The Addict in All of Us

Gabor Maté's Unflinching Vision

BY RICHARD SIMON & LAUREN DOCKETT

Over the past several decades, popular attitudes toward addiction have undergone a radical destigmatization. Many attribute the beginning of this shift to former first lady Betty Ford and her decision to go public about her addiction to alcohol and opiates soon after leaving the White House. She hadn't been a public nuisance or a barfly. She'd never driven drunk, she said, or stashed bottles so she could drink secretly when she was alone. But by openly addressing her problems and becoming an outspoken advocate for rehabilitation through the Betty Ford Clinic (now the Betty Ford Center), she helped change the face of addiction. Perceptions of addicts as out-of-control gutter drunks and junkies were replaced by images of glamorous celebrities like Liza Minelli, Mary Tyler Moore, and Elizabeth Taylor as they checked in and out of Betty Ford.

While Ford's clinic was opening, a counseling educator named Patrick Carnes was finishing *Out of the Shadows*, a book that proposed compulsive sexual activity was a form of addiction and popularized the notion that someone could be addicted to something other than substances. Carnes's concept of sex addiction made a splash in the popular psyche and among many mental health professionals, and it spawned treatments that were influenced by 12-step programs all around the country. In the decades that have followed, the addiction label has ballooned in common usage to include a list of behaviors such as overeating, gambling, shopping, kleptomania, and internet overuse and gaming.

The concept of overdoing a behavior to the point of addiction has resonated with the general public, even as many mental health professionals have cringed at the implications. When the *DSM-5* included gambling disorder under a new addiction heading that extended the moniker to behaviors, Allen Francis, chair of the *DSM-IV*, objected strongly and advised clinicians to reject the diagnostic change, writing in *The Huffington Post* that "If taken beyond its narrowest usage, 'behavioral addiction' would expand the definition of mental disorder to its breaking point and would threaten to erase the concept of normality."

Today, as the debate over the wisdom of extending our notions of what constitutes addiction continues, one of the most eloquent and influential spokespeople for that broader conception is a haunting-looking, charismatic Canadian physician named Gabor Maté. As much social critic as clinician, Maté is the author of *In the Realm of Hungry Ghosts*, a bestseller about addictions. His TED talk on "The Power of Addiction and the Addiction of Power" has had almost 700,000 views. He insists that addictive patterns of behavior are rooted in the alienation and emotional suffering that are inseparable from Western capitalist cultures, which, by favoring striving and acquiring over noticing and caring for one another, end up short-changing—and too often traumatizing—children and families. He argues that the more stressful our early years, the likelier we are to become addicts later as a substitute for the nurture and connection we never received.

With his mop of wayward curls, heavily hooded eyes, and the Mick Jagger-ish concavity

of his thin frame, Maté is a striking figure on the workshop circuit as he challenges his audience to ask not what's wrong with addiction, but what's right with it. What is the addict getting from it that makes his addiction worth the price he pays? Why is the ameliorative quality of a behavior or a high so necessary for so many? If addicts can find peace and control only when they're using, what agonizing discomfort must they feel when they're not?

Much of what Maté knows about addiction he learned doctoring to the hardcore drug addicts of Vancouver's Downtown Eastside, which has one of highest concentrations of active drug users in North America. His former employer, the Portland Hotel Society (PHS), is known for its controversially permissive treatment, which helps addicts get by while they're actively using by providing food, shelter, and healthcare. PHS's most radical service is a clinic called InSite, which goes a step beyond clean needle exchanges and helps IV drug users shoot up safely. It dispenses crack pipes for a quarter in its vending machines to reduce the spread of disease.

Part of Maté's appeal is his willingness to talk about his own addictive tendencies and his view that most of us fit somewhere along the addiction spectrum. He's vocal about being a workaholic: who is he if not a doctor and an author and an in-demand public speaker? he asks. For years, he freely talked about his inability to control the urge to go on shopping sprees for classical music CDs, referring to it as an addiction that "wears dainty white gloves." He openly places himself on an addiction continuum where he believes compulsive shoppers and crack fiends can both be located. Be it a need to score horse tranquilizers in a scummy alley, or escape by melding into the glorious fantasy world of an online video game, or, in Maté's case, plunking down cash for a set of obscure violin concertos, the denial, the craving, the temporary pleasure, the fallout—it's all there.

Classical music thrills him, he says, but it's not the listening to it that he's addicted to: it's the momentary thrill he gets from buying and possessing it. As with any addict, it's the release he's after: that adrenaline push when the drug is within reach (as he approaches the door to the music store) and the brief endorphin flight of freedom when he's found and paid for what he wants. But, he confesses, he's barely left the store before he's fixating again on his next buy.

Maté insists that while every traumatized child doesn't grow into an addict, every addict has been a traumatized child.

When he was most deeply in the throes of this addiction, Maté sometimes spent thousands of dollars in a week on music that he never listened to. At one point, he left a mother in the middle of active labor to go on a shopping spree. Seeking an answer to his bondage to this kind of behavior, he attended AA meetings in Vancouver, becoming an addict among addicts, and sometimes being recognized.

Although the shopping addiction has receded, Maté still struggles with his workaholism. He's clear that his addictions have failed him, as they fail all the addicts he knows, but he recognizes that the trauma of his childhood enhances his enslavement to them. Born to a Jewish family in Nazi-occupied Budapest, he lived in a household filled with fear. His father was forced to labor with the brutally abused Jewish battalions in Hungary. His maternal grandparents died in Auschwitz. An aunt disappeared.

Some treatment professionals have publicly disagreed with Maté's pronouncements about the inevitable connections between addiction and trauma, including his statement that while "every traumatized child doesn't grow into an addict, every addict has been a traumatized child." And they take his disagreement with the current biomedical model of addiction, and his flat-out rejection of a genetic component, as ill-informed and potentially dangerous. He counters that focusing on a disease model makes it too easy to ignore the thorny societal and familial issues that underlie the power of addiction.

Whether he's right about the devastating effects of early trauma, or has gone so far into his cultural critique that he's lost sight of distinguishing differences among addictions and other kinds of disorders, he clearly has a gift for articulating the suffering and desperation of people caught in the grip of deep inner compulsions, no matter how innocent seeming or how darkly self-destructive they may be. His work forces us to look closely at the sense of emptiness and the failed search for meaning that characterize our hyperstimulating times.

In the interview that follows, Maté explores the meaning of addictions and how he's tried to come to terms with the inner demons in his own life.

■■■■■

PSYCHOTHERAPY NETWORKER: Let's start off by talking about your view of addiction. You've written that "any passion can become an addiction." What do you mean by that?

GABOR MATÉ: Addiction is a complex psychophysiological process, but it has a few key components. I'd say that an addiction manifests in any behavior that a person finds temporary pleasure or relief in and therefore craves, suffers negative consequences from, and has trouble giving up. So there's craving, relief and pleasure in the short term, and negative outcomes in the long term, along with an inability to give it up. That's what an addiction is. Note that this definition says nothing about substances. While addiction is often to substances, it could be to anything—to religion, to sex, to gambling, to shopping, to eating, to the internet, to relationships, to work, even to extreme sports. The issue with the addiction is not the *external activity*, but the *internal relationship* to it. Thus one person's passion is another's addiction.

PN: Okay, but the whole subject of addictions is shrouded in a certain amount of controversy these days. What do you think is the most common misconception about addictions?

MATÉ: Well, there are a number of things that people often don't get. Many believe addictions are either a choice or some inherited disease. It's neither. An addiction always serves a purpose in people's lives: it gives comfort, a distraction from pain, a soothing of stress. If you look closely, you'll always find that the addiction serves a valid purpose. Of course, it doesn't serve this purpose effectively, but it serves a valid purpose.

PN: Lots of people believe that the term *addiction* has become too loosely applied. So what's the difference between saying "I have an addiction" and "I have bad habits that give me short-term satisfaction, but don't really serve me in the long term?"

MATÉ: The term *addiction* comes from a Latin word for a form of being enslaved. So if it has negative consequences, if you've lost control over it, if you crave it, if it serves a purpose in your life that you don't otherwise know how to meet, you've got an addiction.

PN: Some people are critical of the term *addiction* because they believe it medicalizes and pathologizes behavior in a way that's not helpful.

MATÉ: I don't medicalize addiction. In fact, I'm saying the opposite of what the American Society of Addiction Medicine asserts in defining addiction as a primary brain disorder. In my view, an addiction is an attempt to solve a life problem, usually one involving emotional pain or stress. It arises out of an unresolved life problem that the individual has no positive solution for. Only secondarily does it begin to act like a disease.

PN: What's lost by just thinking of addictions as bad habits?

MATÉ: It falls short of a full understanding of addiction. Let's say a person has a bad habit of picking his nose in public. That's a bad habit, right? Frequently scratching one's genitals while giving a public talk would be regarded as a bad habit. But neither of these things is an addiction because nobody craves doing them, nor do they particularly get pleasure from them. They're compulsive behaviors, perhaps, but if there's no craving involved and no inability to give it up, there's no addiction. Some bad habits aren't addictions. But, for example, if somebody can't stop having affairs, despite the negative consequences, that's not just a bad habit.

PN: The notion of trauma is closely tied into your conception of addiction. Why is that?

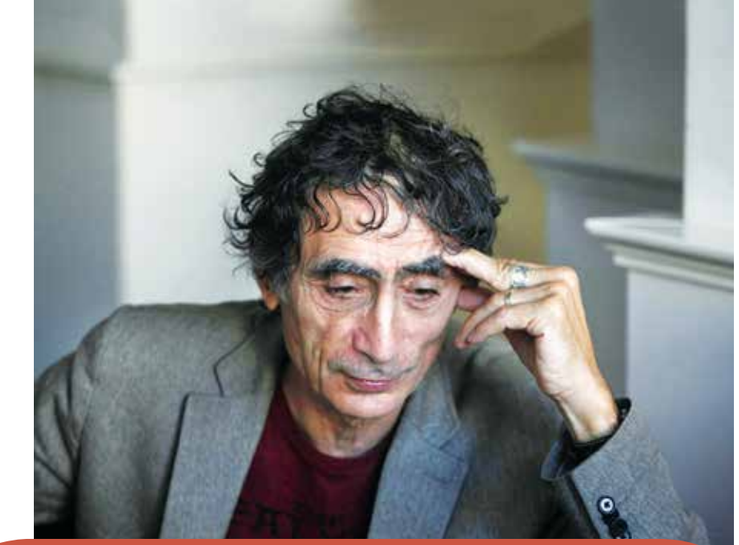
MATÉ: If you start with the idea that addiction isn't a primary disease, but an attempt to solve a problem, then you soon come to the question: how did the problem arise? If you say your addiction soothes your emotional pain, then the question arises of where the pain comes from. If the addiction gives you a sense of comfort, how did your discomfort arise? If your addiction gives you a sense of control or power, why do you lack control, agency, and power in your life? If it's because you lack a meaningful sense of self, well, how did that happen? What happened to you? From there, we have to go to your childhood because that's where the origins of emotional pain or loss of self or lack of agency most often lie. It's just a logical, step-by-step inquiry. What's the problem you're trying to resolve? And then, how did you develop that problem? And then, what happened to you in childhood that you have this problem?

PN: Some people have challenged your belief that addiction is inevitably connected to trauma. Looking at the research, they say that most addicts weren't traumatized, and most traumatized people don't become addicts.

MATÉ: Then they're not looking at the research. The largest population study concluded that nearly two-thirds of drug-injection use can be tied to abuse and traumatic childhood events. And that's according to a relatively narrow definition of trauma. I never said that everybody who's traumatized becomes addicted. But I do say that everybody who becomes addicted

was traumatized. It's an important distinction. Addiction isn't the only outcome of trauma. If you look at the Adverse Childhood Experiences Study, it clearly shows that the more trauma there is, the greater the risk for addiction, exponentially so. Of course, there are traumatized people who don't become addicts. You know what happens to them? They develop depression or anxiety, or they develop autoimmune disease, or any number of other outcomes. Or if they're fortunate enough and get enough support in life to overcome the trauma, then they might not develop anything at all.

When I give my talks across the world, it's not unusual to have somebody stand up and say, "Well, you know, I had a perfectly happy childhood, and I became an addict." It usually takes me three minutes of a conversation with a person like that to locate trauma in their history by simply asking a few basic questions.



> "Addiction is an attempt to solve a life problem. Only secondarily does it begin to act like a disease."

PN: What are they?

MATÉ: Sometimes I ask if either parent drank and I hear, "Yeah, my dad was an alcoholic." At that point, the whole audience gasps because everybody in the room gets that you can't have a happy childhood with a father who's an alcoholic. But the person can't see that because they dealt with the pain of it all by dissociating and scattering their attention. Maybe they developed ADD or some other problem on the dissociative spectrum. They shut down their emotions, and now they're no longer in touch with the pain that they would've experienced as a child. That's an obvious one. Less obviously, I might ask about being bullied. And when a person says, "Yeah, I was bullied as a kid"—or just sometimes felt scared, or alone, or in emotional distress as a child—I ask to whom they spoke about such feelings. The answer is almost uniformly "nobody." And that in itself is traumatic to a sensitive child.

So trauma can be understood in the sense of the Adverse Childhood Experiences criteria: emotional abuse, physical abuse, sexual abuse, a parent dying, a parent being jailed, a parent being mentally ill, violence in the family, neglect, a divorce. Or it can be understood in the sense of relational trauma. That means you don't have to be hit or physically abused. If the parents were stressed or distressed or distracted—if their own trauma got in the way of their attuning with the child—that's enough to create the lack of sense of self in the child. Or it's enough to interfere with the development of a healthy sense of self, and with normal brain development itself. This point must be emphasized: the physiology of the brain develops in interaction with the environment, the most important aspect of which, to cite a seminal article from the Center on the Developing Child at Harvard University, is the mutual responsiveness of adult–child relationships.

PN: Recently, more and more attention is being devoted to expanding our conception of addiction to include behavioral addictions. What's the difference between substance and behavioral addictions?

MATÉ: First, let's look at what's similar. The pattern of compulsive engagement in the behavior that one craves, finds temporary pleasure or relief in, but suffers negative consequences from—that's similar across all addictions. Also, many of the behaviors around both kinds of addiction, such as denial, are similar. So workaholics will deny the effect of workaholism in their own life or the lives of their family members. There will often be subterfuge and dishonesty about the addiction. The sex addict isn't going to be publicly talking about his addiction, or even acknowledging it. Shame is the common undercurrent in addiction, whatever the object of the addiction may be.

The other thing that's common among all addictions has to do with brain circuits. I can't overemphasize this. It doesn't matter if you look at the brain of a fervent shopper or a cocaine addict: the same incentive and motivation circuits are activated, and the same brain chemicals are being secreted. In the case of the shopper or the gambler or the sexaholic, it's dopamine. If the sexaholic was only after sex, the solution would be simple: marry another sexaholic. You could have all the sex that you wanted whenever you wanted it. But what is it really about? It's about the hunt, the search, the excitement of the chase. And that has to do with the brain's incentive and motivation circuitry, the *nucleus accumbens* and its projections to the cortex, and the availability of dopamine, which is also what cocaine and crystal meth and nicotine and caffeine elevate.

So what I'm saying is that on a biochemical and brain circuitry level, there's no difference between behavioral and substance addictions—or more accurately, only a quantitative difference, not qualitative. It all has to do with the brain's pleasure-reward centers, pain-relief circuitry, incentive-motivation circuitry, and impulse-regulation circuits. You know that it's not good for you, but you can't stop yourself. That's the same thing in all addictions.

Finally, there's the matter of poor stress regulation. When you ask people who have some addictive behavior, like gambling or sex or shopping, what induced them to go back to the behavior after having given it up for a while, they usually say something stressful happened—which means that their own stress-regulation circuitry isn't fully developed. They have to try to regulate it externally. And that, too, is an artifact of childhood circumstances: these crucial circuits didn't develop properly for lack of the right conditions.

PN: What's the distinction between having addictions and OCD?

MATÉ: The person with OCD is compelled to perform some behavior, but finds it unpleasant to have to engage in it. It's not egosyntonic. The person doesn't like it. There's no pleasure in it and no craving for it.

PN: And does their brain look different than the brain of an addicted person?

MATÉ: To really answer that, I'd have to look over the research more. But I suspect that, while there may be certain similarities, the pleasure-reward centers aren't activated in the person with OCD. I think OCD is also rooted in trauma, a different manifestation of it than addiction, but rooted in it nonetheless.

In any case, the difference between the substance addict and the so-called process or behavior addict is that the substance addict relies on an external substance to create that change in the state of their brain, and the process addict can do so just through the behavior.

PN: In your books, you're very disclosing about your own behavioral addiction to buying classical music, what you call the "dainty white gloves form" of behavioral addiction. Could you talk a little bit about that?

MATÉ: First of all, I appreciate you seeing the distinction. I wasn't addicted to classical music; I was addicted to *shopping* for classical music. I love classical music; it's one of my passions. But if I just loved classical music, then I could just buy it and stay home listening to it. I wouldn't have to keep running back to the store to get more and more and more. It's the shopping that gave me that dopamine hit I was looking for. And then, when I wasn't doing it, I was craving acquiring it. You can love classical music without being addicted to shopping for classical music. So it's the acquisition that was really the addiction—the process of the hunt, the chase, the thrill.

PN: How did that particular addiction take root in your life?

MATÉ: Interestingly enough, it began during a therapy seminar I was attending as a participant. They were playing some of Bach's solo violin sonatas, which I wasn't familiar with and loved listening to. And somebody said, "There's a classical record store just a few blocks away from here." I walked down to that store, and I was hooked. I started buying records, and then I had to keep going back over and over again. Then CDs came out, so I had to exchange all my records for CDs. I was lost for years. One week, I spent $8,000 on recordings. Obviously, there's a reason why the music meant so much to me. What was I looking for? I was looking for spiritual meaning, for aesthetic beauty, for depth, for a sense of completion. These were all qualities lacking in my life. So that's what I sought to receive through the music.

PN: A striking quality of your writing is how self-disclosing you are. Is that something that comes easily to you?

MATÉ: Once we get that there's nothing personal about these patterns, self-disclosure is perfectly natural. As Eckhart Tolle says, the ego isn't personal. Neither are the emotional and behavioral manifestations of trauma. So I'm not ashamed of anything I write about in my personal

CONTINUED ON PAGE 43