Breaking the Mold: Reflecting on Our Experiences in Same-Gender Therapist Teams with MDMA-Assisted Psychotherapy

ANNE WAGNER, PH.D., C.PSYCH.
ANNIE MITHOEFER, BSN
CANDICE MONSON, PH.D., C.PSYCH.

What started for us as a pragmatic decision to have same-gender therapist teams in our pilot study of MDMA-assisted Cognitive-Behavioral Conjoint Therapy (CBCT) for posttraumatic stress disorder (PTSD) has now resulted in a larger discussion of the need for mixed gender therapists in providing MDMA-assisted psychotherapy. We contend that, for philosophical, theoretical, and scientific reasons, it is important to question this precedence in psychedelic research. The issue of gender in this line of research is an important one, from many different angles, and we are pleased to bring these issues to the forefront of research and practice.

Historically, the majority of clinical studies of psychedelic-assisted psychotherapy have used male-female co-therapist teams to support people through their psychedelic experience. This tradition flowed largely from the influence of Stanislav and Christina Grof, Bill Richards, George Greer, Requa Tolbert, and other early psychedelic researchers and practitioners. Much of the reasoning for this practice in more recent clinical trials has been that for many people, especially those with a history of sexual abuse, having a male-female co-therapy team can add to the participant’s sense of safety; however, this is based on assumptions about gender that do not apply for many people. In addition, from the Jungian perspective, the experience of a non-ordinary state of consciousness could elicit strong autobiographical, as well as more universal experiences, of the mother and father. This perspective holds that having a male-female co-therapist team facilitates these experiences by having the therapists symbolically represent the mother and father roles, with the potential of having new, corrective, positive, and supportive interactions with these archetypes.

We question these positions on sociopolitical and theoretical grounds. Philosophically, they inherently assume gender is a reality as opposed to a social construct, and privilege a heteronormative and essentialist male/female parental experience. In reality, therapists can elicit a wide range of reactions from clients due to their individual per-
sonality characteristics, alongside their age, ethnicity, nationality, perceived level of experience, and many other characteristics, in addition to their gender. We believe that to choose co-therapist teams based on their genders unnecessarily emphasizes this particular set of stereotypes. Our team provided a therapy grounded in cognitive-behavioral theory, which does not assume a universal archetype of stereotypical mother-father roles.

Also inherent in our philosophical stance (from an anti-oppressive perspective) is that we want to be embracing of all gender identities, including transgender and non-binary identities, by setting a precedent both for other therapy teams and for clients. Specifically requiring a male-female co-therapist team inadvertently excludes non-binary or transgender therapists, as well as separating out the experience of clients who do not identify as cis-gender.

Our pilot study combining CBCT, an empirically-supported protocol for PTSD that demonstrates strong evidence for both decreases in PTSD symptoms and improvements in relationship satisfaction, with MDMA included four therapists. Two of us were experts in MDMA-assisted psychotherapy (Annie Mithoefer and Michael Mithoefer), and two of us were experts in CBCT (Candice Monson and Anne Wagner). In our work, we privileged expertise in the two interventions in determining the therapist teams. There was always one therapist per team who was an expert in MDMA, and one expert in CBCT. It happened to be that both of our CBCT experts were female. We encountered no issues in having female-female co-therapist teams; rather, what participants appeared to be interested in (from comments and conversation) was the respective expertise of each of the therapists, and participants would often ask each of us about either MDMA work or CBCT.

Scientifically, we do not yet know the impact of having male-female, same-gender, or multi-gender co-therapist teams. To our knowledge, there have not yet been same-gender therapist teams in psychedelic-assisted psychotherapy studies prior to ours. Thus, we do not have evidence that they are not as effective, or that male-female co-therapist teams are preferred. We do not yet have empirical data to test this assumption. Rather, going forward, it would be ideal to have a variety of different therapist pairings, or even solo therapists, to determine the comparative effect of having different therapist team constellations. Having a choice of therapist team would also be useful and important to explore, since clients often have preferences for therapist gender (as evidenced by clients in private practice actively seeking out and requesting therapists of a particular gender). We also do not know, however, the impact of having a therapist of a gender that does not match your initial preference—it is possible that this could be hindering to the therapeutic process, or useful, by giving opportunity to work through dynamics with the therapist.

We see gender as only one factor to consider in forming therapy teams, and in our experience with this pilot study, it did not appear to influence outcomes, nor did clients have any objection to having same-gender therapist teams.

Going forward, our next study, which will combine Cognitive Processing Therapy, an individual, evidence-based therapy for PTSD, with MDMA, also will not require male-female co-therapist teams. In order to make psychedelic psychotherapy accessible to more people, having a requirement of male-female teams may limit the opportunities people have by limiting who can provide treatment, and does not capture the lived experiences of many people who may inadvertently not be included in this process (e.g., gender non-binary therapists).

Although the utility of working through family-of-origin archetypes in different treatment models should not be dismissed, we do not actually know if it is the gender of the therapists that elicits these archetypes, or rather other therapist characteristics, which anyone could hold. For example, a father figure for a given client may be quiet and warm, and a mother figure louder and brusque, or vice versa. If we are assuming the usefulness of a male-female co-therapist team for what they potentially elicit, we should actually be testing what they do indeed elicit, gender notwithstanding.

In an era where women are increasing in leadership roles within psychedelics, as well as being the majority of practicing therapists in many areas of the world, it is important to examine how a gendered lens of psychology, psychiatry, and the therapeutic professions may have created our understandings and the teachings of the past, and to approach these assumptions now with curiosity. An open-minded perspective, that can be tested empirically, can help us support our clients in the best way possible today.

On a personal note, the three of us have each been able to work as co-therapists together over the years, and in this particular study, Anne and Annie were paired together, as were Candice and Annie, and both Anne and Candice also saw cases with Michael Mithoefer, the fourth member of the study investigator team. We each had incredible learning experiences from our co-therapists, developed excellent rapport with our clients, and helped the clients move toward healing. In our opinion,
the greatest differences were in our different backgrounds of expertise, not in our genders, and we found that working together was incredibly useful, enriching and productive. We hope to demonstrate that working in same-gender or multi-gender teams can yield results, and offers new opportunities for bringing different backgrounds of expertise and therapeutic minds together. We encourage others to consider this approach going forward, which involves questioning assumptions: a fitting perspective when working with psychadelics.

Dr. Anne Wagner, C.Psych., is a clinical psychologist and researcher who is committed to helping understand and improve trauma recovery. She is the founder of Remedy, a mental health innovation community. She is an Adjunct Professor in the Department of Psychology and an Associate Member of the Yeates School of Graduate Studies at Ryerson University, in Toronto, Canada. She completed a Canadian Institutes of Health Research Postdoctoral Fellowship at Ryerson University. She is the Chair of the Traumatic Stress Section of the Canadian Psychological Association, and sits on the Quality Committee of Casey House (Toronto’s HIV/AIDS Hospital). She is a trainer for Cognitive Behavioral Conjoint Therapy for PTSD and a consultant for Cognitive Processing Therapy, and has mentored dozens of clinicians in each of these treatments. She has presented and published extensively in the use of trauma-informed care, trauma treatment, stigma and interpersonal factors. Her work has been funded by the Canadian Institutes of Health Research, the Ontario Trillium Foundation, the Canadian Foundation for AIDS Research, and the Canadian Armed Forces. Dr. Wagner is one of the investigators of the MAPS funded pilot study of Cognitive Behavioral Conjoint Therapy for PTSD + MDMA. Dr. Wagner is the lead investigator for the upcoming MAPS funded pilot study of Cognitive Processing Therapy for PTSD + MDMA.

Annie Mithoefer, BSN is a Grof certified Holotropic Breathwork Practitioner and is trained in Hakomi Therapy. Since 2004 she has been a co-therapist for a series of MAPS-sponsored clinical trials. She and her husband, Michael, completed the first phase 2 clinical trial of MDMA-assisted psychotherapy for PTSD in 2009, a subsequent study of MDMA-assisted psychotherapy for PTSD in military veterans, firefighters and police officers, and, in collaboration with Candice Monson, Ph.D. and Anne Wagner, Ph.D., a recently completed study with couples receiving MDMA-assisted psychotherapy in conjunction with Cognitive Behavioral Conjoint Therapy for PTSD. She and Michael are now leading trainings in MDMA-assisted psychotherapy for therapists, supervising MAPS Phase 3 therapists and providing FDA-approved MDMA sessions for research therapists.

Candice M. Monson, Ph.D., is Professor of Psychology and Director of Clinical Training at Ryerson University and Co-Founder of Evidence-based Therapy, Training and Testing (EBT3) in Toronto, ON. Dr. Monson is one of the foremost experts on traumatic stress and the use of individual and conjoint therapies to treat PTSD. She has published extensively on the development, evaluation, and dissemination of PTSD treatments more generally. She has been funded by the U.S. Department of Veterans’ Affairs, U.S. National Institute of Mental Health, U.S. Centers for Disease Control and Prevention, U.S. Department of Defense, and the Canadian Institutes of Health for her research on interpersonal factors in traumatization and individual- and conjoint-based interventions for PTSD. Recognizing her distinguished contributions as a clinical psychologist and educator, she is a Fellow of both the American and Canadian Psychological Associations, a Beck Institute Scholar, received the Canadian Psychological Association Trauma Psychologist of the Year Award in 2013, was named the Outstanding Mentor by the International Society of Traumatic Stress Studies in 2014, and was inducted into the Royal Society of Canada in 2016. She has co-authored 7 books, including Cognitive Processing Therapy: A Comprehensive Manual and Cognitive-Behavioral Conjoint Therapy for PTSD, and has published over 100 peer-reviewed publications. Dr. Monson is well-known for her efforts in training clinicians in evidence-based assessments and interventions for PTSD.

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Ashawna Hailey, who left $5.5 million to MAPS in her will

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