When Trauma and Addiction Overlap

What Project Harmony and the broader evidence clarify, and what they do not.

Austan Sloan • Recover-You

A note before you begin. This guide argues that trauma treatment shouldn't be indefinitely postponed when it overlaps with addiction. It is not an argument for starting trauma processing right now, and it is explicit that readiness, pacing, and stabilization still matter. If you are in early or fragile recovery, read it as something to raise with your care team, not as something to act on alone.

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Before We Get Into It

This does not settle every question about trauma and addiction, nor does it claim that trauma explains every substance use disorder. Addiction is too complex for that. Genetics, environment, drug exposure, mental health, pain, poverty, social connection, access to care, and reinforcement all matter.

Its purpose is narrower. It examines a common clinical overlap: people trying to recover from substance use disorder while also carrying PTSD or clinically significant trauma. For them, treatment has often begun with a cautious question: should the addiction be stabilized first and the trauma addressed later?

Project Harmony brought serious data to that question. Not one anecdote or a single small trial, but a large research program designed to compare what happens when PTSD and substance use disorder are treated together, separately, or with only one side of the problem in view.

The point of this guide, stated precisely. The claim here is not that trauma is the only cause of addiction. The claim is that trauma is common enough, biologically relevant enough, and clinically important enough in addiction recovery that treating it as secondary, optional, or indefinitely delayed has become difficult to defend. When PTSD and substance use disorder overlap, the evidence increasingly points toward integrated care: preparation, pacing, addiction-specific support, and trauma-focused treatment when the person is ready. It does not mean automatic separation or indefinite avoidance. This is not a manifesto against stabilization. It is a challenge to systems that mistake postponement for safety.

So the question is not "does trauma explain all addiction?" It does not. The better question is: when trauma and addiction clearly overlap, what does the evidence say about treating them?

The Bigger Signal

Before turning to treatment, it helps to widen the frame. One of the clearest lessons from the trauma literature is that early adversity rarely confines itself to one diagnosis, one behaviour, or one corner of a person's life. It can show up across stress regulation, emotion, attachment, threat perception, coping, physical health, and risk-taking behaviour.

That does not mean trauma caused every problem that followed. It means trauma can become a major upstream force, shaping how a person learns to survive, regulate, disconnect, numb, attach, defend, and cope. When substance use enters that system, it may become more than recreation or poor judgment. For some people, it becomes regulation by chemical means.

This is what makes the research uncomfortable. Medicine often treats anxiety, depression, compulsive coping, substance use, chronic shame, avoidance, and stress-linked illness as separate downstream problems. They can look very different when viewed in the context of a person's early environment and nervous-system development.

> *Trauma is not always the whole story of addiction. But when it is part of the story, treating addiction as if the trauma is merely background detail can leave a major driver of suffering untouched.*

Prevalence: How Common Is This Overlap?

Anyone who has spent time in treatment settings, or in honest conversation with people in long-term recovery, starts to notice something. Trauma histories are not occasional background details. They appear often enough that they should change how we think about assessment, pacing, relapse, shame, and recovery planning.

A necessary distinction between two kinds of number. Clinicians working in residential treatment sometimes estimate that trauma exposure is present in the majority of people seeking help, with some informal estimates landing as high as 80 to 90 percent depending on how trauma is defined. Those are not peer-reviewed prevalence figures, and they should not be presented as if they are. They do reflect a clinical reality that formal diagnostic categories often undercount, but the formal data below is the part that carries weight.

Around 6 to 7 percent: lifetime PTSD prevalence in the general population, per large-scale epidemiological research.

Around 30 to 50 percent: PTSD rates commonly reported in residential substance use treatment settings, depending on the population, setting, and methodology. Roughly one in three at the conservative end. Broader trauma exposure is higher still.

That distinction matters. PTSD is a narrower diagnostic category. Many people in addiction treatment may not meet full PTSD criteria but still carry clinically relevant trauma histories, attachment wounds, toxic stress exposure, grief, shame, or nervous-system dysregulation that affects recovery.

This is not a footnote issue. If a third or more of a treatment population meets criteria for PTSD, while many more carry trauma histories that shape coping and relapse risk, trauma cannot remain a side topic in addiction care.

The One Thing I Never Put on the Table

Through years of addiction and treatment, I always knew there was one thing I was not putting on the table. The only thing, really. My trauma.

For a long time, I believed time and distance were the same as healing. I convinced myself I no longer thought about what happened. In a way, that was true. But I had not moved past it. I had built walls around it. I had no idea it could still pull strings from the dark recesses of obscured memory.

A small part of me knew the story I was telling myself was nonsense. I knew I needed to talk about it, and I was terrified of what that would mean. Worse, I knew of nowhere safe to take it. I had tried before and watched it backfire. I trusted no one with it.

When trauma therapy was finally offered, I did what I always do. I researched. Then I kept researching. I chose Accelerated Resolution Therapy. I started the session in tears, recalling one of the most painful memories of my life, and I left smiling. That might sound small. For me, it was anything but. The memory was not erased. When I return to it now, I reach the gentler, padded version I created for myself. I can remember without feeling that same familiar sting of pain.

I want to be careful here. I do not believe therapy alone was a magic bullet. The real shift came from therapy working alongside the education I pursued on my own. ACEs, toxic stress, allostatic load, the HPA and SAM axes, Dunedin, DOHaD, epigenetics, and most importantly, C-PTSD. Together, they showed me that trauma can be relational, that it exists on a spectrum, and that no two paths through it are identical. For the first time in my life, I understood myself. You cannot put a value or metric on the importance of that.

> *Therapy helped me change how I carried the memory. Education helped me understand the person who had been carrying it.*

This is where my experience meets the evidence. The ACE Study, Dunedin, toxic stress research, and developmental trauma literature show how adversity can shape stress, emotion, reward, threat detection, and self-regulation. Project Harmony asks the next practical question: what works when PTSD and substance use disorder are already both in the room?

The Question Research Had to Catch Up To

For decades, PTSD and addiction were often studied and treated through separate lenses: separate literatures, separate treatment trials, separate clinics, separate professional languages. Some integrated approaches did exist, including Seeking Safety and exposure-based work going back to the early 2000s. But the field still lacked a large, harmonized way to compare treatment approaches across many studies.

When PTSD and substance use disorder occur together, what actually works best? What have we been assuming without enough evidence? Single trials could not fully answer that. Traditional meta-analyses were limited by the fact that studies used different measures, populations, substances, therapies, and comparison groups. The evidence was important, but difficult to line up cleanly.

> *That is the problem Project Harmony was designed to address. It did not make the topic simple. It made the comparison more honest.*

What Is Project Harmony?

Project Harmony is a research program funded by the National Institute on Alcohol Abuse and Alcoholism and led by experts in PTSD and substance use disorder treatment from Rutgers University, RTI International, the Medical University of South Carolina, UC San Diego, and the City College of New York.

It was built to do something conventional reviews struggled with: integrate individual patient data across a large and diverse body of trials. Rather than only summarizing published findings, the team worked with the underlying study data to compare outcomes more precisely.

The methods included individual patient data meta-analysis, integrative data analysis, and propensity score weighting. In plain language, researchers found ways to align studies that used different measures, populations, substances, therapies, and designs. That allowed for stronger comparisons than conventional reviews could provide.

36 randomized controlled trials in the individual patient data analysis.

More than 4,000 participants in Project Harmony 1.0.

39 studies in the systematic review pool.

More than 8,000 participants targeted in Project Harmony 2.0.

This is not a single study that closed the issue. Project Harmony is an ongoing research program that continues to refine what we know about treating co-occurring PTSD and alcohol or other drug use disorders.

What Project Harmony Helps Clarify

The findings require care. They do not say that every person with addiction needs immediate trauma processing or that trauma causes addiction in every case. They do not erase the need for stabilization, addiction-specific treatment, medication, harm reduction, peer support, or clinical judgment.

What they do suggest is that when PTSD and substance use disorder are both present, keeping them in separate treatment silos by default is not well supported by the evidence.

Trauma-focused and integrated trauma-focused therapies showed the clearest benefits for PTSD outcomes when PTSD and substance use disorder co-occur.

Substance use outcomes improved most when addiction-specific interventions were part of the treatment picture, including alcohol-targeted pharmacotherapy where appropriate.

The strongest clinical direction is integration, not isolation: both should be assessed and addressed through a coordinated pathway rather than treated as unrelated problems.

> **Being precise about what this evidence is.** Project Harmony is comparative effectiveness research. It helps answer which treatments perform better when both conditions are present. It does not test whether trauma caused addiction in any one person, nor can it resolve that question for everyone. The relationship between PTSD and substance use is complex and bidirectional. Either can precede, worsen, or maintain the other, and the pathway differs from person to person.

Earlier concerns that trauma-focused treatment would be categorically unsafe for people with active or recent substance use problems were not supported at the group level. That does not mean trauma work is easy, risk-free, or right for every person at every moment. It means the blanket fear that trauma processing will generally destabilize people with substance use disorder, worsen substance use, or make treatment impossible is broader than the evidence supports. Clinical pacing still matters. Readiness still matters. But avoidance should be an individualized clinical decision, not the default architecture of care.

This is the practical shift. The evidence does not demand reckless exposure work. It points toward preparation, pacing, education, and integration. It asks treatment systems to build a path toward trauma care instead of leaving people to hope that path appears later.

> *"Trauma-informed" cannot simply mean admitting that trauma is in the room. If we do nothing to help people understand how trauma shaped them, and provide no responsible pathway toward trauma therapy, then trauma-informed care fails on its own terms.*

What This Challenges

For years, and still in many settings today, addiction treatment has followed a sequential logic: stabilize the addiction first, address the trauma later.

The reasoning was not absurd. Trauma work can be intense. Early recovery can be fragile. Clinicians did not want to open material that might overwhelm someone, increase distress, or contribute to relapse.

The problem is what happened next. In many places, a cautious timing principle became a structural delay. Later became vague, and no clear path toward trauma therapy was built. People with long histories of addiction were treated for substance use while the fear, shame, grief, and nervous-system patterns underneath it remained largely untouched.

Early coping-skills approaches like Seeking Safety made sense in that historical context. They addressed PTSD and substance use without trauma processing because the field was concerned that direct trauma work could destabilize people. That concern deserved respect. But it also deserved testing.

The sequential model assumed trauma work usually needed to wait until addiction was stabilized.

That assumption was clinically understandable, but the evidence behind blanket avoidance was limited.

In practice, "not yet" too often became "not here" or "not at all."

Project Harmony strengthens the case for integrated pathways that address both instead of forcing people through disconnected silos.

> *Caution about timing is care. Indefinite avoidance is not the same thing.*

What This Does Not Mean

None of this is an argument for forcing trauma work on people who are not ready. Timing matters. Stabilization matters. The therapeutic relationship matters. Safety matters. Immediate trauma processing may be inappropriate when someone is in acute crisis, lacks basic coping supports, faces a high risk of destabilization, or has not built enough trust with a provider to do the work safely.

The goal is not to rush. Readiness is not a myth. Pacing is not avoidance. A careful clinician should adjust trauma work to the person's stability, capacity, supports, and consent.

The goal is to stop disappearing the trauma. For many people in long-term addiction, trauma work never arrives. Not because they refuse it, but because no practical pathway was built.

Project Harmony does not solve every clinical question. Integrated care is complicated. Dropout is real. People respond differently. Substance use outcomes can be harder to shift than PTSD symptoms, and addiction-specific treatment still matters. Those limitations do not restore the old default or justify treating trauma as a side issue forever. They point toward a better middle path: stabilize where needed, prepare carefully, treat addiction directly, and build a real bridge into trauma-focused care when the person is ready.

Before You Go

This doesn't settle the entire argument. It adds one important body of evidence to a much larger conversation. The value of Project Harmony is that it brings stronger data to a core issue people in recovery have been living with for years: trauma and addiction often do not behave like separate problems, even when systems treat them that way.

The evidence points away from two extremes: immediate trauma processing for everyone, and indefinite trauma avoidance for almost everyone. The better path is sequenced integration. Stabilize where needed. Treat the substance use directly. Use education to reduce shame. Build a responsible path toward trauma-focused therapy when the person has enough support and readiness to begin.

If you're the person this affects, the practical use of this is a question rather than a decision: what is the plan for the trauma side, and what would need to be true before it could begin? Asking that is reasonable at any stage. Acting on it alone, without support in place, is not what the evidence recommends.

> *The evidence does not say trauma explains every addiction. It says that when trauma and addiction overlap, treating them as unrelated problems is no longer good enough.*

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Sources & Further Reading

These references support the evidence reviewed here, from prevalence data and mechanistic research to the Project Harmony program and the broader clinical literature on co-occurring PTSD and substance use disorder.

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Hien, D. A., Papini, S., Saavedra, L. M., et al. (2024). Project Harmony: a systematic review and network meta-analysis of psychotherapy and pharmacologic trials for comorbid posttraumatic stress, alcohol, and other drug use disorders. Psychological Bulletin, 150(3), 319–353. *The expanded network meta-analysis drawing on 39 trials, finding the clearest PTSD benefits for trauma-focused and integrated approaches while reinforcing the importance of addiction-specific interventions for substance use outcomes.*

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Anda, R. F., Felitti, V. J., Bremner, J. D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood. European Archives of Psychiatry and Clinical Neuroscience, 256(3), 174–186. *Bridges the epidemiological findings of the ACE Study with neuroscientific evidence of lasting biological change, supporting the argument that early adversity shapes the systems regulating stress, emotion, and behaviour.*

Teicher, M. H., & Samson, J. A. (2016). Annual research review: enduring neurobiological effects of childhood abuse and neglect. Journal of Child Psychology and Psychiatry, 57(3), 241–266. *Documents the specific pathways through which early maltreatment produces lasting changes in stress regulation, emotional processing, and reward systems: the same systems implicated in addiction.*

Herman, J. L. (1992). Trauma and Recovery. Basic Books. *The foundational clinical text establishing the framework of complex trauma and the importance of safety before processing: the intellectual foundation for much of what Project Harmony has since tested empirically.*

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