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Dear John,

I will continue to be optimistic that the funding from NIMH will yet come through; but will answer your inquiry in the meantime.

The book on the Greek study was published in July and should be available within the next few weeks. In it, as in the prior Jamaica study, and the one from Costa Rica to follow, there is little evidence that chronic hashish (ganja) smoking has any long-term effects. These observations are in direct contrast to the earlier literature, particularly from India and Egypt; and the more recent reports from these countries by Souief and Chopra. Their latest data may be found in the 1976 conference proceedings (New York Academy of Sciences, vol 282, edited by Dornbush, Freedman and Fink) where these authors cite large numbers of psychotic cases which they ascribe to hashish use. Not only do they cite evidence for psychosis, but criminality (other than possession of hashish) as well. Chopra does not limit his findings to patients in hospitals in India: he says that in interviews with drug users (site ?) he made the observations. Souief worked in prisons, so his population also is not a hospitalized one.

I would re=phrase the question: Considering the differences in incidence of behavioral abnormality, including psychosis, reported from India and Egypt compared to the studies in Jamaica, Greece, and Costa Rica, could the findings reflect differences in material smoked; in the observer ratings; in the sample populations selected for study; or in the standards used for diagnosis ? If one were to start in India, it would be important to visit Chopra and assess his populations, his methods of assessment, and the material his subjects smoked first. If some differences between the studies emerged from these observations, they can be verified in subsequent studies.

If hospitalized patients are the focus of study, one could start with Frank Knight in Jamaica. In the same NY Ac Sci volume, he has a report, mostly anecdotal, but well written that there is a defined incidence of psychosis due to ganja. In Athens, Miras was still convinced that this was true, but when a Greek team visited the major mental hospital, they were unable to verify a cannabis psychosis syndrome in the patients hospitalized for a long time. Perhaps the same

re-assessment made in Athens could be done in Jamaica. There is the advantage of language-- they speak English.

The need for anthropological and sociological studies is great. We did not answer these questions at all, partly because we wished to focus on the findings reported by Miras, that most of his users had brain damage. But the more interesting question emerged in our study, as in others: why do cannabis users continue to use the drug ?

There are many first steps-- one is outlined in your letter. Another, is to call or visit Steve Szara and get a picture of the present studies in progress, and the possibility of undertaking such a study in India. I would also suggest that you write to Dr. Chopra after reading his report and asking whether he would cooperate in other studies. Perhaps someone from NIDA is already there. If not, and Chopra is willing, I think it should then be possible to formulate a proposal based on his observations (much as we did with Miras' observations) with the additional data from Szara (and perhaps Bob Petersen). Finally, you would do well to visit a number of the others still interested in this question, to get an idea of what the present thinking of the chronic cannabis syndrome is: Sidney Cohen, Vera Rubin, Henry Brill come to mind.

From my awareness of the issues, the NY Ac Sci volume provides the basis for the questions to be answered. The Greek, Jamaica, and Costa Rica studies are internally consistent in major matters-- only the Indian and Egyptian data are incongruous and I think that this is the area of study now.

As I said in Irvine, I would be pleased to help you develop such a study, and when the time comes to negotiate with NIDA or other agencies for support, I have some experience which may be helpful. You will need a social-anthropologist or anthropo-sociologist in addition to your psychiatric background. If you need a psychologist, and I think you will, then one aware of cultural differences in testing would be the one to identify.

Separately, I am sending you a copy of the NY Ac Sci volume. I think the questions come from it's papers.

My best regards.

Sincerely yours,

Max Fink, M.D.
Professor of Psychiatry