Healing the wounds of trauma

Catherine Jackson talks to **Dr Gabor Maté** about trauma and compassionate inquiry

Catherine Jackson: ***You are a qualified medical doctor, an internationally celebrated writer, speaker and trainer on trauma and addictions, and you worked for many years in addictions services. Counsellors and psychotherapists look to you for answers to the issues that turn up in their counselling rooms. Yet you have never crossed the line from medical into psychiatry or had formal training in talking therapies. Is that right?***

Gabor Maté: I've never had a stitch of training in talking therapies. But to say 'crossing the line' is making an assumption that there is a line to be crossed. There isn't. I was a family physician for 32 years, a dozen of them in addiction medicine; I've delivered babies, looked after the dying and everything in between; I've worked in palliative care. What I've found is that, in virtually all chronic physical illness, there are deep-seated emotional issues that relate to people's entire lives. There is no separation to be made between the psyche and the soma - between people's emotional lives, their limbic systems, their life histories and their physiology.

My medical practice was in a poorer part of Vancouver, Canada. People couldn't afford to see private therapists, and the psychiatrists who were paid by the medical [insurance] plan were really inept at doing any psychotherapy. Hence, I began to talk with my patients myself. I found I had a bit of a gift for it, and that is when I developed my counselling approaches.

I also did my own work. In my mid-40s, I found myself very depressed, very unhappy in my marriage, very frustrated in my parenting, so I had to do a lot of work on myself. That combination of what I observed in my patient population and dealing with my own issues made me realise that you have to talk with people. My work has been my training.

CJ: ***One of the fields in which you have developed an international reputation is trauma. I sometimes worry that every 'psy' issue these days is attributed to trauma and people may feel, if they have no history of childhood trauma, their mental and emotional suffering isn't valid. How do you conceptualise trauma and its impact?***

GM: If trauma is defined as horrible things having happened to you in childhood - sexual abuse, neglect, physical, emotional mistreatment, severe parental dysfunction, loss of parents, divorce, bereavement - then it's true, not everyone is traumatised. But if you look at the origin of the word 'trauma', it's simply the Greek word for wounding. Trauma is a wound. You can think of a wound in two ways. One is that it doesn't heal, and every time you touch it, it really hurts. Or it's a wound that's healed, leaving scar tissue. And what's the nature of scar tissue? It's thick, it has no feeling in it, it doesn't grow. So the trauma is not what happens to you in terms of severe injury and harm - a lot of people are not traumatised in that way - but in the sense that you were wounded during your development because you were not seen for who you are, you weren't understood, you weren't held when you needed to be held. That's a very common phenomenon. Trauma can be due just to relational misalignments that leave a mark on your psyche and in your body that impairs your functioning in later life.

CJ: ***Another point that I've heard raised about the trauma hypothesis is that it positions the person as a lifelong victim. It can disempower them, in the same way that a medical diagnosis does. It tells them they are ill and need someone expert to cure them. You could say, it allows them not to take responsibility for their own situation.***

GM: Even when it comes to medical illness - if, say, I diagnose you with multiple sclerosis - I don't see it as this entity that has somehow entered your body; I see it as a manifestation of your life. Trauma is a process, a part of your life, and therefore you have agency, you can do something about it. Trauma isn't what happened to you, it's what happened inside you. Recognising that you have experienced trauma and that the trauma is showing up in your life right now doesn't disempower you; in fact, it empowers you - 'Oh really? Is that how it works? So, what can I do about it?'

'Trauma can be due just to relational misalignments that leave a mark in your psyche and body'

'If I as a therapist am going to be a mirror to somebody, that means I'd better be pretty clear myself'

As to healing, it's obvious. The word for healing comes from the Anglo-Saxon word for wholeness, and the essential nature of trauma is that it's a loss of wholeness. It's the impact of what happened and how that's manifesting as a disconnect right now in our lives, and how we can reconnect. A proper understanding of trauma actually says, 'This happened inside me, it's with me in the present, and because it's with me in the present, I can do something about it.'

CJ: ***So what is the therapist's role in that?***

GM: If you come to me and say, 'I've got an addiction to... whatever,' I could say three things to you. One is that you have a genetic disease, which is the mantra in most of the medical world. Or I could tell you, 'You are an idiot, you made a bad choice, you are morally degenerate, you are lacking will power,' or I could say, 'Hmm, what is that addiction doing for you? Oh, it's soothing your pain, is it? So how did you develop that pain? What happened to you? And how can we help you heal that pain and handle it in ways that are not self-destructive?'

So, the role of the therapist is in helping people understand that what happened to them has a role in what happens inside them, so they don't see themselves as deficit, bad or stupid, or as diseased; they see that how they are functioning is actually a fairly reasonable and understandable response to what happened to them.

Second, you help them realise that the very fact that they have come to you for help, whatever they think of themselves - and most people who come into my office have a core belief they are worthless at some level - shows that they do, on some level, believe they have some value, and that there is some possibility of healing. If they didn't, they wouldn't be in your office. In other words, they hold a set of contradictory beliefs - that they are doomed, stuck, hopeless and worthless on the one hand, and on the other, they are none of these or they wouldn't be there. So you work with how they developed that first set of beliefs and how together you can strengthen the part of them that doesn't accept all those negative labels.

That is the role of therapists - to hold up an accurate mirror to that person. And, if I as a therapist am going to be a mirror to somebody, that means I'd better be pretty clear myself. Because nobody can see in a dirty mirror. This is where a lot of therapy goes awry. Many therapists think they can learn a technique or a method and just apply it, but they haven't done the work internally. It's particularly true of many psychiatrists, but it's also true of therapists as well, which is why there's some horrendously bad therapy out there - people haven't done that internal work and they are not able to be that clear mirror that a lot of work with the client demands.

CJ: ***You talk very openly about your own life and how your drive to help others was driven by your own need for healing. You talk about the 'rush to symptom control', when a therapist is unable to sit with a client's pain because they haven't dealt with their own. Should the unhealed healer not be practising or can the unhealed therapist work with their wound or scar tissue, without it harming their clients?***

GM: If I had waited to be perfectly healed, I would not be talking to you right now! I would not have written any books, conducted any programmes or counselled anybody. You can't wait for that complete healing, even if it is possible. But, if you don't recognise that you are wounded and that you need to keep working on it and that, whenever there is a block in the therapy, you had better look to yourself, then you can create a lot of problems. It's not a question of waiting for some state of perfection; it's a question of being alert to one's own wounding and how that shows up sometimes.

CJ: ***You are currently writing a new book*** **– The Myth of Normal: illness and health in an insane culture –** ***a brilliant title. Can*** ▶

'A society that separates the mind from the body is going to create all kinds of dysfunction'

you say a bit about the book? What is the myth of normal?

GM: The assumption in medicine is that illness is an abnormality, whether that's physical illness or what is called mental illness. I am saying that these are actually normal responses to abnormal circumstances. That, in a society that's not geared to meet human needs - in fact, a society that's meant to frustrate and exploit and deny human needs - what we call illness is a normal response.

What I am showing in this book is that a society that separates the mind from the body, that doesn't recognise the multidimensionality of human existence and pretty much reduces it to the physical level, is going to create all kinds of dysfunction. Modern medicine, for all its genuine triumphs, separates the mind from the body and separates the individual from the environment. So, somebody comes to the doctor with, say, multiple sclerosis, and we see it as some terrible condition that somehow, for some reason, struck them by misfortune. But no, it's actually a response to living their life in a certain context. I write about this in my book, *When the Body Says No*.[1] We can mitigate the illness with our medical techniques, but actually I know lots of people who find, once they look at their whole life in context and structure it differently, their illness abates. There is nothing magical about that; it is what you'd expect if you understand the unity of everything. It's only a mystery if you separate the body from the mind.

CJ: ***Would you say the same for psychiatric diagnosis?***

GM: Society is mad in the sense that it's not aligned with human needs. I have experienced depression. I was very grateful for the impact of antidepressants. I have seen people who tell me that the diagnosis of bipolar disorder and taking lithium literally saved their lives. I don't want to be evangelistic about any particular point of view. What I can say is that people's psychosis and depression and bipolar tendencies all have meanings that are related to their life experiences and we can help people much better if we take those life experiences into account than if we just see them as having this 'illness'. One doesn't have to deny there is physiology involved in what we call mental illness, just as there is physiology in physical illness, but to look only at what we understand about the physiology - which, in the case of mental illness, is very little, by the way - is far from the whole story. Many British theorists, Joanna Moncrieff among others,[2] make the valid point that no one has ever accurately identified any physiology when it comes to any mental illness.

Having said that, we also know that, in some cases, medicine that changes people's brain physiology can be of some help. I have experienced that myself and so one doesn't want to be dogmatic one way or another. I am just saying it is so much more helpful to see every manifestation of what we call illness, whether physical or what we call mental, as a manifestation of a life, a life history and a multigenerational life history, in the context of a certain society. If we reflect on all that, we can be much more effective in helping people, no matter what their issues are. Biology rarely provides the full picture, least of all in what we call mental illness.

CJ: ***The model you use to work with trauma is 'compassionate inquiry'. Can you tell us a bit about how it works and achieves what it does?***

GM: First, it's just a name. For a number of years, people kept telling me I had to teach the method of how I worked, and I said, 'I can't teach it because I didn't learn it. I didn't consciously develop it. I just do it.' Finally, they convinced me and, with the help of others, we developed a formal training that hundreds of people are now taking online, internationally.[3] So I had to call it something. It's not like I sat down to design a programme called 'compassionate inquiry'. But it seemed to fit the bill, because it is an inquiry - it's asking, 'What is this all about, what does it represent?' And it's compassionate in that it totally eschews any kind of judgment. It's not, 'Why did you do this?' it's, 'Hmm, I wonder why you did this?'

One of the ways it works is that it very quickly drills down to what the issues are - it's a way to very quickly get at the heart of the issue and help the person develop compassion for themselves. But it's not, 'Here's this method, that is all you need to know.' It's entirely about how you approach people and help them to recognise that, if they did develop that pattern of behaving, there is a very good reason for it; that is how they survived, that is how they coped, and to ask themselves, 'Is it still helping?' If the answer is no, then it's, 'Let's see how it is showing up in your life and how you can drop it.' That's the intent of compassionate inquiry.

CJ: ***It has a lot of resonance with person-centred counselling – the listening, unconditional acceptance, non-judgmental positive regard – what you call 'presence with acceptance'. I'm also interested that you also say, 'We are hurt in relationship, so healing will happen in relationship.' Is it all about relationship? Is there no place for technique in healing?***

GM: Yes, the wounding happened in relationship so the healing for the most part has to happen in relationship. Stephen Porges says, 'Safety isn't the absence of threat but the presence of connection.' That is what I apply in my compassionate inquiry work. The vast majority of what makes therapy effective, according to the research, is about the relationship itself. Therapy is not a surgical technique; the patient is not unconscious and we are not operating on them. We don't do therapy with people who are asleep. They may be psychologically unconscious of all kinds of things but all I do is wake them up to what is going on. But to be able to look at themselves, they have to feel very safe, because when they are safe, their own natural healing process can unfold. That is the nature of life - there is healing capacity but what is needed for that to unfold is safety. I'd rather be with somebody who is capable of being present with me and compassionate, and can give me that connection, than with somebody who is super-clever, with all kinds of insights and techniques, but is disconnected from themselves and therefore can't connect with me.

'People's psychosis and depression all have meanings that are related to their life experiences'

CJ: ***You also talk about fierce compassion. What's that?***

GM: Ordinary human compassion is, 'I am suffering and you feel bad for me and wish I wasn't suffering.' That's not enough. You might feel bad to see a drug addict injecting in the street, but if you are not curious about what happened to them, you can't really help them. There has to be some desire to understand, which means having to drop your judgments and look at what happened to this person. That means going to the next, deeper level. You also cannot help them much if you are not ready to understand that you are just the same as that person; the same dynamics are going on inside you, you are just more fortunate, perhaps. You are not as able to help them because you see them as 'other'.

Then on the deepest level, you want this person to recognise the truth about themselves, and that's what I mean by fierce compassion. The truth hurts. The fact that your mother and your father didn't love you the way you needed to be loved - that's painful. A lot of people spend their whole lifetime running away from that pain, including with addictions, for example.[4] This whole society is based on people running away from pain, using all kinds of distractions. But, if I am afraid that you are going to experience pain, I can't help you. Compassion is not about helping people avoid the pain. It's about helping people face it.

People say, 'Oh that will hurt, it will retraumatise people.' No, it won't. The trauma happened in the first place when people, usually in childhood, tried to deny and escape from their pain because there was no one to support them. The point of therapy is not to deliberately cause pain but to understand that, when you are doing it right, the pain will emerge. In fact, if it doesn't emerge, you are not helping. So fierce compassion is not being afraid of people experiencing pain. It is about being there for them in a way that can help them face that pain, which as children they couldn't and that's why they developed the problems in the first place.

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CJ: ***Finally, I'm interested that you apply these same concepts of trauma and its effects to communities and societies in general. How should we be acting after the 'awakening' of COVID-19 and the Black Lives Matter protests?***

GM: My first question is - why did we need this to wake us up? What is new about American police brutality towards black people? Why did it take the death of George Floyd for the people of Bristol to recognise that they had a monument to a slave owner in their city's midst?

The real question is not what should people do but will people go back to sleep or not? Will we have learned? Will we be able to look at ourselves compassionately, not blaming ourselves for being racist but asking, 'What was it that put me to sleep to those dynamics?'

In the UK, as you know, the first 10 doctors to die of COVID-19 happened to be from the BAME community. What a coincidence. First of all, often those people are in the front line; second, they are the most stressed, and the more stressed you are, the more likely you are to get ill. So COVID-19 is not uncovering anything new. It's lifted the veil, but this society has a tremendous capacity to draw the veil back down over uncomfortable truths. So it's about what capacity do we retain to keep looking at uncomfortable truths. If we are willing to look truth in the face, we'll know what to do. The question is, will we just retain this time as a bad memory and go back to 'normal' business, or are we going to learn the lessons that have been here to be learned all along?

CJ: ***Thank you, Gabor, for your time.***

GM: It's my pleasure. ■

About
Gabor Maté

Dr Gabor Maté is a speaker and teacher with more than 20 years of family practice and palliative care experience and knowledge of research. He has written several books, including the award-winning *In the Realm of Hungry Ghosts: close encounters with addiction*; *When the Body Says No: the cost of hidden stress*; and *Scattered Minds: a new look at the origins and healing of attention deficit disorder*.
Dr Maté will be headlining the international speaker line-up at the AD4E Online Festival on 18 September.
www.adisorder4everyone.com

About the interviewer

Catherine Jackson is a freelance journalist specialising in counselling and mental health.

REFERENCES

1. Maté G. When the Body Says No: the cost of hidden stress. London: Vermilion; 2019.
2. Moncrieff J. A Straight Talking Introduction to Psychiatric Drugs (2nd ed). Monmouth: PCCS Books; 2020.
3. https://compassionateinquiry.com
4. Maté G. In The Realm of Hungry Ghosts: close encounters with addiction. London: Vermilion; 2018.