

What Worked in 1945 Won't Win Today's War

Real recovery runs on connection, science, and what we actually know now, not on the ceiling of what 1939 could imagine.

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A note before you begin. This guide is a direct critique of Alcoholics Anonymous and the 12-step model. If AA is currently working for you, it is not written for you, and nothing here is a reason to stop going. It is written for people who tried it honestly and left feeling worse, and who were told that was their fault. It also names what AA gets right, at length, because that part is true too.

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Preface: Who This Is For

This is for anyone who has ever sat in an AA meeting, listened hard, tried honestly, and walked out feeling more broken than when they walked in. You deserve to ask why that happened without being told you're in denial, without being handed another slogan, and without feeling like the failure was your willingness instead of the fit.

If AA is working for you, genuinely working, not just white-knuckling you from one meeting to the next, that's real and worth honouring. This isn't aimed at you right now. Come back if something stops fitting down the road.

But if you've worked the steps, tried to surrender, opened up in rooms full of strangers, and repeated the slogans until they went hollow in your mouth, only to feel like you were swimming upstream against your own nervous system, then I need you to hear something almost no one in those rooms is likely to say out loud:

You are not broken. You are not resisting. You are not the problem.

AA helps some people build lives they're genuinely proud of. For others, it was never built to go where they need to go: people carrying complex trauma, nervous systems rewired by years of adversity, brains that don't respond to surrender the way the model assumes. That isn't a personal failing. It's a design limitation.

This is for the second group: the ones who've spent years trying to shoehorn themselves into a program that was never engineered around their wiring, and quietly concluded the problem had to be them. It isn't. You're not failing the program. The program is failing to fit you. And that difference is worth understanding.

Eighty Years Is a Long Time

This comparison first hit me while watching the WWII tank film *Fury*. I love war movies, but something about it landed differently. One of the mechanized battles showed just how brutally

outmatched those soldiers were: unreliable tanks, armour that barely deserved the name, horses still dragging supplies through the mud while steel monsters shredded the landscape around them. Everything about the scene radiated fragility and desperation. Men doing their absolute best with equipment that had no business being in the same war.

Then came the scene that stuck with me. The last pause before the last stand: one crippled tank, a few hundred enemy soldiers closing in, a crew that already knew how the night would end. They weren't strategizing. They weren't posturing. They sat together in the dim light, breathing the same air, passing a bottle in the kind of silence that doesn't need to explain itself. One of them cracked a joke: "Screw it. Not like I'll be around for the hangover." Dark, resigned, and painfully human.

That's when it hit me: even inside the chaos of the Second World War, AA was the best weapon anyone had against addiction. I don't say that dismissively. In that world, it really was the most compassionate option available. Yet more than three-quarters of a century later, here we are, still handing people the same weapon.

Eighty years. Warfare moved from trench lines to satellites and precision strikes. Medicine went from penicillin to gene therapy. We mapped the human genome, harnessed the atom, put rovers on Mars, and built therapies that can process decades of trauma in months, not lifetimes. And yet, in far too many treatment settings, the same Big Book from 1939 is still the primary weapon, and sometimes the only one, we hand someone fighting for their life. That should bother us more than it does.

Why AA Looked Like the Best Weapon We Had

To understand why AA became the default, you have to understand the world it was born into. In the 1930s and 40s, psychology still revolved around Freud, moral weakness, and the conviction that your character was the problem. Medicine offered barbiturates, institutionalization, electroshock, chemical aversion therapy, and yes, lobotomies for something as common as depression. Trauma wasn't recognized as a clinical reality. Neuroscience didn't exist as a field. And virtually every doctor believed something we now know to be completely false: that the adult brain was fixed, static, unchangeable, incapable of rewiring itself.

If the brain couldn't adapt or heal, then addiction wasn't a pattern you could change. It was a life sentence you had to manage. In that world, AA's structure, community, and ritual didn't just seem helpful. They seemed like the only rational response. If nothing inside you could shift, the only option was to build an external container strong enough to hold you in place.

And here's the part I mean sincerely: if I'd been alive back then, I would have bowed before AA too. In that era, addiction wasn't a health issue. You were morally weak, spiritually defective, socially repugnant. There was no trauma lens, no nervous-system science, no developmental psychology. Just shame, blame, and whatever the church had on offer. In a society where Christianity shaped the cultural air everyone breathed, AA's spiritual framing wouldn't have felt foreign. It would have felt like finally being spoken to in a language that made sense. Almost overnight, people who had spent their whole lives being cast out could walk into a room and be welcomed without condition.

In the Room, Nearly a Century Later

Not long ago I sat in an AA meeting. Big Book discussion, everyone taking turns reading aloud. The story was "Me an Alcoholic?", around page 382. It follows a wildly successful man living a double life who spends seven years and ten thousand dollars on psychoanalysis (for context, roughly \$320,000 Canadian today, equivalent to seven or eight years of a median worker's salary in 1940), only to emerge more broken than when he started. His psychiatrist eventually

tells him there is nothing more medicine can do and sends him to AA as a last resort. The room I was sitting in received this as revelation. The takeaway was unmistakable: professional help is a dead end. AA is where you actually get saved.

Heads nodded almost in unison. I sat there with a feeling I can only describe as quiet grief. Not for the story itself, which I understood. The double life, the desperate attempts to fix something nobody yet had the tools to name: I knew that feeling in my bones. But the story was written in the late 1930s. Before the ACE Study. Before neuroplasticity was even a concept. Before EMDR, ART, medication-assisted treatment, trauma science, or any real clinical picture of how addiction actually operates in the brain. And it was being read as though it described the current ceiling of what medicine can offer. Not as history. As diagnosis.

The danger isn't that the story exists. It's that we keep treating 1930s limitations as if they're modern realities, and that people in that room are making life decisions on the basis of them.

In the 1940s, I would have chosen AA, and I, along with everyone else, would have been right to. It was the most compassionate, ethical option on the table. But that was eighty years ago. The people in that room deserve to know what's been discovered since. The brain rewires. Trauma heals. Identity evolves. The question was never whether AA was revolutionary in its time. The question is whether we're willing to let recovery grow beyond it.

AA as Folk Art, Not Science

I think of AA as a kind of folk art for addiction recovery, shaped by tradition, storytelling, ritual, and shared struggle. Collective wisdom handed down like an heirloom: valuable, heartfelt, often genuinely comforting. But like folk art, it wasn't built through research, peer review, or controlled trials. It emerged from lived experience, which gives it real power, *and real limits*.

Folk remedies help some people. Herbal teas, acupuncture, prayer: these practices have mattered to millions, and that isn't nothing. But we don't prescribe them as the sole treatment for cancer or heart disease, no matter how many people swear by them. We integrate them alongside evidence-based medicine where they help, and we don't shame anyone when they aren't enough. We just reach for something better.

AA emerged before neuroplasticity had a name, before developmental trauma was recognized, before anyone understood the biochemical mechanics of addiction. It was built in a world where the brain was considered fixed, trauma was invisible, and shame was treated as a legitimate motivator. Put simply, the solutions of that era carry the limits of that era.

The tragedy isn't that this folk art exists. The tragedy is that we still present it as the gold standard, sometimes the only standard, while quietly defunding or dismissing the treatments we now know reach further: trauma therapy, medication-assisted treatment, neurofeedback, somatic work. We would never treat diabetes with a 1939 remedy just because many people swore by it. Yet with addiction, a condition woven through with trauma, neurodevelopment, and biology, we routinely do exactly that. And when it doesn't work, we tell the patient they didn't try hard enough.

A pathway isn't a map. When someone says, "this isn't working for me," the answer shouldn't be "try harder." It should be "let's find what does."

Where AA Falls Short, and Why It Matters

AA was revolutionary in its time. In a world that saw addiction as a moral failing, it dared to say you weren't bad, you were sick. That shift mattered enormously. It offered dignity when no one else would. But over the decades, what began as one option quietly became the default. Not because the evidence demanded it, but because it got there first and then built walls around itself.

I've known people, too many to count, who walked into AA genuinely wanting it to work and walked out convinced they were defective because it didn't. I was one of them. If that's been your experience, understand something before you read the list below: the problem was never you.

1. It can feel like swapping one set of chains for another

For some people, AA's structure is a relief. For others, especially those with trauma histories or nervous systems that recoil from rigid frameworks, it can feel less like freedom from addiction and more like a lifetime sentence to a different set of rules and rituals. The substance is gone. The compulsory attendance isn't. For someone who spent years being controlled by something they couldn't escape, that trade doesn't always feel like recovery.

2. The identity is permanent, whether you want it or not

"Once an addict, always an addict." I understand why the framing exists; it's meant to keep people honest about vulnerability. But it also asks you to build your entire identity around the thing you're trying to move beyond. Modern psychology, and the research on post-traumatic growth, tells a very different story: we evolve by integrating our past, not by stapling it permanently to our name tag. I am someone who struggled with addiction. That's part of my story. It isn't the whole sentence.

3. Some of the language is fatalistic, and factually wrong

The Big Book contains phrases that have no business being read aloud as clinical truth in a room full of vulnerable people. "There are such unfortunates... they seem to have been born that way" is dehumanizing and implies a kind of hopelessness the neuroscience flatly contradicts. And "rarely have we seen a person fail who has thoroughly followed our path" isn't just unverifiable. It's the exact kind of unfalsifiable claim that insulates a program from accountability while parking all the blame on the person who didn't make it.

4. It reinforces all-or-nothing thinking

In CBT, black-and-white thinking is a recognized cognitive distortion, one that fuels anxiety, depression, and shame spirals. AA bakes it into the architecture. One drink resets the counter. One slip means starting over. One bad night means you failed. For someone whose nervous system already catastrophizes, that framing doesn't build accountability; it builds a shame loop that makes the next relapse more likely, not less.

5. It lacks trauma integration, and for some people actively makes things worse

AA's founders couldn't have known what we now understand about trauma and the nervous system. But we do know it now, and that knowledge changes what we should be doing. Running the inventory-and-amends process before a person's wounds are stabilized can be genuinely harmful. Asking a trauma survivor to catalogue their wrongs before you've built any safety or regulation isn't moral inventory. It's an accelerated shame spiral dressed up as spiritual work. This isn't a theoretical concern. For people with C-PTSD or complex developmental trauma, it can be clinically contraindicated.

6. The spiritual framing is a barrier, and sometimes a wound reopener

"God as you understand Him" is meant to be inclusive. In practice, the steps lean hard on religious language that isn't actually neutral for everyone. For people raised in religious environments that were themselves sites of trauma (shame-based theology, spiritual abuse, conditional love dressed up as faith), being told to surrender to a Higher Power doesn't register as liberation. It registers as the original dynamic showing up in different clothes.

The Closed Loop

It's almost elegant, once you step back and see it. Relapsed again? Back to the steps. Must've missed something. The genius of AA's design is that the program itself can never fail; only you can. That isn't treatment. It's a closed loop with no exit. I used to joke that if I ever wrote a self-help book, the fine print would read: "Didn't work? Read it again, but this time, mean it."

I've heard it in meetings more times than I can count: "if it wasn't for this meeting, I don't know what I'd do," or "this week was brutal, I was this close to using before I came here." I don't say that to minimize the moment. For those people, in that moment, the meeting was the lifeline. That's real. But a lifeline tied to a single anchor point is always one bad week from snapping, and I've watched that happen to people who deserved better infrastructure.

The more layers I added to my recovery, the less any single one of them could take me down. When meetings got to be too much, I could step back without it meaning everything had collapsed. My sobriety stopped being a tightrope and started being something I could actually stand on. That shift, from one pillar to many, was the difference between surviving and building.

What made it sustainable was grounding recovery in understanding instead of compliance. Once I stopped reading urges as moral failures and started reading them as signals, information from a system that was still hurting, I could respond instead of collapse. A slogan tells you what to do. Understanding tells you why it's happening. And once you know the why, your brain stops hunting for holes in the argument.

The main problem with AA is its dichotomised view: it is an illness that you have or haven't got. The idea of permanent disease restricts people's lives. — Nick Heather

The Problem Isn't the Program. It's the Assumption.

AA, NA, CA, CMA: these programs work for some people. Genuinely, meaningfully, life-changingly work. I have no interest in taking that from anyone. The problem isn't the program finding its people. The problem is what happens next, when someone finds salvation in the rooms and, with the best possible intentions, starts mistaking their personal rescue for a universal prescription. The logic is almost inevitable: this saved me, it must save everyone, and if it didn't save you, the variable has to be you.

But no one's suffering is a template. The ceiling of one person's pain is the floor of another's. We almost never see the full picture: the trauma history, the nervous-system wiring, the specific biological vulnerability that shapes how a person actually responds to any given approach. What lands as surrender for one person lands as retraumatization for another. The same room that saved one life sent someone else home more broken than they arrived. Both outcomes are real. Only one of them gets talked about.

And so recovery gets preached as a formula, "do what I did and you'll get what I got," which holds up right until it doesn't. When it doesn't, the system rarely examines itself. Instead the person gets told to surrender harder, pray longer, work the steps again, dig deeper for the defect

they must have missed. The trauma underneath the addiction stays exactly where it was. And the shame gets a fresh coat.

The tragedy isn't having faith in what saved you. The tragedy is being so certain of your own path that you can't see when it's becoming someone else's obstacle.

Just as Plainly: What AA Absolutely Gets Right

I've spent a lot of words on what AA gets wrong. That's the point, and I stand by it. But intellectual honesty demands the other side too, and I'd be doing this badly if I didn't name what AA actually got right. Some of it was genuinely ahead of its time. Some of it is still worth building on.

Here's something worth considering: in the 1940s, people were already surrounded by spirituality. Churches were full. Prayer was routine. Faith was woven into the cultural fabric. The church did not need to be taught that people should carry one another through suffering. That principle was already there.

But alcoholism occupied a different category. It was not spoken about like grief, illness, or ordinary hardship. It carried moral disgrace. It threatened reputations, families, employment, and belonging. People knew they were supposed to lean on one another, but this was one of the things many felt they could not safely admit needing help with.

That was the opening AA stepped into.

AA did not invent faith, fellowship, confession, or mutual care. It brought those things directly into contact with the taboo. It created a room where people could speak the unspeakable without being expelled from the circle. The spiritual framing mattered, but so did the fact that nobody flinched when you told the truth. People who had been pushed to the edges could sit beside others who had been through the same hell, and know they were not beyond God, beyond community, or beyond hope.

AA gave the outliers a place to be seen. It made spiritual belonging possible in the very place where shame had told them to hide.

Connection as medicine. AA understood something neuroscience would only later confirm: isolation doesn't just hurt people in addiction; it kills them. Long before fMRI scans, social buffering research, or nervous-system co-regulation were on the map, AA got the most important thing right: we heal in connection, not in exile. That truth hasn't aged a day.

Structure in chaos. When your life is in freefall, structure isn't optional; it's survival. The steps, the meeting schedules, the familiar rituals can act as scaffolding while the actual rebuilding begins. It doesn't fix anything on its own. But it can hold you together long enough for something else to.

Accountability. The sponsor relationship, at its best, gives you someone who has been where you are, who can see through the stories you tell yourself, and who will notice if you go quiet. For a lot of people in early recovery, the difference between relapsing in secret and reaching out is simply knowing that someone will notice, and will show up anyway.

Anonymity as a shield. In a world where addiction carried devastating social consequences, the principle of anonymity was genuinely radical. It created one of the first spaces where a person could be fully honest about what they'd become without fear of it following them out the door. In cultures where stigma runs deep, it remains one of the most valuable things the rooms have to offer.

A place to start. AA is free. It's accessible. There's almost certainly a meeting within reasonable reach of wherever you are, tonight, if you need it. For a lot of people it's the first doorway into recovery they ever found. A doorway isn't the whole house, but without it a lot of people never make it inside at all.

Emphasis on service. There's solid psychological grounding behind the idea that helping others reinforces your own recovery. But beyond the research, service shifts the internal story. For someone who spent years convinced they were a burden, becoming the person someone else calls changes something no amount of willpower can. It moves you from "I'm broken" to "I'm useful."

The spiritual pillar. AA tapped into something deeply human: the need for meaning beyond yourself. The doctrine matters less than the function: meaning reduces suffering. That's not theology, that's neuroscience, and the fact that AA understood it intuitively eighty years before the research caught up is worth acknowledging.

Personally, I've always felt AA tries to straddle the line between Christian language and genuine inclusivity, and doesn't quite land on either side. I respect the intent behind "God as you understand Him." But intent and impact aren't always the same thing. Even so, the principle beneath the doctrine is real. For me, the power was never in the specific script. It was in what happened when meaning, community, and acceptance showed up in the same room at the same time. That combination, whatever you call it, wherever you find it, is worth carrying forward.

A Critical Safety Note: When the Steps Collide with Trauma

Here's something the original AA founders genuinely could not have known: for many trauma survivors, the 12 Steps aren't just unhelpful. They can be clinically contraindicated. Like penicillin, which is life-saving for most and dangerous for some, the Steps can stabilize one nervous system and destabilize another. The difference isn't willingness. It isn't faith. It's physiology.

C-PTSD reshapes the brain, the stress response, and the very sense of self. Those changes don't just make the program harder to work. In some cases they make the program actively harmful. Not as an edge case, but as a predictable outcome when a specific kind of nervous system meets a specific kind of demand.

1. Powerlessness Versus Agency

AA begins with admitting powerlessness. But trauma is the experience of powerlessness: the original, defining wound of it. Many survivors are already living inside a kind of collapsed, defeated helplessness they've spent years clawing their way out of. Asking them to go back in, to recommit to powerlessness as a spiritual starting point, doesn't open a door. It closes the one they were finally standing in.

I've been told more times than I can count that I need to admit I'm powerless over my addiction. I understand why the framing exists, and for some people it's exactly what breaks through the ego and opens a door. But I don't believe anyone is truly powerless. Even in the darkest moments, there's still something: a small, quiet movement toward trying. Toward wanting things to be different. That impulse, however faint, is power. It's the part of you that hasn't given up. Asking for help isn't surrendering your strength; it's proof you still have some.

And for anyone who wants to make this argument on scriptural grounds, it's worth noting that the Bible used to justify powerlessness is the same Bible that speaks extensively about the power

within us. Not a power we manufacture alone, but the power of a God described as dwelling inside the believer: active, strengthening, present. You can find a verse to support almost any claim if you lift it out of context. Read in full, Scripture doesn't paint a picture of a collapsed, passive supplicant waiting to be rescued. It describes a real, ongoing relationship, one where the human side shows up, wrestles, acts, and is met.

2. "Character Defects" Versus Survival Adaptations

What AA labels as defects (shutting down, people-pleasing, hypervigilance, emotional numbing) are, through a trauma lens, adaptations. Strategies that kept someone alive and functioning in environments that would have broken most people. Calling them defects doesn't invite growth. It confirms the belief many survivors already carry: that the problem has always been them. That isn't healing. That's fertilizer for shame.

3. The Fourth Step and Victim-Blame Dynamics

"Where were we to blame?" is a reasonable question in some contexts. In interpersonal conflict between adults, sure. But applied to childhood abuse, chronic neglect, or domestic violence, it doesn't just miss the mark. It mirrors the exact gaslighting the survivor absorbed from their abuser. I was told to find my part in things that happened to me as a child. That step didn't build accountability. It recreated the original injury with a spiritual justification bolted to it. For some people, this step isn't therapeutic. It's dangerous.

The core risk, stated plainly. When you ask a trauma survivor to surrender to a system that demands self-abnegation, you risk recreating the original dynamic of abuse: you are flawed, you are wrong, and you must submit to be saved. Most trauma survivors have heard that message before. It didn't help them then either. This isn't an argument that AA harms everyone. It doesn't. It's an argument that for a large share of people carrying unhealed developmental trauma, the group most represented in addiction statistics, the 12 Steps contain specific elements we now know can destabilize, shame, or retraumatize. That isn't a flaw in the people. It's a gap in the model.

Modern recovery needs guardrails that 1939 simply didn't have the science to build. The contrast is stark, and worth stating plainly:

Where AA asks for surrender, trauma recovery rebuilds agency.

Where AA names defects, trauma work offers compassion.

Where AA revisits resentments, trauma work restores safety first.

These aren't the same process. For many people, they're opposite ones.

Bridging the Gap

The lesson from history isn't that we should throw out the tools of the past. AA was a genuine breakthrough in the specific world it was built for, with the specific knowledge available at the time. But breakthroughs become barriers the moment we stop asking whether they're still the best we can do. We have to refuse to mistake age for wisdom.

The enemy isn't AA. The enemy is stagnation.

We now have what Bill W. and Dr. Bob could never have imagined: trauma-specific therapies that process the past without re-opening it; EMDR and ART that update neural patterns frozen in place for decades; neurofeedback that recalibrates a dysregulated brain; medication-assisted

treatment that stabilizes the physiology long enough for the real work to begin; somatic and mindfulness tools that rebuild the mind-body connection addiction severs. None of this existed in 1939. All of it exists now. And people are dying in the gap between what we know and what we're willing to use.

Call the war analogy dramatic if you want. The cost of fighting a modern battle with outdated weapons is the same either way: human lives.

Connection, community, and meaning will always be part of what heals people. AA understood that before anyone else did, and that understanding is worth honouring. But it was never the whole answer, and treating it as if it were has cost people their lives. The rooms can stay. The assumption that they're enough has to go.

Before You Go

If you're currently in the rooms and they're holding you, keep going. Nothing in this guide asks you to abandon something that is helping you stay alive. The argument is about what gets added alongside it, and what happens to the people for whom the program, by itself, is not enough.

I'm one of those people. I do not follow the Twelve Steps, but I still walk into the rooms sometimes.

It took me time to make peace with that. During the long process of discovering what worked for me and what didn't, I realized that the curriculum may not always offer what I need, but sometimes the room does. Sometimes simply being in the orbit of other people in recovery is enough to recharge something in me when I've been isolated, worn down, or running low. There is value in being around people who understand the fight without requiring an explanation.

I still find something in those rooms. I just find it for different reasons.

I can recognize that AA was not a complete treatment model for me without pretending it has nothing to offer. I can reject the idea that it must be the whole answer while remaining grateful for the parts that help. A room does not have to contain everything I need in order to contain something I need.

If you're the person the program didn't fit, the one who tried honestly and left feeling worse, the most useful thing here may simply be permission to stop auditing yourself for the defect you must have missed. There may not be one. The fit may simply have been wrong. And a wrong fit is not a character problem.

What changed things for me wasn't finding a better program. It was building more pillars: trauma therapy, regulation work, a few real relationships, an understanding of what my nervous system was doing, and, sometimes, a room full of other people trying to stay in recovery. No single pillar has to carry the entire structure anymore. One can wobble without bringing everything down.

AA can be one pillar without becoming the whole building.

Every year we cling to an incomplete model; people die who might have lived. Not because we lack other tools, but because we remain too attached to the old ones to reach for the new ones. That is the only part of this I find unforgivable.

Feeling overwhelmed by what you're reading? Support is here. Call or text 988, Canada's 24/7 Suicide Crisis Helpline • In Alberta, call 211 for community and mental health referrals • Distress Line 780-482-HELP (4357) • Call 911 in an emergency.

Sources & Further Reading

These sources highlight the evidence base for trauma-informed addiction treatment, the limits of 12-step generalization, and the clinical necessity of integrating trauma care for individuals with C-PTSD or early-life adversity.

Kaskutas, L. A. (2009). Alcoholics Anonymous effectiveness: faith meets science. *Journal of Addictive Diseases*, 28(2), 145–157. Also: Ferri, M., Amato, L., & Davoli, M. (2006). Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database of Systematic Reviews*, 3, CD005032. *Kaskutas found AA associated with sustained sobriety in motivated populations but noted high dropout rates and limited evidence for trauma-complex presentations. The Cochrane review found insufficient evidence to assess AA's effectiveness relative to other treatments. Together: AA helps some people, but the evidence base has clear limitations and was not designed for the neurobiological challenges of trauma survivors.*

Herman, J. L. (1992). *Trauma and Recovery*. Basic Books. *Explicitly addresses power and control as central to trauma healing, arguing that restoration of agency, not further surrender of it, is the therapeutic direction for trauma survivors. The clinical basis for the powerlessness critique in this guide.*

Donovan, D. M., & Floyd, A. S. (2013). 12-step interventions and mutual support programs for substance use disorders. *Psychiatric Clinics of North America*, 36(2), 261–275. *Reviews the clinical evidence for 12-step approaches, including their documented effectiveness for many participants alongside evidence for significant dropout rates and population-specific limitations.*

Mendola, C. (2016). Addiction, 12-step programs, and evidentiary standards for ethically and clinically sound treatment. *AMA Journal of Ethics*, 18(6), 587–598. *Examines the ethical dimensions of 12-step recommendations, particularly when evidence standards are applied and when population-specific factors including trauma history are not adequately considered in referral decisions.*

Lortye, E., et al. (2021). Treating PTSD in substance-use-disorder patients: a randomized controlled trial. *BMC Psychiatry*, 21(1). *Randomized controlled trial examining whether treating PTSD alongside addiction improves outcomes compared to treating substance use alone.*

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology*, 35(7), 845–862. *Outcome evidence for the practical value of the integrated model argued for here.*

Chen, L., et al. (2017). EMDR for PTSD in patients with substance use disorders: a systematic review. *Frontiers in Psychology*, 8. *Reviews EMDR in co-occurring PTSD and substance use, suggesting trauma-focused interventions can reduce trauma symptoms and may support improved substance use outcomes.*

Ogilvie, R., et al. (2022). Trauma, stages of change, and post-traumatic growth in addiction recovery. *Journal of Substance Use*, 27(2), 185–194. *Shows that post-traumatic growth is possible within the recovery framework when trauma is explicitly addressed: a hopeful counterpoint to the critique in this guide.*

Chadwick, M., et al. (2022). Barriers to delivering trauma-focused interventions: a meta-review. *Frontiers in Psychology*, 13. *Documents the systemic, training, and resource barriers that prevent trauma-focused treatment from being delivered even when clinicians recognize its necessity.*

Not medical advice. This guide is educational. If you are struggling, please reach out to a qualified professional or the support lines listed above.

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