays for Future* and *Last Generation)* have understood this. They are being discriminated against and imprisoned because they refuse to remain silent and are fighting back in a very thoughtful way. The transport minister is bowing down before the Christian God and the car industry. The right-wing party has 20 per cent of the vote, and the army of Erdogan Turks in Germany is large. Together, this makes for an extremely unappetising mixture. But let's take it as a framework for our consideration and ask again: *what do you understand by happiness?* The survival of humanity? The FDP below 5 per cent? Hertha in the 1st Bundesliga?

Sex, happiness and cannabis as enhancers

You are an upright mammal. You have a metabolism, you react to stimuli in a e manner, and you reproduce and direct sexual desires or desires for closeness, comfort, tenderness, etc. towards other people. Whether you are old or young. You are drawn to a fellow human being of your choice. Sexuality is just one piece of the big pie that is our social relationships. How big that piece of pie is depends on your needs, your assertiveness, what's on offer, and the needs and assertiveness of your competition. When

asked about their idea of happiness, most younger people answer with "satisfaction", while older people answer with "peace". Straight men are often attracted to busty blondes, while gay men and heterosexual women are just as often attracted to well-trained athletes with six-pack abs, sex addicts in swingers' clubs, etc. Some people are happy on their boat, on their bike, in the mountains, by the sea, eating chocolate, eggnog, steak or burgers. Most of us' hearts melt at the sight of animals and human children. Others use the "amplifier function" of cannabis and inhale a few puffs from their vaporiser to slightly increase the little bit of happiness they are currently feeling.

At this point, it is worth studying the Tibetan wheel of life. The axis shows the driving forces that push us into incarnation: the rooster, snake and pig as symbols of greed, envy and ignorance/delusion. The areas show the realms in which living beings become flesh (or chitin): the realm of hungry ghosts (symbolically: those with thin necks), hell, the realm of humans, that of the "highly born" (heaven) and the animal kingdom. Things get really exciting at the outer edge. I will highlight just one aspect: consciousness jumps like a monkey from the object of desire to the next tree, so to speak, and on and on, ever on. The cycle continues. Lust, procreation, birth, ageing, death.

And it starts again immediately after physical death: the promise of happiness immediately takes on familiar forms, faces and shapes, hidden genitals that want to be exposed. That is why, in Buddhism, the deceased are given teachings that go something like this: "Deceased one, you who wander in the bardo of death, remember the teachings and your teachers, and do not immediately pass through the next womb gate." That would be the speech to a male deceased in an ancient language. I sometimes translate "womb gate" as club, disco, darkroom or similar, although that is not entirely accurate. In the Tibetan wheel of life, there is only one path to heaven (to Buddhahood): out of hell, through the human realm, out of the spiral of rebirth and into refuge with the Enlightened One. If you don't like Buddhism, just take it symbolically: you have to hit rock bottom to appreciate being born human. That alone should sometimes make you happy.

We are drawn to other people because otherwise we feel incomplete and alone. We feel sympathy, desire and longing, depending on our own situation (loneliness, age?) and the attractiveness of the other person. In doing so, we are subject to unconscious genetic mechanisms: evolution controls the choice of partner by matching suitable genes wherever possible: *survival of the fittest.* Our individual search for happiness is determined by this archaic biological mechanism.

The question of the extent to which sexuality contributes to one's

happiness is something that each person must answer for themselves. The chapter on cancer contains some information about prostate cancer. There are two extremes here: patients who are completely impotent and incontinent after radical surgery and who experience this condition as a relief, provided they are well supplied with "incontinence aids" (nappies). Sexuality has often been a source of stress or even a burden for them throughout their lives. Now they can breathe a sigh of relief.

The other extreme is the person who cannot imagine a life without sexuality and wants to avoid at all costs the state that others experience as relief. They would rather take their own life than have to live without sexuality. However, this decision is often based on misunderstandings and ignorance: there are joyful and satisfying ways to interact with and be close to other people without having genital contact.

People do not normally go to the doctor to philosophise or seek help with their spiritual quest. However, they do go (usually after much hesitation) when they notice that they are suffering from sexual appetite loss, erectile dysfunction, vaginal dryness, *premature ejaculation or* *ejaculatory deficiency,* anorgasmia, etc. Cannabis can be helpful if the doctor knows what they are doing. **Under favourable circumstances**, **cannabis has a sexually stimulating effect due to its "amplifying function" (**see chapter "Consciousness expansion in cannabis medicine"), but it is not a true aphrodisiac. A large proportion of patients experience an increase in their sexual desires and needs when using cannabis because these desires and needs already exist but are only now emerging from the shadows and becoming pleasurably noticeable.

In the case of sexual dysfunction, however, it must be taken into account that the disruptive factors can also be intensified by cannabis. Premature ejaculation, which is widespread among young men, requires a complex range of treatments. Cannabis alone will not help. I usually ask right at the beginning: You say you come too early
– too early for whom? For your partner or for you? Most of the time, I am met with two wide, questioning eyes, and a conversation about the patient's relationship and self-confidence develops during the first treatment session. This is where the treatment begins. Cannabis may play a role.

In my opinion, cannabis should be used earlier in cases of ejaculatio deficiens and anorgasmia. But here, too, the psychotherapeutic "homework" must be done. The doctor and the patient find out what has been disturbed since when and to what extent, and develop a treatment plan.

The **importance of TTM in the treatment of sexual disorders** cannot be overstated. An experienced therapist will be able to quickly release muscular blockages in the pelvic floor muscles and adductors (functional

unit of the thigh muscles). She knows that the patient may experience strong sexual arousal under her hands and will respectfully and empathetically do everything possible to prevent the tension from being released genitally. This would render the massage ineffective. It may seem strange to read this. It is best to see for yourself: good TTM therapists usually do not mind if you watch them at work. On the contrary, they are happy when their work is appreciated. If there were ever any doubts about Wilhelm Reich's theory of muscular armouring, they will be dispelled here!

The energy that is flowing again will find its physiological pathways (see acupuncture meridians above). This is an essential step towards recovery. Unfortunately, the opposite is all too often the case in German TTM studios. For tax reasons, prostitution is sometimes offered here under cover. Outwardly, there are some parallels to TTM, but in terms of content, there are none. A good masseuse will pray that you and she are well and that the massage helps you. She will give you everything she can muster in terms of knowledge and strength during these two hours. A shorter Thai massage is unnecessarily expensive because it takes at least two hours to break down all muscular blockages. A massage with a "happy ending" is neither a therapeutic nor a traditional Thai massage, but simply prostitution. Sexual gratification in exchange for money. In my experience, however, masturbation and commercial sexual gratification are often precursors to premature ejaculation. The reasons lie deeper, but both actions accelerate the development of this symptom.

Chapter 11 – Addiction

Under normal circumstances, you will feel rejuvenated after our standard procedure (cbd-thaimassage.co.uk), which has been tried and tested for years: alive and – more or less – "uplifted". Some people take a CBD muffin before the massage. Others do not. Some choose "space cakes" with a little THC. Brought along, of course. Until now, the cultivation, possession and sale of THC-containing cannabis has been punished as severely as robbery, assault, etc. But insignificant trends should not blind us to the real conflict: Tom Petty, who has also passed away, sings in his song: "I'm learning to fly, but I ain't got wings. Coming down is the hardest thing." Icarus: At some point, he flew too close to the sun and his wings melted.

No matter how high you fly, how you fly or where you fly to, you have to come back down again. It makes a huge difference whether you've taken heroin, alcohol or crystal meth, or a little cannabis to go with your TTM because it just fits so well. If the effects complement each other favourably or if you have found "your" means of feeling better, it will not remain a one-time use. With the right disposition, you will want to repeat even "harmless" pleasures sooner or later. The result is a lot of sugar for children. Or daily TTM for adults, because their wallet allows it and the therapist is likeable. Or cannabis as a daily stimulant. Multiple times. Regardless, the process is always the same: the reward centre in the brain (nucleus accumbens, among others) normally becomes active when we have been efficient, diligent and successful, and conveys to us
- probably mainly through increased dopamine release - a pleasant state. **All drugs hack directly into the synaptic circuits, so to speak, and stimulate the reward centre to varying degrees at different points.** Heroin and nicotine, incidentally, affect the same area of the reward system. The addictive potential of cannabis is low. There are no physical withdrawal symptoms whatsoever. At this point, however, I would like to refer you to the chapter "Enrico, ADHD". According to current research, cannabis should not be used before the brain has finished developing (approximately between the ages of 21 and 24).
Depending on where and how strongly the substance activates the reward system, we distinguish between different levels of addictive potential: **alcohol, nicotine, opiates (especially heroin) and benzodiazepines ("mother's little helpers") have a very high addictive potential, cannabis has a low** addictive **potential, and LSD has a negligible addictive potential.** However, it should be noted that in addiction medicine, the classification of addicts into different types has proven

effective: the opiate type will not become addicted to cocaine, and the cocaine type will not become addicted to opiates. The alcohol type is fixated on what I consider to be the hardest drug.

Incidentally, the only drugs that, after prolonged use and sudden withdrawal (e.g. due to an accident), still cause the life-threatening condition of **delirium** tremens[21] are **alcohol and benzodiazepines** (diazepam, lorazepam, oxazepam, etc.). These are legal and available on a standard prescription. When opiates are discontinued, a very unpleasant condition quickly sets in, which I don't need to elaborate on. John Lennon's song "Cold Turkey" describes withdrawal much better than I could. But opiates do not cause delirium after prolonged use and abrupt discontinuation! It remains an unpleasant, flu-like condition.

The number one killer drug (even ahead of alcohol) is and remains **nicotine.** It provides us with an example of withdrawal symptoms that everyone is familiar with. The industry is making a fortune from nicotine gum and e-cigarettes with varying concentrations (down to zero) of nicotine to help people "wean themselves off" the habit.

It is not always possible for elderly patients and those who are seriously ill, but when it comes to addiction, the rule of thumb is: **don't try to quit tomorrow and don't follow a plan (gradual reduction): first ¾, then ½, etc.** That never works. **If you want to quit, quit. Now.** The last cigarette, the last shot, the last beer, the last line – you can celebrate that if you feel like it. But if you don't really want to quit, you'll relapse immediately at the first craving (jitters, urge, craving – add whatever you like). Like a large proportion of clinically treated addicts on their way to the train station after their stay in hospital. There's usually a kiosk there.

It is better to join a **self-help group** from the outset. The 12-step programme of anonymous groups works best worldwide. It began with Alcoholics Anonymous, and Narcotics Anonymous now has its own tradition. You can show up at a meeting completely drunk – you are welcome. They will ask you to shut up, listen and come back. Until the penny drops and you reveal something about yourself for the first time – still shaky, but honest – even if it's just: My name is X, I am an addict. This is often when the tide turns.

When recovering addicts look back, they all report that everyone else noticed. Their partners, children, neighbours, colleagues – everyone knew. The sick person had changed dramatically. Their whole being had been transformed into a tragic caricature of the person they used to be. Everyone noticed, except them. They were convinced for a long time that they could control and hide their change.

It is easy to defame anonymous groups as sects with various gurus.

This happens quite often. Sayings such as "Better to be a well-known drunk than an anonymous alcoholic" are typical. David Poster Wallace, the writer who sadly died far too young (suicide), featured a "crocodile″ in his epoch-making novel *Infinite Jest*. The protagonist, who is lying in intensive care, understands crocodiles to be the long-term dry alcoholics in the American AA. 10 years dry, 20, 30. I was lucky enough to meet such a crocodile in the winter of 87/88. Dale. He had watched the film *Apocalypse Now* in Karlsruhe, where he worked as a soldier at the helicopter airfield, experienced a flashback to his special missions in Vietnam and trashed part of the cinema until he was sedated with a straitjacket and a diazepam injection and taken to a psychiatric ward. He had already been abstinent from heroin and alcohol for decades at that point and, to my knowledge, remained so until his death.

Cannabis for withdrawal

David Poster Wallace has addressed this phenomenon in a unique way, without passing judgement. *Infinite Jest* is well worth reading. The author knew what he was writing about. Alcoholism – probably the most common addiction and exemplary of all others – is incurable and fatal if left untreated. Typical symptoms in the early stages are personality changes and increased consumption. Abstinence is always a prerequisite for recovery. Anonymous groups have the great advantage of having had an effective recovery programme (12 steps) available for decades. Long-term dry alcoholics in this country are more likely to be called camels than crocodiles; they use the camel as a symbol for creatures that can live for a very long time without drinking.

A high percentage of intravenous opiate addicts (formerly known as junkies) do not achieve abstinence. They can usually be helped with professional oral substitution treatment (methadone, buprenorphine). In Chapter 6, I tried to describe how Kevin incorporated cannabis into his withdrawal and detoxification.

Chapter 12 – Cancer

Franjo Grotenhermen's book *Cannabis Against Cancer* has been available since 2017, and I highly recommend it. Please read it if cancer is an issue for you, your parents, friends or family! I also use it and recommend it to my patients. In this chapter, I share experiences and thoughts that are important to me and, I hope, complementary.

The causes of cancer are complex. Environmental toxins, psychoimmunological and genetic reasons can be mentioned. We can assume that in every organism, individual cells constantly degenerate, are identified by the immune system and killed: cells whose DNA originally contained the information to adhere to the organ boundaries specified in its blueprint and which became **cancer cells** through **spontaneous mutation**. They then divide uncontrollably. We now refer to this as a malignant tumour or a space-occupying process with the formation of secondary tumours.

Stress on the immune system

The technological advances of recent decades have been enormous: fibre optics in the early 1970s provided the basis for modern minimally invasive surgery. For example, brain tumours can now be removed from areas that were inaccessible years ago. Advances in radiation therapy and chemotherapy have also been considerable.

But here, in radiation and chemotherapy, we encounter the phenomenon of **induced mutation.** As has long been known from evolutionary theory, the best-adapted organisms survive under changing environmental conditions. In cancer, the cells that are least sensitive to radiation or chemotherapy receive a higher selection value in the supposedly eternal race for a place in life: *survival of the fittest* to the detriment of the patient. Epithelial cells now develop into carcinomas or adenocarcinomas, connective tissue cells into sarcomas. This could be one of several reasons why, despite all the effort and accelerated technical developments in diagnostics and therapy, **the morbidity and mortality rates for cancer** remain remarkably constant. A few exceptions confirm this rule. Even today, common chemotherapeutic agents are still so toxic and radiotherapy so effective that only the tumour cells that are most stable against radiation and cytotoxins survive treatment. This is probably the main reason why cancer "comes back" after initially successful treatment ( ). It never completely disappeared, but now returns more aggressively and spreads metastases throughout the body. The immune system (in the bone marrow, intestines, liver and spleen: lymphocytes and

other white blood cells, antibodies, etc.) is severely strained by the treatment and ultimately damaged.

All common cancer treatments put strain on the immune system. The surgical, radiation and chemotherapy procedures used to rid patients of cancer are often heroic and are sometimes carried out to the point of immune system collapse. Let's take a look at the usual vocabulary and imagine someone saying, "I have taken up the fight against cancer." We probably think of a patient in the oncologist's reclining chair, with an infusion solution dripping into their arm. Pale, emaciated, bald, with fungal infections in their mouth and oesophagus. Is that what a fighter looks like? In a military hospital, probably. And against which enemy are they fighting so bravely with chemical weapons of mass destruction and radioactive radiation? If you look at a tissue sample from a carcinoma in comparison to embryonic tissue, i.e. tissue from an unborn human being (same staining, same magnification), you will probably not notice any difference. **Cancer tissue looks like embryonic tissue under the microscope.** We see many cells in the process of division. However, it does not recognise the boundaries of other organs. We can also see this under the microscope: cancer cells breaking through a connective tissue organ capsule. Cancer cells divide continuously unless they are identified and destroyed by the immune system. They invade lymph and blood vessels and form secondary tumours (metastases) in other organs. Bronchial carcinoma likes to nestle in bones and the brain, as does breast cancer. The latter also likes to migrate to the lungs and liver. The internationally accepted staging system describes, for example, a cancer whose primary tumour is very large and which has formed small lymph node and medium-sized liver metastases as T3NlM2.

Inpatient tumour therapy in Thailand

I visited the *Wat Khampramong*[23] Cancer Centre in north-east Thailand for the first time in 2017, which I still consider to be the best place for inpatient tumour therapy. Every patient is admitted. Those who can afford to donate do so. No one is turned away. The patients live in small bungalows in a village atmosphere. Care must be provided by family or friends. This is customary in Thailand. Only the wealthy can afford a carer. The founder and first abbot (structurally, the centre is Buddhist, of course) of was "terminally" ill with cancer. He had the same cancer as Freud: a carcinoma in the sinus area that had already spread to the palate and the floor of the eye socket. He had undergone surgery, chemotherapy and radiotherapy and was most likely suicidal when he took stock of his situation: I cannot live like this and I cannot die like this. The pain is driving me mad. I am going to stop this treatment. What then? The only thing I can do is meditate. Sitting, lying down, walking, always. Luanta = Dad, as people had affectionately called

him over the years, had lived in the temple since childhood and could truly meditate under any circumstances. The treatment had dragged on for several years, the tumour grew and decayed, stinking. Right in the middle of his face. Luanta was desperate, at the end (of a phase of his life).

On the third day after his decision, he had a dream. His deceased spiritual teacher appeared to him and gave him precise instructions for a mixture of eleven herbs from traditional Thai medicine and tree bark. The potion is still cooked and drunk daily by the patient community. Outpatients are sent it. However, the main component of the therapy is meditation. Individually and in community. Vegetarian food (similar to the anthroposophic tumour diet in this country) and modern group therapy methods are also used.

In 2018, cannabis medicine found its way into the Wat, after Thailand had long since legalised cannabis for medical use and has now legalised it altogether. Thailand is a Buddhist country. Buddhists follow five precepts as far as possible: do not kill, do not lie, do not steal, no sex without love/fidelity, no drugs. This is not about oppression or regulation, but about creating a solid foundation for expanding consciousness and insight, ultimately leading to enlightenment. This is not an end in itself, but the only way to reduce the suffering of living beings. **Thai Buddhism increasingly views cannabis as a remedy and no longer as a drug with the corresponding negative connotations.**

Luanta has made a full recovery and is still the abbot of the institution. I had the opportunity to talk to him in 2017 and remember him very well. He was a portly man at the time, with a warm laugh.

I will visit Wat Khampramong again and will not forget Luanta's words: **"Cancer is your best friend: it is the only thing that will die with you!"** Just as anthroposophic cancer therapy cannot be reduced to mistletoe preparations alone, cannabis medicine cannot be reduced to cannabis preparations alone.

Mistletoe against cancer?

Mistletoe *(Viscum* spp.) was recommended as "the cure" for cancer by the founder of anthroposophy, Rudolf Steiner, as early as the last century. This insight may have been intuitive; he himself describes it as the result of imaginative practice, as he recommended in his seminal work *How to Attain Knowledge of Higher Worlds*.

Mistletoe, a plant that grows parasitically on trees, is processed in a complex manner (using rhythmic processes, from winter sap and summer sap) and is now offered by several companies in ampoule form and in

various strengths. In addition, different host trees are used. Helixor M, for example, is obtained from fresh apple mistletoe. Mistletoe preparations have a firm place in today's complementary medicine, but are only prescribed by most doctors at the insistence of the patient or their relatives.

Cannabis is far more effective. There are studies on the effectiveness of THC in cell culture that give cause for hope. Recently, there have been increasing reports on the tumour effectiveness of CBD as well. Randomised, prospective double-blind studies are lacking (see Chapter 1: "My Cannabis Medicine").

Palliative care **has long used cannabis in cancer treatment.** It is regularly used to stimulate appetite and combat nausea, which almost always occurs during radiotherapy and chemotherapy. **Curative cancer treatment** with cannabis, on the other hand, is still rare.

However, there is one very common type of cancer for which the proposed therapy is just as frequently rejected. Julius Hackethal began criticising the established treatment of prostate cancer in the 1970s. He was a highly renowned accident and orthopaedic surgeon who pointed out the difference between pet and predator cancer in prostate cancer, and one of the first who was brave enough to stand up to the powerful mainstream medical profession and draw attention to the fact that the following can be learned from the example of prostate cancer: Chemotherapy and/or radiotherapy can worsen the patient's prognosis and, in any case, their quality of life. In the case of prostate cancer, there is the additional factor that, for anatomical reasons, radical surgery can lead to incontinence and impotence, even when a robot is used. Although this cuts much more precisely than is possible for humans, the course of the nerves in the prostate tissue varies, and even the robot cannot always take this into account. Incidentally, it only works when a human operates the joystick.

Hackethal died shortly before his 76th birthday, probably from lung metastases caused by untreated prostate cancer. Could he have lived longer if he had treated himself with high doses of cannabis? There were and are no evidence-based studies that could help with this decision. So, considering his year of birth (1921), Hackethal lived to a ripe old age. He probably did not consider cannabis as a medicine because complementary medicine in the 1970s to 1990s was mainly concerned with mistletoe, proteolytic enzymes and psycho-oncology.

To cut a long story short: I myself would undergo curative treatment with cannabis and support my patients in doing so if they have made a serious decision after a correct diagnosis and in-depth discussion with their

urologist, after obtaining a second medical opinion and at least one brief visit to a self-help group.

The tumour is part of us

Thais in the poor north-east (Isan) bring their seriously ill relatives to Wat Kham Pramong when their families are unable to cope. This does not happen very often because families tend to stick together. So it is usually patients with advanced cancer who end up there. The centre's statistics on discharged patients have been identical for years in one respect: about 25 percent of patients go home. In the case of cancer, a cure can only be declared after five to ten years, based on international oncology standards. Its representatives generally assume that humans and tumours are enemies. Is this really the case? Cancer is undoubtedly experienced as malignant, insidious and cruel. This disease tears wounds in our lives and equally in those of our children, partners and friends. Do we need to rethink our approach? The tumour is a part of us, a living organism that depends on us, like mistletoe depends on its host tree or tapeworms depend on cattle. Shouldn't we first understand and possibly learn to accept this symbiosis before allowing others to eradicate the cancer, i.e. to intervene massively in our bodies? This may sound hair-raising to some. But it is worth thinking about.

A tumour can also bring peace

We all die, mainly as a result of accidents, cardiovascular disease or cancer. We cannot prevent or influence accidents and cardiovascular disease with cannabis; in the case of cancer, I urge my patients to inform themselves well, to network and possibly to set up a self-help group if one does not already exist.

Of course, a pregnant woman does not have a cancerous tumour in her abdomen, and a patient with liver metastases and ascites (abdominal fluid) is not pregnant, even though they may look that way when viewed from the side. But there are parallels: the foetus also lives parasitically in the mother. It does not immediately reveal its vampiric side. But anaemia is a very common finding in pregnant women. Or the loss of a tooth.

The foetus lives off the mother's blood; she sacrifices herself, so to speak, but does not die from the pregnancy. The tumour, on the other hand, is not born; it usually continues to grow until it or one of its daughter tumours destroys the wall of a large blood vessel and massive internal bleeding kills the patient. Or the tumour gradually consumes the patient. Or it blocks the intestine. There are many other possibilities. But it can also be dormant. It does not die, but it does not continue to grow. This finding is

more common than is generally assumed. War and peace. Enmity or peaceful coexistence. This can also lead to remission, a regression of the tumour until it is cancer-free. The very aggressive black skin cancer (melanoma), which has often already metastasised before the primary tumour is discovered, is known to sometimes regress spontaneously, probably due to a very effective immune system.

Bob Marley suffered from melanoma. His primary tumour was located under the nail of his big toe, which he had injured while playing football. His lungs and liver were already affected. As a Rastafarian, cannabis was sacred to him, and he made ample use of it. But at that time, it was not yet used in high doses in complementary medicine. It was still called alternative medicine and was practised in Germany by Josef Issels at the private Ringberg Clinic on Lake Tegernsee. A pioneer and lone fighter, he was dismissed as a charlatan by the established medical profession. He probably understood a great deal about the human immune system and cancer. Marley's illness was too advanced. He wanted to die in Jamaica, so he left the clinic at Lake Tegernsee, but only made it as far as Florida. We now know that malignant melanoma responds well to modern immunotherapy for cancer. For Bob, it came too late.

Chapter 13 – Ayahuasca, "magic mushrooms", coaches, spiritual healers and shamans – *thoughts on a hype*

For some time now, virtually all major cities have been offering healing spiritual journeys, shamanic rituals or explicit guidance on the use of ayahuasca. Ayahuasca is the name of a drug made from various plants, including lianas, by shamans, who take it themselves during the ritual and administer it to those seeking help. Other providers use psilocybin (in "magic mushrooms") or mescaline (in peyote and San Pedro cactus or in chemically pure form). These are powerful psychedelics. Ayahuasca contains **DMT (N,**N-dimethyltryptamine26), which is also found in other plants.[27]
What are these people looking for? Most are seeking a powerful high, a smaller proportion are seeking a spiritual experience, and a few are seeking healing, usually from a serious chronic illness. As mentioned elsewhere, **THC also has a psychedelic effect**, **albeit** a **mild** one**.** Psychedelics dissolve familiar psychological structures, even leading to synesthesia: see the chapter "Consciousness expansion in cannabis medicine". I would now like to pick up this thread again and continue:
In my experience, a change in consciousness is a necessary component and/or prerequisite for recovery or even healing.
For most of us, this seems impossible without the use of a suitable substance. This is very understandable: from the very beginning, we are conditioned to take something to make us feel better. A sip from our mother's breast or a milk bottle, later a chocolate bar. Psychoanalysis refers to this as **oral fixation.** But even newborns have far more needs than just hunger and thirst. It may be wet, sore or suffering from stomach ache because it is bloated. Or is it missing the warmth and smell of its mother? Over the course of their lives, adult patients have mostly come to terms with the fact that they are mainly prescribed medication when what they really need is expertise, experience and empathy. The expectations placed on cannabis as a medicine are often unrealistic.

An example: I am convinced that there will be a curative tumour therapy with cannabinoids (see chapter "Cancer"). It is currently under development ( ). A patient in Nong Khai (a city on the Mekong River, on the border with Laos) asked me to visit him in March 2023. He was being treated as an inpatient at the local clinic because he was suffering from advanced liver cancer, with ascites (abdominal fluid) and severe weight loss, pronounced jaundice and intense itching. A Scandinavian company

that sells equipment for cannabis cultivation was willing to provide us with unlimited supplies of highly concentrated cannabis extracts, each containing 25% THC and CBD. However, the patient had imagined that he would simply take a few drops of cannabis oil in addition to his ongoing, comparatively "mild" chemotherapy.
This did indeed relieve his itching and increase his appetite, but he was not prepared for the extent of the curative therapy: the enteral (= via the gastrointestinal tract) intake of several grams of THC and CBD in an oily solution within 24 hours is difficult. Diarrhoea and nausea are to be expected, and the question arises as to when cannabinoids need to be administered parenterally (usually as an infusion). There are water-soluble forms of preparation, and for more than three decades it has been possible to inject or infuse cannabis. However, practical implementation still requires a huge amount of effort.
If cannabis is to be used curatively for cancer, oral administration or inhalation (vaporiser) will quickly reach its limits. Cannabinoids are fat-soluble, and therefore several grams would have to be administered as an oily solution or as an additive to dietary fats, i.e. we quickly reach the limits of oral treatment. Both CBD and THC are effective in cell cultures for various types of solid cancer. **In curative cancer therapy, they will have to be administered intravenously as an infusion.**

Whether you like to hear it or not, **the safest and completely side-effect-free way to deal with illness is meditation, a method proven over thousands of years to achieve a higher state of consciousness through practice** – a state of heightened, calm awareness of the present. All senses are equally alert and fully awake. This can be done anytime, anywhere and under any circumstances. The more you practise, the easier it becomes and gradually becomes recognised as a natural state. To be honest, I don't really care what neuroscientists find out about meditators using brain wave curves and imaging techniques. Anyone who meditates regularly can tell you how the practice of daily meditation has affected their physical and mental state. As a rule, a side effect of reduced susceptibility to infection is reported.

Petit mort, the little death
In all in-depth treatments of sick people, conscious or unconscious consideration is given to the fact that, **after fertilisation of the egg cell, humans live in two worlds.** Every human being lives in the womb for about ten months, i.e. in a state of weightlessness and freedom from need, at a constant comfortable temperature of 37° Celsius. They are nourished and supplied with oxygen through the umbilical cord. Maternal and foetal tissue interlock in the placenta. Over time, it becomes cramped for the

unborn child until they are expelled from paradise as a result of strong contractions of the womb. At birth, we are abruptly thrown into a world of suffering. Even the gentlest birth does not change this. A caesarean section certainly doesn't. Have you ever seen a newborn baby happy about its birth? The opposite is true. It usually screams its head off!
The prenatal state is by no means forgotten; on the contrary, the colder and more loveless the world we live in, the more we long to return to the womb. In dreams, we often come close to our prenatal existence: we fly weightlessly over the land or the sea. Orgasm may give us a brief impression of this. Whether longer or shorter, it remains the *petit mort,* the little death. It satisfies our longing for a while. But it is guaranteed to return! Incidentally, oblivion does not mean a lack of memory in the strict sense. Most people cannot remember experiences that happened before they were two years old – keyword: brain development.

At this point, a thought about narcissism seems appropriate. When we grow up among emotionally cold and aggressive adults, we are thrown back on ourselves and compensate for our powerlessness with fantasies of grandeur. If we are not loved for our own sake, we constantly check (like Narcissus in Ovid's *Metamorphoses)* in everything that reflects us whether we are beautiful enough to be loved. Caravaggio's famous painting is unique and very vivid. The term "narcissistic age" refers to the fact that more and more people are caught up in extreme self-absorption and want to be admired (secondary narcissism). Without recognition and applause, they do not feel comfortable. It makes a big difference whether narcissists are empathetic or emotionally detached. The transition to becoming an insensitive, cold-hearted psychopath is fluid.

The era of group therapy
In this narcissistic age of influencers, personal trainers, coaches, etc., there is now a hype surrounding shamanic initiation rituals, because that is what they were originally **about** – **initiation and acceptance into the adult world.** I find this remarkable and would like to comment on it because it touches on the field of cannabis medicine. When three or more people interact with each other, even if they initially only share the same space, we can speak of a group. The era of group therapy began in the 1970s; a key proponent was Bhagwan Shree Rajneesh, later known as Osho, an Indian philosopher who had experienced a spiritual awakening. His spiritual roots lie in Hinduism, Lao-Tse (Taoism), Krishnamurti, Gautama Buddha, of course, and Japanese Zen Buddhism.

As more and more people flocked to his ashram in Poona, Osho had no choice. People were searching for meaning and fulfilment in their lives.

Their questions could not be satisfactorily answered by established religions and philosophies. So far, so good, but Bhagwan saw sick people before him. Neurotics and seriously ill people. Muscularly and emotionally armoured, mostly white women and men who, because of their symptoms, were unable to benefit from traditional methods (contemplation, meditation, yoga). Quite a few of them may have suffered from ADHD. How is someone with untreated ADHD supposed to sit still in the prescribed meditation posture (?-point posture)?
He had no other choice but to "prescribe" group therapy for the new arrivals, or more precisely, the most modern and "hardest" group therapy of his time. Carl Rogers had introduced encounter groups to the world. In Poona, the group members stayed together continuously for several days. Physical violence was forbidden. It would have been difficult to find better group leaders than those in Poona at that time. In addition, Bhagwan developed intensive new forms of meditation, which are still exemplary today, in which movement plays a major role in reducing chronic physical tension and muscular armouring (Wilhelm Reich). Bhagwan's Dynamic Meditation can still be highly recommended today, provided it is not misused as a gymnastic exercise. The same applies to Kundalini meditation.
At around the same time, other important group therapies emerged in which emotions were expressed and tension was released. Arthur Janov ("Primal Scream" therapy) also gave individual sessions. John Lennon was one of his patients. At around the same time, but on the east coast of the USA, Daniel Casriel developed his group therapy of the "New Identity Process" while working with heroin addicts. Here, too, after a few hours, condensation drips from the walls and ceiling.
The popular RTL jungle camp does at least provide an insight into group dynamics. Although it features B-list celebrities who are likely to have above-average narcissistic needs, viewers do at least get an impression of what happens when a group of people live together in a (relatively) confined space without media, luxury foods and expensive meals. Whether they like it or not, sooner or later everyone is thrown back on themselves. I have participated in many groups throughout my life: self-help groups in the narrower sense, therapeutic groups as a patient, learner and, for a long time, as a group leader, and I think very highly of group therapy.

Superego, group leaders and shamans

In every therapy, the patient encounters their "inner judge". This refers to their internalised commandments and prohibitions, mainly from their upbringing. It means roughly the same thing as conscience. Freud introduced the concept **of the superego**. The superego does not need to be

softened and individually reshaped; it must be shattered so that the patient is enabled to find their own moral and ethical boundaries and values. Otto Gross was perhaps Freud's most intelligent student. I found this idea in his work. Freud simply ignored him and preferred the more obedient ones: C.G. Jung and then Ferenczy. But they too soon fell out of favour. They were all alpha types, leaders.

This brings us to the group leader and thus we have all the elements of these sometimes very expensive seminars together: psychedelic substances administered in a group therapy setting. The group leader does not have to be Freud or Jung, but he will have to legitimise himself. What is his agenda? What does he do when he is not offering ayahuasca or LSD seminars? Does he have experience? Does he know what he is doing? These questions are not only legitimate, they must be answered. If you are fortunate, you will encounter a shaman who is not self-appointed, but who comes from a tradition (self-appointed shamans are not real shamans). I have met several shamans and "healers" in my life. In Europe and Asia. As a patient and as a student. I did not have the good fortune that Carlos Castaneda had – to be taken on as an apprentice by a Mexican shaman – but I like to think that I have learned to separate the wheat from the chaff.

In a Siberian tradition (which I believe is not unusual), the shaman passes on his knowledge to a young person he considers suitable. Most of the time, this person lives in the same village and has recurring dreams of dismemberment; very often, he is beheaded in his dreams. The shaman introduces him to the world of the normally invisible. A protective or power animal (crow, wolf, snake, etc.) is obligatory. The shaman's ability to find and use medicinal plants is usually highly developed. A shaman falls into a trance state effortlessly, without showmanship or antics.

Beware of charlatans!

Any self-promotion and prices in the four-digit range for a weekend seminar are suspicious. I assume that at most 10 percent of so-called shamans are part of a shamanic tradition. The other healers, seers and coaches may be narcissistically disturbed individuals, occasionally megalomaniacal believers, but also failed existences and charlatans. In this age of excessive information, we are seeing a growing demand for initiation rituals – initiation as an entry (introduction) into the adult world.

Could it be that we need to mature emotionally faster than ever before in order to master our lives? Materially speaking, people in the northern hemisphere live in relative prosperity and security, while in the southern hemisphere they are fighting for their very survival. Spiritually, it seems to be exactly the opposite.

Conclusion: it could be expensive, or it could cost you dearly to go along with this trend. In my opinion, you can have it easier, considerably cheaper and safer. In the last chapter, the "secret" of **intensive cannabis medical therapy** is revealed.

Chapter 14 – Life without end or *an end to illusions*

What will the medicine of the future look like? Heads will be transplanted if technocrats fail to make backups of our experiences and memories stored in the brain and transfer them to living matter or artificial intelligence (AI). But that is to be expected. Human creativity is enormous. So is human destructiveness.
Life at the end of our current era. Life in extremes. In the slums, the poor live in filth and on the waste of the rich. The rich ladies, as slaves to the beauty industry (and unscrupulous cosmetic surgeons), have implants inserted into their noses, cheekbones, breasts and buttocks and, for example, botulinum toxin injected into their lips to paralyse the peripheral nerves so that the ladies look smooth and full-lipped. What for, actually? To satisfy the perverse blowjob fantasies of their crazy tie-wearers at home? Those with private insurance receive massive over-treatment. The poor can queue up until the counter closes. Come back tomorrow, if you're still alive.
And the gentlemen travel in droves to Turkey or other countries to have hairy skin areas transplanted from the back of their heads to their foreheads. Given that more and more men are sporting huge full beards and bald heads, I understand this even less.

Life in extremes
The thermal catastrophe is drawing nearer and we are dancing on the edge of the volcanic crater. Manic-depressive basic rhythm. Is there still hope for a cure? Improvement? Relief? It's not like cancer, it is cancer. Collective cancer. Unrestrained growth of suppressed life. Perversions like metastases. Paedophilia. Obsessive sex. The muscle-bound body as the ideal, six-pack abs and monster breasts as a fetish. This could go on endlessly, but it's completely irrelevant.
In developing and emerging countries, every hand is needed. In the West, hands and arms are trained to the extreme and used for self-gratification, so to speak. Doesn't anyone see that? Of course, everyone sees it. But always in others. It is not only the age of extremes, but also the age of projection. We immediately see the splinter in the other's eye. We are used to the beam in our own. Operational blindness.

Of course, this book contains a "secret," and that secret will now be revealed, right at the end, . We are all oversupplied with information of all kinds and conditioned to build and increase tension. Until the showdown. I will deliver that now.

Instructions for self-exploration

This is what you can do if, sooner or later (usually between the ages of 40 and 50 and upwards), you realise that "it" is not going away. "It" can also start earlier: it can be chronic lower back pain, constant bloating and constipation, persistent low mood, insomnia, chronic coughing, stubborn psoriasis, to name just a few examples. **I repeat: acute symptoms and all cardiovascular diseases do not belong in the spectrum of cannabis medicine.**

If you take this into account, you can proceed as follows:

1. You don't have to wait until you are given the prognosis (directly or between the lines): your time is running out. You set it yourself and **live** from now on as if every day were your last. In doing so, you would take a big step away from the standard illusion that you are the only one who does not die. As grotesque as it sounds, we are all more or less convinced of this. According to academic theory (psychoanalysis), it works through repression, dissociation and reaction formation. If you want to learn more about this, do your research. You shouldn't take these theories too seriously, as they won't get you anywhere. Psychotherapists who work with the National Health Service need them to get your treatment covered by your health insurance.

2. Instead, find a quiet place where you will be undisturbed for a period of 12 to 36 hours (or longer). This sounds easier than it probably is. If you are financially flexible, get a room with a balcony or terrace overlooking a lake or with a mountain view. If you are on a tighter budget, you will have to improvise. On hot summer days, it has proven useful to follow the example of one of my patients: for his little *"vision quest,"* he cleared his balcony except for the poured concrete floor (which was warm because it was midsummer) and cleared a path through the bedroom to the bathroom so that he could be alone for as long as necessary. When he tried to simply lie on his back on the balcony, he found that it was not possible at first. Only his chest touched the ground, and it took quite a while before he could lie pain-free on the warm concrete with his arms and legs stretched out.

3. Now it's time to get down to business: you can't ignore yourself if you want to know how to move forward in your life and with your health. You've made all the preparations, you're now alone for the time being, and you have enough water and fruit. The door is closed, the doorbell, mobile phone, TV, etc. are turned off. Maybe you've already started fasting. **Modified fasting** is sufficient, for example, fruit or rice fasting. At this

point, if you haven't already done so, you should make a deal with yourself to keep your hands off the bookshelf. Your mobile phone is switched off anyway. The Dalai Lama was once asked what Western students are unable to do. As so often, he laughed and replied: They cannot simply be there. As if under compulsion, they always have to be doing something. We have now created the right conditions for the opposite experience. At this point, I do not recommend a group experience (see chapters "Consciousness Expansion in Cannabis Medicine" and "Ayahuasca"), but simply: **stay on your own for a while and fast from your habitual behaviour.**

4 At first, thoughts, memories and habits will probably tumble around in your head. If possible, remember your last antenatal class and breathe deeply (diaphragmatic breathing) **into** your belly. Even men who did not attend their partner's classes are capable of deep breathing. Try to let your thoughts and feelings come and go until you feel calmer. Perhaps a crow will visit you and keep you company. Or a pigeon.

Once you have calmed down, you will most likely be confronted with your habit of distracting yourself – just a quick look at the news, a quick glance at social media. **For now (and in the future), keep your hands off your smartphone, laptop, TV and radio.** Remember, you wanted to figure out how to deal with the fact that you are no longer the youngest and have chronic complaints that 'won't go away'. Perhaps you are only convinced of this because you have forgotten something:

4. **Most of us experience falling ill as children and recovering after varying lengths of time.** This sounds like a matter of course, but it is not. Many people are taught that they are "to blame" for getting sick, that they have done something wrong . Illness can be seen as a flaw, a weakness, an expression of inadequacy. Fortunately, however, most people experience illness as a temporary condition that comes to an end. Afterwards, we are healthy and happy again.

We are now trying to recall this **basic experience** and build on it. It should not be forgotten under any circumstances. Especially not now that we have begun to deal with our chronic complaints. We will not get a new spine or youthful knee or hip joints. At best, we will get a prosthesis. But in our search for our individual path, we can now imagine a state in which we feel healthy and mobile.

Perhaps the crow will take off from the balcony railing, and we will remain connected to it for a while in our imagination as it glides weightlessly through the air. **Whether you incorporate cannabis into your search** by

using a vaporiser or baking yourself a cannabis muffin is up to you. **I would advise against stronger psychedelic substances (e.g. psilocybin).** If you want to use them, it is better to do so in a group or with knowledgeable guidance (see chapter "Consciousness expansion in cannabis medicine"). The idea that our illness is a temporary condition and that suffering is finite should be maintained, especially when death is near.

In a sense, we live in prison. Life imprisonment and under the death penalty. Locked in our bodies, dominated by the idea of being the crown of creation and entitled to use other living beings as we please. What does crocodile actually taste like? Like ostrich? Or kangaroo? Do Humboldt squids also wonder what humans taste like when they go on raids close to shore due to the warming of the oceans? Does it taste better without neoprene than with?

We live as prisoners – as long as we cling to the illusion of having a self and expanding and strengthening it, comparing ourselves with others and competing with them. In the 1970s, psychoanalysis dealt with the difference between the ego and the self, fighting veritable ideological trench wars in the process. Gradually, we are also collectively beginning to understand what we have done, how clumsy, sluggish and ultimately brutal we are in our treatment of other living beings and Mother Earth. From one extreme to the other: on the one hand, the slaughterhouse culture that originated in North America and served as a model for the German concentration camps; on the other, vegans who, for ideological reasons, reject the protein source of the future: insects and their eggs. Ant eggs, for example, are an excellent and delicious source of protein.

Accepting death

I believe it is appropriate to view the fact that we are born human beings with gratitude. Because we are not driven to slaughter once we reach our slaughter weight. It may be that we are the only living beings on this planet who are aware of their mortality. This fact would greatly relativise gratitude. However, in my opinion, it remains advisable because we should not confuse ourselves.

If you fear sinking into suffering and/or death is knocking at your door, there is only one proven way: under no circumstances lose sight of your fellow sufferers! Don't give up, give away. You will leave as naked as you came. *"You can't take nothing with you but your soul"* (John Lennon). You will leave, and you will fare like the others. Nothing special. A link in the chain *of* periods and states that we call life. Age is not an illness; dying is part of life.

Be careful! Think carefully before you start looking: You wouldn't be the first or the only one to come to the conclusion that you want to quickly

leave the treadmill you find yourself on for all the "right" reasons: social security obligations, skyrocketing rents, relationship problems, bullying at work because you don't give a damn about fashion and styling, for example. You could stop your search at this point. Then you would have taken stock, but your mind would not have been freed for a vision, no matter how small. There are good reasons to estimate the search will take two to three days. Before that, most of us remain stuck in this jumble of thoughts and memories. Nothing becomes clear.

So back to point 1. Accept that you will die sooner or later. It is wise and helpful to be aware of this fact without immediately moving on to the order of the day. Our birth and death are the cornerstones of our existence. The old image of the Grim Reaper allowing the doctor to heal when he stands at the patient's head is now relegated to the realm of fairy tales. If death stands at the foot of the patient's bed, the patient will die. If he stands at the head, the patient will live, even if the doctor is only messing around. My translation into modern thinking is: the doctor is able to make a prognosis for the patient based on his training and experience. I am not talking about vocation and intuition at all. It **is always about the position of death in the patient's life,** and the doctor "sees" death, unlike the patient and his relatives.

Dealing with death

The Tibetan Book of the Dead (Bardo Thödol), which dates from the 8th century and offers a precise description of the process of dying through to the next incarnation, was used very creatively in the late 1960s and 1970s by Timothy Leary, Ralph Metzner and Richard Alpert (Ram Dass) as a guidebook through the LSD experience. Time has not stood still, and the era of acid freaks is long gone. But I would like to point out one key point: **in death, as after taking potent psychedelics (**see chapter "Consciousness expansion in cannabis medicine"**), the deepest and most comprehensive experience occurs immediately, right at the beginning, very quickly, very strongly and briefly. It cannot be conveyed verbally.**

The much-described out-of-body "near-death experiences" deal with a later phase of the dying process or (banally) with LSD trips. It makes sense and is very realistic to prepare for death. Your death could happen today. Don't forget your helmet when you get on your motorbike, and don't forget your blood pressure medication either! But also try again and again to tear away the veil of illusions that separates us from the truth. We waste most of our time dealing with trivialities: career, competition, politics, to name but a few. Even charitable alibi actions count for nothing in the face of your death. Whatever you do and have done voluntarily and lovingly for others

is relevant. Einstein and Hawkins were religious, Freud was not. He worked until his last day and had his first and last morphine injection when his dog turned away from him because the rotting cancer on his face smelled so bad. I believe he was loving towards people.

We are all attached to life. We know what we have. When used correctly, cannabis can be a great help, especially to elderly and seriously ill people. It increases appetite, lifts the mood, relieves pain and gives us restful sleep, which includes dreams (REM phase of sleep). At the very least, cannabis does not block our confrontation with death. On the contrary: for some people, it is only possible under the influence of cannabis.

About the author

Dr Bernd Wessollek is a pioneer in the field of cannabis medicine. In his practice, he has successfully treated numerous patients over many years who are able to lead better lives through the use of cannabis medicine. Today, he works on a voluntary basis and in an advisory capacity.

Footnotes

1 - TCM: Traditional Chinese Medicine

2 - Evidence-based: proven effectiveness

3 - The prospective, randomised study allows random treatment successes to be clearly distinguished from results that can be reliably expected. Probability calculation methods can be used to calculate the significance of the results: were they achieved by chance or is it due to the medication (or the method being investigated)? If the latter is the case, the treatment success is considered evidence-based.

4 - migrainous; migraine-like

5 - Pathogenic: causing disease. However, we live in a beneficial symbiosis with the vast majority of viruses, bacteria and fungi.

6 - Peristalsis: rhythmic contraction of the walls of hollow organs to transport their contents. This definition applies to the small and large intestines, stomach, oesophagus, gallbladder, urinary tract and fallopian tubes.

7 - Cannabis monotherapy: inhalation or oral administration of cannabinoids without any additional consumption as an intermediate step towards abstinence or a permanent solution instead of substitution with methadone or buprenorphine. Methadone is a very strong opioid, as is buprenorphine.

8 - e.g. Shake Sugaree and Junkers Blues, Willy deVille, Unplugged in Berlin.

9 - A little tip: The Dalai Lama's favourite prayer: "For as long as space endures, and for as long as living beings remain, until then may I too abide to dispel the misery of the world." The prayer is by Shantideva. Translate it yourself and think about it, or better still: meditate on compassion and mindfulness.

10 - Ery(throcyte) concentrate = blood minus plasma = enrichment of red blood cells and thus oxygen carriers. Preferred to whole blood reserves in cases of massive bleeding. Originally used to reduce hepatitis C virus transmission.

11 - *turkey,* monkey: Slang for withdrawal symptoms. If you have no idea what this means, listen to "Cold Turkey" by John Lennon. John suffered the same misfortune as Kevin now. The cold turkey tormented him with all

the accompanying symptoms when he was withdrawing from heroin in the Dakota building, at times paranoid behind the wall panelling.

12 - warm withdrawal: gradual withdrawal from the addictive substance

13 - Polyarthrosis: degenerative disease ("calcification") of several joints. The hip and knee joints are most commonly affected.

14 - Pure tilidine is subject to the Narcotics Act. However, the combination with naloxone can be prescribed normally in Germany. Pure naloxone is commonly used in anaesthesia and emergency medicine. In the event of impending respiratory paralysis due to an opiate overdose, the doctor injects naloxone intravenously. In my opinion, both points should be considered: the combination of both substances in tablets/capsules and drops can be reasonably justified. However, it would probably never have come onto the market if the pharmaceutical lobby had not exercised its corrupt power. Tilidine has a strong euphoric effect, is a bestseller, and the addition of naloxone allows it to be dispensed in pharmacies on a normal prescription (avoiding the need for a prescription for controlled substances). In many cases, it causes severe physical dependence.

15 - Endorphin system: Older people will remember: it began in the 1970s and ultimately took decades to research the endorphin system and observe the concrete effects of this discovery in everyday medical practice. I began studying medicine in the winter semester of 1969/70. At that time, and even in later years, death often occurred in inhumane circumstances: in the bathroom or storage room of the ward. Pain patients (e.g. patients with extensive bone metastases) suffered from the fearful and stingy attitude of established medicine towards opiates and opioids. At that time, it was not unusual to hear the cries of pain patients in hospitals.

This improved over the years. The discovery of the endorphin system enabled palliative and pain medicine that can now help most seriously and terminally ill patients. Hospices were established. Dying still largely takes place in secret, but it has lost much of its horror. From a depth psychological perspective, the now collectively anchored awareness that the human body constantly produces highly potent opioids, i.e. that opioids occur in the body and are released during severe trauma, known as endorphins, has played a significant role in this. Those affected unanimously describe their amazement: after accident-related amputations (circular saw) or massive contusions (railway buffer), they initially felt no pain, but only during transport to the hospital. Research into the endorphin system ( ) enables a complete understanding of these clinical observations. Today, pain patients are given sufficiently high doses. Modern opioids such as fentanyl and buprenorphine enable freedom from pain even in extreme situations.
The endocannabinoid system can now also be considered to have been

extensively researched. It is somewhat more difficult to understand than the endorphin system, as it is not solely concerned with pain.

16 - DHV and ICAM: German Hemp Association and International Working Group on Cannabis as Medicine.

17 - CSC Berlin = Cannabis Social Club Berlin. Unlike the Spanish CSCs, the Berlin association was founded as a self-help organisation specifically for patients. We had pharmacists and lawyers in our ranks, and by 2016 we were already supplying several patients with medical cannabis for a membership fee, mainly cancer and pain patients. Our medicine was Jack Herrer, flowers for vaporiser inhalation, similar to Bedrocan at the time. We had everything in our hands, from production to treatment. Application procedures were in place for all steps. At that time, several pain and tumour patients, mainly in North Rhine-Westphalia, had successfully appealed to higher courts against the rejection of their applications for personal cultivation. The change in the law in March 2017 took the wind out of these pioneers' sails, so to speak. However, the rulings of the relevant regional courts are still relevant today as precedents.

18 - Pathogenesis: the development of disease. Pathogenesis takes into account external and internal factors: pathogens, genetic disposition, psychodynamics, etc.

19 - Aphrodisiac = sexually stimulating agent

20 - Ejaculatio praecox or deficiens; premature or absent ejaculation.

21 - Delirium tremens: withdrawal syndrome occurring after long-term, regular use of alcohol and/or benzodiazepines and discontinuation of the drug(s), characterised by restlessness and tremors. This is followed by convulsions and visual hallucinations. Mortality is high!

22 - Flashback: sudden hallucinatory recollection of serious trauma. Dale had been forced to "clean up" villages in Vietnam with a flamethrower, was on a high dose of heroin at the time, and assumed in Karlsruhe that he would have refused the order with all its consequences if he had not been under the influence of drugs.

23 - Arokhayasala Khampramong Temple

24 - palliative - derived from the Latin pallium = cloak. Palliative therefore means cloaked, enveloped. During palliative treatment, the patient is enveloped in freedom from pain and care.

25 - Curative - Curative treatment attempts to cure the disease: to improve

or heal it.

26 - DMT is one of the strongest known psychedelic substances, which every human being produces as an endogenous molecule in the body. Even more potent is the derivative 5-methoxy-DMT (5-Meü-DMT), which is also an endogenous ligand in humans.

27 - Some people milk the secretion from DMT- or 5-Meü-DMT-producing toads *(Jncilius alvarius;* formerly *Bufo alvarius,* English: Colorado toad), which is then smoked. The secretion also contains 5-HO-DMT, i.e. bufotenin, which is structurally closely related to N,N- and 5-Meü-DMT, but has only weak psychedelic properties. (Some say that the secretion of the toad is licked off, which is firstly psychedelically ineffective and secondly can even be life-threatening.
The psychoactive tryptamines are not effective when taken orally, but require an MAO inhibitor to prevent them from being broken down directly by the endogenous (body's own) enzyme system monoamine oxidase (MAO)
ingestion (in ayahuasca, the MAO inhibitors are present in the form of beta-carbolines from the ayahuasca vine *Banisteriopsis caapi*). However, the secretion also contains cardiac bufotoxins, which are effective when taken orally. Licking the toad's secretion is therefore not only stupid and psychoactively ineffective, but also dangerous.

28 - Narcissism: primary and secondary. The summary in Wikipedia is highly recommended. If you want to know more, check out Kohut, Grunberger and Wurmser, Winnicott and Balint.

29 - Carlos Castaneda: American anthropologist who wrote several books, including *The Teachings of Don Juan.* His encounters and experiences with the Native American (Yaqui) medicine man Juan Matus are partly fictional, but provide a profound insight into shamanism.

30 - Cosmetic surgeons - I sometimes wonder why citizens tolerate the fact that - as a rule - wealthy citizens' children are allowed to complete a very expensive course of study largely at the expense of taxpayers, , only to then undergo specialist medical training with the sole aim of selling unnecessary operations at inflated prices to neurotic high earners and victimised ladies. Plastic surgery, on the other hand, deals with the alleviation and, in the best case, healing of serious conditions: cleft lips, jaws and palates, reconstruction of severe facial injuries or, for example, after removal of the mammary gland due to cancer (mammary carcinoma: currently the most common form of cancer). These are the areas of work of ENT doctors, general surgeons and oral surgeons. In contrast, cosmetic surgeons receive their clients in an exclusive setting to pin back their ears and – every few months or years – change their noses.

31 - *"Vision Quest"* - originally part of the spiritual practice of the Hopi Indians. The aim was to make contact with a *"leading spirit*" in order to find answers to questions about one's own life, its meaning and questions about transformation and healing.
Originally, and still today, this journey is undertaken in the wilderness. For our purposes, the slimmed-down version will suffice.