

# Psychedelics: Podcast with Ira Byock



In this week's podcast, we talk with Dr. Ira Byock, a leading palliative care physician, author, and public advocate for improving care through the end of life.

Ira Byock wrote a provocative and compelling paper in the Journal of Pain and Symptom Management titled, "[Taking Psychedelics Seriously](#)."

In this podcast we challenge Ira Byock about the use of psychedelics for patients with serious and life-limiting illness. Guest host Josh Biddle (UCSF Palliative care fellow) asks, "Should clinicians who prescribe psychedelics try them first to understand what their patients are going through?" The answer is "yes" -- read or listen on for more!

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## TRANSCRIPT

**Eric:** Welcome to the GeriPal Podcast. This is Eric Widera.

**Alex:** This is Alex Smith.

**Eric:** Alex, I spy someone in our studio office.

**Alex:** We have a guest host with us. This is Josh Biddle, who is one of our palliative care fellows at UCF, who is graduating shortly. Welcome to being a guest host.

**Josh:** Thank you very much. Very excited. Love the podcast and happy to be here.

**Eric:** And we have somebody skyping in.

**Alex:** We have a distinguished guest, who is skyping in from southern California, who will be well-known to many of our listeners, maybe all. Ira Byock, who is a famous author, physician, advocate for better care. He's a founder and director and CMO of the Institute for Human Caring, and we're going to talk to him today about psychedelics.

**Eric:** Nice.

**Alex:** Welcome to the GeriPal Podcast, Ira.

**Ira:** It is a pleasure to be here, gentlemen. Really good to be with you.

**Eric:** I got to admit, Ira, I'm your number one fan. I'm such a fan of you that I'm going to nerd out on this podcast.

**Ira:** Thank you very much. I have a very small fan base, but I'm glad you're one of them.

**Eric:** We start every podcast with a song. Do you have a song request for Alex?

**Ira:** Absolutely. I would go with White Rabbit by Jefferson Airplane.

**Eric:** I don't need to ask why you're choosing that song, but Alex, can you give us a little bit?

**Alex:** I'll try.

**Alex:** [singing "White Rabbit"]

**Alex:** With my cold, that's the best I could do.

**Eric:** That song feels very apt for our discussion today on psychedelics. This came from a JPSM article titled ... What was the title? It was ...

**Ira:** "Taking Psychedelics Seriously"

**Eric:** "Taking Psychedelics Seriously." How did you get interested in this as a subject?

**Ira:** I'm a child of the '70s. I was a hippie in college, and had plenty of experience with the non-prescription of use psychedelics. Some of it, in your own town.

**Alex:** That's right.

**Ira:** Part of my association with White Rabbit is, it's a very San Francisco song. It was an obvious choice, by the way.

**Alex:** Who is Alice?

**Ira:** Alice is Alice in Wonderland.

**Alex:** Oh, okay. All right.

**Ira:** She goes down the rabbit hole, and has a transformative experience, where perspectives change a lot.

**Alex:** Right.

**Ira:** It's all very relevant. That song was about LSD, basically. It was about Alice in Wonderland, of course, as well. Anyway, I had experience with psychedelics, and it was genuinely transformative. We'll talk about this, but it was not a recreational drug experience by any means whatsoever. I knew early on, from the very first moments of the psychedelic experience that this was something else. It really, for me, and I think for many of the people who are associated with that whole hippie thing, this was more important and more profound than it appeared to the rest of the public, and probably the way it appears in retrospect. It was an important experience that I long understood would have potential therapeutic value, as it has for millennia, of course, in indigenous peoples around the world. Various types of psychedelics in various culture have been used for eons.

**Ira:** That period of time in my life came and went, partly because of the insights I had. I ended up in medical school, and being very interested in working with seriously ill people, whether it be in emergency medicine or critical care, or in what has become the field of palliative medicine. I was very aware of the research in the 1950s and '60s. At the time, if you were interested, you could find articles about this from time to time, in The Atlantic, or in Harper's, or in various other ... Look Magazine, I think. Look or Life did a big story about it. It was really fascinating that there was this psychiatric aspect to it, and it seemed to be au courant among some of the even literaté at the time, and their therapies.

**Ira:** Then, of course, with the mele of the sociopolitical turmoil, the Vietnam War, and Richard Nixon and his attorney general John Mitchell, and all those people, they understood that basically nobody who had a psychedelic experience was signing up to go to Vietnam and fight. Somehow there was some association between resistance and this drug. They demonized it and they made it a schedule one drug. We lost all of that research. Let me say one another editorial comment. Having had that perspective for years, I've been following the research as it has trickled out from some really intrepid researchers with a lot of tenacity and persistence, that were able to get approval, and some overseas research.

**Ira:** I've been struck by how that work, published work, in some mainstream journals, involving seriously ill and dying people with some frequency, totally was absent from the literature of our field, was never cited. It was if it never existed, which always seemed really odd to me. I'm finally going to answer your question, Eric. With a number of articles coming

out in The New Yorker and Harper's, new research from Johns Hopkins and UCLA Harvard, and NYU, I haven't been involved, I've been doing other things in medicine, but this is something I could contribute to the field of hospice and palliative medicine, by saying, "Look, there's people suffering. This stuff is actually real. It's really time to take this stuff seriously."

**Eric:** I really like your article, because it says take it seriously, which includes potential benefits, and also, there are potential risks associated with this. We should also have caution, as not just to jump headfirst into the deep or shallow end. I always forget which one.

**Ira:** No, this is really serious stuff. No question about it, these are potentially really dangerous drugs. They need to be used in a highly prepared, safe environment with people who know what they're doing. However, when they are used in a way that you are screening for people who are at higher than usual risk of having an adverse reaction, where you're actually preparing those people and guiding them through it, these drugs are very, very safe and quite profound. Yes, this is not something that people should take lightly. It's not a recreational drug by any means, but this is really serious medicine that can respond to significant needs that our field has, but frankly, more importantly, that the people, patients, and families we serve have.

**Eric:** How about maybe, we can take a step back, when we say psychedelics, what are we talking about here?

**Ira:** We're talking about things that were initially plant-based. Psilocybin and mushrooms, those sorts of things. There are a number of psychedelic chemicals in the environment, if you will, if you know how to look or where to look for them, I guess.

**Eric:** Mescaline and Peyote. DMT and Ayahuasca are probably the two other main ones.

**Ira:** Right. Yes. There's the toad skin. We won't get to that probably. Synthetically, the main one is LSD, which has an experience very similar to the psilocybin experience. A little longer in duration, but very similar.

**Alex:** Ecstasy or Molly?

**Ira:** Ecstasy or Molly, or MDMA, is somewhat similar. It's often talked about in the same category, but it is importantly different. It's actually categorized as an empathogen. There's more emotive, compassion, or empathetic parts to the experience, and you can see that also functional PET scans and the like. It lights up slightly different areas in the brain than the entheogens that induce, for lack of a better term, is called a mystical or a spiritual experience. Most of what we just mentioned, the LSD, psilocybin are the two that has gotten the most clinical attention, are in that pathway, if you will, or that category.

**Ira:** Kenamine is also sometimes mentioned in this regard, and has some similar properties when used at full dose, or higher than the doses that we use them for analgesic properties in our practice too.

**Alex:** Ira, I don't know if you find this distinction helpful, but sometimes people classify the classic psychedelics, like you said, psilocybin, LSD, Mescaline, TMT, as being the serotonin 2A receptor agonists, and other of the psychedelic related molecules, like MDMA releases serotonin. Other ones have different mechanisms. Some people group them in terms of the brain receptors that they target.

**Ira:** Yeah. We're getting into the weeds here, but yes, indeed.

**Eric:** I'm going to go away from the weeds. It sounds like the ones that give you trips are the LSDs and the psilocybins versus something like Ketamine or ecstasy, an MDMA.

**Ira:** MDMA came into availability in the illicit market later, and was, by the way, made illegal later, but it was different. Some of this stuff, including Ketamine, was actually available during the heyday of all of that stuff happening, a lot of it in your city.

**Alex:** A lot in this city.

**Eric:** Which one, when we look at the research base around this, what are people advocating for? Are they advocating for all of these or psilocybin?

**Ira:** What we're advocating for, just to be clear, is further research and the careful, supervised, screened, and prepared use of these agents. I'm very strict, probably haven't done it this afternoon, but just to use the term psychedelic assisted

therapies. These days, to get to your question, psilocybin is being used most consistently. There are MDMA studies as well for PTSD, particularly severe anxiety, some other things, autism, even, is being explored. For the patients dealing with the things that we're interested in, depression, severe anxiety, demoralization syndrome, things associated with facing the fact that your life is threatened, usually it's psilocybin. It previously, in the 1970s was mostly LSD.

**Alex:** These medications are proposed as second or third line treatments after usual first or second line treatments have failed. Is that right, or are they farther up? What I'm saying is, you might try methylphenidate first, cycled therapy, or counseling, and then if there's still an issue, then consider moving to psychedelics.

**Ira:** Yes. When we're dealing with people who have lost meaning and value, have a sense that life isn't worth living, I think one of the first therapies is in fact, a relationship with that person. Letting that person know their life does still have value. That's really a very powerful thing. This therapeutic relationship thing is not "woo-woo." It's real. Secondly, I think some of the counseling and the meaning making counselings, logo therapy, dignity therapy, outlook intervention, Karen Steinhauser's work, my own work about developmental stuff, is key, and really often helps people reframe what they're going through in a larger framework of their life, and all of a sudden, sometimes their life has meaning.

**Ira:** When people really are deep into that demoralized, "There is nothing. Things are over. I'd be better off dead." Before we decide that there's nothing left to offer them, they deserve to be offered a trial of psychedelic assisted therapies, because in some probably significant portion of people, they will achieve that reframing that makes whatever life they have left seem well worth living. People commonly speak to an enhanced sense of meaning, and intensity of life, moving closer to people that they love, all of that. At very least as a late stage therapy, and maybe in the process in the next 10 years we'll find that there is other, earlier roles for this, or situations in which we can predict that this has an important therapeutic role.

**Alex:** This could be achieved potentially with one six or eight hour supervised session.

**Ira:** I know that sounds too good to be true, but that typically is the case. Yes.

**Eric:** I got to say, it does sound a little ... I feel like in palliative care, we kind of jump on bandwagons quickly. We jumped on lidocaine. Like, "Oh, my God. Lidocaine." You don't hear much about lidocaine anymore. Ketamine, ketamine, ketamine. Ketamine's a great wonder drug. It's a miracle drug. It'll cure depression. They got the ketamine studies. I know it just got FDA approved, but if you look at the studies, it's great to have in your back pocket in a very specific population, but it's no wonder drug. It does make me wonder about ... Now we're jumping on a new miracle wonder drug. I know you're not saying that.

**Ira:** I'm not saying that at all. You're absolutely right. That paper that we were talking about opens by saying, "Please be cautious because these are highly vulnerable people."

**Eric:** Yeah. While certainly it would be great to have another tool in our pocket, having that pause that we do need further study and research before we jump into this, I feel like is really important. I think that was again, a great part of your paper. With that said, you also said for these people who are really in this demoralized state, do you think that there's a current role for providers to use this medicine? Are you saying, "Let's get some further research first"?

**Ira:** I would be saying let's get some further research first, but I want to be utterly honest here. First, I'm a fierce advocate for patients, but I also respect professional boundaries. If this was my mother or father, and they were demoralized and I had access to psilocybin, I'd be lying if I said, with my experience and being able to guide them, that I wouldn't consider them doing that. Particularly, and here's where I can even generalize, particularly personally, but we have seven states, including the state of California, where it's legally possible for physicians to write lethal prescriptions. If you look at the reasons why people are choosing to have lethal prescriptions and to hasten their own death, it is by and large feeling helpless and hopeless, feeling a burden, life is not worth living. This is exactly the sorts of experiences that these drugs have shown in pretty well done studies, that they can change dramatically.

**Alex:** Let me challenge you on that a little bit, Ira, because I think the studies primarily looked at treatment of anxiety or depression. Depression, number one, anxiety, maybe number two, as opposed to loss of sense of control, which is a number one reason that people often give for participating in physician aid in dying. Those are similar, but not the same, right?

**Ira:** I agree. If you also read the narratives of people who have gone through that, like the NYU group has published a series of long quotes from people who have gone through that, you'll see that what they're subjectively expressing is a reframing. That's my word, but a new sense of their life and perspective, and their current situation, in perspective of having inherent value moment to moment. You're right that these studies, largely, that they needed a pathologic

diagnosis. Here's a big limitation of these studies. You have to have a DSM five level of depression or anxiety, get into the newer studies.

**Alex:** Right.

**Ira:** However, a number of those people were terminally ill and were having that level of anxiety or depression in relation to their terminal illness. I would also say if you go back and read the Spring Groves studies from the '70s, Stanislav Grof studies or Eric Kast studies from Chicago, in those, although they were tracking depression, a lot of those people were simply terminally ill, and their level of mood disorder was related to the terminal illness. Again, the experiences were quite substantial.

**Eric:** We're going to go back to this. Eight hour session, significantly changing things that it's difficult to do with any other therapy or treatment. How does it actually work? What's the theoretical-

**Ira:** Let me just say, I can hear the skepticism in your voice, Eric. As I said in that paper, there's a difference between skepticism and cynicism. I applaud your skepticism. It's warranted. The cynicism, however, may keep us from looking at something that just happens to be damn near good. The six hour thing, how that changes perspective, here's an analogy. Let's say that you were Elon Musk or you were a friend of Elon Musk's, and he could take you to space for eight hours and deliver you home in a SpaceX. You go off and you spend eight hours looking at the world, watching it turn, seeing cycles of night and day, and you come back and say, "Holy heck. Things just look a lot different. I had no idea. I was stuck in my own little head with my assumptions about what's important, thinking about my career, and the mortgage, and wow. No. This is different." That's kind of what people experience.

**Ira:** It's not an intoxication. It is a new perspective that seems absolutely as legitimate. In retrospect, testing it is absolutely as legitimate as your current worldview. You just had your mind expanded. I know that sounds like '70s ...

**Eric:** I was with you until the end there.

**Eric / Alex:** [laughter]

**Alex:** I think that's a terrific argument. That's a much stronger argument to me than the, we have states who are legalizing physician aid in dying, and that we should have this in our own armamentarium. That we should do this because it has the potential to treat suffering, to treat depression, to treat demoralization, sense of hopelessness, loss of purpose, and that's an argument that appeals broadly to all folks regardless of your position on physician aid in dying.

**Ira:** Listen, I wasn't making a political statement, well, I was making a political statement but not in opposition to aid in dying. I was just simply saying that in those states, the Puritan notion that we shouldn't be offering these medications kind of falls short, because for the same exact indications you would offer this, they have a right to try.

**Alex:** In today's political climate, what can we do? What can our listeners do in order to advocate for the next step here of, research, changing laws? What do we do?

**Ira:** I would say this is not political. This is not one where the initiative has been taken up on one side or another, of the bipartisan or the partisan debates. I think what we need to advocate for is more research. Clearly, research is warranted. I think our listeners, if you're interested, frankly, read Michael Pollen's book, "How to Change Your Mind." He's done a really nice job. He's an investigative reporter, a very good journalist. Has written multiple bestselling books. He did his homework. He's such a skillful writer that he really lays out the history, the indigenous people stuff, what has happened in the history of the medical use and research, and what's happening. I know we didn't get to your question, but he even looks at some of the current research, and in pretty clear English, lays out some of the pharmacology and the neuroimaging and functional neurophysiology of what is importantly called the default mode network, which is sort of why we have assumptions, and why we go through the world so seamlessly, because we've already figured stuff out. That default mode network is actually the association of different neuro centers in the brain that kind of get relaxed on these medications for six or eight hours.

**Ira:** So you're figuring things out again. In a sense, the experience is, you're testing all those assumptions, kind of that all of a sudden I'm in space perspective, and "Wow. Things all of a sudden look differently. I'm not sure I think the same way."

**Eric:** I was actually listening to Michael Pollen. There's not as a good of a podcast as GeriPal, but some other people may have heard of Fresh Air [laughter].

**Alex:** I've heard of that one.

**Eric:** He was on Fresh Air. He must've not heard about our podcast [laughter].

**Alex:** I don't know why we didn't have him.

**Ira:** Yeah. Just yet.

**Eric:** Great podcast with him. He was talking about how as humans, the way we think about things is through stories. We know stories matter a lot. We get into the cycle of creating our own story, and that can kind of spiral down with negative stories about ourselves, about what's going on, about hopelessness, and that psilocybin and some of these other agents can actually help rewrite the stories that we tell ourselves. I may have had a bad trip last night, but does that sound right? Am I summarizing that right?

**Ira:** It's sort of one way of expressing their potential beneficial effects. You get to write your story again, or kind of reframe your story. I like that sense of reframing. Over the years, my counseling with people, that's where I've been most successful. You're not changing their situation. Their situation is what it is, and many times it kind of sucks, but if they can have a different perspective, their current lived experience just feels different. Yes, their narrative changes. Some of us talk about restoring the continuity of a person's narrative.

**Eric:** It also feels like a lot of current therapy is around that too. You're helping somebody redefine and get perspective over what's happening in their lives.

**Ira:** Yes. Exactly. That's why I think psychedelic assisted therapy must not remain in the realm solely of psychiatry, that in the context of full service palliative care, in the context of that relationship that is already addressing not only physical sources of discomfort, but the emotional social spiritual and helping people indeed, review their lives, create legacies, achieve some sense of meaning, that these are a potentially important expansion of our therapeutic capacities.

**Josh:** Ira, to that point, I remember at AAPM a couple months ago, Dr. Anthony Bossis from NYU, the psychologist that ran one of the recent control trials really said that he thought that palliative care was the house in which this research should live. I agree with you on that point. I had a question, maybe this is a little bit provocative. I really appreciate you talking about how important the relational aspect of the work is with our patients, and that really psychedelics are just a tool to enhance that relationship and do really hard therapeutic work for the patient. As we, as you said, advocate sending our patients off into space, do you think that providers have some ethical or moral responsibility to also go to space, so to speak, and so that they know what their patients are going through and can have a more empathic relationship to them?

**Eric:** It sounds like he's suggesting another GeriPal taste test, Alex.

**Josh:** I know GeriPal loves a taste test. Bringing that up here, yeah.

**Alex:** Bring the frog in next time.

**Ira:** It's the toad.

**Alex:** Oh, a toad.

**Ira:** Smoking the toad. Short answer is yes. Certainly if you're going to be a guide, I think under careful, prepared circumstances with serious intention, yes, that this would be an important part of the training, if you will. Just like psychiatrists or psychoanalysts used to have to go through psychoanalysis, and I think if psychiatrists don't go through therapy, that's a real problem in training, honestly. You have to have an experience of what this feels like. I think, in this regard, yeah, it would be highly beneficial.

**Alex:** Shifting gears again, getting back to the, what's it going to take to get this approved. FDA is the one who is in charge. That's the body that decides what schedule the medication is for the substances?

**Ira:** I think it's the FDA and the DEA.

**Josh:** The DEA schedules the drug.

**Alex:** DEA schedules. It's really the DEA that we need to bring pressure on. The DEA is a federal entity, so it's probably the current administration is appointing the head of DEA. However, if they had pressure from Congress it might help as

well.

**Ira:** I think we just need more research right now. Honestly, I think the research will be strong enough to erode the politics. I think if we don't screw this up this time, and don't jump too fast ... What happened last time -- even though I was personally a beneficiary of it -- was not good. This thing got out into the public and was misused. These are serious drugs that became in fact, this kind of recreational stuff, and some people were having phenomenal trips. It was like we created an epidemic of manic depression among people using this stuff. We don't want to do that. You really want to keep this tightly supervised and studied for the moment, but we need to move swiftly along those lines, because this puppy is not going to stay in its cage. It will be used elsewhere.

**Alex:** What's really going to change? How is this really going to happen? If the public clamors for it, yes, that would be one way. If there are drug companies, pharmaceutical manufacturers who stand to make a big profit from it, then maybe.

**Eric:** That's how ketamine got FDA approved. Basic ketamine that's \$1,000 a pop.

**Ira:** I worry about the absolute inverse of this one, because one dose, one treatment, or maybe once a year treatment with psilocybin for somebody with treatment resistant depression might alleviate their need for daily medications. What's the business case for that?

**Alex:** There may be more pushback. We've never asked our guests before, but Eric and I were talking about how we should do this. Do you have any conflicts of interest with regard to these medications?

**Eric:** Are you part of big psilocybin? [laughter]

**Ira:** I'm part of big mushroom. Yeah. [laughter]

**Eric:** Didn't Colorado ... I thought they also-

**Ira:** Denver decriminalized-

**Eric:** Denver decriminalized it.

**Ira:** Use of psilocybin. It looks like the state of Oregon may do so. They're going to qualify a citizen initiative.

**Eric:** I think the city of Oakland is voting on it this week.

**Ira:** Right. That raises the question that we all have to ask. Is this a great country or what?

**Eric:** If you had to think of the next trial that you would like to see happen, what would that be?

**Ira:** In full disclosure, and I don't want to talk about this in too much detail, but some of the aforementioned researchers and I are actually actively designing and interesting some academic centers on a multi-site trial, randomized control trial of full dose palliative care, outpatient palliative care for people over a few weeks at least, maybe five sessions, can be standard everything, but including some supportive counseling around life completion, legacy work, et cetera. Full service palliative care with an interposed psilocybin assisted session.

**Eric:** That's an eight-hour session led by ... Are they usually led by two therapists? Is that what I heard?

**Ira:** Think about six to eight led by ... Yes. Two therapists. These would be now not from the psychiatric community, but from the palliative care team. We would be training up people to sit with the patients. We wouldn't require entry criteria of having serious DSM five level depression, anxiety, demoralization. Basically, what we want to ask is, isn't dying enough?

**Eric:** Does the control group also get to hang out with those people for six to eight hours?

**Ira:** No. I want to keep this clean. At the moment, the design is, with and without. We track people with standard quality of life, depression scales, anxiety scales, demoralization scales, spiritual scales, and play this out. I think that's the study that needs to be done, frankly. I've long thought that. Some of our thought leaders in our field, I think, thankfully agree with me. To date, as hopeful and exciting as the studies have been, they have been based in psychiatry with significant, definable psychiatric pathology. I hate that term, but there it is.

**Eric:** Can I ask one another question? It may seem like a stupid ... How hard is it to actually get psilocybin for a research

study? Is this a huge uphill battle to try to do this study? Is there a mechanism?

**Ira:** We have to get FDA approval. The FDA has shown itself to be willing to do what's needed. Some of what we've talked about and the perspective of, we don't have a lot else to offer. The selective serotonin reuptake inhibitors, the methylphenidate. They're good. The SSRIs take a long time, and you have to recycle them, and blah, blah, blah. I do think there's a general impression that there's a backdrop of allowing people to end their lives.

**Eric:** There's a recent article on esketamine from the FDA, published in The New England Journal. It said the same thing. There are not many great alternatives for these treatment resistant depressive patients, and that's part of the reason they approved that drug, because there's really not much out there. I think you could probably make the same case here with psilocybin, depending on what the research says.

**Ira:** I don't know anything about the DEA, but I think the FDA is listening to reason. The other thing that we should mention, just for the listeners is, we haven't mentioned the right to try laws in 37 or 38 states. The expanded access provisions, and what is called compassionate use provisions of the FDA, where people can get access to pre-approved or unapproved medications, sometimes, if there's nothing left within the approval line to offer them, and they're facing the end of their lives. I think our patients kind of fit in that category. There's that, that has softened the regulatory environment to a certain extent.

**Alex:** That's a compelling argument.

**Eric:** Ira, is there anything else you'd like to talk about? We took a lot of your time. I learned a ton here. Any other thoughts before we go on to the last piece of White Rabbit?

**Ira:** Either White Rabbit, or the Grateful Dead maybe. I'm seeing Dead and Company at the Hollywood Bowl in a week.

**Alex:** Oh, nice. We are about 80 podcasts in, and no one has requested the Grateful Dead. We've suggested it to several people, but still, no one has requested Grateful Dead. I'm not quite prepared to do the Grateful Dead right now, so we'll do a little bit more White Rabbit.

**Ira:** There's some soulful stuff there that would fit. You can have me back, please, and I'll request the Dead.

**Alex:** Great. Thank you so much, Ira. This was wonderful.

**Eric:** Alex, do you want to play a little bit more, a snippet?

**Alex:** A little bit more.

**Alex:** [singing "White Rabbit"]

**Eric:** Ira, a very big thank you for joining us. Josh, also, a very big thank you, and to all of our listeners, thank you for joining us.

**Alex:** We'll see you next week. Go ahead, Ira.

**Ira:** I said this was really fun. Thanks, guys.

**Alex:** This was fun.

**Eric:** I had a good trip.

**Alex:** What a long, strange trip it's been. Thank you. Bye, folks.