

Trauma-Avoidant Care

When "trauma-informed care" becomes avoidance in a softer accent.

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A note before you begin. This guide contains references to childhood abuse, including sexual abuse, in the context of what people disclose in treatment settings. It is also a systems critique that may be uncomfortable if you are currently in a program. Read it as a set of questions to ask about your care, not as a reason to walk away from it.

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A note before you read this. This is a critique of systems: the frameworks, funding structures, and institutional defaults that shape how addiction care gets delivered. It is not a critique of the people working inside them. I owe my life to many of those people. Counsellors, caseworkers, nurses, intake workers, and peers who showed up with more care than their job descriptions ever asked of them. I've also watched some of them carry a grief I wouldn't wish on anyone: losing a client after watching them complete treatment. That kind of heartbreak doesn't leave a person. The people inside these systems aren't the problem. In many cases they're the only thing standing between someone and the floor. This critique is for them as much as anyone, because they deserve better tools, better frameworks, and systems that give their care somewhere to actually land.

The Hollow Label

"Trauma-informed care" has become one of the most repeated phrases in addiction treatment, and one of the least meaningful. Most programs carrying the label aren't trauma-informed. They're trauma-avoidant. And the people running them usually know it.

For anyone trying to heal from addiction, that isn't a minor gap in service delivery. A facility that doesn't offer trauma-specific therapy, or a clear pathway toward it, isn't treating the condition. It's managing the symptoms while the wound stays open. That's not care. That's containment.

What makes this particularly hard to excuse is that adopting trauma-informed language is itself a formal admission. When a treatment centre designates a program as trauma-informed, training staff in trauma principles, updating intake language, building policy around it, it is officially acknowledging that the population it serves is traumatized. That acknowledgement is on the record. It's in the frameworks they signed onto. It's in the room.

And yet the pathway to actual trauma processing, the therapy that addresses what the acknowledgement names, is routinely absent. Underfunded. Referred out with no real coordination. Or deferred until after stabilization, which for many people never arrives.

The institution has looked at the wound, documented the wound, built policy around the existence of the wound, and then declined to treat it. That isn't a service gap. It's a contradiction inside the system's own stated framework.

There are excellent centres that genuinely integrate trauma and addiction work, and they're worth seeking out. But they remain the exception in a field still more comfortable polishing the

surface than examining what's underneath it. If a trauma-informed facility doesn't offer trauma-specific therapy, or a clear, accessible pathway toward it, it isn't trauma-informed. Full stop.

The Core Driver of Addiction Isn't the Substance

For trauma survivors, this was never just about bad choices. It was about pain deep enough that escape felt worth any consequence.

After more than two decades in active addiction and thousands of conversations with people in use and recovery, one pattern held steady: unresolved pain, especially childhood trauma, was one of the most significant drivers I kept encountering. Studies report very high rates of trauma exposure in substance-use treatment, but estimates vary widely with the population and definition. That is not proof that trauma caused every addiction. It is a signal too large to keep treating as background.

One person can try a drug and walk away. Another spirals. The difference isn't willpower. It's whether there's a wound deep enough that escape feels worth the cost.

Even the Rat Park Experiment Missed a Piece

Before Rat Park, early addiction research was brutally simplistic. A single rat in a barren cage was given two bottles: one with water, one with a drug like morphine or cocaine. Predictably, the rat kept choosing the drug until it died. I doubt the researchers saw it this way at the time, but that wasn't an addiction experiment. It was a controlled study in despair.

Rat Park added nuance. Researchers first got rats addicted, then moved them into an enriched, social environment, and drug use dropped dramatically. A logical next step that revealed something real: connection and environment matter. Even rodents crave belonging.

But Rat Park changed the animals' current environment. It did not directly test the full range of early adversity, fear learning, or developmental stress that can shape later behaviour. That missing layer matters enormously when we try to apply an animal demonstration to human addiction. It is not the only layer. It is one we cannot afford to erase.

Rat Park corrected the environment. It didn't examine motive. It assumed drug use rises when connection is absent and falls when connection is restored. Often, that's true. But it leaves an unanswered question sitting at the centre of the whole model: what if the drive to numb predates the cage entirely?

What if the organism enters the experiment with a nervous system already sensitized by chronic threat, not because of what's happening now, but because of what happened then? What if the substance isn't chosen because the present feels empty, but because the internal state is unbearable no matter what the present looks like?

This is what we rarely ask: not what conditions surround the behaviour, but what internal pain the behaviour is regulating. Early adversity wires hypervigilance. Chronic unpredictability lowers the threshold for stress. Attachment rupture teaches the body that safety is unstable. When those things happen early enough and go unaddressed long enough, the substance stops being a reaction to the environment. It becomes the only available answer to an internal state that nothing in the outside world has ever reached.

A beautiful cage doesn't erase the need to numb inner torment.

When the Real Pain Finally Surfaces

The most honest moments I've experienced in treatment didn't happen in group or in a therapist's office. They happened quietly and unceremoniously, late at night, or tucked off in a corner somewhere, between people who had built enough trust to mean it. There's a point where words stop being managed. An unspoken understanding settles, and both of you decide it's safe enough to tell your truth:

- "I've never told anyone this before."
- "I know it wasn't my fault, but it still feels like it."
- "I don't think I'll ever truly be okay."

Sometimes what comes out is almost unbearable to hear. Stories of emotional, physical, or sexual abuse. People hurt by strangers, parents, friends, partners. People who witnessed or endured things no one should ever have to.

And when the truth finally surfaces, it's astonishing, in retrospect, to see how close we really were without knowing it. In those moments we were already ninety percent there and completely oblivious: standing at the threshold, the point where real work could begin if someone knew how to catch it. But no one does. So it passes. And what could have been a breakthrough becomes what it always does: two hopeless, uninformed addicts swapping war stories in the dark.

And then the question comes. "Are you going to talk to someone about it?" Nine times out of ten, the answer is some version of "screw that, I don't want to talk about that." And the tenth? They'll say yes, not because they mean it, but because they want the conversation to end.

We get defensive, and why wouldn't we? When someone asks if we're going to talk to someone about our deepest wounds, it can feel invasive, even threatening. It isn't arrogance; it's protection. Of course we shut down. Especially when we don't have a clue where to take it, or what the very real cost of leaving it buried actually is.

The only reason I finally faced mine was education: being lucky enough to learn the science of how unprocessed trauma keeps the body and brain locked in survival mode. Knowledge gave it shape. It turned avoidance into something I could actually work with.

The caveat that matters. We can't, and shouldn't, force anyone to relive trauma. Treatment centres also fail when they never explain why trauma may matter, never assess it properly, and provide no route to evidence-based care. Processing is not essential for every person in recovery. A responsible pathway is. Education gave me a reason to stop working around the wound and decide, with support, whether I was ready to work on it.

Trauma-avoidance isn't compassion. It's abandonment dressed as care.

Addiction is neither a choice nor an inherited disease, but a psychological and physiological response to painful life experiences. — Gabor Maté

When Nobody Asks About the Beginning

Across detoxes, inpatient stays, outpatient programs, and psychiatric assessments, not once did anyone ask the most basic question: tell me about your life.

I sat through intakes that ran for hours. The focus never changed: how much, how often, how long. Charted. Documented. Categorized. That was the entire picture they wanted. It felt like

being read the way you'd read a volatile stock. Someone tracking the price action of a human life without once asking what was driving it. Nobody looking at the early conditions, the instability, the nervous system shaped long before the first drink. They had the numbers. No one asked about the whole person.

Context forced its way in accidentally. When you walk through your use chronologically, you remember what was happening around it. The breakup. The chaos. The fear. The event always comes with the substance. That should matter. But the system didn't stay there. It went back to the numbers. Even when medications were prescribed, trauma was treated as interference. The whole signal, filed under background noise, unless I forced it into the room myself.

*When no one asks about the beginning, the pattern becomes the diagnosis.
For people like me, the beginning is the story.*

What I've Witnessed Firsthand

For years I couldn't understand why my friends could stop after a night out while I kept disappearing for days. What I eventually had to accept, and what nearly cost me my life before I did, was that they weren't escaping anything. I was. For them, the hangover outweighed the fun. For me, the escape outweighed the crash. Every single time.

And the echoes from the recovery rooms were consistent enough to be a pattern rather than a coincidence:

- "I didn't feel safe as a kid."
- "I had to raise myself."
- "I was punished for showing emotion."
- "I was abused and couldn't stop it."
- "I hated going home."

These weren't unusual disclosures. They were nearly universal. In room after room, across years of treatment and recovery, the same story kept surfacing in different words. Addiction is often the medication for wounds that never healed.

The Dangerous Logic of Trauma-Informed Care That Avoids Trauma

In practice, organizations often use trauma-informed to mean some combination of three things, all genuinely worth having, but none guaranteeing that trauma treatment is actually available.

Practice 1 — Gentler Language

Staff trained to communicate with more sensitivity and care.

Softer framing around difficult topics.

Language that acknowledges trauma exists, without addressing it.

Practice 2 — A Calmer Environment

Less chaos, cleaner spaces, more predictable structure.

Environments designed not to retraumatize.

Safety as a setting, not as a therapeutic outcome.

Practice 3 — A Policy of Not Digging

Clients aren't forced to revisit trauma, which is a genuinely important protection.

But "not forced" quietly becomes "never invited."

And "never invited" becomes the default end of the conversation.

The Gap: What's Missing

A clear, funded pathway to trauma-specific therapy.

Clinicians trained and resourced to do trauma processing, not just trauma awareness.

Any answer to the question: what happens after we acknowledge the wound?

These are meaningful steps. But when trauma-informed becomes a reason to avoid trauma entirely, the label stops describing the care and starts covering for the absence of it. If unresolved trauma fuels relapse, how can tiptoeing around it be justified? Not naming it doesn't protect people. It abandons them with the same wounds that drove them to substances in the first place.

This avoidance isn't always deliberate. Some of it is under-resourcing. Some of it is real uncertainty about how to hold what comes up. But I can't help wondering about the reasons that are harder to name:

Are some staff simply not equipped to hold what surfaces when the door actually opens, and does the system know it?

Are some centres keeping trauma outside the scope of practice, not out of uncertainty, but out of liability?

Does the cost of real trauma treatment make it easier to stop at trauma-informed and call that close enough?

I don't have clean answers to those questions. But they're worth sitting with, because whatever the reason for the gap, the consequence doesn't change. Good intentions don't heal pain. Pain left unaddressed becomes relapse waiting to happen. If a treatment centre claims to focus on what happened to you, there has to be a clear, accessible pathway to clinical, trauma-specific therapy. Without it, it's marketing language wrapped around avoidance.

Where Are the Real Trauma Supports?

These are the questions the system should be answering. The fact that they aren't isn't an oversight. It's a choice.

Where are the trauma-specific support groups inside treatment centres, not process groups, but spaces actually designed for what trauma survivors are carrying?

Where is consistent, funded access to trauma treatments with strong evidence, including CPT, EMDR, and Prolonged Exposure? And where are honest conversations about ART, IFS, and somatic approaches: options some people find useful, but whose evidence bases are smaller or still developing?

Where is the public funding for trauma healing instead of another round of revolving-door detox that sends the same people back through the same doors with the same wounds?

Until those questions get real answers, treatment will keep failing the very people it claims to serve. Not missing the mark. Failing them. The ones using substances not to party, but to survive unbearable pain.

Before You Go

If you're currently in a program, the useful thing to take from this isn't suspicion. It's a question: is there a pathway from here to actual trauma processing, and what is it? Ask it plainly, of the people responsible for your care. A good program will have an answer, or will help you find one outside the building.

And if you've been through treatment that acknowledged your trauma without ever offering to treat it, that experience wasn't a misunderstanding on your part. It's a documented, structural gap that clinicians write papers about. You weren't imagining the thing that was missing.

Behaviour management isn't recovery. Polishing the surface isn't compassion; it's a way of avoiding the work while still collecting the credit. Lasting recovery requires going to the root.

These questions weren't being asked out loud. That's why this site exists, so the next person doesn't have to wait as long as I did to find out what the root actually is.

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Sources & Further Reading

These sources cover the evolution of trauma-informed care, the documented gap between its principles and its implementation, and why moving from accommodation to actual trauma processing is the necessary next step for systems serious about durable outcomes.

SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. *The federal policy document that defined trauma-informed care and established its Six Key Principles: the framework argued here to have become widespread in language but inconsistent in depth.*

Harris, M., & Fallot, R. D. (Eds.). (2001). Using Trauma Theory to Design Service Systems. Jossey-Bass. *The foundational text introducing trauma-informed service design, and one of the earliest articulations of the central distinction here: trauma-informed systems create conditions for disclosure and avoid retraumatization, but do not themselves constitute trauma treatment.*

Edelman, N. (2023). Doing trauma-informed work in a trauma-informed way: understanding difficulties and finding solutions. Health Services Insights, 16. *Contemporary paper documenting the gap between trauma-informed care as a policy commitment and its actual implementation, and what structural conditions are required for it to function as designed rather than as a risk-management framework.*

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, contextualizing this critique as structural rather than a failure of individual intention.*

Najavits, L. M. (2002). Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. Guilford Press. *Developed specifically because standard substance-use treatment was failing trauma survivors. A direct clinical argument for moving beyond avoidance into structured processing.*

Ford, J. D., & Courtois, C. A. (2014). Complex PTSD, affect dysregulation, and borderline personality disorder. *Borderline Personality Disorder and Emotion Dysregulation*, 1(1), 9. *Establishes why generic trauma-informed approaches designed for simpler presentations frequently fail complex trauma survivors, and why avoiding trauma-specific care produces the misdiagnosis and dropout patterns described here.*

Briere, J., & Scott, C. (2015). *Principles of Trauma Therapy* (2nd ed.). SAGE. *Covers the distinction between stabilization-focused and processing-focused approaches, and why both are necessary components of a complete model rather than alternatives.*

Felitti, V. J., Anda, R. F., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, 14(4), 245–258. *The original ACE Study, establishing that early adversity is pervasive and its effects dose-dependent, and that systems treating only symptoms while leaving trauma unaddressed are working against their own outcomes.*

Van der Kolk, B. A. (2014). *The Body Keeps the Score*. Viking. *Influential synthesis of how trauma can be expressed through sensation, action, implicit learning, emotion, and physiology. It does not prove that memories are stored outside the brain or that behaviour-focused care can never help; it supports looking beyond behaviour when embodied distress remains unaddressed.*

Maté, G. (2008). *In the Realm of Hungry Ghosts*. Knopf Canada. *The source of the framing that addiction is neither a choice nor an inherited disease, but a response to painful life experience.*

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