Why Traditional Treatment Often Falls Short

You're not broken. The model is incomplete.

Austan Sloan • Recover-You

A note before you begin. This guide is critical of how addiction treatment is commonly delivered, and it describes a relapse that nearly ended in death. If you are currently in a program, please read it as an argument for asking your providers a specific question, not as a reason to leave. The programs criticized here also kept the author alive, and he says so.

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

I Did Everything Right. It Wasn't Enough.

The first time I entered inpatient treatment, I believed the problem had a name and the name was alcohol. It was the most visible thing in a life full of wreckage, so I assumed removing it would let everything else settle back into place.

For a while, it looked like it had. Clear-headed. Optimistic. Repairing relationships, rebuilding finances. I fell in love with Calgary during treatment, found work, relocated from Edmonton. From the outside, I was a success story. Inside, I was quietly coming apart.

What followed was the worst relapse of my life. It nearly killed me, and it came close to destroying every relationship that mattered. In hindsight, it was never a question of if. Only when.

Alcohol was never the problem. It was the solution. Crude and borrowed, but mine. Without it, I was exposed. Decades of unprocessed pain with no container and no tools. I had stripped away the symptom and left the cause completely untouched. Not because I failed. Because no one ever told me there was a cause.

This is the gap traditional treatment so often leaves open. It stabilizes, educates, and supports. For many people, that's genuinely life-saving. But for trauma survivors, stability is not the same as recovery. When the substance is removed, we don't return to a healthy baseline. We return to the trauma, the dysregulation, the unresolved grief. Only now without the thing that once made it survivable.

> *When treatment doesn't reach what's underneath the addiction, sobriety doesn't feel like freedom. It feels like standing in a burning building with the fire alarm finally silenced.*

What Traditional Treatment Actually Does

To be clear: most addiction programs do what they're designed to do, and they do it well. The priority is immediate and correct. Help a person stop using and regain enough stability to

function. The structure, the medical oversight, the peer support. These things save lives. I wouldn't be writing this without them.

Where these programs struggle isn't in what they do. It's in what they don't ask. They're built to manage behaviour in the present, not to understand where it came from. They restore functioning: sleep, nutrition, routine, accountability. They teach addiction science and relapse prevention. They give people a fighting chance at the first 30 days. But the origins of the behaviour, the nervous system that learned to need the substance, rarely enter the room.

The pillars below represent what most treatment centres actually offer. Each one is legitimate. The problem isn't any individual piece. It's what the model, as a whole, consistently leaves out.

Detox and stabilization: supporting withdrawal safely, monitoring vital signs, and helping the body re-establish basic physical stability. This is where sleep, appetite, hydration, and nervous-system regulation begin to recover.

Education and relapse prevention: teaching how substances affect the brain, identifying high-risk situations, understanding triggers, and learning practical skills like urge surfing, delay strategies, and building healthier routines.

Group therapy and peer support: a structured space for sharing experiences, building accountability, practising communication skills, and creating a sense of connection with others who understand the struggle firsthand.

12-step or faith-based programs: encouraging self-reflection, accountability, spiritual growth, and community. These frameworks offer structure and consistency, and for many, a sense of belonging and meaning.

Aftercare planning: creating a plan for ongoing support: therapy, meetings, structure, habits, and accountability. The goal is maintaining progress once the protected environment of treatment ends.

Medication management: using medications to reduce cravings, ease withdrawal, stabilize sleep, and support mood. Often essential tools for early recovery and maintaining stability.

The Typical Addiction Model, and What It Misses

A Healthy Brain

A balanced system. Emotion, reason, and reward working in sync.

The amygdala fires at real threats, then powers down.

The stress response turns off when danger passes.

The prefrontal cortex regulates impulses and aligns actions with values.

Dopamine rewards authentic pleasure and motivation.

Balance fosters trust, curiosity, and resilience.

The Brain Under Addiction, Without a Trauma History

Repeated use can reorganize reward learning until the substance becomes a dominant predictor of relief.

Dopamine-linked learning strengthens attention to substance cues and expected reward.

Withdrawal, stress, and conditioned cues can make the absence of the drug feel urgent or threatening.

The stress response stays overactive, driving craving.

Executive control can weaken under craving or stress, making short-term relief overpower long-term values.

Daily life narrows to seeking and escape.

The Childhood Trauma Brain (PTSD and C-PTSD)

An alarm system stuck on. Safety never fully registers.

Threat-detection systems may become more reactive, scanning even in moments that are objectively safe.

The stress response can become dysregulated; cortisol may be elevated, blunted, mistimed, or unusually reactive.

Chronic adversity is associated with group-level differences in development and function; regulation can become harder without any one brain region being simply broken.

Dopamine reward is blunted; joy and motivation feel distant.

Trust and safety struggle to take root.

When Trauma and Addiction Collide

Two forces compounding each other. The alarm never powers down, and the only available relief is the substance.

The threat system rarely powers down when it needs to.

The stress response runs hot, fuelling dysregulation.

Reward pathways lock onto compulsive relief, not true pleasure.

The prefrontal cortex struggles to regulate impulses.

Homeostasis and allostasis become dysregulated, and sobriety alone may not restore balance.

> *Without addressing trauma, expecting the brain to reset through sobriety alone is unrealistic. Childhood wounds don't course-correct in standard treatment.*

What's Overlooked for Childhood Trauma Survivors

Most addiction programs focus on stabilizing behaviour. But childhood trauma survivors carry an entirely different set of challenges beneath the surface. We don't just manage cravings. We're living with fear, shame, hypervigilance, and a stress system that never learned how to turn itself off.

Sobriety removes the substance. It doesn't automatically repair the dysregulation that made escape feel necessary in the first place. In my case, when the underlying pain wasn't addressed, being sober often felt worse than using. I never admitted that out loud. For many of us, recovery isn't just about abstinence. It's about safety, understanding, and learning how to calm a brain that has been in survival mode for decades.

Trauma processing and integration: safe, evidence-based approaches to reprocess overwhelming memories, so the past stops intruding on the present.

Nervous system regulation: learning tools to calm an overactive stress response and shift the body out of chronic fight-or-flight.

Attachment and trust repair: relearning safety in connection. Building the capacity to trust, depend, and be depended on.

Identity and self-worth rebuilding: reconstructing a sense of self that isn't built around survival, performance, or self-protection.

Shame and self-compassion work: shifting from self-blame to self-understanding. Rebuilding the ability to see yourself as worthy.

Trauma-focused and body-oriented options: using treatments with strong PTSD evidence, such as EMDR, CPT, and Prolonged Exposure, while considering ART or somatic approaches with a clear understanding that their evidence bases are smaller. The aim is not to 'release trauma stored in the body.' It is to reduce symptoms, avoidance, distress, and the grip of the past on the present.

The Wall I Kept Hitting

Every program I went through could stabilize me. None of them reached what was driving the addiction. I was told to work the program while quietly doing the real work elsewhere. Trauma therapy in one office, nervous-system regulation in another, attachment repair wherever I could find someone willing to go there.

The deeper I went, the more I realized these weren't alternative theories or fringe ideas. They were the foundations that had been missing all along. The ones that finally made healing feel possible instead of performative. And I had to find every single one of them myself.

Where the Model Breaks: Even When You're Ready, Where Do You Go?

In every treatment centre I've been in, the overwhelming majority of people had significant trauma in their history. That wasn't a clinical observation. It was just obvious from the conversations. But even if every one of them decided today to finally address that trauma directly, the system couldn't absorb it. There isn't enough qualified support to go around. Not even close.

Within Alberta Health Services, and now Recovery Alberta, trauma-specific therapy is severely under-resourced. Waitlists run months, sometimes over a year. Specialized providers are scarce. And if your trauma doesn't fit a narrow diagnostic profile, or doesn't look severe enough on paper, you can fall through entirely. People do. Regularly.

The honest answer: trauma-specific care exists in Alberta across private practice, community organizations, and parts of the public mental-health system, but availability, modality, eligibility, and wait times vary sharply. Recovery Alberta provides public addiction and mental-health services, including in correctional settings; that does not mean everyone can quickly access the trauma method they need. Private care can widen choice, but cost shuts many people out. The gap is not total absence. It is inconsistent, unequal access.

> *In addiction, a waitlist isn't an inconvenience. It can be a death sentence. That's not hyperbole. That's what I watched happen.*

Through private conversations with clinicians over the years, I've learned that many working inside the system see these gaps clearly and are just as frustrated. They're doing what they can inside a structure that isn't keeping pace with the science, the need, or the people in front of them. The question isn't whether people want help. It's whether the system is equipped to give it when they finally ask. Too often, it isn't. And what gets offered instead, care that doesn't match the actual problem, isn't recovery. It's a holding pattern with a better name.

Six Places the Model Breaks Down

Diagnosis-Driven, Not Causality-Driven

The DSM-5 gives clinicians a shared language, and that matters. But it also pulls the focus toward whether a symptom exists rather than why it does. I was treated for anxiety, depression, and substance use for years without anyone looking underneath them at the nervous-system dysregulation driving everything. It felt like treating a fever without ever asking what was causing the infection. The fever came down. The infection stayed.

Funding Structures That Fragment Care

The Canadian system reinforced separation at every level. Addiction in one lane. Trauma in another. Mental illness somewhere else entirely. Even when a clinician recognized the connections, funding rules, referral criteria, and eligibility requirements often forced them to treat each issue in isolation. What was one interconnected problem got divided into disconnected parts, managed by people who weren't allowed to talk to each other.

Trauma Isn't Always Obvious, and It's Rarely Asked About

Emotional neglect. Chronic unpredictability. Persistent invalidation. None of it felt like trauma to me at the time, and many of the clinicians I saw weren't trained to recognize it either. It wasn't until I started trauma-specific work that the full picture came into focus. Naming it was the first thing that made the addiction, the anxiety, and the shame-driven behaviour stop feeling inexplicable. They weren't random. They were responses.

Siloed Treatment, Disconnected Stories

One program for addiction. Another for anxiety. Another for depression. Rarely did anyone step back and ask: what's the bigger story here? The DSM acknowledges comorbidity with PTSD, but in practice that link often went unexplored. Nobody was looking for the thread that connected everything. Without the narrative, treatment became patchwork. And patchwork doesn't hold.

The Medical Model Doesn't Do Narrative

It excels at naming what's wrong. It rarely asks what happened to you. No one ever asked me: what did you have to believe to survive? How did your nervous system adapt in ways that once protected you but now work against you? Trauma work asked those questions. It reframed behaviour as communication rather than pathology. That reframe was the beginning of something that actually held.

The System Is Changing, Slowly

The ACE Study confirmed what survivors had already lived: childhood adversity reshapes the brain and drives significant long-term risk for addiction and mental illness. Trauma-informed approaches are gaining ground. Integrated models are beginning to appear. And people who

once suffered silently are building the resources they couldn't find. The gap is real. So is the momentum closing it.

A Critical Distinction: Trauma-Informed Care Is Not Trauma Treatment

Many facilities advertise trauma-informed care. What that actually means is that staff have been trained to recognize trauma and avoid retraumatizing people. It does not guarantee they are equipped, or permitted, to treat it.

> *Trauma-informed is an orientation. Trauma treatment is a clinical intervention. They are not the same thing, and the difference matters enormously.*

Actual trauma treatment requires trained clinicians using evidence-based approaches: EMDR, ART, somatic therapies. The work processes overwhelming experiences, regulates the nervous system, and rebuilds a person's internal narrative. A program that is merely aware of trauma is not doing that work.

The danger is when the label becomes a substitute for the work. When systems adopt trauma-informed language and stop there, as if acknowledgment alone heals anything. It doesn't. Awareness creates a safer space to hold pain. It does not resolve it.

The question to ask. If you or someone you care about is exploring treatment, ask directly: do they offer trauma-specific therapy, not just trauma-informed care? If not, can they connect you to external trauma services, or allow you to bring in your own clinician? Those are the right questions. The answers will tell you everything.

Before You Go

Nothing in this guide is an argument against getting treatment. The programs described here stabilized me more than once, and I would not be here to criticize them if they hadn't. The argument is narrower: stabilization and healing are two different jobs, and most programs are resourced for only the first.

If you take one thing from this, make it the question in the box above. Asking it costs nothing, and the answer tells you what kind of care you're actually being offered.

And if you've been through treatment more than once and it hasn't held, please consider the possibility that this says something about the fit between the model and your history, rather than something about you.

> *Addiction is rarely just about the substance. For trauma survivors, lasting freedom doesn't come from removing the escape. It comes from healing whatever made escape feel necessary in the first place.*

I had to learn to heal the wound before I could put down the anesthetic. For good.

Feeling overwhelmed by what you're reading? Support is here. Call or text 988, Canada's 24/7 Suicide Crisis Helpline • In Alberta, call or text 211 for community, social, health, and

government services • In Edmonton and area, call the 24/7 Distress Line at 780-482-HELP (4357) • Call 911 in an emergency.

Sources & Further Reading

These references explore the systemic limitations of traditional treatment, the neurobiology of trauma and addiction, and the evidence supporting integrated, trauma-informed care approaches.

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, addressing the substance but not the co-occurring PTSD. Directly substantiates the central structural argument here: the limitation is not a failure of effort but of design.*

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders. Harvard Review of Psychiatry, 4(5), 231–244. *Argues that substance use is motivated primarily by the need to relieve painful affect rooted in trauma rather than to achieve euphoria. Removing the substance without addressing the underlying affect creates the crisis described here: sobriety as exposure, not resolution.*

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: the research that makes the connection between trauma and addiction impossible to ignore, and that exposes the inadequacy of models addressing only the substance.*

Mahon, D. (2025). A systematic review of trauma informed care in substance use settings. Community Mental Health Journal, 61(4), 734–753. *Systematic review documenting the current state of trauma-informed care implementation in addiction treatment, confirming both the evidence for its effectiveness and the systemic gaps in its adoption.*

SAMHSA. (2014). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) 57. *Federal clinical guidance for integrating trauma-informed approaches into behavioural health and substance-use settings, formally acknowledging the gap between trauma's known role in addiction and the infrastructure built to address it.*

Porges, S. W. (2011). The Polyvagal Theory. Norton. *Influential theory emphasizing autonomic state, social connection, and felt safety. Some clinicians find the framework useful; several of its specific evolutionary and physiological claims remain debated. It should not be used to claim that cognitive treatment cannot help a body under threat.*

Briere, J., & Scott, C. (2019). Principles of Trauma Therapy (3rd ed.). SAGE. *Differential diagnosis and trauma-informed treatment planning framework, documenting the clinical complexity of co-occurring trauma and substance use and why standard protocols require structural modification to serve this population.*

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: trauma-informed care in homelessness services settings. Open Health Services and Policy Journal, 3, 80–100. *Documents the structural barriers that prevent standard systems from delivering trauma-informed approaches, contextualizing the argument that the gap between knowledge and practice is systemic rather than incidental.*

National Institute on Drug Abuse. (2020). Drugs, Brains, and Behavior: The Science of Addiction. NIH. *Establishes why abstinence alone does not restore normal regulation, and why the brain changes produced by chronic use require more than willpower and behavioural accountability to reverse.*

Maté, G. (2008). In the Realm of Hungry Ghosts. Knopf Canada. *The ground-level clinical case that addiction is most accurately understood as a response to the unbearable pain of early adversity, and that any approach ignoring this root is addressing only the symptom.*