

Trauma-Focused Recovery Model (TFR)

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Bridging the gap. Evolving the system. Offering a coherent way forward.

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WHAT THIS IS

The TFR Model is a synthesis framework – it draws on established bodies of evidence across adjacent literatures rather than representing a named program that has itself been directly trialed. The sequencing proposed here reflects that synthesis.

It was born at the tail end of a 24-year battle with addiction.

For most of that time, I was taught that my problem was alcohol. Abstain. Build structure. Work the program. Manage cravings. Regulate behaviour. Stay accountable.

The logic was straightforward: remove the substance and recovery follows.

So I tried. Repeatedly.

I learned the disease model. I studied dopamine hijack theory. I practiced CBT skills. I leaned into moral and spiritual frameworks. I did what was asked of me.

What I did not understand – and what was never systematically explained – was that addiction was not the origin of my suffering.

It was the adaptation. The origin was trauma.

Not only obvious events, but developmental stress, attachment disruption, chronic dysregulation. Trauma was not just a chapter in my story – it was the organizing principle of my nervous system. It shaped my threat perception, my impulse control, my attachment strategies, and my need for relief long before I ever drank.

Addiction wasn't the origin.

It was the symptom.

This model integrates two established bodies of work:

1. Triphasic trauma recovery
2. Addiction stabilization

because treating symptoms without addressing underlying injury can leave key drivers of recurrence intact.

WHY THIS MODEL EXISTS

Across years of engagement in treatment environments and recovery communities, a consistent pattern emerged – one familiar to many clinicians: in a substantial subset of substance use cases, trauma exposure predates the onset of addiction.

When someone initially says, “Nothing traumatic happened,” it often reflects a narrow definition of trauma – not its absence. Once developmental, relational, and attachment-based trauma are explained, the picture changes.

This isn’t a radical claim. The ACE Study, and decades of trauma science converge on the same conclusion: **early adversity is consistently linked to higher rates of substance dependence** (Felitti et al., 1998; Anda et al., 2006; Moffitt et al., 2011).

And yet, addiction treatment and trauma treatment are often delivered on parallel tracks rather than sequenced within the same recovery arc.

Addiction programs stabilize. Trauma programs process.

Alberta does many things exceptionally well. Stabilization, structure, community, peer accountability, skill acquisition – these are real strengths.

Many programs are rightly proud of them. But stabilization is Stage 1 of trauma recovery (Herman, 1992).

Calling Stage 1 “trauma-informed” and stopping there is where the gap begins.

This discontinuity in care may leave core drivers unaddressed, contributing to ongoing relapse vulnerability (Mills et al., 2012; Hien et al., 2010; McCauley et al., 2012).

Throughout this paper, 'trauma' refers to a broad spectrum – including both diagnosable PTSD and the wider range of trauma-related dysregulation that may not meet full diagnostic criteria but still meaningfully shapes nervous system function and addiction patterns.

Research confirms the scale of this gap: in SUD treatment populations, 25% meet full PTSD criteria on intake, with an additional 15% carrying subclinical trauma symptoms – meaning roughly 40% enter treatment with significant trauma-related distress that standard addiction protocols don't systematically address (Karsberg et al., 2025).

THE MOMENT CLINICIANS RECOGNIZE

This cycle is frequently observed:

A client stabilizes. They are sleeping. They are eating. They are attending groups. They begin to feel safe. In that safety, they disclose something from childhood they have never said out loud.

The group holds them. Peers validate. Staff support.

Then the program ends.

They are discharged with relapse-prevention plans and coping skills – but no structured pathway for trauma processing. Within months, activation resurfaces.

Nightmares, relational conflict, emotional flooding, dissociation. Substances once again become regulation.

No one did anything wrong.

But something essential was missing.

Research confirms this pattern: in addiction treatment settings, over one third of patients meet criteria for current PTSD – yet the majority go undetected when clinicians rely on unstructured judgment alone (Gielen et al., 2012).

Addiction treatment created enough safety for trauma to surface – but not enough structure for it to be metabolized.

Trauma was opened, but not integrated.

That is both the proof of concept and the core problem.

THE STRUCTURAL GAP

Judith Herman's trauma framework remains one of the clearest maps of recovery:

Stage 1 – Safety and Stabilization

Stage 2 – Remembrance and Mourning (processing)

Stage 3 – Reconnection and Integration

Addiction programs already do Stage 1 well.

They provide containment, regulation skills, peer accountability, structure, medication support, and behavioural stabilization.

But the system often stops there.

Stage 2 – structured trauma processing – is often not embedded within addiction programs.

Stage 3 – identity reconstruction and attachment repair – frequently lacks structured scaffolding within addiction treatment systems.

The result is the Stage-1 Loop (Scott, Foss & Dennis, 2005; McLellan et al., 2000):

Stabilize.

Discharge.

Relapse.

Re-admit.

Not because clients lack willpower. Not because staff lack skill.

Because the deeper driver was never processed.

Failure to identify and treat PTSD in addiction settings has been consistently linked to poorer outcomes and elevated relapse vulnerability – a significant contributing pattern, not an incidental one (Gielen et al., 2012).

This is not an indictment of the system.

It is a sequencing problem.

TRAUMA-INFORMED VS. TRAUMA-FOCUSED

Trauma-informed care, as currently practiced, emphasizes safety, trustworthiness, collaboration, and avoidance of retraumatization (SAMHSA, 2014). It is a necessary foundation.

However, trauma-informed care is primarily an organizational framework rather than a treatment modality.

By itself, trauma-informed care does not constitute trauma processing. It reduces harm – but does not automatically produce healing.

Trauma-focused care builds on that foundation and adds a pathway forward. It begins with stabilization, incorporates structured psychoeducation, and then either provides or clearly connects clients to trauma processing modalities – EMDR, ART, IFS, somatic therapies, grief work, narrative reconstruction.

Trauma-informed sees trauma.

Trauma-focused moves through it.

If clients leave treatment unaware of how trauma shaped their addiction, without understanding available processing options, and without a clear referral pathway, then we are stabilizing trauma – not resolving it (McCauley et al., 2012).

That distinction matters.

When the prevalence of current PTSD in SUD populations ranges from 25% to 42% (McCauley et al., 2012; Karsberg et al., 2025), an organizational framework that sees trauma but provides no processing pathway is leaving a substantial portion of the clinical problem unaddressed.

THE MISSING MIDDLE: EDUCATION (STAGE 1.5)

Education is the hinge.

Many clients do not fully understand what trauma and trauma processing encompass. They often equate trauma with catastrophic events while overlooking chronic relational stress. Complex trauma, nervous system dysregulation, attachment injury, and the regulatory function of substances are frequently unrecognized.

Without education, trauma feels like identity.

With education, trauma becomes processable.

Stage 1.5 is structured psychoeducation delivered during stabilization. It explains:

- What trauma is – including developmental trauma How trauma reshapes the brain and stress systems (Teicher & Samson, 2016; McEwen, 2007)
- Why addiction often emerges as regulation (Khantzian, 1985)
- What trauma processing actually involves
- Why avoidance maintains symptoms
- What healing can realistically look like

Critically, this phase requires no disclosure. Clients are not asked to recount history. They are given a framework.

Education can reduce shame, lower defensiveness, and build readiness without forcing exposure. Shame is a significant and well-documented barrier to engagement in this population – one that psychoeducation is well positioned to reduce indirectly by increasing understanding and lowering self-blame (Bhuptani et al., 2024; Mahoney et al., 2019).

Psychoeducation delivered as a standalone intervention produces limited symptom change; its value lies in preparation and sequencing rather than resolution (Mahoney et al., 2020; Cloitre et al., 2010).

It is the ethical bridge between stabilization and processing.

STAGE 2:

TRAUMA PROCESSING

Emerging evidence suggests that integrated approaches to PTSD and substance use treatment can improve outcomes – not by avoiding trauma, but by addressing it safely rather than leaving it unprocessed (Mills et al., 2012; Persson et al., 2017; Hien et al., 2023).

Most treatment centers cannot provide in-house trauma processing – and they do not need to.

The TFR Model asks something more modest: that clients leave prepared, not just stabilized.

That means three things at discharge:

- Stabilization sufficient to tolerate trauma work
- Education sufficient to understand why it matters
- A clear pathway to actually access it

That pathway does not require new clinical infrastructure.

It can be built through referral partnerships with trauma-trained clinicians, insurance navigation support, sliding-scale resources, and structured follow-up protocols.

Access to trauma-specialized services varies significantly across regions – but even modest improvements in discharge planning and referral clarity can meaningfully shift outcomes for clients who are ready.

The goal is not to turn addiction treatment centers into trauma clinics.

It is to stop discharging clients at stabilization alone.

The Necessary Off-Ramp

Not everyone is ready for trauma processing.

A trauma-responsive system must respect that.

After education, clients choose:

Path A – Trauma Integration
(Stage 2 → Stage 3)

Path B – Continued Stabilization and Integration without processing

Path B is not failure.

It is not noncompliance.

It is sequencing.

Premature trauma exposure can increase destabilization and treatment dropout (Cloitre et al., 2010; Cloitre et al., 2012; Najavits, 2002).

Allowing choice preserves autonomy and psychological safety.

What changes under the TFR Model is this:

Even clients who choose Path B leave with an understanding of trauma and a clear re-entry point.

The door remains open. And in practice, many return when stability deepens.

ADDRESSING THE RESOURCE QUESTION

Clinicians are already stretched. That reality cannot be ignored.

Repeated relapse cycles contribute to increased healthcare utilization and system strain (McLellan et al., 2000; Rehm et al., 2017).

Stage 1.5 does not require new hires. It requires intentional curriculum integration.

Stage 2 does not require in-house processing. It requires partnerships and discharge planning aligned with trauma science.

This is not about adding workload indiscriminately.

It is about reducing churn.

WHY THIS MODEL WORKS

It honors what Alberta already does well. Stabilization, structure, community, peer accountability – these are genuine strengths. The TFR model builds on them. The foundation isn't the problem. The ceiling is.

It integrates decades of trauma research into addiction sequencing. The ACE Study, toxic stress research, Herman's triphasic framework – none of this is new. What's new is placing it in direct conversation with addiction treatment design, rather than running the two on parallel tracks that never meet.

It is worth noting that the modalities listed under Stage 2 vary in the depth of their evidence base within PTSD/SUD contexts specifically. Exposure-based approaches – particularly prolonged exposure and EMDR – have the strongest empirical support. Other modalities listed have clinical value and are widely used in trauma-informed practice; research within addiction treatment contexts continues to develop (McCauley et al., 2012; Mills et al., 2012).

It reduces shame by reframing addiction as adaptation. When people understand that their nervous system built addiction as a solution – not a character defect – shame loses its grip. And without shame, people are more honest with clinicians, more willing to engage, and more likely to stay.

It provides clinicians with a coherent conceptual roadmap. The Stage-1 loop – stabilize, discharge, relapse, re-admit – is not a mystery to anyone working in the system. What may help explain the persistence of this loop is the absence of a sequenced framework that names why it exists and what could structurally interrupt it. TFR provides that map without requiring anyone to rebuild what's already working.

It is designed to interrupt the Stage-1 Loop. Not by adding complexity, but by adding sequence. Stage 1.5 costs no new hires and no structural overhaul. It costs intentional curriculum integration and the willingness to name trauma as a driver rather than a complication.

Most importantly, it aligns stabilization with resolution. Stabilization without a pathway to resolution is incomplete care. Most programs know this. TFR gives the field a practical, evidence-grounded, autonomy-preserving sequence to act on it.

EXAMPLE: HOW THIS WOULD HAVE CHANGED MY RECOVERY

When I first entered treatment, I believed I simply “liked using.” I had no framework for understanding developmental trauma or attachment disruption.

Stage 1 gave me structure and temporary stability. But the underlying activation remained.

When I left treatment, life triggered what had never been processed.

If this model had existed:

I would have stabilized.

I would have understood why addiction formed.

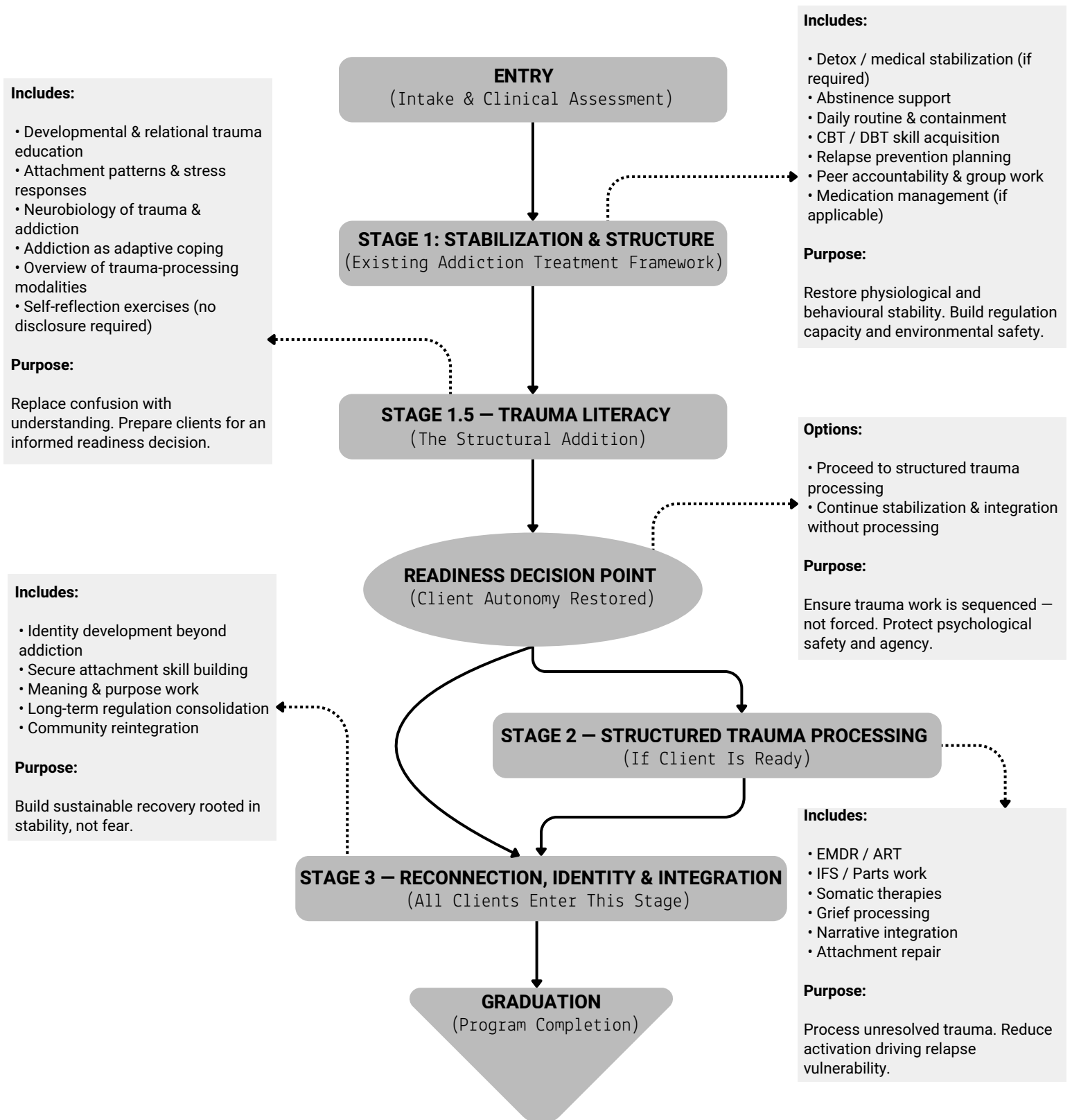
I would have been connected to trauma processing earlier.

I would have rebuilt identity on stable ground.

Instead, I cycled through treatment several times before identifying trauma as the core driver. Integration could have shortened that by years. That vignette is not hypothetical.

Clinicians have seen versions of it repeatedly.

THE TRAUMA-FOCUSED RECOVERY MODEL: A SEQUENCED INTEGRATION FRAMEWORK FOR ALBERTA



STABILIZATION → UNDERSTANDING → CHOICE → PROCESSING (IF READY) → INTEGRATION

FINAL STATEMENT

The Trauma-Focused Recovery Model is not a rejection of Alberta's system. It is an evolution of it.

Stabilization → Education → Choice → Processing (If Ready) → Integration.

If this framework reflects patterns you've observed in your own practice, the next step isn't just sharing a document – it's examining what's already within reach: discharge protocols that include a Stage 2 referral pathway, curriculum space for structured psychoeducation, partnerships with trauma-trained clinicians in your region. None of this requires a structural overhaul. It requires a sequencing decision.

Share this model with colleagues. Bring it to a team meeting. Put it in front of a program director. The ask is small. The gap it addresses is not.

Systems do not shift overnight. But they do shift when enough people recognize the same gap.

This model does not require perfection. It requires sequencing.

SELECTED RESEARCH SUPPORTING THIS FRAMEWORK

The Trauma-Focused Recovery Model builds on established trauma science, addiction research, and phase-based treatment literature. The sequencing proposed here reflects synthesis – not reinvention.

Foundational Trauma & Development Research:

Anda et al., 2006 Felitti et al., 1998 McEwen, 2007 Moffitt et al., 2011 Teicher & Samson, 2016

Addiction as Adaptation / Regulation:

Khantzian, 1985 McLellan et al., 2000

The Relapse-Treatment-Recovery Cycle:

McLellan et al., 2000 Scott, Foss & Dennis, 2005

Integrated PTSD & Substance Use Treatment: Hien et al., 2010 Hien et al., 2023 McCauley, Killeen, Gros, Brady & Back, 2012 Mills et al., 2012 Najavits, 2002 Persson et al., 2017

Phase-Based Trauma Treatment & Sequencing:

Cloitre et al., 2010 Cloitre et al., 2012 Herman, 1992

Psychoeducation as Preparatory Intervention:

Bhuptani et al., 2024 Mahoney, Karatzias & Hutton, 2019 Mahoney, Karatzias, Halliday & Dougal, 2020

Trauma-Informed Care Framework:

SAMHSA, 2014

Health System & Burden Context:

Rehm et al., 2017

Diagnostic Gap & Prevalence in Treatment Settings:

Gielen et al., 2012 Karsberg et al., 2025

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