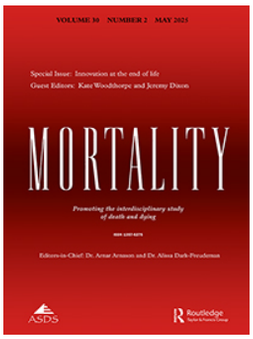

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Psychedelic-assisted grief therapy: a mixed-method case study

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ABSTRACT

This paper focuses on a single case of ayahuasca-assisted grief therapy for the prevention of complicated grief, conducted within a clinical trial. The participant, a woman in her thirties who lost her father to cancer, completed a 9-session process of Meaning Reconstruction Therapy (MRT) organised around two ayahuasca sessions. Following each psychedelic experience, she also completed a psychedelic integration session. The case study investigates the effect of the intervention, the observed changes in the participant, and the potential processes of change which may account for this improvement. The analysis relies on a qualitative narrative approach to examine the content of each therapy session, as well as on the psychometric measures completed at baseline, post-treatment, and at the three-month follow-up. These results are linked to emerging theories in the field, with a particular focus on the role of meaning reconstruction, psychological flexibility, and a continuing bond with the deceased.

KEYWORDS

Counselling; bereavement; felt presence; ayahuasca; qualitative; narrative

The last two decades have witnessed a renaissance of mental health research into psychedelic substances. A series of clinical studies have shown preliminary safety, feasibility, and efficacy for their use in the professional treatment of a range of mental health difficulties such as major depression, illness-related anxiety, post-traumatic stress disorder, substance abuse, and obsessive-compulsive disorder (Andersen et al., 2021; Smith et al., 2022).

The intervention being researched, Psychedelic-Assisted Therapy (PAT), involves the administration of a classical psychedelic (e.g. psilocybin) or an atypical one (e.g. MDMA) within a psychotherapeutic framework. Building on previous waves of psychedelic research (Hartogsohn, 2017), and our current scientific understanding of the psychedelic experience (Cavarra et al., 2022), this structured framework involves three differentiated stages of treatment:

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(i) an initial phase of psychotherapy, aimed at establishing a therapeutic alliance and preparing the patient for the psychedelic experience (i.e. preparation phase);
(ii) one or more dosing session(s) with the psychedelic substance, during which a therapist (or a therapeutic dyad) is present as a way to provide a safe and effective setting (i.e. dosing phase); and
(iii) a final phase in which the psychedelic experience is shared, made sense of, and worked through with the therapist (i.e. integration phase).

Despite the increasing evidence indicating that psychedelic substances (when administered within an appropriate therapeutic setting) may have the potential to induce lasting mental health improvement, much is still unknown about the psychological and interpersonal processes mediating that change (Swanson, 2018). There is preliminary quantitative and qualitative evidence pointing towards a series of potential processes of change (see Table 1), but the way they may overlap with each other (or be integrated with our current understanding of mental health treatment) is poorly understood.

Therapeutic potential of ayahuasca

Ayahuasca (from the Quechua *huasca*, vine, and *aya*, the dead, spirit, or soul) is a psychedelic brew usually prepared from the *Psychotria viridis* bush (rich in N-N-dimethyltryptamine, DMT) and the *Banisteriopsis caapi* vine (adding a Monoamine Oxidase Inhibiting action, MAOI) (Schultes & Hofmann, 2001). DMT, a classical psychedelic, becomes orally active in the presence of MAOI activity, inducing an altered state of consciousness. The concoction is safe and well-tolerated (Dos Santos et al., 2012; Riba et al., 2003) when consumed in an appropriate setting, and the psychedelic experience usually wanes after four to six hours after the substance is consumed (Riba et al., 2001). The qualities of this altered state usually involve heightened emotion and psychological

Table 1. Defining key processes of change in the PAT literature, according to the existing evidence.

Process	Definition	Evidence
Mystical (or peak) experiences	Characterised by a noetic quality (i.e. a sense of encountering a transcendent reality), a transcendence of space and/or time, ineffability, paradoxicality, a sense of sacredness, external and internal unity (e.g. a sense of oneness), and deeply felt positive mood (e.g. joy or awe) (Richards, 2015, p. 78).	Bogenschutz et al. (2015); García-Romeu et al. (2014); Griffiths et al. (2016); Ross et al. (2016).
Psychological flexibility	"Contacting the present moment as a conscious human being, fully and without needless defence and persisting with or changing a behaviour in the service of chosen values" (Hayes et al., 2012, pp. 96–97),	Davis et al. (2020); Luoma et al. (2019); Zeifman et al. (2020), Zeifman et al., 2023.
Mindfulness-related acceptance	"To attain a non-evaluative stance toward their experience of 'being', their thoughts and their emotions without getting carried away by them, no matter how painful these may be" (Soler et al., 2018, p. 4).	Sampedro et al. (2017); Soler et al. (2016), 2018.
Self-compassion	A mindful and non-judgmental attitude toward one's own distress, involving self-kindness (instead of self-criticism), a sense of common humanity (instead of separation and isolation) and mindfulness (Neff, 2003, p. 83)	Agin-Liebes et al. (2023); Fauvel et al. (2021).
Connectedness	"A state of feeling connected to self, others and the wider world" (Watts et al., 2022, p. 3461)	Breeksema et al. (2020); Noorani et al. (2018); Watts et al. (2017), 2022.

insight, significant perceptual changes (ranging from heightened visual imagery to hallucination), a sense of ineffability, and an altered sense of self (Letheby, 2021; Milliere, 2017). However, these experiences are highly dependent on what is usually termed set and setting (Grob, 2002; Hartogsohn, 2017), especially the cultural context of the experience (Dupuis, 2021a, 2021b).

Ayahuasca has been consumed in shamanic ceremonies by several Amazonian indigenous cultures for centuries,[1] both for ethnomedicinal and spiritual-religious purposes (Luna, 2011). During the second half of the twentieth century, ayahuasca use began to expand outside of South America through the work of Christian syncretic churches of Brazilian origin, such as the Santo Daime (Labate & Cavnar, 2014; Labate & Jungaberle, 2012). Ayahuasca, as other classic psychedelic substances, does not produce addiction. Existing studies of people who consume it ceremonially have found have better psychological functioning, and lower hopelessness, substance abuse, and depression rates, in comparison to the general population (Bouso et al., 2012; Santos et al., 2007). At the moment of writing this report, a series of randomised controlled studies has found ayahuasca to be potentially effective for treatment-resistant depression (Osório et al., 2015; Palhano-Fontes et al., 2019; Sanches et al., 2016), and non-controlled studies suggest it may be effective for the treatment of addiction (Nunes et al., 2016; Thomas et al., 2013).

Grief therapy

As the term indicates, Psychedelic-Assisted Therapy (PAT) is not the isolated prescription of a psychoactive substance, but a complex combination of psychotherapy and pharmacotherapy (Villiger, 2022). Empirical research into the psychotherapeutic component of PAT, however, is sorely lacking (Cavarra et al., 2022).

Although psychodynamic approaches predominated during previous waves of psychedelic research, contemporary clinical studies have primarily relied on cognitive-behavioural and integrative modalities. Special attention has been paid to Acceptance and Commitment Therapy (ACT), Cognitive Behaviour Therapy (CBT), and motivational interviewing (Bogenschutz et al., 2015; Cavarra et al., 2022; Yaden et al., 2022). This has led to research into psychological processes of change tied to these modalities, such as psychological flexibility (Davis et al., 2020; Luoma et al., 2019; Zeifman et al., 2020, 2023) and cognitive change (Wolff et al., 2020), that could potentially be applied both to the psychedelic experience and the therapeutic component of PAT. Alongside disagreements about which modality is more appropriate (or evidence-based) for such role (e.g. Burton et al., 2022; Yaden et al., 2022) some have suggested that the common factors hypothesis may apply to PAT (Gukasyan & Nayak, 2021; Villiger, 2022). This hypothesis argues that various *bona fide* psychotherapies do not significantly outperform each other, and that their commonalities (especially the therapeutic relationship) are the main contributor to their effectiveness (Wampold, 2015).

The field of bereavement studies and grief therapy, however, has experienced a significant rearrangement during the last decades, and deserves special attention. First, the field has moved away from a phased understanding of the grieving process due to the lack of supporting evidence (Stroebe et al., 2018). Second, and based on cross-cultural research, new theories argue that not every grieving process has to conclude with the severing of the bond with the deceased (Klass & Steffen, 2017). This resulted in the normalisation of having 'an ongoing inner relationship with the deceased person by the

bereaved individual' (Stroebe & Schut, 2005, p. 477), which Klass (2006) termed a 'continuing bond'. Third, special attention has been given to therapeutic modalities that are specifically designed to target complicated grief.[2] A key intervention emerging from this new understanding of grief is Meaning Reconstruction Therapy (MRT, Neimeyer, 2000, 2016), also referred to as meaning-centred grief therapy (Lichtenthal et al., 2019). Together with CBT for complicated grief, they represent the most well-researched therapies in the field at present (Johannsen et al., 2019).

MRT is, at heart, an integrative approach to grief therapy: a combination of a narrative understanding of grief, a set of primarily cognitive-behavioural techniques, and an existential-humanistic emphasis on meaning-making, all anchored upon constructivist philosophical premises (Neimeyer, 2012, 2015, 2021). Despite being an intrinsically flexible intervention, MRT is anchored upon three processes of change: accepting the fact of the loss, re-constructing a worldview challenged by it, and repairing the bereaved person's identity (and their attachment security) now that the deceased person is gone.

Ayahuasca-assisted grief therapy

The case study presented in this paper is part of a clinical trial exploring the effect of ayahuasca-assisted MRT for the prevention of complicated grief. This trial is part of the first line of research exploring the therapeutic potential of psychedelic-assisted grief therapy. As part of it, an initial retrospective study ($N = 60$) compared grief intensity between a group of bereaved people who consumed ayahuasca and a group who attended a bereavement peer support group (González et al., 2019). The former group presented a lower grief severity, and three interconnected processes of change were identified through a qualitative analysis of interview data: an emotional confrontation with the reality of the loss, re-visiting biographical memories, and experiencing or contacting the deceased person. A second study ($N = 50$), a longitudinal observation study, followed a group of bereaved people who underwent several ayahuasca ceremonies in a traditional medicine centre in Peru (González et al., 2020). A significant reduction of grief intensity was found, despite the fact these ceremonies were not grief-focused, and this improvement was sustained a year after leaving the centre (Cohen's $d = 1.39$). A reduction in grief severity, and a correlation between experiential avoidance ($r = .55$, $p < .01$), and decentring ($r = -.47$; $p < .01$), were also observed. A qualitative analysis of these participants' accounts further highlighted the importance of emotional processing, meaning and identity reconstruction, and an ongoing bond with the deceased person (González et al., 2021). Following this, a pilot study was conducted to explore how to integrate MRT with the ayahuasca administration. A case report of this pilot study, focused on the process of psychedelic integration using restorative retelling, has already been published (González et al., 2022).

This paper discusses the effect of a single therapeutic process of ayahuasca-assisted MRT to reduce grief severity, and outlines the changes that can be detected in the participant (RQ1). Crucially, this analysis explores the psychological processes these changes may be attributed to (RQ2), linking them where possible to existing theories and hypotheses in the field (RQ3). Unlike comparable existing studies, the qualitative analysis was focused on the transcribed audio recording of each session (i.e. naturally-occurring data) rather than on retrospective recollection through a follow-up semi-structured interview. The identification of processes of change, during this initial phase

of clinical psychedelic research, is essential in order to understand the complex recovery process, to determine which processes should be quantitatively assessed and tracked, and to link theory and practice in a way that can be both effective and rigorous.

Case context and method

Procedure

This therapeutic process was part of a clinical trial sponsored by the Beckley Med Foundation (Trial ID NCT06150859). The trial, which took place in Barcelona, Spain, was approved by the Ethics Committee of the Hospital Universitari Germans Trias i Pujol (CEIC PI-19-188). Although the clinical trial protocol has been published elsewhere (Sabucedo et al., 2024), key information regarding this case is outlined below.

Before the treatment started, and as per the project's protocol, the participant completed a psychometric assessment involving a series of questionnaires. She also completed a screening interview with the principal investigator (author DG) to confirm she met all the necessary inclusion criteria: being an adult able to consent, having lost a first-degree relative, no more than a year having lapsed since the loss, and a grief severity score >39 in the Texas Revised Inventory of Grief (TRIG). No exclusion criteria were met: psychotic disorder (or a family history of psychosis), comorbidity with another mental health disorder, alcohol intake of over 40 g/day, undergoing another psychological or psychopharmacological treatment during her participation in the trial, pregnancy or lactation, or cardiovascular disease. In addition to this psychological assessment of the participant's emotional state, her blood pressure and heart rate were assessed by a physician: at baseline, to confirm eligibility, and before administering ayahuasca.

Pharmacological and psychological intervention

The participant, Diana (pseudonym), completed a 9-session process of psychotherapy which followed the protocol of Meaning Reconstruction Therapy (MRT), adapted specifically for this controlled trial (Sabucedo et al., 2024). Although this protocol is briefer than the usual 12-to-16-session intervention (Lichtenthal et al., 2019; Neimeyer, 2016), it also includes a two-session psychedelic integration process taking place after each ayahuasca session. A brief summary of the treatment protocol is presented in Table 2. This protocol is aimed at specific processes of change: acceptance of the loss, meaning-making, and restructuring the self.

Every session of psychotherapy took place online, through secure videoconferencing software, and was audio-recorded with the participant's consent. The therapist who provided the psychological intervention (author PS) is a chartered psychologist with a decade of clinical experience, trained at doctoral level, and experienced in behavioural and humanistic therapies in the context of grief. Following session 3 and session 9, the participant took part in an ayahuasca session with other bereaved participants (see Table 2). During the week after each session took place, the participant also completed a ninety-minute psychedelic integration session with her therapist via videoconference. During the session, lasting a complete day and night, the participant drank two doses equalling 0.75 mg/kg of DMT. A facilitating team, led by the primary investigator (author DG), supported the participant by providing a safe, non-directive, emotionally supportive space.

Table 2. Brief summary of the treatment protocol of ayahuasca-assisted meaning reconstruction therapy (MRT) for the prevention of complicated grief.

The 9-session MRT protocol (see Sabucedo et al., 2024) can be subdivided into three distinct treatment phases, each focused on a different mechanism of change according to the model. The initial session is focused on assessment, psychoeducation on grief, and the establishment of a therapeutic relationship. The participant is introduced to the dual process model of grief (Stroebe & Schut, 1999) and thetherapeutic modality (Neimeyer, 2012, 2015, 2021, 2022). This is followed by:
(1) A two-session block focused on processing the loss through restorative retelling: revisiting the event story of the death, and introducing mindfulness and relaxation training when needed.
(2) A three-session block focused on revisiting the back story of the relationship to restore attachment security with the deceased (Neimeyer & Alves, 2016).
(3) A three-session block focused on restructuring the self after the loss, involving values clarification, and behavioural activation through aligning with those values.
In addition to this, an integration session takes place after each ayahuasca session, following the non-directive principles of restorative retelling to promote the integration of the psychedelic experience. These principles havebeen described in more detail in a previous case study (González et al., 2022).

Context of the case

Among those who volunteered for their therapeutic process to be recorded, in the experimental group of the trial, the participant's selection was not due to the exceptionality of her improvement. Rather, the first reason she was selected was the way in which she was representative of the demographic profile, and difficulties, of most of those who participated in the trial. This was especially the case regarding her age (middle-aged), type of loss (losing a parent), ethnicity (Spanish), and level of education (university-level education). The second reason was the severity of her grief, based on the baseline psychometric assessment and the clinical interview. The third and last reason was her reporting style: the participant had been in psychotherapy before, was significantly self-aware, and was talented at describing her emotional state and inner world in fine detail. Her case was selected for analysis after the first session was completed.

The participant volunteered the audio data being used for research purposes twice, when the therapeutic process started and ended, verbally and in writing. Additionally, she provided written informed consent for the publication of this paper. This was not a condition for her participation in the trial: she was aware she would receive the same intervention should she decline. She received no incentive for her participation: she volunteered to contribute to scientific research on grief therapies. Every potentially identifiable detail (e.g. names, places) presented in this paper, as well as some information about her life, were anonymised (or altered) in order to protect her anonymity.

Psychometric assessment

The participant completed a full psychometric assessment in three stages: pre-therapy, post-therapy, and at three-month follow-up. Grief severity was measured by two self-reporting questionnaires: the *Texas Revised Inventory of Grief* (TRIG, Faschingbauer, 1981; García et al., 2005) and the *Traumatic Grief Inventory Self-Report* (TGI-SR, Boelen, Djelantik, et al., 2018; Boelen, Lenferink, et al., 2018). Quality of life was measured through the *World Health Organisation Quality-of-Life Scale* (WHOQOL -BREF, Huerta et al., 2017) and post-traumatic growth through the *Posttraumatic Growth Inventory Short Form* (PTGI-SF, Castro et al., 2015). Finally, three processes of change were measured through the *Acceptance*

and Action Questionnaire (AAQ-II; Ruiz et al., 2013), a measure of psychological flexibility, the *Integration of Stressful Life Experiences Scale* (ISLES-SF, Holland, 2015), a short measure of meaning-making, and the *Self Clarity Scale* (Campbell et al., 1996), a measure of self-concept consistency and stability.

Qualitative analysis

All audio session data was transcribed, after which the verbatim transcription was checked against the audio files for accuracy. The analytic procedure followed the principles of McLeod and Balamoutsou (2001), a form of Qualitative Narrative Analysis (QNA) tailored to working with transcribed psychotherapeutic data. QNA is a 'bottom-up' approach to data that prioritises working with the whole narrative, constructing in-depth case studies rather than coding themes across narratives (McLeod & Balamoutsou, 1996, 2000; McLeod & Lynch, 2000). The QNA procedure can be subdivided into three phases once the analyst has been immersed in the text: (i) a preliminary phase focused on the identification of the core stories, stages and themes identified in the data, (ii) a micro-analytic phase involving the selection of key instances of the process, and their analysis focusing on the narrator's linguistic choices (i.e. the *way* the story is told) and their reliance on wider socio-cultural narratives, and (iii) a macro-analytic phase integrating it all into a coherent account of the data, linking it as well with existing theories and hypotheses. A more detailed outline of what the analysis involved is presented in Table 3.

Each session was analysed by one researcher (authors PS or DN) and reviewed by the other, to account for potential bias or omission. Key instances were analysed by both independently, and their analyses were then compared and collated. When arriving at Phase 3, the team met to exchange perspectives based on the analysis of every session, and to arrive at a collaborative interpretation. At a later stage, key quotes were translated into English (from the original Spanish) for the purpose of this paper, and each excerpt turned into stanzas to better illustrate the rhythm of what the participant said.

This analytical framework is also rooted in a narrative approach to the self (McLeod & Balamoutsou, 2006). Given the evidence pointing towards the therapeutic importance of a reconfiguration of the patient's sense of self in PAT, we posit that such change (i.e. the way the patient can redefine their identity and their past) has to be made sense of from their cultural worldview and from a reconstruction of their self-narrative (i.e. the stories we constantly tell about our lives, both to ourselves and to people around us). This is in line with phenomenological and narrative perspectives on PAT, but also with recent theorisation from anthropological (Dupuis, 2021a, 2021b) perspectives.

Epistemological grounding

Properly describing and explaining a whole psychedelic experience, through written text, may well be intrinsically impossible: because of the sense of ineffability that it usually involves, and because they are among the most meaningful and complex human experiences that exist (Huxley, 2004; Letheby, 2021). Consequently, we are not focusing on the content of the participant's psychedelic experiences in this paper: the emphasis is on their consequences in her life, and on the underlying processes that may help explain her recovery. Quantitative data is not presented as a supposedly objective way to capture this improvement, but as a form of

Table 3. A summary of the Qualitative Narrative Analysis (QNA) procedure developed by McLeod and Balamoutsou (2000, 2001).

Phase 1 *Preliminary analysis: Analysing the structure and meaning of each session as a whole*
1.1. Reading and immersion in the transcript.
1.1. Identification of the main stories narrated by the participant.
1.2. Identification of the core themes present in the narration.
1.3. Identification of the stages of the session.
1.3. Summary of the main themes, stages and stories.
Phase 2 *Micro-analysis of the most relevant therapeutic instances and processes*
2.1. Selecting the instances to be micro-analysed.
2.2. Separating the stories of the participant from the stories of the therapist and turning them to stanzas.
2.3. Identifying the main voices, or perspective-taking, focusing on the way in which the stories are told.
2.4. Identifying the figurative use of language, and the linguistic choices of the person, paying special attention to metaphorical figures.
2.5. Identifying the structure and the narrative progression of the story being told.
2.5 Identifying the macro-narratives present in the story, be they religious, interpersonal, political or cultural, and the way in which they are used.
Phase 3 *Systematisation and theoretical interpretation*
3.1 Comparative analysis of themes, stages, stories, and processes found.
3.2 Contrasting these themes and processes with the theories and hypothesis present in the literature.
3.3. Creation of hypotheses based on this coherent account of the data.
3.4. Construction of a summary representation.

triangulation: providing data on the treatment from the perspective of (a) the therapist, (b) the data obtained during each psychometric assessment, and (c) the interaction captured in the transcript of each session. We are grounding this mixed-method analysis in philosophical pragmatism: despite our effort to minimise and analyse the effect of our own premises and biases, this is still one among many potential analyses.

The fact that this paper primarily focuses on the psychotherapeutic intervention, and that it relies on a psychological methodology, should not hide the fact that what made this treatment possible was a long-standing tradition of ayahuasca healing in indigenous cultures (and religious communities). Much of our existing knowledge, in the field of PAT, can be traced back to ethnomedical knowledge in Amazonian and Central American cultures (Labate & Cavnar, 2021). A current point of contention in the field is how to ensure scientific research (and clinical practice) can (a) advance without neglecting traditional psychedelic use in a non-scientific context and (b) adapt to the patient's cultural context. Our intention to deepen our psychological understanding of PAT, therefore, is not an attempt to deny the importance of alternative religious or traditional practices.

Findings

Presenting the participant's story of the problem

Diana is a married woman in her thirties: she is an academic at a Spanish university. She lives with her partner, an artist. She underwent long-term psychotherapy in the past, and has some experience with psychedelic substances in a recreational context: this is what led her to seek help through participating in the trial.

When the first session takes place, through a video-call, she arrives feeling tense and guarded. When asked directly about her loss, she chokes up, explaining how she lost her father to cancer almost a year ago. Crying, she describes the 8-month period from the first diagnosis of her father's illness to his death. During that time, Diana saw him being progressively consumed by the illness, both physically and emotionally. He became depressed, paler, and thinner, until he died in a hospital room with her next to him.

The therapist then explores how Diana has been coping with her loss over the past month. She is overwhelmed by the intensity of her grief, and she is struggling to manage her sadness and anger. She is not sleeping well, plagued by memories and regret every night when going to bed. This level of emotional distress is new to her: she had never experienced clinically-significant psychological issues in the past. She described a certain oscillation in her emotional pain: phases of sadness (from a day to a week) in which she does not feel able to get out of bed in the morning, followed by phases in which she can feel paralysed by anxiety rather than sadness. In addition to the intense sorrow and longing she is experiencing, Diana is concerned by her constant preoccupation with the circumstances of the death: her repeated retelling, for example, of her father's last day at the hospital. She is also frequently troubled by unwelcome images of her father's physical and emotional decay. As a result of this, and her demotivation, she is struggling to continue working. She described her struggle with anxiety and demotivation in the following way:

> I experienced …
> an anxiety that I had never experienced before:
> it's paralyzing.
> I'm unable to dress myself,
> I'm unable to …
> I don't know, I go to the gym every day,
> which keeps me in a good mental state,
> but there are some days when I feel incapable of even going to the gym,
> putting on my workout clothes,
> or expressing myself.
> I'm usually good at that but, on those days,
> I struggle to speak
> or comprehend what others are saying to me. (S1, 501–508)[3]

Diana explained how much of her world was shattered by the death of her father. He was 'the rock' of the family, she said, and the existing underlying issues unravelled when he died: she is now distant from her mother. She lost a family member, but also 'a confidant': she would rely on him before making any significant decisions and would speak with him every day over the phone to discuss 'life, the state of the world, political ideas, academia'. She described their relationship in the following way:

> My father was like …
> he was my main figure […]
> He was my childhood:
> […] we had a very close relationship,
> too close perhaps.

He was the first person I would talk to when I woke up,
and I would talk to him many times a day.
We would share it all:
if there was a decision to be made,
or anything else,
I would discuss it with him before discussing it with my husband, or anyone else [. . .]
Yes, he was a joker and quite a philosophical person (S1, 262–297)

The conversation is often stopped, during this first session, to give her space when feeling overwhelmed, or when she is choked up by her need to cry. When asked about what she would like to achieve during the therapeutic process, she describes how she would like to change the way she is confronting her loss: to find a healthier perspective. She would like to understand that this is 'the circle of life' (S1, 880), and that 'it's normal that my father [. . .] died in his sixties, he was relatively young, but he lived his life fully' (884). There is this 'childish part of myself . . . like a little girl' (556–557), however, angry and lost because he is gone. She is afraid of her own helplessness, and of the suicidal ideation she is experiencing.

There are other thoughts as well that keep coming up, you know?
And there's the idea that life no longer makes sense.
That's an idea that I have at the back of my mind
right now [. . .]
Yes, there's a part [of me] . . .
I mean,
there's a part that feels completely unsupported,
as if I were a child whose hand had been let go,
abandoned,
and now I don't know how or where to . . .
and then, on the other hand, there's this unease,
the thought that everything is going wrong,
it's a feeling that everything is going wrong
and everything is heading toward destruction [. . .]
But the idea of dying, and going with him, it's there (S1, 611–722)

Based on the information collected during the initial session, and her scores on both self-reported grief measures, it was concluded that Diana met the criteria for a diagnosis of Prolonged Grief Disorder (PGD; World Health Organisation [WHO], 2019).

Summary of the therapeutic process

The assessment session was primarily focused on understanding her story and establishing a solid therapeutic relationship. The therapist explained to Diana how the following session would focus on the story of the loss, and was asked to choose a difficult memory to work on. Session 2 was difficult for her: she arrived at the session feeling very anxious and, given she had some previous experience with breathing techniques, a mindfulness exercise was introduced. Once she felt ready and emotionally stable, restorative retelling was then focused on a memory she classified as traumatic: her denial when seeing her

father becoming weaker, thinner and paler at his home, her refusal to accept the fact of his deterioration. During half of the session, the therapist helped Diana explore the sensory features of the memory with openness (what she saw, and heard), the feelings and sensations involved (sadness, fear, hope), and her own sense-making (her understanding at the time, and at the time of the session). This proved challenging for her, and very different to her usual preoccupation with the circumstances of the loss. A second mindfulness exercise was introduced towards the end of the exposure to help her feel more grounded. She later described her exhaustion after the session was over, and the nausea she experienced when anxiety was high mid-way through the session. She described feeling better the week after, however, once the fatigue passed: more present, more motivated. Restorative retelling resumed with another memory (i.e. her father's last day) during session 3, with a similar result. The end of the session was also dedicated to exploring how she felt about the upcoming ayahuasca session, and how to best prepare for the experience. The mindfulness exercises introduced during this phase (i.e. mindful breathing and mindfulness of the body) were often practiced during the rest of the therapeutic process, and were also part of the preparation for each ayahuasca session.

The first ayahuasca experience proved transformative for Diana, and the therapist and she worked together to identify what she had learnt in the psychedelic integration session. During the ayahuasca retreat, Diana described a letting go of her constant search for her father and, paradoxically, experiencing the relief in noticing her father's presence all around her. She connected this to a change in her bond to him, and with the world, which was partly a re-connection with a more spiritual view of the world. Diana experienced a dramatic improvement at this stage: her insomnia was resolved, as were the intrusive images she had been struggling with, and she began referring to 'sadness' and 'nostalgia' rather than to 'hopelessness' and 'anxiety'. Her psychedelic experience marked the beginning of the second phase of the therapeutic process: she revisited both the helpful and unhelpful features of the relationship with her father, and how they are still shaping her behaviour at the moment.

During the third and final phase of the process, Diana and her therapist focused on meaning-making. They discussed her future, what she would like to do with her life from now on, and what she would prefer to stop doing. They concretised what she learned during the psychedelic experience through values that could be followed in day-to-day life. The process ended with a week in which her last ayahuasca retreat was followed by a psychedelic integration session, and a therapy session focused on summarising her recovery. Her last psychedelic experience allowed her to deepen what she experienced after the first ayahuasca session: her transition from being paralysed with grief to feeling ready to appreciate and enjoy life. When the process ended, every symptom detailed in her presenting complaint had been resolved: she felt able to work again, with her usual passion and attention to detail, and found herself feeling hopeful, determined, and energetic.

Quantitative analysis of the psychometric outcomes

The participant's pre-, post-treatment and follow-up psychometric scores are presented in Table 4. Regarding outcome measures, the WHOQOL-BREF (a measure of quality of life) indicated a significant increase in the participant's psychological health, physical health, and social relating scores, and the PTGI-SF scores suggested the presence of post-traumatic

Table 4. Pre- and post-treatment psychometric scores.

Questionnaire	Outcome	Pre-treatment score 9m after the loss	Post-treatment score 12m after the loss	Follow-up score 15m after the loss
TRIG	*Grief severity*	55	22	20
TGI-SR	*Complicated grief severity*	70	20	26
PTGI-SF	*Post-traumatic growth*	14	43	44
WHOQOL-BREF	*Physical health*	20	35	27
	Psychological health	15	27	23
	Social relating	3	10	12
AAQ-II	*Psychological inflexibility*	33	7	7
ISLES	*Meaning-made*	8	30	30
	Comprehensibility	3	15	15
	Footing in the world	5	15	15
SCS	*Self-clarity*	21	48	60

growth. Before the process started, her TGI-SR score was clearly above the cut-off point (≥59 for PGD, Boelen, Djelantik, et al., 2018). As previously highlighted, these scores suggested that the ICD-11 criteria for PGD (World Health Organisation, 2019) were met, and that the only missing criteria for PGD as defined in the DSM-5-TR (American Psychiatric Association [APA], 2022) was the one-year timeframe. Caseness was no longer met when the process concluded, a year after the loss, and this was maintained at the 3-month follow-up.

On the more process-focused measures, her scores indicate a significant increase in psychological flexibility (as measured by the AAQ-II), adaptive meaning-making (or 'meaning-made', as measured by the ISLES), and self-clarity (as measured by the Self-Clarity Scale), all maintained (or even incremented) at follow-up.

Qualitative analysis of the session content

The following section focuses on a series of potential processes of change identified through QNA. All were spontaneously reported by the participant in session, and identified focusing on the stories and themes present in the transcribed session data. Some were identified through a micro-analysis of her linguistic choices, and metaphorical figures being used, or by the way her self-narrative began to change as the process evolved. They are all titled following the participants' own linguistic choices. Each process is presented contrasting the pre-treatment, unhelpful processes that were present versus the new, emerging processes that were key in her recovery (see Table 5). They are exemplified through transcribed instances in the therapeutic process, each identified by a code detailing the session and line number.

Table 5. Potential processes of change identified through a Qualitative Narrative Analysis (QNA) of the transcribed session data.

Unhelpful processes present before the treatment started	New processes of change emerging during the treatment process	#
Dichotomous view of the world	All is one	1
	Sewing together the opposites	2
Clinging to her father's material form	Letting go of her father . . .	3
	. . . and feeling his presence everywhere	4
The vicious cycle of self-demands	Letting herself be	5
	Stop: the beauty of now	6
Losing perspective	Observing herself from a different place	7
	Trusting life and herself	8

All is one

This process focuses on an insight that took place during the first ayahuasca session, and was explored in detail during the subsequent integration session. Diana described a sudden realisation that '*all things are connected*' (S4, 775) and '*all is one*' (S10, 154): a unity of nature, the dead and the living, and the universe. This realisation was experienced with joy and peace: '*all is well*' (40) and everything is developing according to '*a higher order*' (38). She relied on a metaphor to explain this sense of wholeness:

> . . . as if it all were an engine where everything is where it should be . . .
> and everything is aware of where it should be . . .
> and everything is perfect as it is. (S4, 585–587)

This is a higher order she can trust: she experienced a sense that she could now trust life and her own experience. Later in the process, Diana explained how the psychedelic experience helped her reconnect with a belief she had held at some point in the past, but that she had not held anymore. She did not connect this belief to any specific spiritual-religious tradition: she referred to a '*connection*', '*nature*', '*cosmos*' and '*life*' when describing it to her therapist. It cannot be clearly mapped, therefore, onto a concrete socio-cultural narrative. She experienced this realisation as a deep truth about existence, and with awe, but also as a concrete shift in the way she understood the relationship with her deceased father:

> I have to be more loving with people around me.
> My father is in all of them,
> but I also am in all of them,
> and because all is united
> life, and death, me, and my father [. . .]
> and everyone else in that room
> are one. (S4, 782–787)

Sewing together the opposites

During the same integration session, Diana mentioned a phrase that came to her during the experience as '*a mantra from I don't know where*': '*this is my opportunity to sew dichotomies together*' (S4, 730). This is a phrase she frequently returned to during the rest of the therapeutic process.

This distrust of a dichotomising way of understanding the world derives from her belief that '*all is one*' (S10, 154). She explained that she had previously seen life and death, herself, and other people, as divided by a clear boundary: as clearly opposed as black and white. She now realises, however, that these boundaries are '*liquid*', and that sticking to that black-and-white view of the world only led to suffering in her case. Diana is using this visual metaphor (liquid boundaries) to explain her insight that language (as a tool to understand the world) is inherently limited. Connecting these ideas, therefore, '*sewing*' together these opposites, is a way for her to preserve her realisation of an underlying interconnectedness of everything there is. Diana continued to insist on the need to separate her experience from her thinking during the rest of the therapeutic process, in order to avoid what she experienced as an over-abundance of mental activity.

Letting go of her father . . .

Two metaphorical figures were key in Diana's first psychedelic experience. The first one, 'sewing together the opposites', has been previously analysed as a process of change in itself. The second encapsulates a dramatic switch in her bond with her deceased father. She referred to the metaphor, a vision she had during the ayahuasca session, as 'the little girl clinging to her father':

> I see myself.
> I see myself, squatting, closed, and crying.
> I see myself trying to cling to . . . [my father]
> or search for . . . [my father]
> looking down like not wanting to see. (S4, 451–454)

Her vision was not connected to a past memory, but seemed to represent how she often felt since her father's death:

> For nine months I have been in . . .
> he's not here,
> he's not here [. . .]
> I want to call him,
> and he's not here,
> and he's not,
> and don't tell me that he is all of us,
> or that he's in the plants, or . . .
> I mean, I was angry.
> And clinging [to him]. (S4, 919–929)

Diana is describing in this fragment, therefore, a searching behaviour connected to despair: constantly searching and longing for her father, without fully realising it. This searching behaviour towards him, she realised during the ceremony, was just increasing her grief: 'suffering due to searching where there is nothing' (S4, 381). Once she realised, she was able to stop it. She described this 'letting go' the following way:

> I felt that
> it was time to let him go.
> I gave him permission to die.
> I'd already given it to him [permission to die] when we talked,
> but in reality, there was a part of me
> that didn't let him go (S4, 945–959)

. . . . and feeling his presence everywhere

What followed Diana's acceptance of the loss of her father was, paradoxically, that she felt him present in her life. This transformation in the accessibility of her father was clear in the way she moved on from narrating past stories of them to refer to him in the present tense. The reconstruction of this new bond of connection was related to the transcendent experience that was previously analysed: if '*all things are connected*' (S4, 775) and the boundaries between life and death, and ourselves and other people,

are more 'liquid' than she previously realised, then her father is still present somehow. Diana did not present this insight in the form of a rational argumentation, but as a sudden, intuitive discovery. It was triggered by feeling his presence (and a deep connection with him) during each ayahuasca session: she felt his presence in nature around her, and in other people that surrounded her. She laughed when observing her previous searching behaviour, naming it 'nonsense', and saw it as an obstacle getting in the way of her connection to her father:

> Well, one of the most fundamental things I understood,
> that came to me very quickly, was like . . .
> where am I looking for my father?
> If my father is already in everything.
> I mean, I am searching so I can find him again in his [old] form . . .
> my father is already in everything.
> I am working to find him again in his material form, his body.
> And it was like . . . he is not there anymore, but he is here.
> I felt that he is in me,
> that he is in you,
> that he is in every living being,
> that he is in the clouds,
> that he is in the breeze,
>
> that he is in the birds [. . .] [crying softly] (S4, 119–132)

This felt presence started an ongoing conversation with him, in her mind, that continued until the end of the treatment process. During the second ayahuasca session, Diana remembered a small stone owl that her father gave her when she was little. She saw an owl during her psychedelic experience, and decided to remember it as a symbolic image of everything her father taught her in life.

Letting herself be

During the mid-section of the therapeutic process, and relying on what she experienced during the first ayahuasca session, Diana became increasingly aware of the suffering that was arising from what she called '*the vicious cycle of self-demands*'. It started with her identifying what she described as '*a voice I can't turn off*' (S4, 640). She was referring to repetitive thoughts pushing her to be disciplined, to work hard, and to do everything perfectly '*as it should be*'.

> My self-demands to set a task for myself,
> to be disciplined,
> and to understand the rules of what I have to do,
> and for other people to explain the rules well to me,
> because if not I may do it badly.
> And at the same time I see how
> I fuck the experience of trying to enjoy something
> while trying not to [laugh] (S4, 619–629)

It was during the fifth session, however, that Diana crucially connected that voice to her father's attitude in life, and this led to a re-evaluation of their relationship. She explored her 'idealisation or obsession' (S5, 280) of her father, growing up, and how that led to him being 'too present in my life' (S5, 95) in her adulthood. She fondly remembered how generous, adventurous, and affectionate her father was, but increasingly spoke about his controlling, insisting and 'despotic' (S5, 307) side as well. She was anxious when describing her constant effort to obtain her father's approval growing up:

> I think there was a bit here of . . .
> well, of admiring him, because that's what I saw in him and what I liked
> in fact, I've done that ever since I was so little.
> But then I also think it was about wanting to have a conversation with him
> and wanting to be loved by him, or to adapt to his world.
> So it was like, well, if we have to talk about Tolstoy,
> just wait because tomorrow I'll read Tolstoy
> and then if we have to talk about something else . . .
> It's true that I found a lot of connection through that.
> I guess a part of that little girl adapted so he would see me. (S5, 284–294)

That is an implicit demand that she 'swallowed whole' (S5, 325), internalising her father's expectation of a hard-working, well-read, intellectual daughter. Suddenly, she realises that despite her paralysing sadness when her father died, there was also a certain sense of relief, and '*the freedom of being able to say I can do whatever I want*' (S5, 365). In this part of the therapeutic process, Diana is constructing a more complex and nuanced perspective her relationship with her father: she is able to describe him as an imperfect multi-faceted person. She can also separate her father's wishes from her own, and with that comes a sense of relief: she does not '*have to do anything*' (S6, 36) and, rather than asking the impossible of herself, she can let herself be.

Stop: the beauty of now

As the process continued, Diana became more aware (and more frustrated) with other behaviour that caused her to lose contact with the present moment. She reflected on how much time she spent analysing her own behaviour, and present life, or reminiscing about the past. She also resented the role that some of her intellectual tendencies played in this: '*all that understanding doesn't let me live*' (S10, 707), because:

> . . . if you're thinking about how you see beauty,
> or where beauty can be found,
> you've already lost it. (S10, 775–777)

Against that over-emphasis on mental activity, she described how freeing it was for her to experience being fully present during the psychedelic experiences, resting in nature and absorbing the world around her: '*the key was to breathe, just that*' (S10, 661). She also benefited from the formal mindfulness exercises that were part of the psychotherapeutic process and, towards the end of the process, she decided to find a group to continue practicing meditation.

There was a part of me that saw
how much importance I give in my life to understanding things,
to understanding what happened, retrospectively,
to understanding how other people experienced it . . . [. . .]
The greatness and beauty of 'now'
was far more powerful than to continue hooked
to understanding what was behind me.
Like kids playing, just getting on with it,
forgetting about what happened a second before. (S10, 322–339)

Observing herself from a different place

Diana often returned to the image of the little girl during the rest of the treatment process: a metaphor of her previous emotional state, dominated by sadness and hopelessness. When doing so, and observing it again, she increasingly emphasised a loss of perspective as key in that initial state of mind:

I have observed, like
I've seen myself visionless,
stuck in there,
afflicted,
crying and crying and,
how did I let myself get into that? (S6, 183–187)

In this fragment, Diana is narrating the story (the metaphor of the little girl) as if she were an external observer. She often relied on that new perspective from then onward: taking a step back, noticing what she is experiencing, and deciding what to do next. This perspective-taking gave her the opportunity to behave differently when facing distress, rather than immediately reacting to it. When spending a weekend at the beach towards the end of the treatment process, for example, Diana mentioned another moment when she saw herself 'as if from out there'. Rather than 'clinging' to her father, and the pain of loss, she decided to try and talk to him in her mind instead:

What happened at the beach is that, in that moment, I missed him.
When I started talking I thought, I would have been walking here with him,
I would have talked with him,
so I said, okay, talk then.
Instead of [getting stuck on], like, 'he is not here, he is not here', I said:
'Well, c'mon, why do you want to talk to him? Talk to him then'.
And then I started saying what I wanted to say.
So I was like re-channelling that nostalgia [. . .]
In fact, it was the first time that I consciously re-directed it.
And then I found my balance
in how I was about to get [lost] in clinging to him. (S6, 443–486)

Trusting life and herself

During the final part of the process, Diana started to re-construct her daily routine to make more space to be present, and 'in my body'. She was determined to return to practices she found useful in the past, but had given up, such as yoga. She felt ready, as well, to take on a new project at work she felt passionate about. This was not phrased as a project of discovery, but of re-connection with what was lost. In that process of re-connection, Diana felt able to trust herself 'and life' to find balance again. Some of this involved connecting what she explored during the treatment process with her previous experience in psychotherapy, and her past psychedelic experiences. Some involved reflecting on how to keep her worldview alive in the presence of challenges, stress, and emotional pain. Some relied on a more nuanced perspective on her relationship with her loved ones, and on establishing firmer boundaries when needed. Diana, at this stage, was relying on pre-existing resources emerging from her own process of self-care, and self-exploration. This trust in her own capacity to grow, and rely on herself, is also anchored upon an overarching trust in life:

> I have much more trust now, in life
> and, again,
> in that he is there in another form,
> and so also in myself. (S4, 68–70)

Discussion

This single case study explored the recovery process of a participant who completed a 9-session process of ayahuasca-assisted Meaning Reconstruction Therapy (MRT) for the prevention of complicated grief. When the initial assessment took place, her difficulties met the criteria for a diagnosis of Prolonged Grief Disorder (PGD, WHO, 2019). After completing the treatment process, case level scores were no longer met, and her recovery was maintained at the three-month follow-up. These changes were juxtaposed against a Qualitative Narrative Analysis (QNA) of session data and her scores on two self-reported grief measures (TGI-SR and TRIG). The QNA was aimed at capturing how this process of recovery developed, and how the participant made sense of her recovery. This section is then focused on connecting theory and practice: the participant's processes of change with the existing PAT theories and empirical evidence.

Meaning reconstruction

MRT, and therefore the trial's treatment protocol, focuses on re-constructing the worldview of the mourner, and their own self-narrative, in the absence of the deceased person. This is due to the significant body of evidence indicating how the grieving person's attempt to make sense of the loss can predict their adaptation to bereavement (Neimeyer, 2016; Neimeyer et al., 2006).

The processes identified through QNA, and the participant's ISLES psychometric scores, illustrate the participant's success in repairing her fractured view of the world. She started the therapeutic process struggling with hopelessness and despair: not finding sense in life without her father. The first psychedelic integration session, which took place after the

first ayahuasca session, marked the turning point when the participant started to construct a new narrative: a non-dualistic view of the world (and death as part of life) and of an underlying order that could be trusted. This is an aspect of her post-traumatic growth (Janoff-Bulman, 2014) which is further evidenced by her pre-post PTGI-SF scores.

This reconstruction was deeply intertwined with the ability to re-tell her self-narrative in a different way: a perspective from which she could increasingly trust her own capacity to change and self-care, and separate her own wishes from her family's wishes. This is congruent with existing evidence (Amada et al., 2020) and theorisation (Letheby, 2021) on changes in self-representation as a key mechanism of change: how psychedelic experiences can catalyse an adaptive reconstruction of the person's self-narratives.

This re-authoring of her narrative about herself and the world relied on mystical sources of meaning-making. Her transcendent experience of unity, which she encountered during the first ayahuasca session, was an essential part of this process of making sense of her loss: this is a finding that resonates with the existing evidence on the role of mystical (or peak) experiences in PAT (Bogenschutz et al., 2015; García-Romeu et al., 2014; Griffiths et al., 2016; Ross et al., 2016).

Continuing bond with the deceased

The QNA illustrated the way the continuing bond with the participant's deceased father emerged during the course of treatment. The first psychedelic experienced marked the inflection point: from then onward, a significant part of the therapeutic process was focused on exploring, refining, and maintaining an internal relationship with him. A key part of this initial psychedelic experience was what is frequently termed as a 'felt presence' of the deceased (Bennet & Bennet, 2000; Hayes & Leudar, 2016). Felt presences are common among the bereaved, and they are primarily experienced as welcome or beneficial (Kamp et al., 2020). Little is known about non-spontaneous felt presences, a phenomenon we began to analyse in our previous work (González et al., 2019; Sabucedo et al., 2020): the participant experienced it for the first time under the effect of ayahuasca, and then continued to experience it after the effect waned. This helped her recognise and abandon her constant searching behaviour, which only increased her sense of fear, despair and worry (i.e. an anxious attachment style). Instead, she started an internal conversation with him, explaining what was previously unsaid, and she found comfort and peace in it (i.e. a secure attachment). We posit, in sum, that feeling her father's presence initiated a process re-arrangement of what is frequently termed an internal representation (or schema) of the deceased (Shear & Shair, 2005). This meant developing a more nuanced appreciation of her past relationship with her father, of the effect it had on her, and of him as a whole person. This re-evaluation allowed her to restore a sense of attachment security, and became a secure base from where to redefine her own identity and values.

Psychological flexibility

Moving beyond the processes of change that are central to the theoretical corpus of MRT, there is clear evidence in the data of processes that are prioritised in other therapeutic modalities. Our previous work has explored psychological flexibility as a potential mechanism of change in PAT (González et al., 2021; Luoma et al., 2019). Although connected to a specific

treatment modality and to a branch of behaviour science, it likely that psychological flexibility is also indirectly targeted through other therapeutic modalities. ACT and MRT, moreover, share several principles and techniques, such as an emphasis on acceptance and meaning.

The participant's AAQ-II scores, a measure of psychological inflexibility, decreased substantially as the process developed, an improvement maintained at 3-month follow-up. In light of the QNA results, moreover, several of the identified processes of change can be mapped to the psychological flexibility model. This is not to say these qualitative processes can be reduced to psychological flexibility processes, but that they provide additional evidence of the participant's increase in psychological flexibility (as measured by the AAQ-II). First, because these qualitative processes are tied to the participant's context, and are too complex to be simplified to a theoretical construct. Second, because psychological flexibility is thought to be a unitary mediator, which is subdivided into six processes that are mutually intertwined. These mutual linkages are presented in Figure 1.

The overlap between different theories of change across modalities is clear, such as the importance placed on behavioural activation: whether termed as values clarification or meaning reconstruction, much of the later work in the process was focused on the participant engaging in meaningful action that was previously avoided or feared. Cognitive defusion,[4] however, can be a helpful construct to identify several ideas the participant expressed about the 'double-edged-sword-like nature' of language, and how this translated into a certain narrowing of her life experience.

An interesting contrast can be seen here between the different uses of the word 'acceptance' in the psychological literature. In MRT, the term is referring to an acceptance of the fact of the loss: one theme clearly explored how this could have been a factor in the participant's recovery. In ACT and the PFM, however, the term 'acceptance' is referring to a willingness to contact unwelcome internal experiences. The participant's experience is

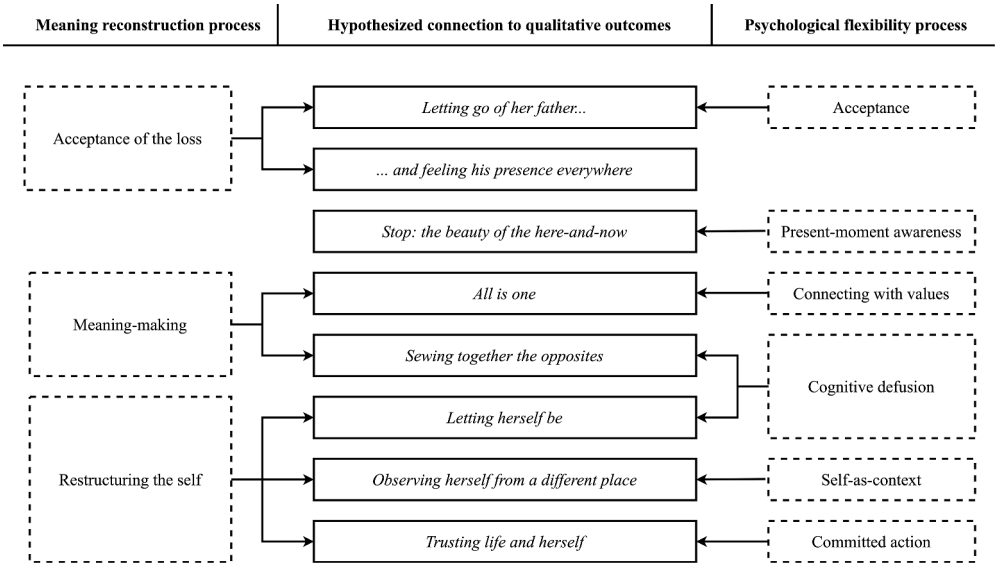

Figure 1. Potential linkages between the processes of change identified through qualitative analysis, based on transcribed session data, and the existing literature on PAT and grief.

a good example of the overlap between the two uses of the term: the acceptance of the fact of the loss involved a considerable degree of exposure to the distressing internal experiences the participant was struggling to contact (e.g. guilt, grief, anger), and this was targeted through restorative retelling and through her psychedelic experiences.

Reflections for research and practice

Clinical case studies are not aimed at establishing causality or providing generalisability. The fact that the participant was psychologically literate, and had a considerable capacity for self-awareness, is both a limitation and an advantage. Although this allowed for an in-depth analysis of her process of change, based on psychometric outcomes as well as on her own description, it is not representative of a usual client attending grief counselling. This is a wider issue in psychedelic research, as existing clinical studies have had to rely on highly motivated, psychedelic-experienced samples (Aday et al., 2022), and future research should focus on whether this intervention is effective for the general population, and whether an adaptation of the psychotherapeutic process is required. We hope to dedicate future work to exploring ayahuasca-assisted psychotherapy processes that were either challenging or unhelpful for the participant, in order to better understand how to maximise benefit and minimise risk.

Regarding the clinical evidence presented, the importance of meaning reconstruction and psychological flexibility in the participant's recovery are underlined by a different perspective on self. From a narrative viewpoint, we have explored how the participant's narratives of herself and the world changed during the treatment process. From a behavioural viewpoint, we have explored how this implied a distancing from her own thoughts and feelings, and a reorientation in life based on own-chosen values. Both hypotheses share a change on perspective-taking on the self, and what Letheby (2021) termed changes in self-representation. We hope to see future research and theorisation exploring the potential overlap between these theories, and their relevance for clinical work.

Notes

1. Although the earliest written evidence of ayahuasca use dates back to the sixteenth century, at the time of the Spanish conquest, some archaeological evidence indicates it could date back a millennium (Miller et al., 2019). Ayahuasca was practically unknown to Western cultures until a century ago, when it became the subject of the ethnographic work of Spruce, Villavicencio and Schultes (Grob, 2002; Schultes & Hofmann, 2001).
2. There is an ongoing debate regarding how to term complicated grief, how pathological grief is conceptualised in the DSM-5-TR (APA, 2022) and ICD-11 (WHO, 2019), and even whether such conceptualisation would be useful to bereaved people (Bandini, 2015). The term complicated grief is used here in a broad sense, not aligning with either psychiatric framework.
3. The line after each direct quote indicates the session when it took place (S) and the line number within that transcript.
4. Defusion is defined as 'making closer contact with verbal events as they really are, not merely as what they say they are' (Hayes et al., 2012, p. 244), that is, changing the way one is relating to thoughts (i.e. metacognitive change) instead of trying to change their actual content or frequency (i.e. cognitive change).

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No potential conflict of interest was reported by the author(s).

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Data availability statement

Data not available – participant consent. The participant of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data is not available.

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