

Between Science and Spirit: Rethinking Mental Health with Psychedelic Therapy

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Dr. Brian Anderson is a psychiatrist and assistant professor at the University of California, San Francisco School of Medicine. A founding investigator at the UC Berkeley Center for the Science of Psychedelics and the recipient of the UCSF Department of Psychiatry's Academic Award, Dr. Anderson seeks to improve health policy and generate research that will define the parameters of psychedelic use.

Learn about Dr. Anderson's latest clinical trial in palliative care, how he has used a multidisciplinary approach to treat patients' mental well-being, and what this experimental portion of the medical field needs to provide better care.



BSJ: As a physician and clinical researcher, how has your background in anthropology and ethnographic fieldwork informed your professional decisions?

BA: I am a physician and a psychiatrist on the faculty at UCSF. My academic background includes a master's in medical sociology, though in many ways, it felt more like a blend of anthropology and sociology. About 10 to 15 years ago, I was more deeply involved in ethnographic work, particularly with people who use drugs in both the context of addiction or traditional, ceremonial settings.

That training and learning opportunities have been foundational for me. Spending time in the community—listening, observing, and understanding how people live, how they speak, and how they make sense of the world—has shaped not only my research but also how I approach clinical care and team dynamics. Anthropology and the broader study of culture have really informed every aspect of how I think. It has been helpful for me to have both a scholarly background and my personal experiences.

Without that early ethnographic work, I might never have lived in Mexico City for 6 months, getting to know the local communities and how they navigate addiction and mental health care. I might not have gained as much from my semester abroad in Brazil during undergrad, where I really had the opportunity to understand the cultural relationships to plants and the use of ayahuasca in spiritual practice at a time when that was much less visible globally.

Now, I speak Spanish and Portuguese and can talk to my patients in those languages. I can provide clinical care to those who do not speak English well. I can not only be a better provider for them but also understand a little bit more about where they are coming

from. In mental health and psychiatry, you need to understand the person, not just treat their symptoms.

One of the main reasons we conducted the trial on psilocybin-assisted group therapy for long-term AIDS survivors was that, at the time, none of the modern clinical trials on psychedelic therapies had been done in a group setting. They all followed an individual treatment model: one participant working with guides, therapists, or facilitators. But to me, that never made sense. So often, these psychedelic substances, plant medicines, and sacraments are used in community contexts. The preparation and integration that happens within a community can be critical to healing, and the absence of that in the clinical trials and literature felt like a real gap.

Those experiences in the social sciences have been really helpful and actually continue to inform the work I do: how we deliver the care, how we anticipate what the aftercare might be, the follow-up, and the challenges that people go through. I collaborate with an anthropologist at the University of Notre Dame, and we have a study looking at spirituality and secularism amongst Americans today seeking transcendent or spiritual experiences through psychedelic care. These collaborations keep my work grounded, and for me, they make the work feel more meaningful and dynamic.

BSJ: Your research suggests that psilocybin-induced neuroplasticity may underline the observed reduction in attachment anxiety. Could you elaborate on how psilocybin can induce flexibility in stable brain networks? What broader implications might this have for treating other psychiatric disorders characterized by entrenched brain patterns?

BA : There is a whole literature there, and more data and studies to point to. More generally, I think one of the big hopes with psychedelic medicine and mental health is that these compounds, the psychedelics, can be used to help fix brain networks or patterns of brain activity—to sort of be modulated or adjusted, even if they have been set for quite some time. That is a fundamental reason why behavior can change. Why people's symptoms or emotional repertoires, their thought styles and thought patterns, shift, which is what people often report after a supported, high-dose psychedelic experience.

It is one thing to look at someone's mood—how they feel, how often they feel sad, guilty, dysphoric, or have a lack of enjoyment in their life. Is that a fixed state they are in? Can you shift their emotional status quo by going through a psychedelic experience that is supported and safely done, and allow them to access new emotions, engage with emotions in a new way, or acquire a different perspective on life, and hence, start to feel differently about their situation, past, or future?

In that study, we looked at attachment because that is something we think is critical in mental health care, particularly in psychotherapy. One's experience of connecting with others and being cared for is very predictive of future mental health and how one functions. In particular, administering psychedelics in a group or communal setting, where there is an opportunity to bond not just with one's therapist but also with the other members of the group undergoing care, was something we wanted to start to explore.

Our study was a pilot study. It was an open-label study, meaning there was no blinding to the treatment people were receiving, and there was no control. We were not comparing this to group therapy alone, or a different dose of the drug or placebo. We were wondering: can people connect with each other in a different way, and might that actually be an important impetus for, or mechanism of, improvements in mental health symptoms?

If you look at all the work that has been happening since—including at Berkeley, where Gül Dölen studies connection and how psychedelics seem to affect plasticity in our nervous systems in a way that allows us to engage with our setting or context in a different way—you will see that if we can amplify the way positive things come in, or the way we can learn from the environment around us, hopefully that is a real mechanism for change that improves people's lives.

BSJ : You observed that participants with higher attachment anxiety tended to report more intense mystical-type experiences in response to psilocybin, while those with higher attachment avoidance had more challenging experiences. Why do you think these differences arise, and how might attachment shape the quality or depth of a psychedelic experience?

BA : Thanks for pointing that out. I want to emphasize that this was a pilot study, and even the correlations we found were pretty exploratory. The main outcome of the study was really focused on safety and feasibility. Looking at these secondary or tertiary outcomes and the correlations between them gave us some preliminary data to suggest hypotheses we might test in future work. I think we can use these findings to start asking good questions, even if it is too early to draw strong conclusions.

It was interesting to see that people with higher attachment avoidance—meaning they often find it challenging to connect closely with others—might have a harder time with psychedelic therapy. In a short amount of time, you have to build trust and rapport with

facilitators or therapists, and during a sensitive, vulnerable state, you need to rely on them for support. If someone has difficulty with close relationships, it is easy to imagine how that could make the experience more challenging. If this preliminary signal holds up in future studies or aligns with what others in the field are seeing, it might give us a tool to predict who could have a harder time during a psychedelic experience.

That said, we were working with a specific population—many participants had significant trauma exposure, and we selected for that. We also used a relatively high dose of psilocybin, so outcomes might look different with MDMA, LSD, or other treatments.

It was also notable that people with higher attachment anxiety, who strongly seek closeness even though it can be difficult for them, seemed to have a different response. There might be something about their background that allows them to embrace a more transcendent feeling of being connected to others and their surroundings. That trait could help them enter the psychedelic state in a way that allows for different types of therapeutic work, which some studies suggest correlates with symptom improvement.

Again, I would emphasize that this data is very preliminary. But I hope that people continue thinking about attachment and therapeutic alliance as important factors. For instance, the psilocybin for major depressive disorder study out of Johns Hopkins also found that therapeutic alliance was predictive of outcomes, which we would expect, given its importance in many psychotherapies. I am hopeful that future research will keep exploring this and see if attachment style might be a real predictor we could use to help guide treatment.

BSJ : Going into the next study, The Pragmatic Trial of Psilocybin Therapy in Palliative Care, how does the psilocybin therapy trial reflect or challenge the concept of medicalization in end-of-life care? Does using psilocybin pathologize existential distress, or offer a way to depathologize it?

BA : Existential distress is a very common human experience. There is no diagnostic code that I am aware of that people bill for in allopathic medical care. It is something that we see a lot, certainly in psychotherapy, and so to the extent that we address and treat it in talk therapy, is that medicalization, or making it a clinical concern? It can be.

Demoralization is a syndrome that is a type of existential distress; it is what we have studied in a few of our trials with psychedelic medicines for people with serious medical illnesses and more. A number of other studies are looking at how demoralization specifically responds to psychedelic therapy. Demoralization, you know, is not a diagnostic code in the DSM—what the American Psychiatric Association publishes as our book of diagnostic codes that we use for billing in mental health care. Still, you can bill for it because it is a code in the ICD-10, the International Classification of Diseases, that we sometimes use for billing.

Bottom line is, there has been a pretty rich and interesting debate. When people have existential distress, including demoralization, which is a syndrome of poor coping and a sense of hopelessness, helplessness, and a loss of meaning and purpose in life, should that be medicalized? Is that normal? Is that something we should treat, or is it bad to make it a pathology that we engage with allopathic care?

The debate, I think, is pretty similar to grief. We have a diagnostic code for prolonged bereavement disorder. Grief is something that probably every human will experience at some point. There has been a lot of concern about not pathologizing regular human experiences. The research consensus in the development of the diagnostic entity

of prolonged bereavement disorder is that if your grief is causing you suffering and impairment, and extends for more than 12 months, at that point, it does merit clinical treatment. Let's not just call it normal and say people should continue to suffer with that.

There might be an equivalent treatment response for existential distress. I would say that whether or not demoralization is something that your clinician will bill insurance for, people can really suffer from a loss of meaning and purpose. If there is a way to do clinical care to address the needs of demoralized people, I think that is a good thing.

Additionally, it is powerful and helpful to bring in elements of professional spiritual care. To merge mental health care and medical knowledge and ensure that things are done safely, while including spiritual care, which has a kind of unique set of competencies—I am talking about chaplaincy—that address existential and spiritual needs with its own literature and its own training forms, such is complementary to conventional mental health care.

Taking on the responsibility of giving people psychedelic substances can sometimes lead to profound spiritual or transcendent experiences. It is critical to provide adequate care informed by real expertise on how to support people through those experiences.

BSJ: Your multidisciplinary approach to healthcare is something that the public needs more of. Currently, you are conducting phase II of the Pragmatic Trial of Psilocybin Therapy in Palliative Care trial. Can you explain the process of phases I-IV in this study, and what will happen once the clinical trial ends?

BA: This trial is a phase II trial, but the trial itself does not have different phases. When we talk about a trial of an intervention, be it with a medication or a behavioral intervention, you can think of it being in a couple of different phases.

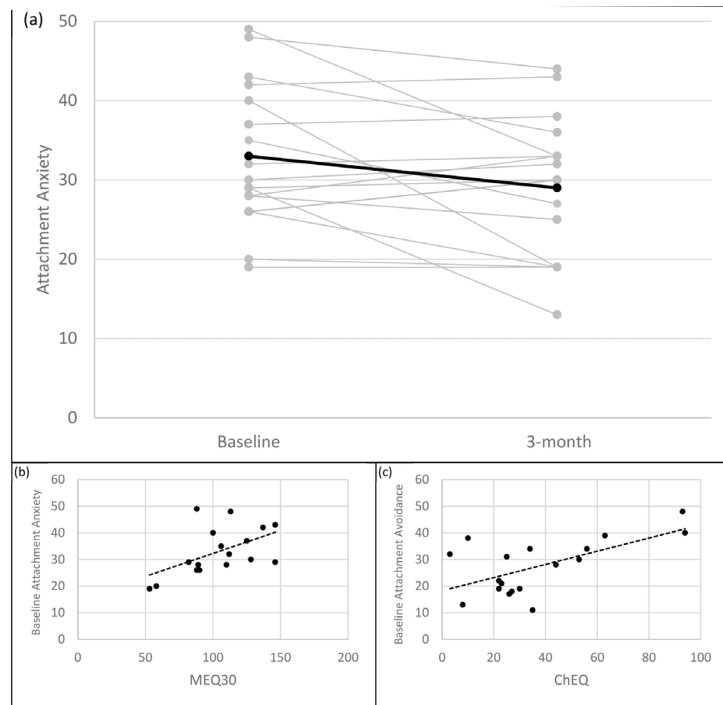


Figure (a). Measure of attachment in intimate relationships (ECR-M16) subscale for attachment anxiety at baseline and 3-month follow-up. The bold line is average attachment anxiety.
 Figure (b). y-axis measures Baseline ECR-M16 attachment anxiety; x-axis records Mystical Experience Questionnaire (MEQ30) scores
 Figure (c). Y-axis measures Baseline ECR-M16 attachment avoidance; x-axis records Challenging Experience Questionnaire (ChEQ) scores.

Phase I is the first time that you try something—maybe it is the first time you are going to use an experimental compound in a human, or you are researching the safety and feasibility of administering an intervention. Phase II is the first time you study the appropriate dose of a medication or a known treatment in a new clinical population. Phase III is more like a pivotal trial: a pharmaceutical study or behavioral intervention that could lead to a change in practice. Studies like this have increased size and quality control so that when the FDA looks to allow a drug company to distribute a drug in the interstate market of medical goods, the data holds integrity. Phase IV comes after approval, and the study involves a drug in use that is not completely understood.

Our trial, The Pragmatic Trial of Psilocybin Therapy in Palliative Care, is a phase II study. We are not a drug company. We are academic investigators studying how to do this in case these drugs are available more in the future, or to inform how we can study these interventions, particularly with patients with psychological distress and life-limiting medical illnesses. This is somewhat of a bigger study compared to academic and psychedelic medicine trials, but not like the industry trials. We are trying to understand new things without necessarily trying to change how people practice medical care, because we are not going to receive FDA approval for psilocybin based on the results of our study.

BSJ: Across UCSE, the Lundquist institution, and Sunstone therapies, have you or your colleagues found any connections between psilocybin, ketamine, and demoralization amongst terminally ill patients?

BA: In this trial, the recruitment is ongoing. Some of the sites are still just starting their participant recruitment, so we do not have any results to report so far from the trial. The design of the study is informed by a careful analysis of how patients with serious medical illness have sometimes shown a rather pronounced response to psilocybin therapy. Based off of those initial findings, initially out of NYU, the pilot data for anxiety and cancer that came out of UCLA, our psilocybin group therapy study out of UCSE, and some data that I do not think is yet published—we will see some data soon coming from single site trials on the East Coast and elsewhere—the ability of patients in small, open label or controlled trials to report purpose in life and less distress after psilocybin therapy, is unlike what we have seen in other parts of our field. Our talk therapies—including those specialized for existential distress—do not have that large of an impact in our recent data, and the medications we have do not seem to help as much either.

In our trial, we use oral ketamine as a control drug because it has psychoactive effects. Our goal is that it addresses issues of unblinding; for example, if you give someone a placebo who knows they could have been given a placebo instead of a psychedelic, they will likely guess what they have received. Hopefully, our use of ketamine as a control impedes the deduction of the kind of drug someone has received in treatment.

We hypothesize that the effect of the psychedelic psilocybin will significantly outlast the benefit that people receive from ketamine, which also has psychedelic-like effects, but is a different class of drug. I hope to tell you guys more about the results when we can share them.

BSJ: We look forward to it. Given your research and background in health policy, you have advocated for a “psychedelic safety net”. Concerning your position as an educator, researcher, and

physician, do you expect your approach and applications to science to change given the current relationship between healthcare and government support? If so, how?

BA: The most helpful comments I can make about research, the current situation with the federal government regarding health, public health, and funding for research, and psychedelics, are to focus locally, given that there is action at the federal level.

I have been encouraged to see legislators and advocates in the state of California try to find a policy that makes psychedelics safe and accessible. In our state, we had two bills to decriminalize psychedelics, neither of which became law. There was a bill last year to create a state-regulated system through which licensed personnel or certified personnel by the state could administer psychedelics procured from state-registered manufacturers; in this case, probably psilocybin mushrooms. Right now, there is a bill in Sacramento—it is currently in the state senate—that would support more research happening in California that is FDA regulated: federally approved clinical trials with academic investigators partnering with community organizations, to do trials of psilocybin therapy that are meant to reflect the needs and the situations of the everyday Californian who might seek out the care this bill is currently focused on. This bill is currently focused on—if it becomes law—working with veterans and inactive first responders, like police and firefighters, who would undergo therapy for suicide in the setting. There are a lot of opportunities for those of us in academics and advocacy to help shape policy.

My hope is that whatever access there is, there will always be care and thought put into how to make psychedelic use as safe as possible. That may involve social structures we do not have.

You know, part of something I have seen in my research—not just in clinical trials but out in communities observing how people use psychedelics in non medical settings—is that there takes a certain level of expertise if people are going to be doing higher-dose psychedelic work for therapeutic purposes, healing, or spiritual practice. In intensive, higher-dose psychedelic work, you want people who know what they are doing, who have experience, who ideally have received some type of training or supervision, and have a real dedication to making sure that people are cared for as best as they can be.

People with that expertise might not be everywhere in California. So, how do you make expertise more available? How do you make our state grow in ways that people who want psychedelic experiences can access them safely? We should study that. We should teach people about that. We should do public education for harm reduction because many people will have these experiences outside of medical and professional settings. That is something our research should be informing, and we should apply that to the public good and public health in ways that some of my colleagues, including at UC Berkeley, are well-positioned to do.

BSJ: As the interest in psychedelic-assisted therapy grows, how do you see treatments being integrated into different forms of care? What is needed for psychedelic therapy to be more widely adopted across healthcare settings?

BA: A major step forward would be creating legal pathways to access psychedelics. We are talking about broader access for clinical treatment, not just for research participants. In current healthcare settings, ketamine is the only widely available drug for medication-induced psychedelic experiences, since it is prescribable in America.

One of the most important things is finding ways to expand the recognition of how professional spiritual care providers can and should be integrated into interdisciplinary teams providing psychedelic treatment. If we are moving toward offering psychedelic medicine more widely in patient care, I hope that includes people with the training and background to respond to the kinds of spiritual questions and spiritual distress that can come up. These are sometimes deeply transformational and transcendent experiences that are very different from most mental health treatments today.

People are working hard to improve insurance access and ensure treatments are offered equitably, especially in ways that address historical harms and barriers to care. Training programs for clinicians are also critical, and there has been a lot of progress with that in California.

However, at the core, we need to stay focused on what it is like for patients to undergo these treatments. What kind of care do they say would help them? Often, that comes down to being able to connect with a therapist or facilitator they truly trust and identify with. This means we need to expand the diversity of the workforce offering this care, and it means creating ways for people to connect with others.

People often leave psychedelic treatments with very powerful, positive experiences and feel the need to share that with others. But if you are talking to people who have not had those kinds of experiences, it can be hard to put into words. On the other hand, when things do not go well, it is just as important to have a broader sense of what psychedelic experiences can look like. Meeting others, hearing different stories, and connecting in a community helps build that reference point. It can also introduce new ways of coping, adapting, and integrating those experiences in a healthy, meaningful way.

For many people, these experiences are not just psychological, they are spiritual. It triggers questions and reflection about beliefs not considered before. For someone who has never thought much about spirituality, that can be disorienting. Navigating that with a clinician who does not have the tools or framework to engage with that can be a real challenge. Integrating spiritual competencies into conventional health care, alongside peer support and group-based models, is important to make this kind of care comprehensive.

BSJ: Psychedelic therapies continue to face stigma in both medical communities and the general public. From your perspective, what are the most effective ways to help shift perceptions and build trust in these treatments moving forward?

BA: What tends to shift people's perspectives is exposure, either through personal experience or seeing someone they trust have a positive experience. Honestly, there is still a lot we do not know, both in the public and within the medical community. If we want to change public perception, the first step is to help people understand what these substances actually are. That might not change everyone's minds, but at least they will be better informed.

This entire class of substances has been largely absent from mainstream medical and scientific conversations for decades. It was not until about 10 years ago that research on psychedelics started to re-enter the public and academic space in a meaningful way. There is still a significant knowledge gap among healthcare providers and biomedical scientists about what these compounds even do. Things are improving, but for a long time, conventional medicine was very negligent in engaging with psychedelics. This is particularly frustrating given that we regularly prescribe and study other

substances with known risks, like opioids and stimulants, while for years, we could not even touch psychedelics in research.

People should have more access to information, but ultimately, they will make their own decisions. I think that what matters most is when people see someone close to them, someone they love or trust, benefit from this kind of care. That has the potential to shift views more than any study or article ever could. If research continues to show positive outcomes, or if policy changes, like state-regulated access or decriminalization, then people may start to hear friends or family say, “That was actually really helpful.”

Of course, not all experiences are positive. Negative stories will shape perceptions, too. So it is not just about doing more, it is about doing it well. We need to make sure that good outcomes are accessible and that people are supported. To do that, we need more than just academic research.

We need people—clinicians, researchers, community members—to spend time with these substances and experiences to understand, both professionally and personally, how they can be used, when they should not be used, and how to support people through them in meaningful ways.

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