Trauma Response or Addiction Symptom? #nervoussystem #addictionrecovery #psychology Transcript

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Trauma vs. Addiction: Why the Distinction Matters

Today, I want to talk to you about a topic that comes up a lot, distinguishing between trauma and addiction and also looking at the overlap. When a patient relapses, when they act out, they shut down, people in the treatment camp and loved ones often assume it's just the substance by itself.

A relapse could actually look like trauma response. and vice versa. And misreading trauma response when someone is in addiction recovery, mis-reading that as addiction symptoms, can actually stall progress or can sabotage care entirely.

I'm Dr. Arwen Podesta, a functional integrative psychiatrist. In this video, I am sharing tools that make that possible. You know, one of the most costly clinical missteps occurs when we assume that every single dysregulated behavior in a patient with addiction is actually caused by the substance itself.

Let's say a person becomes emotionally volatile or withdraws entirely, and our default explanation might be this. It might, oh, that's the addiction acting out.

either with cravings or with behaviors around that or actual relapse. But in many cases, it's just not that simple. What often goes unrecognized is the extent to which trauma response, particularly those rooted in post-traumatic stress or complex developmental trauma, can mirror the symptoms we typically associate with addiction.

Hypervigilance, for example, can resemble symptoms of withdrawal from multiple substances or could resemble stimulant use.

How Trauma Responses Can Mimic Addiction

And no matter what the cause, it is nervous system dysregulation. Emotional numbing could look like opioid effects, avoidance dissociation, even outbursts could all be misread as drug seeking as they call it or denial or manipulation.

When we don't recognize those signs for what they might truly be, we risk applying the wrong intervention. We may push for accountability when what's actually needed is nervous system stabilization.

we may interpret survival adaptations as resistance or relapse, and in doing so, we inadvertently reinforce shame and disconnection, the very dynamics that perpetuate the trauma addiction cycle.

The diagnostic fog doesn't just create confusion, it can fundamentally undermine the therapeutic relationship. Patients begin to feel mis-seen, mislabeled, and unsafe.

And without safety, there can be no trust. Without trust, just no progress. So the challenge for us as clinicians is not just to treat the addiction, but it's to develop the clarity to see when trauma is leading the behavior, even if substance use is still part of the picture.

That distinction is essential if we want to move from symptom management to true recovery. Let's talk about how to begin. making that distinction clearly, reliably, and compassionately.

So the big question for us, how do we tell the difference? How do find the subtle cues, the differences, when both trauma and addiction are part of the picture?

In so many patients, as you know, they are. There's an overlap. We're so often working with someone who has a substance use disorder and unresolved trauma.

The addiction is absolutely real and it's being treated. But trauma doesn't disappear just because detox is complete or just, because cravings have subsided or because someone is medically stabilized.

What often happens is this.

Understanding the Overlap in the Brain and Behavior

The patient hits a moment of overwhelm, a flashback, I perceive threat, subtle interpersonal trigger and their nervous system shifts into hyper arousal, shutdown, dissociation.

They might isolate, they might react impulsively, even return to substance use. But in that moment, the primary driver might not actually be the addiction itself.

It might be a trauma response. The behavior is still maladaptive, yes, but the origin of it is protective instead of what we might perceive as being compulsive.

And that distinction truly matters because how we interpret the behavior determines how intervene. If we treat a traumatic response like a relapse, we risk missing what the patient actually might need in the moment, which might not be stricter accountability or a medication shift, but it might be feeling more safety, re-establishing the safety zone.

It starts with an understanding of what each is trying to do. At its core, trauma is the body's response to overwhelming threat, right? Real or perceived.

The nervous system becomes locked in a state of hyperarousal or shutdown. The behaviors that emerge from the state, whether they're emotional detachment, numbing out, anger, or avoidance, are not signs of resistance or relapse.

They're the nervous systems attempt to protect itself when other resources have failed. Addiction, on the other hand, is often an attempt, to override those exact same sensations.

It's a strategy for escaping the internal chaos or the emptiness that the trauma has left behind. The substance or the behavior becomes a tool to regulate what the body and the mind cannot hold.

What complicates this picture is that both processes live in the same regions of the brain. The limbic system, the hypothalamic-pituitary axis, and reward pathways are all implicated.

So the external behaviors may look identical, but the internal drivers are very different. This is why a patient who appears emotionally flat or checked out might not be using it all.

They might be dissociating because of trauma. A patient, who becomes reactive or defensive, might now be in denial. they might be re-experiencing a moment of helplessness or threat.

And if we don't recognize that distinction, we are likely to reach for the tools that escalate the situation instead of calming it. Good news is once you begin to understand the adaptive logic behind these responses, your clinical lens shifts.

Trauma-Informed Assessment and Language

You stop asking, why is this patient not adherent? And instead ask, what's the nervous system attempting to protect here? That shift from judgment to understanding is where effective trauma-informed integrated addiction care begins.

And it's what allows us to tailor our interventions, not just to the diagnosis on paper, but to human being in front of us. So what does that look like in practice?

Before we dive in, if this is already raising questions for you, maybe about a complex case, a recent patient interaction, or how to balance trauma work with structure, go ahead and drop your questions in the comments.

I'd love to hear what's coming up for your. Let's get back. How do we begin to apply trauma-informed integrated lens into our addiction treatment? Well, it starts with how we frame the encounter.

Rather than beginning with the assumption about relapse as resistance, we need to pause and ask, what is this behavior protecting? What's underneath that might be missed if we're only looking for signs of substance use?

From that perspective, We can begin to shift the way we assess, the where we respond, and the we build rapport. First, we need screen for trauma, obviously, just as routinely as we screened for addiction and other things.

That means not just asking about adverse events, but actually tracking how those events are still playing out through hyperarousal, dissociation, somatic tension, or avoidance patterns that patients often can't really name, that they can feel.

There are tools like the PCL-5 or the VAS-20Q. Those are checklists and there's a 17-question DSM life event checklist. They're not perfect, but they're a start.

What I like to have providers do is read the screening tool so you can just apply it to your clinical evaluation and not necessarily do the checklist for everybody.

Second, we shift from labeling behavior as manipulative or as nonadherent or is drug seeking and instead interpret that through a functional lens. A patient who's numbing out might not be using to escape, right?

They might actually be reenacting a well-rehearsed strategy for emotional survival. And when we see behavior as adaptive, even if it's maladaptive in the long term, we actually create room for our clinical curiosity instead of frustration.

Next, We adjust our language using stigmatizing words. We need to move away from that. So we try to remove away using words like relapse or denial or resistance or drug seeking.

Applying a Safety-First Integrated Approach

Because although those are, you know, maybe technically correct, sometimes they certainly can carry unintended weight. Instead, we want to describe these moments in terms of nervous system overwhelm or protective response.

That doesn't mean we wanna avoid accountability. We anchor it in compassion, though. Finally, prioritize safety in the therapeutic relationship. And that might mean slowing down the pace of treatment, offering more regulation-based tools up front, or simply allowing the patient to be seen and heard without immediate correction.

Safety isn't just a goal, it's actually a prerequisite for engagement. And these aren't drastic changes, they don't require a complete overhaul of your clinical model, but they do require shift in mindset from managing symptoms to understanding systems.

And that shift can change everything. Alright, now let's come back to the core question. When we see dysregulation, when we emotional numbing or impulsive behavior, are we looking at a symptom of addiction or are looking a response to trauma?

If we respond reflexively through a narrow lens, we may miss the opportunity to support real healing. But when we pause, observe, and ask what the behavior is protecting, we shift from managing symptoms to understanding survival.

And that shift matters. It builds trust and it creates space for patients to move out of reaction and into recovery. on a timeline and in language their nervous system can actually tolerate.

And this is the foundation of trauma-informed integrated addiction care. The more clearly we can see the distinction between trauma responses and compulsive behaviors, the more precise and effective our treatment becomes.

If you'd like to go deeper in this approach, click on the next video that appears here on this screen. Make sure to follow along because I'll be sharing more evidence-based tools to help you strengthen outcomes and deepen your clinical impact.

I'm Dr. Arwen Podesta, and thank you for watching.