

Chapter 9

Ayahuasca as an Addiction Treatment in Catalonia: Cognitive and Cultural Perspectives

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Introduction

As in other countries, the cultural background that supported the arrival of ayahuasca to Spain is related to different traditions, usually connected to the so-called New Age networks (Hanegraaff 1996) or psychospiritual networks (Champion 1995). In the case of Catalonia, these networks are composed of a number of traditions and movements, which arrived in different periods of time: the psychedelic movement in the 1960s (Usó 2001), the alternative medicines of the 1970s (Perdigüero 2004), and new schools of psychology, such as bioenergetic therapy in the 1970s, gestalt associations in the 1980s, and transpersonal psychology in the 1990s (Apud 2017b). Nowadays, these networks include a variety of “cultural imageries,” such as oriental spiritualities, natural and holistic therapies, esoteric traditions, and neo-shamanic practices (Prat 2017; Prat et al. 2012). Furthermore, the popularization of ayahuasca, both in Spain and internationally, must be considered in the context of the “renaissance of psychedelic studies,” occurring since the 1990s (Labate and Cavnar 2011; Sessa 2012). In this revival, Spanish therapists and researchers from several disciplines are playing an important role (Apud and Romaní 2017).

The first time ayahuasca arrived in Spain was at the end of 1980s, through a joint meeting organized by Claudio Naranjo (a follower of Fritz Perls’ Gestalt psychology) and a Santo Daime Church (López-Pavillard 2008). Corbera (2012) identifies 17 groups in Catalonia, including shamans (e.g., Latin American healers), “neoshamans” (e.g., Western “spiritual seekers,” “wounded healers”), Brazilian churches (Santo Daime, União do Vegetal), schools of psychology (transpersonal psychology, Gestalt school), and different centers of alternative and holistic therapies.

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People get in touch with these groups for various reasons related to spiritual, religious, and existential quests and also for therapeutic needs. One of the medical conditions often presented in these centers is addiction. In the particular case of Catalonia, initiatives such as the Institute of Applied Amazonian Ethnopsychology (henceforth IDEAA; founded by the psychiatrist Josep Maria Fábregas, in the year 2000, and now closed) were important hallmarks for the boost of a new agenda interested in the therapeutic applications of psychedelics for these conditions.

The current chapter is a summary of the research, “Science, Medicine, Spirituality and Ayahuasca in Catalonia: Understanding Ritual Healing in the Treatment of Addictions from an Interdisciplinary Perspective.” The qualitative study of the biographical narratives of former addicts who recovered using ayahuasca ritual as the main treatment was conducted in Spain in the period from December 2015 to July 2017. The entire research can be found in my doctoral dissertation (Apud 2017a) and in the book *Ayahuasca: Between Cognition and Culture*, published in the medical anthropology collection of the Universitat Rovira i Virgili (Apud 2020).

In the current chapter, I will focus on one topic of the research: the relation between experiences with ayahuasca and ritual healing. I will propose a novel approach to understanding how ayahuasca ritual healing works, using an interdisciplinary perspective that combines cultural and cognitive approaches. Ritual will be considered not only as a therapeutic device but also as a practice aimed at assorted purposes, such as cultural transmission of beliefs and enhancement of social commitment. The model stresses the capacity of ritual to produce “memories of the experience” that trigger new meanings in the biographical narratives of the participants, resulting in different psychological effects.

I will analyze how cultural context, ritual setting, and therapeutic demand are related to the medical outcome of the cases presented. Key concepts, especially, will be taken into consideration: the dynamic between “memory of the experience” and “narratives of the self” to understand what is usually called “integration” in these centers; the importance of social cognition in the cure, since narratives of the self are always a social drama; the belief in ayahuasca as a “superhuman agent” related to the effectiveness of the treatment; and the understanding of these new biographical narratives as “spiritual conversions” with a potential therapeutic effect.

The style of the directors of the center (from a psychotherapist’s style to that of a charismatic authority) and the ideas of spirituality (from “free floating” beliefs to structured doctrines) play their role in the therapeutic process, and this will be analyzed. Finally, in the “Conclusions,” I will stress the importance of connecting cognitive and cultural levels of explanation to understand not only the therapeutic ritual effects but also a variety of other effects. Ayahuasca ritual will be considered as a useful alternative strategy to cope with addiction disorders because it works not only with subjectivity but also with spiritual experiences and beliefs that are usually forgotten by orthodox Western therapies.

Antecedents

Treatment of addiction includes a variety of pharmacological, psychological, and communitarian approaches. The consensus is that treatment should consider different levels of the problem, including neurobiological, psychological, social, economic, institutional, and cultural factors (National Institute on Drug Addiction [NIDA] 2012).

In the particular case of ayahuasca, the compound is used in a variety of traditional, religious, and clinical settings that implicitly or explicitly combine pharmacological, psychological, communal, and spiritual or religious elements. Some novel approaches are related to the renaissance of psychedelic studies, through the emergence of several centers for the treatment of addiction, for example, Takiwasi (Peru), Runawasi (Argentina), and IDEAA (between Spain and Brazil). As Bousso points out (2012), clinical studies of ayahuasca are still few, but the evidence suggests it is safe in the appropriate ritual setting, with no deleterious effects on health, or even on potential therapeutic applications. In the academic literature, various clinical studies, testimonies, and ethnographic accounts suggest not only a low risk of developing dependence—a common feature with others psychedelics—but also its potential application for the treatment of addictions (Chiappe 1977; Da Silveira et al. 2005; Fábregas et al. 2010; Fernández et al. 2014; Grob et al. 1996; Halpern et al. 2008; Labate et al. 2008; Loizaga-Velder and Verres 2014; Mabit Bonicard and González Mariscal 2013; Mercante 2013; Santos Ricciardi 2008; Scuro 2016; Thomas et al. 2013).

Prickett and Liester (2014) describe various models used to understand how ayahuasca could work in the treatment of addiction: (a) the “biochemical hypothesis” (a normalization of the dopaminergic reward pathway through its connection with the serotonergic system), (b) the “physiological hypothesis” (the rewiring of neurons hijacked by addictive behavior), (c) the “psychological hypothesis” (the access to unconscious memories, repressed emotions, and unsolved traumas and the enhancing of psychological insights), and (d) the “transcendental hypothesis” (the production of transcendental experiences that cause radical changes in values, beliefs, and worldviews). Despite their differences, the four hypotheses could also be considered as overlapping each other. Maybe the resulting effect is a consequence of more than one of the processes described by the authors, as multilevel models of ayahuasca’s therapeutic action propose (see, e.g., in this volume, Domínguez-Clavé et al., Chap. 1).

Furthermore, the phenomenological and subjective side of ayahuasca cannot be separated from a neurological level of analysis because biochemical and physiological effects are a necessary flipside of psychological and transcendental experiences. For example, Riba et al. (2006) show how the activation of brain regions are related to emotional and introspective processing: right anterior insula and its relation with the representations of bodily states and subjective feelings; medial prefrontal and anterior cingulate gyrus, related to motivational aspects of emotions and their processing; and left amygdala and parahippocampal gyrus related to negative emotional

valence and the processing of memories. In a later article that specifically address the potential benefits of ayahuasca in the treatment of addictions, Bouso and Riba conclude that “It might be speculated that ayahuasca helps to bring to consciousness memories from the past, to re-experience associated emotions, and to reprocess them in order to make plans for the future” (Bouso and Riba 2014, p. 101).

Considering the qualitative research studies on ayahuasca, the testimonies of the subjective experiences of the participants seem to concur with these findings. For example, Western testimonies include cognitive alterations, such as change of thoughts, loss of volition, emotional changes, body image distortions, changes in meanings, increased capacity for insight, hypersuggestability, biographical revisions, and increased capacity for empathy (Apud 2013; Fericgla 2013; Fernández and Fábregas 2013, 2014; Grob 1999; Lewis 2008; Loizaga-Velder and Loizaga Pazzi 2014; Loizaga-Velder and Verres 2014; Shanon 2014). In the particular case of drug dependence, the experiences are the same but influenced by the specific therapeutic demand. Loizaga-Velder and Verres (2014) interviewed 14 patients treated with ayahuasca for an addiction disorder. As important subjective factors of their recovery, the patients mentioned: better understanding of the personal causes related to their addictive behavior, mobilization of positive resources, reduction of craving and withdrawal symptoms, and spiritual and transcendental experiences reinforcing their purpose in life. Loizaga-Velder and Loizaga Pazzi (2014) describe four main types of subjective experiences: body-oriented (e.g., body awareness, anti-craving), emotional/social (e.g., release of psychological burdens, forgiveness of self and others), insight-oriented/cognitive (e.g., insights into maladaptive psychological patterns and increased self-awareness), and transpersonal (e.g., spiritual healing, sense of meaning and purpose in life). Fernández and Fábregas (2014) analyzed the testimonies of 20 patients treated at IDEAA, describing six fundamental types of experiences: biographical revisions (e.g., memories of negative events related to the drug abuse, traumatic episodes), psychological insights (e.g., personal conflicts, patterns of psychological functioning), emotional experiences (e.g., shame, forgiveness), death-and-rebirth experiences, experiences with nature (e.g., reconciliation with nature, awareness of one’s animal nature), and transcendental experiences (e.g., feelings of mystical union, spiritual experiences).

There are several similarities described in other chapters of the present volume: In Chap. 4, Diamant and collaborators associate the therapeutic effect of ayahuasca with bodily, emotional, and other subjective experiences; in Chap. 8, Cavnar mentions the importance of visionary experiences, psychological insights, and transpersonal experiences to understand the psychotherapeutic effect of the brew; in Chap. 9, Mason and Kuypers describe several cognitive and experiential changes produced by ayahuasca—some of them are related to creativity, empathy, emotion regulation, and feelings of interconnectedness; lastly, in Chap. 12, Argento and collaborators describe their research using ayahuasca with indigenous Canadian participants who have addiction problems, noting how experiences of connectedness with oneself, others, nature, and spirits are usually considered as key elements in recovery.

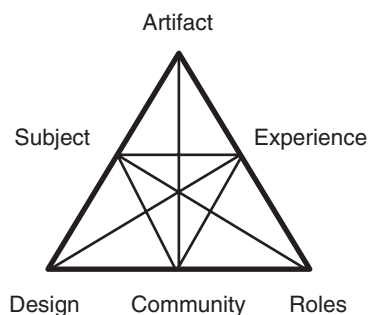
Ritual Healing Using a Multilevel Model

To understand how ritual healing using ayahuasca works, we must consider not only the substance and its pharmacological effect on the brain and cognition but also the final psychological outcome. We must also consider the contextual elements mediating the effect. In the biomedical literature, they are usually labeled as “nonspecific factors” related to the placebo response, and in the psychedelic studies, they are grouped using the classic notion of “set and setting.” Decades ago, Grob (1999) described how these extrapharmacological factors shape the visionary ayahuasca experience, comparing different cultural contexts from psychonautic Western practices to Amazonian shamanic ceremonies. More recently, Talin and Sanabria (2017) (and also Chap. 10 of this volume) analyzed the trajectories of seven Italian addicts who recovered in the Santo Daime church, stressing the therapeutic relevance of the semiotic and social world into which the participants are introduced. As I will show next, these extrapharmacological factors are essential to understanding the effects of ayahuasca.

The interdisciplinary approach proposed in the current chapter is part of the research I conducted in Catalonia, where I analyzed the therapeutic use of ayahuasca under the general framework of theory of ritual, using a perspective that integrates cultural and cognitive levels. Before my research in Catalonia, and during my fieldwork in Latin America, I proposed a theoretical ritual model, inspired by the distributed cognition model of Cole and Engeström (1993). The model (Fig. 9.1) disaggregates various contextual factors—the “setting”—that modulate the ayahuasca experience: the ritual design (rules, spatial order, and technologies used), community (relationships between the members of the group), subject (personal history, spiritual trajectory, cultural background), roles (assigned in the ritual to each of the participants), and artifacts (the set of instruments and techniques used by the healer to stimulate and manipulate the states of consciousness of the participants).

The model proposed in my research in Catalonia adds one further step (Fig. 9.2). It not only disaggregates the ritual and its variables but also the cognitive functions usually manipulated in it. For this, I used insights from interdisciplinary areas of research interested in ritual and symbolic healing: medical anthropology and

Fig. 9.1 Ritual design triangle (Apud 2013, 2015a, b)



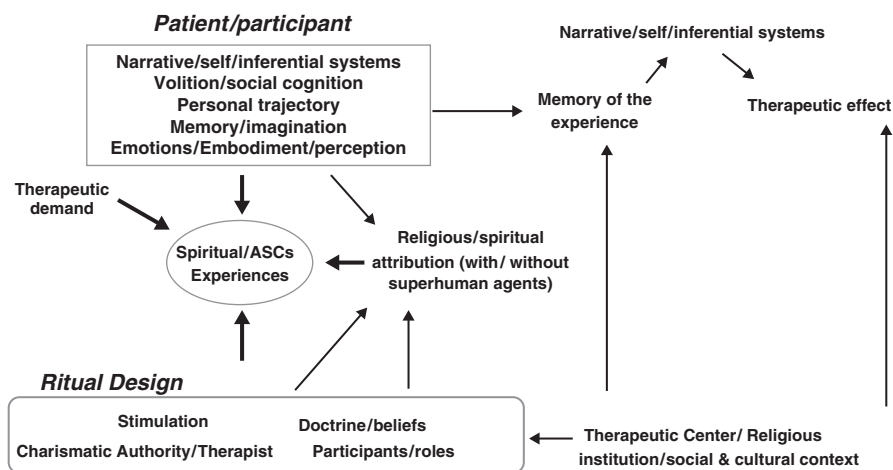


Fig. 9.2 Ritual healing model that integrates cultural and cognitive elements (Apud 2017a)

placebo agenda, ethnographic studies on trance and possession, cognitive science of religion, studies on religious experience, studies on religious conversion, psychedelic studies, and religious and health studies. The model was constructed between these theories and empirical data from my fieldwork in Catalonia and Latin America. The final categories presented are not exhaustive (other categories can be added) or necessarily relevant in different sets and settings (some categories could be excluded for certain cases). It is an open and emergent model, constructed in a “grounded theory” style.

In the model, ritual healing is a dramatic performance (Turner 1977) or a placebo drama (Kaptchuk 2002) where patient and practitioner interact in a therapeutic setting with the common goal of solving a therapeutic demand. The practitioner can be a therapist or a charismatic authority who uses different techniques of stimulation and who can manipulate mythological healing symbols and beliefs (Dow 1986). The ritual effectiveness is usually attributed to a “superhuman agent” who has “full access to strategic knowledge” (Boyer 2001) and is considered to produce a particular “super-permanent effect” (Lawson and McCauley 1990). The attribution of effectiveness to the ritual produces a “meaning response” (Moerman 2002) that could trigger a cascade of psychoneuroimmunological processes that give relief or healing (Geertz 2010; McClenon 1997; McNamara 2009; Winkelman 2010). The symbolic effectiveness does not require a common shared mythical structure, only certain conditions that induce the patient to search for new personal meanings. So, the patients are not mere passive agents; their personal predispositions and trajectories play an important role in the process.

We must also consider that the therapeutic outcome is not related to the experience itself but how it is remembered and re-signified later, in what Czachesz (2017) called “memory of the experience.” It involves different psychological (e.g., agent-action representations) and cultural biases (e.g., narrative styles). The memory of

the experience acts as potential “turning point” in the biography of the participants (Denzin 2014), producing various changes in the biographical narratives of the self (McNamara 2009).

From a cognitive point of view, biographical mental projection involves higher functions, such as self-relevant knowledge stored in the memory (episodic memories, semantic representations, metacognition, social identity), executive functions (valuation, learning, and cognitive homeostasis), reflexivity (interaction between executive functions and representational knowledge), and mental time travel (the capacity to reconstruct specific events of the past and engage in alternative mental simulations of future events), among others (Skowronski and Sedikides 2007). From a cultural perspective, it involves a variety of narrative styles interpreting subjective experiences in a socially interactive process that, within these groups, is usually called “integration.” The new narratives are not only a result of individual experiences but also of a social interpretive process in which patients evoke, assess, negotiate, legitimate, and give factuality to their experiences. The narrative mode of thought situates individuals as social agents within a cultural context, allowing subjects to dive through the cultural past and to project themselves from the present to the future (Bruner 1986).

In sum, biographical narratives have an important homeostatic function, both at psychological and social levels. They influence health, emotions, lifestyles, and social behavior and can also have psychoneuroimmunological effects. But, as was previously mentioned, both rituals and the construction of new narratives are related not necessarily to a therapeutic aim but to other goals, for example, religious conversion, which sometimes is overlapped with healing.

Method

This was a qualitative, case-focused study using a biographical approach. It is important to consider that, unlike quantitative research, qualitative sampling does not have the aim of inferring results to a whole population through statistical procedures but only to describe and analyze the cases in terms of processes and meanings. So, this study is not an assessment of the efficacy of ayahuasca in the treatment of addictions; it is only an analysis of certain cases where the treatment worked.

The units of analysis are former patients who recovered from an addiction disorder using ayahuasca ritual as the main treatment in the period of time between 2000 and 2016 in the geographical region of Catalonia and the surrounding autonomous communities. ICD-10 and DSM-V were used for the construction of the inclusion criteria for the definition of addiction, including features such as the following: at least 12 months of problematic use of the substance; significant social and psychological impairment caused by drug use; the inability to control the consumption and dosage administered; and at least 12 months without compulsively taking drugs. The final sample consisted of 12 subjects (10 males, 2 females) with a mean age of 41.8 (minimum 22, maximum 57) residing in Catalonia, Valencia, and the Balearic

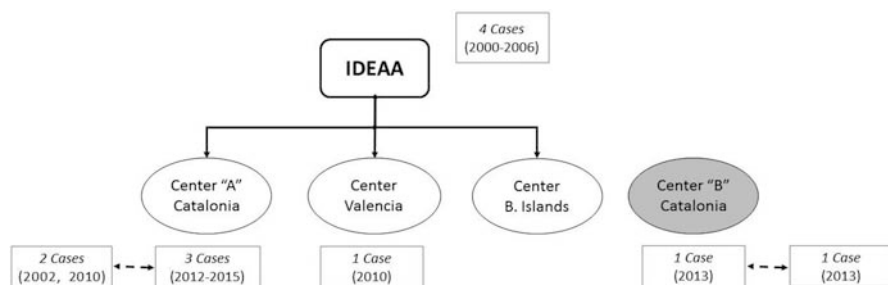


Fig. 9.3 Network of the groups and cases

Islands. The geographical zone was not a preestablished criterion but a consequence of the snowball sampling procedure.

The selection of the cases started with contacting therapists and patients who were part of IDEAA when it was still operating. Those informants gave access to current centers in the surrounding areas, most of them related to former therapists or patients of IDEAA who later became therapists. As shown in Fig. 9.3, four centers were finally contacted: two in Catalonia (one of them not related to IDEAA), one in Valencia, and one in the Balearic Islands (where I did not work with patients from the center but with two members who were previously treated in IDEAA). The final sample includes four former patients of IDEAA: three from Center A in Catalonia, one from Center B in Catalonia, one from a center in Valencia, and three cases recovered on their own, in ceremonies in Spain or Peru (two contacted during fieldwork in Center A and one in Center B).

All the centers are connected to the psychospiritual networks mentioned in the introduction of this chapter. Notably, the rituals at the centers are similar in their main features: they are usually performed at night; participants sit or lie in a circle on the floor; music is played live or on a computer; the rituals encourage self-reflection and insightful psychological or spiritual experiences. The sociocultural background is also similar in each of the centers. The 12 cases were from a middle-class context; all of them had completed secondary education; half of them had finished university studies. Most of them were polydrug users, with cocaine as the most common one, followed by heroin and alcohol (Fig. 9.4).

Results

The experiences of the participants are similar to those found in the previous qualitative studies mentioned, with biographical reviews and psychological insights usually considered to be of the most therapeutic value by the patients. These experiences include childhood remembrances, memories of negative events related to the addiction, traumatic episodes, insights into psychological patterns, and recognition of positive personal resources:

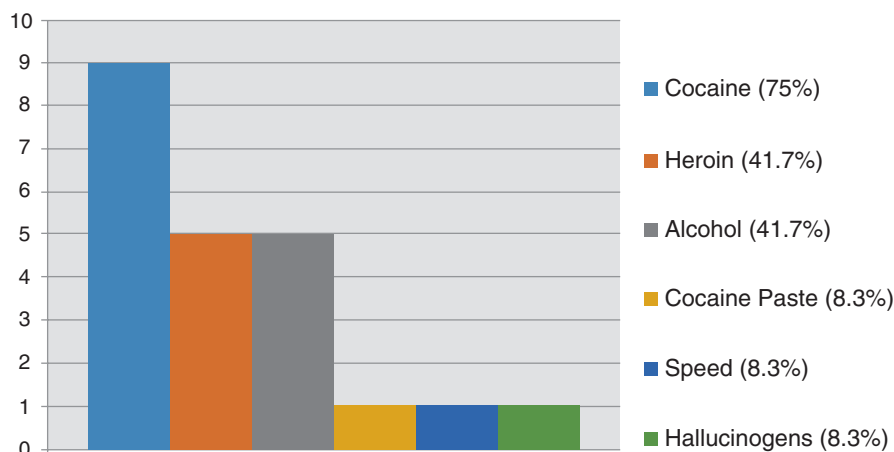


Fig. 9.4 Drugs used by the subjects

Case 1, from IDEAA

If it was for the enjoyment, I would have quit immediately because it was... It was about what you have been going through, the things you have done, the terrible condition you were in that moment. Flashbacks of bad episodes, decisions in which you could have taken a certain path and you finished in the wrong way ... Lots of remembrances, of the problem that I had... [Memories] from my childhood also, but mostly of the problem that led me to the center...

Case 2, from IDEAA

In my case, and also in the case of other drug addicts, your life became a continuous lie. Everything was a lie. And the plant showed this to me. All the world of lies that was my life. And when I started to pull these things out, I saw that everything was a lie! And this was a critical moment when I went through a process with ayahuasca. In the moment when you contact with all of these, you aren't happy at all, the most common thing is to feel really afraid... because of the void that you suddenly see in your life, because everything is a lie, because I am a lie. It is a very delicate moment. And the person needs a lot of care, support, to go through this moment...

Another kind of experience is a variety of emotional states, such as happiness, relief, sadness, grief, rage, and love:

Case 3, from IDEAA

There was a huge fire, and I sat there, dizzy, but fine. And when I looked at the stars, some tears started to fall... but such tears! A feeling that is... very hard to describe. Because it was like a torrent... but not of sadness. The first time I drank it, ayahuasca did something to me. She taught me, showed me, made me see that she was capable of helping me...

Emotional experiences can also be accompanied by embodied experiences, such as crying, vomiting, and the sense of being cleansed or released from a psychological burden:

Case 1, from IDEAA

The remembrance of my path was accompanied with continuous crying... of crying three hours in a row for example... and that was a release... The power of releasing is activated, and you are like a fountain... and I could release all the pain I had been carrying inside me ...

In certain parts of the therapeutic process, emotions such as guilt, empathy, forgiveness, and self-forgiveness start to play a major role in the recovery:

Case 4, from IDEAA

I closed my eyes and I saw monstrosities... knives, all very macabre. But I had a strong comprehension ... I understood lots of things ... What I had done, why I had behaved that way, my complexes, my fears ... What I focused on most was the topic of violence, and why I was engaged in drug trafficking and all those things ...

Case 1, from Center A

I put myself in the place of my father, in feeling as my father feels ... and I could reassess him, ayahuasca made me value him positively... seeing a little bit from his perspective, and consider him not only with a sense of resentment. To see his positive side ...

Finally, a variety of spiritual experiences are also present, including the following: traveling to other places, watching heavenly landscapes, a mystical feeling of union, out-of-body experiences, death-and-rebirth experiences, communication with spirits, and being possessed by entities:

Case 1, related to Center A

... visions... which later, searching in books, different cultures have this vision... of the *axis mundi*... like a column of energy connecting heaven and earth. And there I saw... snakes, crocodiles, low density spirits. And a world below was opened. I saw an amazing column of energy that was the whole universe.

Case 2, related to Center A

I had the sensation that ayahuasca... when I was at the peak of the experience... I opened my eyes and it was like the consciousness of the plant had possessed me ... and it was like she was studying the world from my perspective. And after that ... the plant travelled inside my body ... trying to clean it.

Spiritual experiences do not necessarily involve a superhuman agent but interacting with or seeing them is not an unusual thing. The contact with spirits may include dead or living relatives and friends, animals, and indigenous people. But the most important is the contact with ayahuasca and the belief in it as a teacher and healing plant. Ayahuasca is usually considered as the main agent behind the therapeutic process.

Dark experiences, such as visions of hell, sinister places, and evil entities, can occur. These experiences are sometimes counterproductive, causing strong fear in

the participants and making them avoid ayahuasca for a certain period of time. But, in other cases, these negative experiences are considered as having a message with an important therapeutic value when decoded:

Case 2, related to Center A

I started seeing a monster, a huge, huge demon ... At the beginning, my thoughts were, "this is something wicked, from outside, that wants to enter me" ... But in the middle of the session, I saw an umbilical cord that came out of the monster and that was connected to me. So, I said, "this is not from the outside" ... I fell onto my knees and said to myself, "I have to recognize my dark side" ... I came out of the ceremony totally unstructured ... and it took me a lot of work to come to terms with what happened in that session...

In our 12 cases, the moderate, biographical, insightful experiences are the most common and also the ones most frequently considered important for recovery. But the transpersonal spiritual experiences are also considered a main catalyst for healing. Besides that, it is important to note that spiritual experiences cannot be divorced from psychological ones. There is usually an overlap or connection between both. As a paradigmatic example, the following case describes an experience where an emotional state, a repressed trauma, a death-and-rebirth experience, and a final spiritual awareness of life are chained together:

Case 2, from Center A

There was a turning point when I was 16... the death of my best friend. I was there with him, it was an accident, and after that, I rejected life. I said, "Life is shit and now I will burn it." And I started to take drugs to burn out my life ... I was wondering why, when I was at home and not taking drugs, I started to feel such a huge hole in my life, inside me, and I started to cry, and I did not know why, ok? ... During an ayahuasca ceremony, I asked about that hole. I saw a hole... like a giant black cloud, so, so big that I could not close my eyes. And then it came out, the death of my best friend, and I... cried for three hours, like I'd never cried before. ... I stopped crying and started laughing. ... I started to feel as if I was dying, that I was disintegrating, ok? ... I lay down, and I gave birth to myself, and felt as if I could not breathe because I was coming out of the uterus ... And I finally understood, and all the connections came into my mind. I understood that it was an unfinished mourning process. That life is wonderful, and death is part of it, and that there is no rebirth without death. I had to die and to have this experience of being reborn to understand death in another way. ... I was born again and I was cured of that emptiness. And since then, the void that I used to feel when I came home and made me start crying without knowing why, that void disappeared forever ... Pulling out the trauma of the death of my best friend was a turning point for me to start moving forwards...

An important therapeutic element mentioned by the patients is what they call "integration," that is, how the experiences are interpreted and psychologically assimilated after the ritual. In the cases studied, spiritual conversions could be

Table 9.1 Religious affiliation

Religious affiliation	Before ayahuasca	After ayahuasca
Agnostic/atheist	6 (50%)	1 (8.3 %)
Catholic	3 (25%)	1 (8.3 %)
Spiritual/no affiliation	3 (25%)	6 (50%)
Spiritual/Santo Daime	–	3 (25%)
Spiritual/Reiki	–	1 (8.3%)
Total	12 (100%)	12 (100%)

considered a recurrent final outcome of the process of integration of these experiences into their biographical narratives (Table 9.1).

The reflections on spirituality can be more or less generic, and the interpretations are diverse, particularly in those centers where there is no canonical view or doctrine. But, despite the differences, there are certain common beliefs “free floating” in these centers, related to different traditions within the psychospiritual networks: New Age ideas, transpersonal psychology, perennial philosophy, and Eastern ideas and practices, among others. The integration process will depend on what each participant found useful and how the patient interacted with the style of the center, the group, and the therapist. For example, Center A allowed participants to explore their psychological problems through different strategies. Some of them were learned in the center, but others came from other spiritual or therapeutic practices:

Case 2, from Center A

I had the session of ayahuasca, and later a session of reiki. And the woman with whom I was doing reiki integrated lot of things I had experienced in the sessions of ayahuasca, she helped me to order them...

In the case of Center B, a structured doctrine of a millennial spirituality could be identified, spinning around its controversial leader, who considers himself as a spiritual “guru” who had achieved wisdom:

Case 1, from Center B

When I went to retreats with him, he confronted me during the integrations. He really had a deep insight into what is happening to a person because he had worked on inner conquest, so what he says is pure intuition, not a projection. If he says something, it is because he is seeing it, because he has the ability to see into the depths of the person...

In this particular case, the therapist acted as a “charismatic authority.” He considers himself as having access to spiritual relevant knowledge and teaches the patient how to “heal” and “evolve.” In that way, the patient is introduced to a new worldview in an intellectual kind of conversion.

Discussion

As was already mentioned, the testimonies of the subjects are similar to the ones described in previous qualitative studies. This should not be a surprise, since context (a Western “psi” subculture focused on introspection), setting (the ritual as a psychotherapeutic device for self-knowledge), and therapeutic demand (the healing of an addiction disorder) are mostly the same. Biographical experiences were the most common ones. In addition, and as was previously mentioned, they are connected to other kinds of experiences, usually in a therapeutic plot.

Most of the biographical reviews are associated with emotions, such as guilt, shame, and, later, forgiveness and self-forgiveness. From a cognitive perspective, these emotions are related to social cognition, that is, our natural capacities to interact with others, to see from their perspectives, and to empathize. On one hand, ayahuasca, as well as other psychedelics, may trigger certain brain regions related to social cognition. On the other hand, the psychotherapeutic work of “integration” in these centers involves redefining a narrative of the self. Biographical narratives, too, are always a social drama. We are social beings and we construct our identity in a social scenario, with other agents, with social rules, moral values, and a sense of what is right and wrong (Bruner 1986).

When social dispositions such as empathy, altruism, and love are obstructed, different psychological disorders are more likely to appear (Cloninger and Kedia 2011). In the case of drug dependence, the individuals presented in this chapter connected both intellectually and emotionally with the social consequences of their disorder. Most of the patients described this as an essential part of the therapeutic process: to put themselves into the shoes of relatives and friends, to understand the damage they had done to them, and to find forgiveness in order to construct a fresh starting point for their new identity. Spiritual experiences are usually connected with other experiences in a psychotherapeutic plot; they are especially relevant, since they introduce the participant to a new worldview, producing diverse varieties of spiritual conversions, and the construction of a new narrative of the self. One relevant spiritual category is the contact with or the belief in ayahuasca as a teacher and healer. As was mentioned in the theoretical model, the connection with a “super-human agent” is an important element in the effectiveness of the ritual.

Considering the empirical findings in disciplines such as neuroscience, psychology, and anthropology, it could be concluded that experiences with ayahuasca seem to have a profound psychological impact, affecting cognitive processes, such as perception, emotions, social cognition, corporal perception, and consciousness. It seems to act on mechanisms that are usually addressed by rituals, but the desired effects are easier to reach and also more intense. Despite this, to have a durable effect, the ritual must have an impact on the patient’s self-identity. This effect involves a dialectic between the memory of the experience (how experience is stored, assessed, evoked, and re-signified) and the narrative of the self (identity expressed as a social story).

The experience should act as a significant episode in the biography of the subject, producing positive changes. I would like to stress, however, that these effects are not necessarily psychotherapeutic, and all these cognitive effects can be used in different ways, depending on the ritual design, the mindset of the participant, the cultural context, and the institutional and social background where the ritual is displayed. For example, in the traditional Amazonian shamanic context, the effects are directed to other purposes, such as fighting witchcraft, learning new spiritual knowledge, or healing different culture-bound syndromes (Apud 2013; Beyer 2009; Dobkin de Rios 1973; Luna 1986; MacRae 1992).

Conclusions

Clinical research on ayahuasca is usually interested in the pharmacological properties of the brew, that is, how it interacts at physiological and neurobiological levels. This is an essential level of inquiry if we want to assess both positive and negative outcomes of its use. However, it is important not only to stay solely at one level but to also study the variations and influence of different factors from psychological, social, and cultural levels of analysis, and also try to connect those levels. The interdisciplinary perspective presented in this chapter is concerned with connecting cognitive and cultural levels of explanation. Ritual was considered as a cultural practice that produces certain psychological effects in the participants, including religious conversion, coping with mental disorders and culture-bound syndromes, enhancing social commitment, and as a rite of passage during different life's stages, among others. Religious rituals—and ayahuasca rituals are not an exception—are commonly used as cultural devices that help in the task of putting the new and old pieces of the biographical self together. This is a delicate moment, when the patient is vulnerable and suggestible, so negative effects are also possible. In this process, religious and spiritual conversion, adherence to certain community, and idealization of a charismatic leader can happen in both positive and negative ways.

In the case of addictions, and with the appropriate work of “integration,” ayahuasca ritual seems useful, since it addresses different aspects related to the disorder at the neurological, psychological, social, and cultural levels involved in this complex problem. It can alter a participant's perspective on life, self-identity, lifestyles, moods, motivation, social relationships, and ways of understanding the past and projecting to the future. If the effect is to be long-lasting—in our case, the effect being the avoidance of a dependence behavior pattern—the ritual experience must leave a mark on the narrative of the self, a turning point in the biography of the individual that is usually expressed as a kind of spiritual conversion.

It is important to mention that the effectiveness of ayahuasca ritual varies from case to case, and some participants might not find this kind of approach useful at all. But, even if the treatment with ayahuasca works for only a few cases, we should consider the importance of it anyway, since sometimes these few cases might only find a solution in these kinds of heterodox strategies. For example, in this particular

research, more than half of the cases had a long career of resistance to conventional treatments, and they finally overcame their problem through ayahuasca-related strategies; so, these alternative strategies should not be excluded from the range of potential therapies for addictions. This problem is addressed in the principles of effective treatment of NIDA (2012), where it is stated that no single treatment is appropriate for everyone and that different approaches and strategies should be considered. Some of these strategies should include spirituality as part of the treatment. This is important because most Western therapies do not specifically address spirituality, and the majority of the population has religious or spiritual backgrounds. As scientific literature suggests, spiritual or religious beliefs seem to have a positive effect on the health of their adherents, not only because of the sense of meaningfulness and hope that they usually produce but also because of the networks of support and the healthy lifestyles they promote (Koenig et al. 2001). In the cases studied, the recovery implied staying away from certain social contexts and social habits and starting a new social life, with other rewards, persons of reference, and cultural and spiritual motivations.

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