Breaking the Cycle

Understanding Trauma in Addiction Recovery

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Talia Black

MS, LMFT-S, LPC-S

EMDR I & II
Certified Sexual Addiction Therapist (CSAT)
Certified Trauma Therapist (CTT)

You are in charge of you:
You do not have to share anything you are not comfortable sharing
Participation looks different for everyone — and all of it is valid
Silence is always an acceptable response

This is an education space, not a therapy space:
Today is about information and awareness, not processing or disclosure
If something comes up for you, you are welcome to sit with it privately
Deep personal work is best done with a therapist or sponsor — not in a room of 30 people

Watch your window:
You know your own limits better than anyone in this room
If something feels like too much, that is important information — honor it
Stepping out, taking a breath, or simply putting your pen down is always okay

Keep it confidential:
What you hear today is not yours to carry out the door.

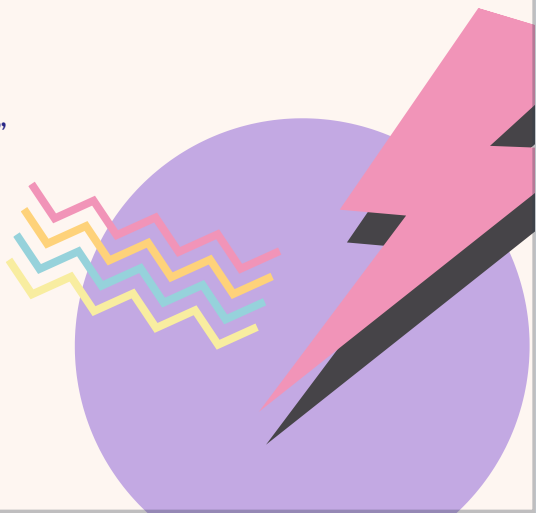
You may experience some feelings:
This material can bring things to the surface — that is normal and expected
Feelings are not emergencies
Support is available — sponsors, therapists, trusted friends.

Take what is useful, leave what is not:
Not everything today will apply to your experience
You do not have to accept any framework that does not fit
Take the pieces that help and release the rest

There is no wrong way to be here:
You showed up — that already took courage
However you experience today is exactly right for you

My most traumatized client's have said...

- "I had a wonderful childhood"
- "But I know my parents loved me"
- "Others had it worse than I did"
- "It happened, but I turned out better because of it"
- "I had a wonderful childhood"
- "It made me who I am today"
- "It probably wasn't that bad"
- "I am just being dramatic"



Session One

HISTORY OF TRAUMA AND ADDICTION:

HOW OUR UNDERSTANDING HAS EVOLVED

1950s–1970s:

Moral Model → Early Disease Model

How people understood addiction:

- Seen as moral failure / lack of willpower
- Heavy shame + punishment mindset
- "Just stop it" culture

What starts to shift:

- Alcoholics Anonymous gains traction (1930s → grows mid-century)
- Introduction of the disease model of addiction

Trauma at this time:

- Largely ignored unless extreme (war-related)
- Early recognition of "shell shock" → later PTSD roots

Moral Failure/Lack of willpower: This concept goes back centuries, it has been reinforced by religion, law, and culture, and was essentially the only mainstream framework until quite recently. That's a massive head start.

1980s: PTSD Becomes Official

Major milestone:
- Symptoms began being named. "Shell Shock", "combat fatigue", "Thousand yard stare"
- PTSD added to the DSM in 1980 (DSM-III)

Why it matters:
- First time trauma is recognized as a legitimate psychological injury.

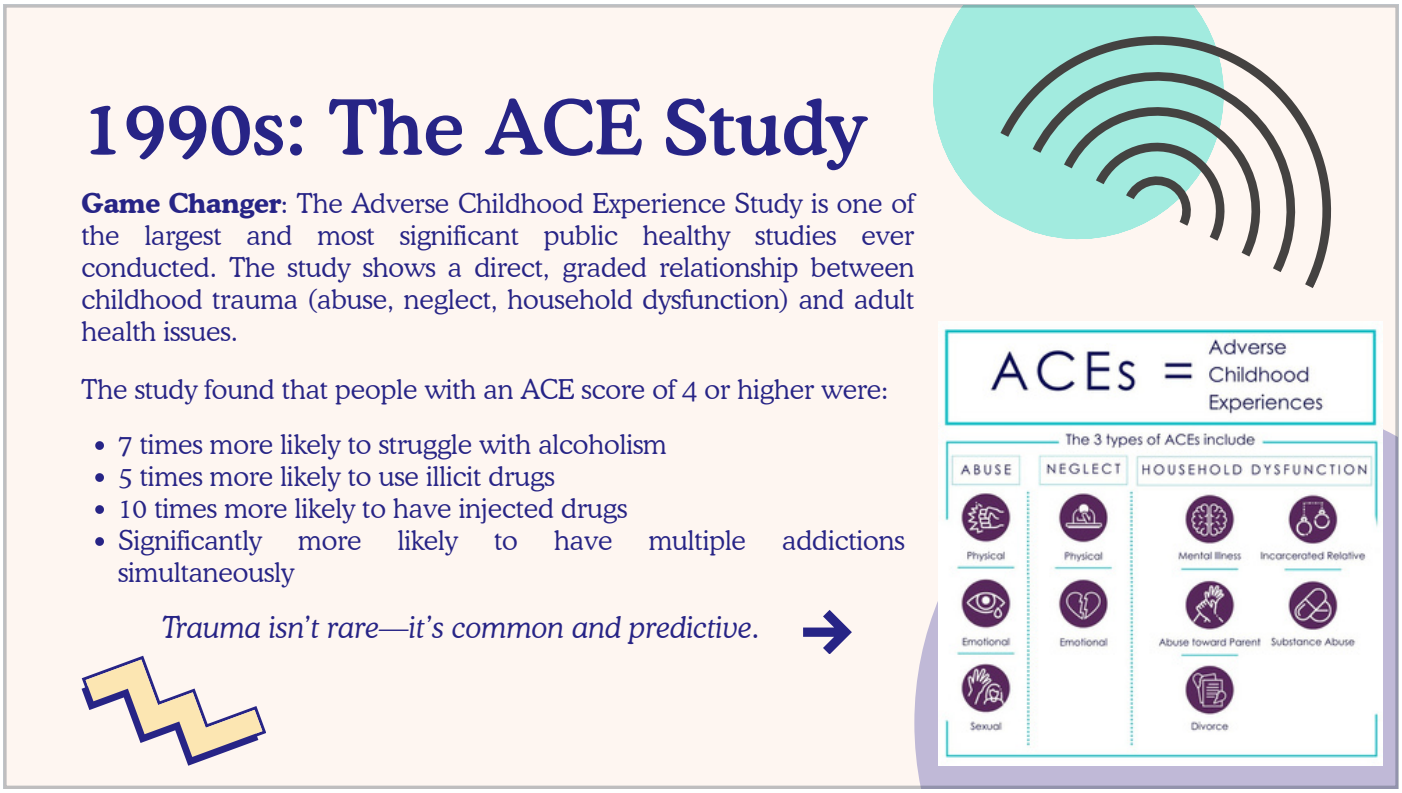
Shift:
- "Something happened to you" vs. "something is wrong with you"

Addiction connection (early stage):
- Still mostly treated separately from trauma
- Clinicians begin noticing overlap

"Soldier's Heart":
Civil War era. Described racing heart, fatigue, and anxiety in veterans. Assumed to be a cardiac condition.

"Shell Shock" — WWI. Tremors, paralysis, inability to speak, nightmares, and that blank dissociated gaze. Initially thought to be caused by literal concussive force from artillery.
"Combat Fatigue" / "Battle Fatigue" — WWII and Korea. A softening of the language, but describing the same core symptoms. The thousand yard stare became culturally iconic here — most famously captured in Tom Lea's 1944 painting "That 2,000 Yard Stare."

"Gross Stress Reaction" — This actually did appear in the very first DSM (1952), but was quietly removed in DSM-II (1968), ironically right as Vietnam veterans were coming home.



The Adverse Childhood Experiences study is one of the largest and most significant public health studies ever conducted.

The study ultimately surveyed over 17,000 middle-class, mostly white, college-educated adults — people who by most external measures had "made it." The findings were staggering precisely because of who the participants were. This wasn't a study of people society had already written off.

The Core Finding
ACEs are not rare. Two-thirds of participants had at least one. One in six had four or more. And the relationship between ACE score and health outcomes followed a clear, measurable dose-response — meaning the higher the score, the worse the outcomes, in an almost perfectly linear pattern. This is what made the study so scientifically powerful. It wasn't correlation — it was a gradient.

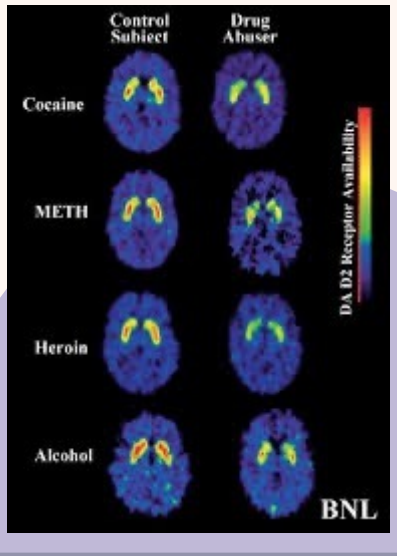
2000s: The Brain Science

Major shifts:

- Advances in neuroscience: (fMRI, PET Scans, Neuroplasticity, The Human Genome Project, Epigenetics, & Stress hormone research)

- **Understanding of:**
  - **dopamine** + reward systems in the brain:
    - The "pleasure" chemical versus the "wanting" chemical
    - Dopamine is what makes us want to chase the pleasure. The hunt or the fantasy is more compelling than the act itself.

This is why the act rarely delivers what the craving promised



We are getting some technology!

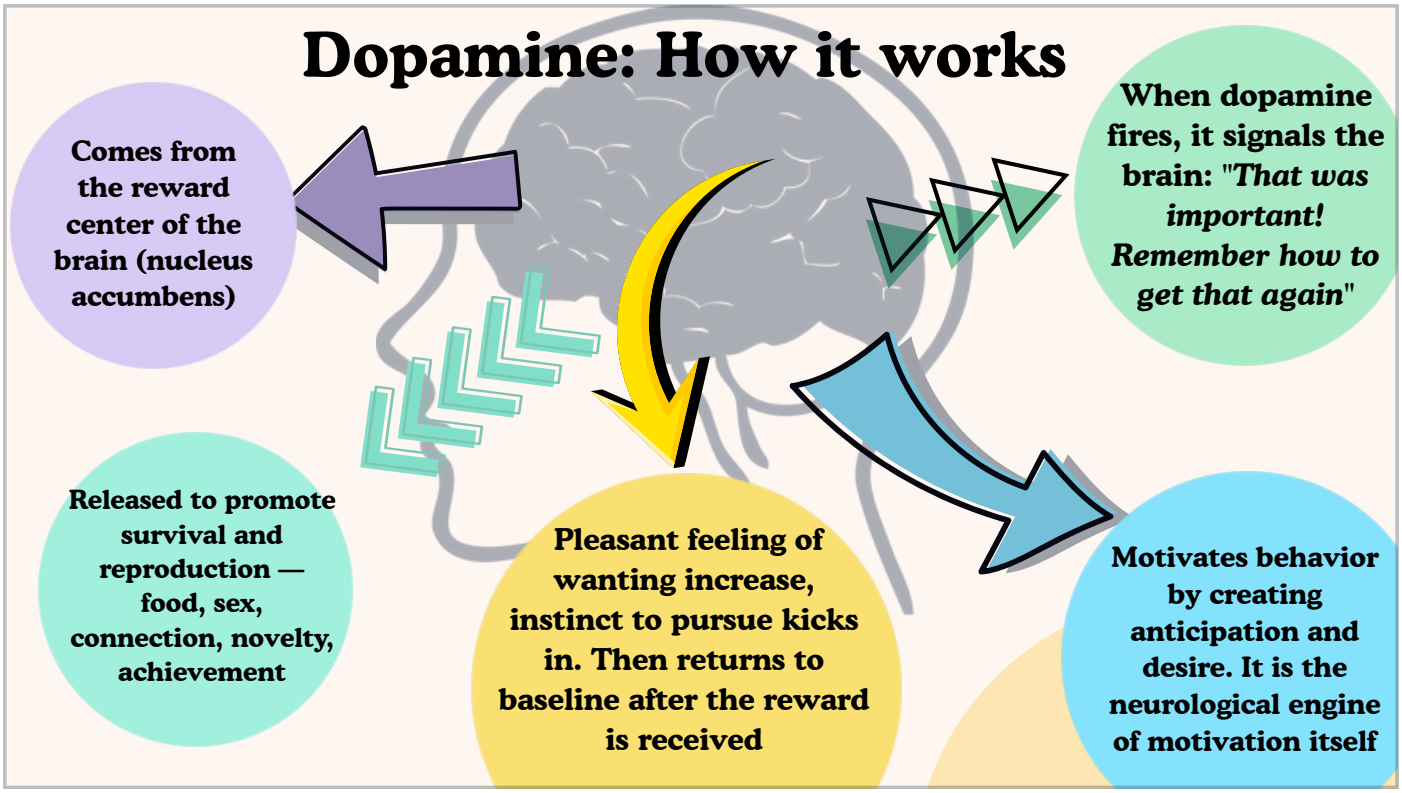
MRI (Functional Magnetic Resonance Imaging)
fMRI shows brain structure and brain activity in real time Scientists could now actually watch what happened in the brain when someone was triggered, craving, or reliving a traumatic memory.

PET scanning tracks neurotransmitter activity — particularly dopamine. This is what allowed us to visually demonstrate the dopamine hijacking that happens in addiction.

Advances in Neuroplasticity Research. This confirmed that the brain is not fixed — it changes in response to experiences, for better and for worse.
It meant that early adverse experiences literally reshape brain architecture.

Epigenetics research helps explains how trauma can alter gene expression across generations. We knew this, but couldn't prove it until this.

Advances in Stress Hormone Research:
stress hormone released during trauma actually does to the brain over time.
The findings showed measurable shrinkage of the hippocampus (memory and context) and enlargement of the amygdala (fear response) in people with chronic trauma histories.



Dopamine is more accurately described as the "wanting" chemical — it drives the pursuit of reward, not the experience of it.

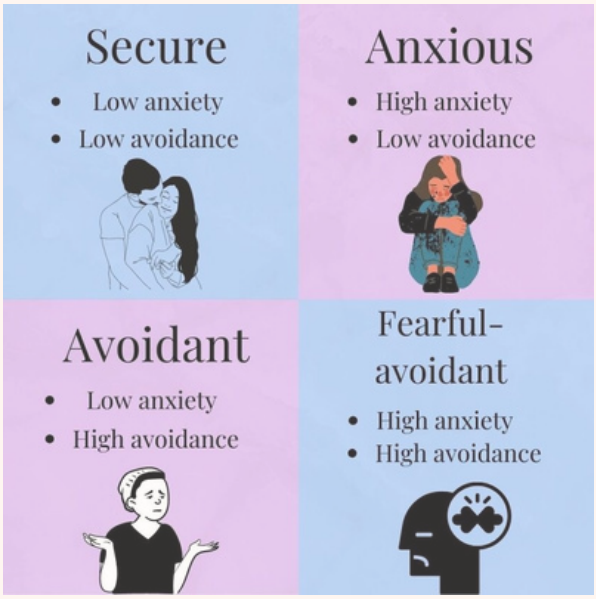
This distinction is everything when talking about addiction.
The pleasure of actually getting something is mediated more by opioid systems in the brain.

Dopamine is what makes you chase it. Understanding this explains why addicts often describe the anticipation, the hunt, the fantasy as more compelling than the act itself — and why the act so rarely delivers what the craving promised.

2000s: Attachment Theory

- Humans are wired from birth to seek close connection with a caregiver — and that early bond shapes everything.
- Every child is born with an attachment system. This biological drive to stay close to a caregiver and seek comfort when distressed
- The caregiver's response to that drive; consistent, inconsistent, absent, frightening — shapes how the child's nervous system learns to relate
- This becomes a template for how relationships work, whether they are safe, whether they are reliable, and whether they themselves are worthy of love.

2000s: Attachment Theory



It answers three fundamental questions that get wired in early:

- Am I worthy of love and care?
- Are other people safe and reliable?
- Is the world a safe place?

Attachment theory is essentially the internal working model is largely unconscious. It runs automatically in adult relationships without people realizing it is there.

2010s: Trauma-Informed Care Movement

Major shift:

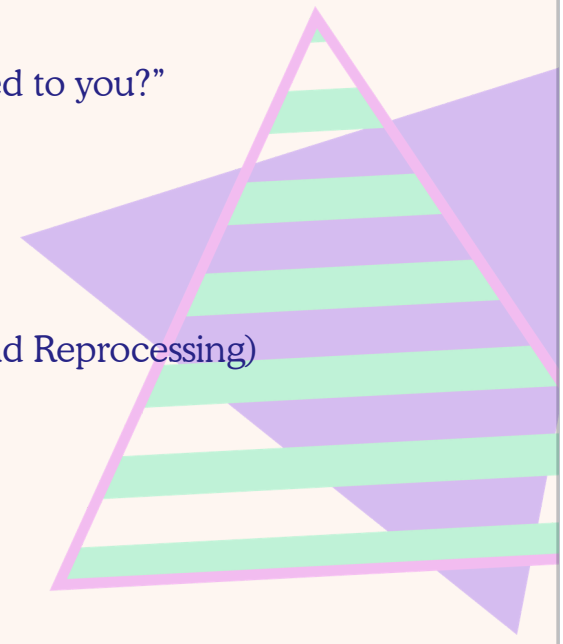
- "What's wrong with you?" → "What happened to you?"
- What makes this make sense?

Integration begins:

- Trauma + addiction are treated together.
- Rise of:
  - somatic (body) therapies
  - EMDR (Eye Movement Desensitization and Reprocessing)
  - Nervous system regulation work

Language starts to evolve:

- Coping instead of pathology
- Adaptation instead of defect



Somatic therapies:
Somatic experiencing
Sensorimotor Psychotherapy
Yoga
Breath work
Biofeedback, neurofeedback

2020s–Now: Connection, Regulation, Integration

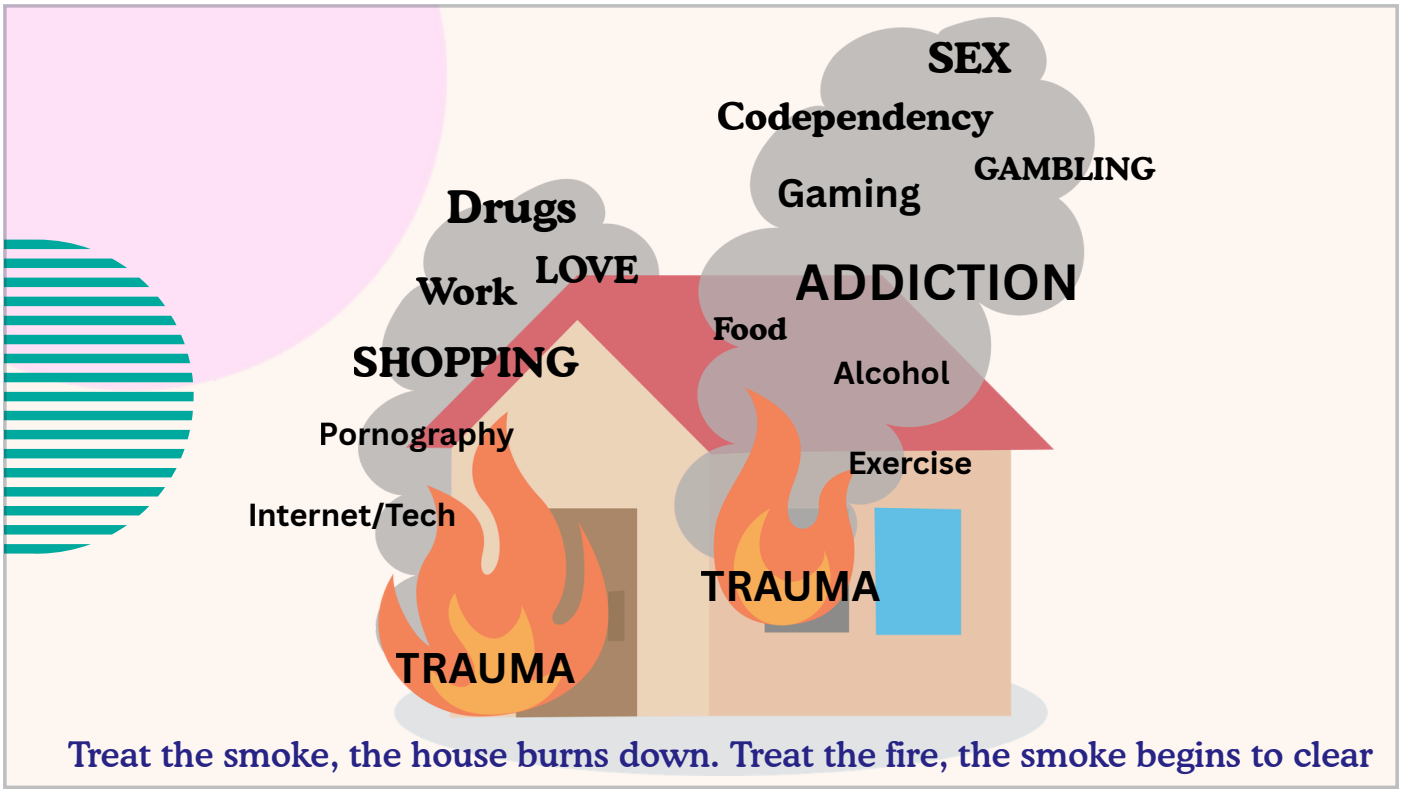
What we now believe is necessary for healing:

- Integration of:
  - trauma
  - attachment
  - neuroscience
  - relational healing

Addiction = attempt to regulate pain.

Healing = safety + connection + regulation

"The opposite of addiction isn't sobriety—it's connection."
Johann Hari



A word of caution here — treating the trauma does not automatically extinguish the addiction.

The fire and the smoke both need direct attention. What changes when we address the trauma is the WHY behind the addiction — but the addiction itself has become its own neurological pattern that also requires its own work.

Think of it this way — you can put out the fire and still have smoke damage that needs cleaning up. Trauma work and addiction recovery are not the same thing. They are parallel tracks that need to run simultaneously.

TRAUMA AND THE BRAIN

Two major players:

Prefrontal Cortex

thinking brain (logic, reasoning, regulation)

Responsible for:

-Reasoning, rational thought and decision making
-Impulse control, considers long term consequences.
-Emotional regulation, empathy
-Perspective-taking
-Language and articulation

Amygdala

The brain's "alarm system"

Responsible for:

-Scanning constantly for threat
-Activating fight, flight, freeze
-Working fast, automatic, and emotional
-Can't tell if the threat is real or remembered
-Becomes overactive / hypersensitive
-Can misread neutral situations as dangerous
-Fires before the prefrontal cortex can weigh in

Snake or Stick?

The body doesn't know the difference between something that happened 30 years ago and something happening right now. If the trauma was never fully processed, the body responds to triggers as if the original event is still occurring.

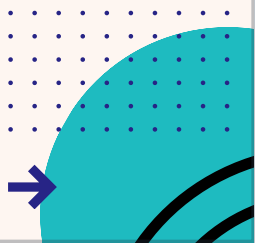
This is referred to as an "amygdala highjack"


TYPES OF TRAUMA
BIG T, Little T, Chronic T

“Big T” Trauma

The “Casserole” Trauma

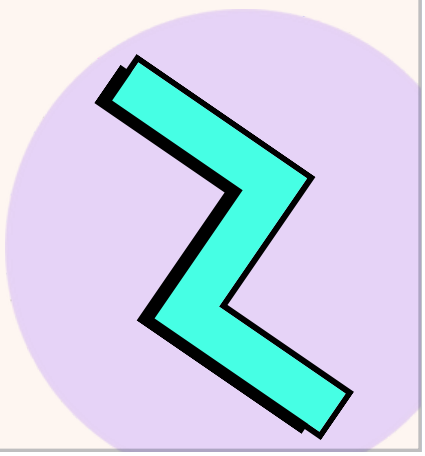
Death of a child or spouse
Sexual assault or rape
Serious car accident or near-death experience
Natural disaster (tornado, flood, fire)
Combat or war exposure
Witnessing violence or murder
Sudden, unexpected loss
Life-threatening illness or medical emergency
Childhood physical or sexual abuse



“Little T” Trauma

The “Toothpick” Trauma

Being told to stop crying or "toughen up"
Having your feelings dismissed — "you're too sensitive"
A parent who was physically present but emotionally unavailable
Being compared unfavorably to a sibling — repeatedly
Being laughed at when you were scared
A teacher who humiliated you in front of the class
Eating lunch alone regularly
Being left out of a group text or birthday party
Having your cultural identity mocked or minimized
Someone taking credit for your work
Being ghosted by someone you trusted
Chronic low-grade criticism from a partner or parent
Apologies that were never given



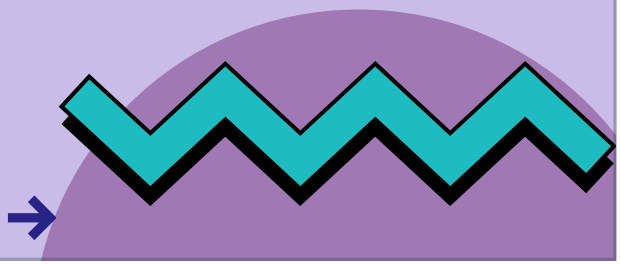
Chronic Trauma

The "Fog"

Growing up in a home with ongoing conflict or tension
Living with a mentally ill or addicted parent
Poverty and chronic instability
Racial or cultural discrimination over a lifetime
Religious shame or spiritual abuse over many years
Living in an unsafe neighborhood
Long-term emotional neglect
Ongoing relational betrayal (affair, deception in marriage)
The slow erosion of identity in a controlling relationship

Physical Symptoms of Trauma:

- How trauma lives in the body
- The fight, flight, or freeze response
- Nervous system dysregulation
- Common physical manifestations



Trauma is not just a memory stored in the mind. In all actuality, trauma lives in the brain.

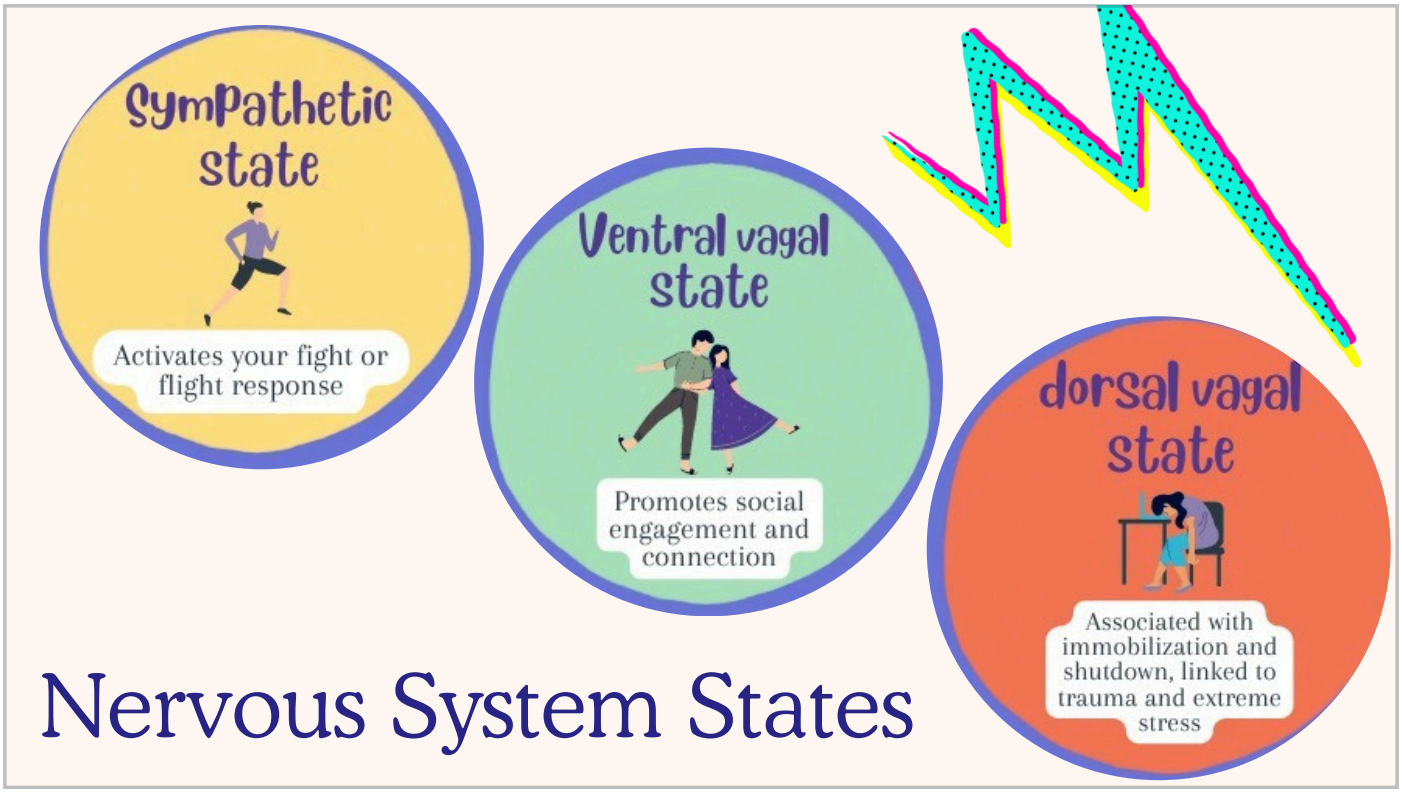
It is a physiological event that gets stored in the brain which in tern, informed the body. If the brain believes it's "unsafe", it will respond as if it is "unsafe" in ways that manifest through somatic response.

Fight, Flight or Freeze

This is the body's built-in survival system. When the brain detects danger (real or perceived/snake or stick) it triggers one of three responses:

- **Fight** — aggression, anger, confrontation
- **Flight** — running, avoiding, escaping (physically or emotionally)
- **Freeze** — shutting down, going numb, dissociating, people-pleasing

In addiction and trauma, most people live in a chronic state of one of these. The addiction often becomes the flight response. A way to escape the alarm that never turns off.



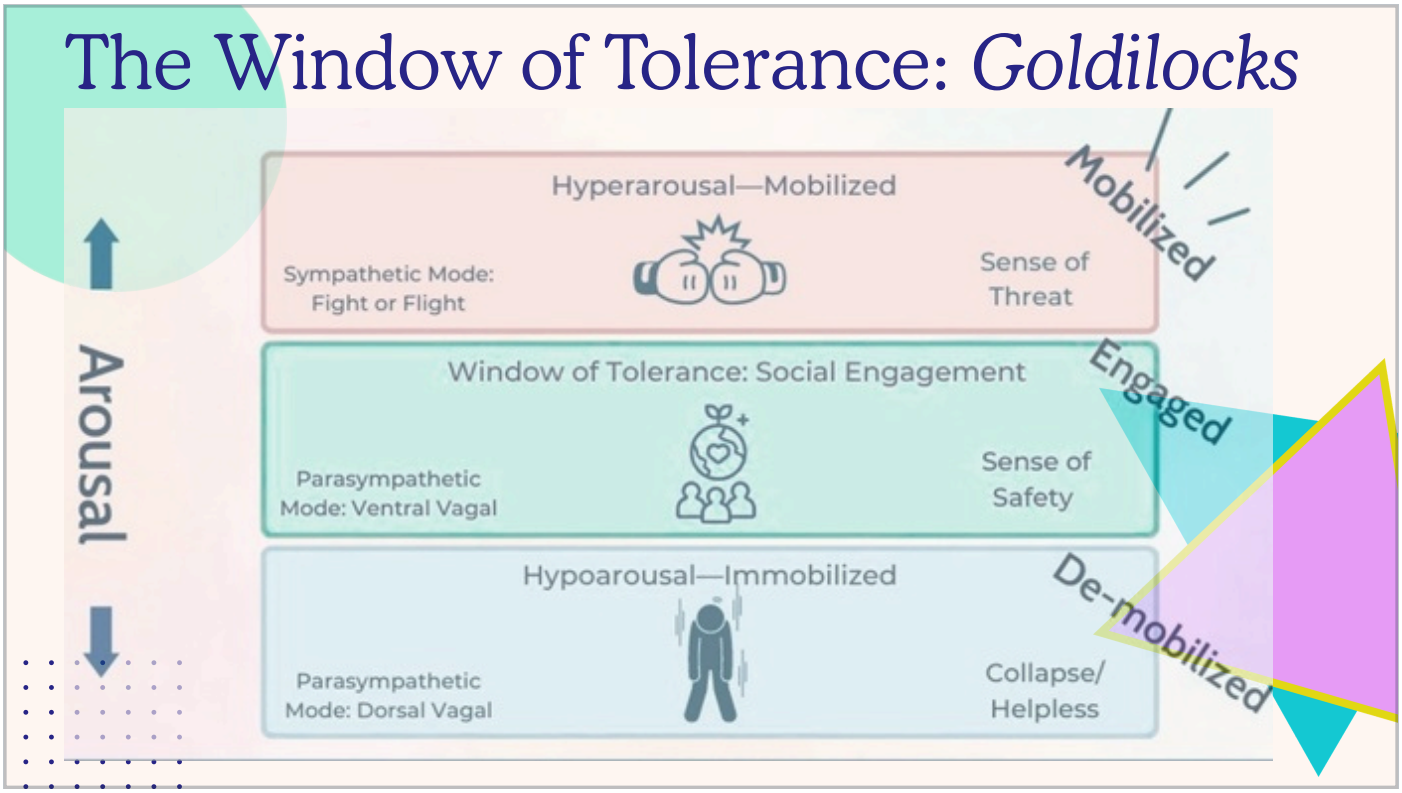
Based on Stephen Porges' Polyvagal Theory, the nervous system operates in three basic states:

Ventral vagal — safe and social. This is the regulated state. Connected, calm, present, able to think clearly and relate to others.

Sympathetic — fight or flight. Activated, anxious, reactive, hypervigilant, on edge. The gas pedal is stuck down.

Dorsal vagal — freeze and collapse. Shut down, numb, disconnected, dissociated, depressed. The system went into survival shutdown.

Many people with trauma histories spend most of their lives in the second or third state — and have never been taught that there is a first state available to them.



Window of tolerance describes the optimal zone of nervous system arousal within which a person can function effectively — think, feel, relate, and process experience.

*Everyone has a window — but the size of that window varies dramatically from person to person based on their history.

Inside the window the thinking brain is online — you can access logic, empathy, creativity, and connection
It is not a state of no emotion — it is a state where emotions are present and manageable

Above the window — the nervous system is flooded
Symptoms: anxiety, panic, rage, hypervigilance, racing thoughts, emotional overwhelm, feeling out of control, impulsivity

The thinking brain goes offline — the survival brain takes over completely

This is fight or flight in action

This is often the state that immediately precedes acting out — the nervous system is flooded and reaches desperately for regulation
Triggers feel enormous. Small things feel catastrophic. Rational conversation feels impossible

Common Physical Manifestations

- Chronic muscle tension
- Shallow or held breath
- Digestive issues
- Chronic pain with no clear medical cause
- Fatigue that sleep doesn't fix
- Headaches and migraines
- Autoimmune conditions
- Sleep disturbances

Chronic muscle tension — particularly in the jaw, neck, shoulders, and hips

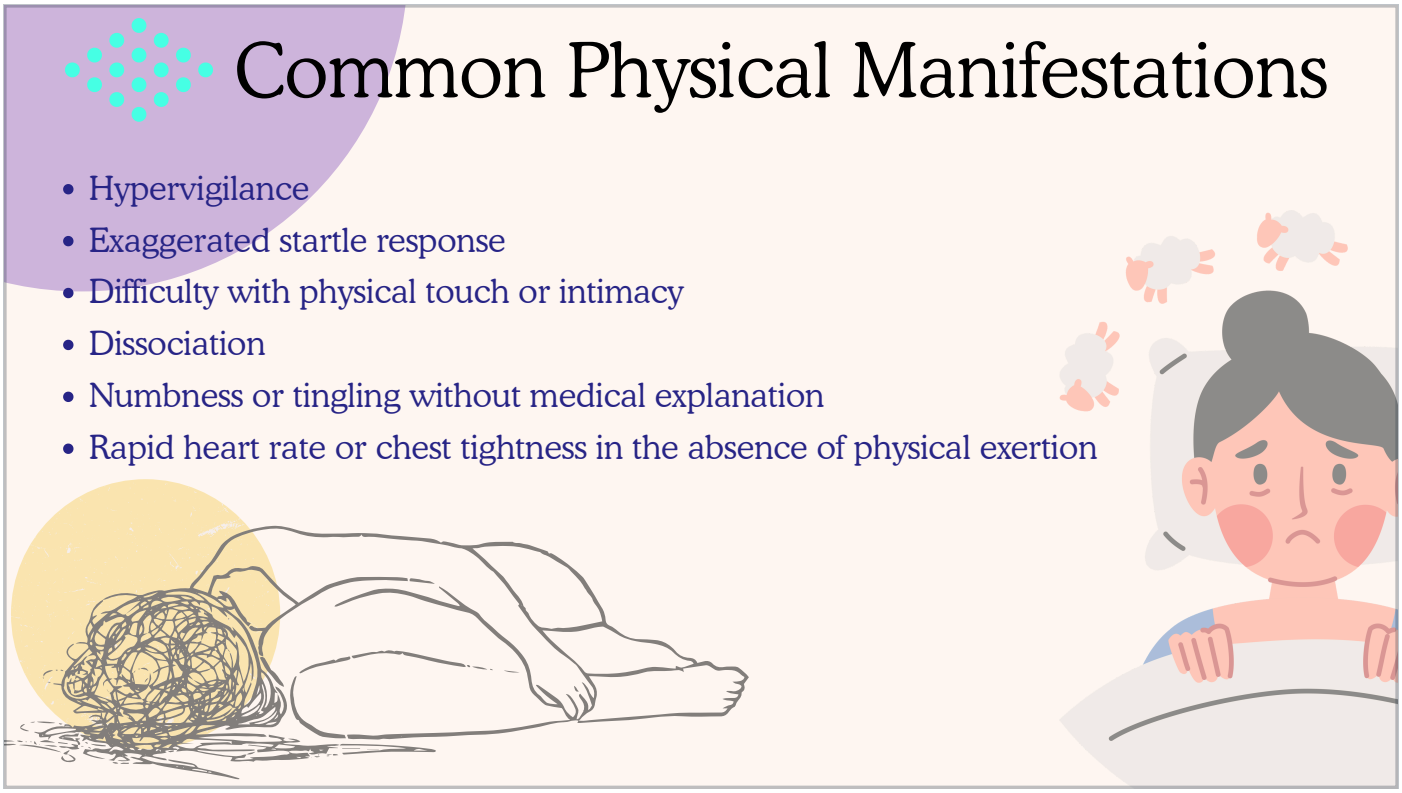
Shallow or held breath — the body bracing for impact

Digestive issues — IBS, nausea, stomach tension, appetite dysregulation

Chronic pain with no clear medical cause

Autoimmune conditions — the body's immune system dysregulated by chronic stress

Sleep disturbances — insomnia, nightmares, difficulty feeling safe enough to rest



Hypervigilance — constantly scanning the environment for danger

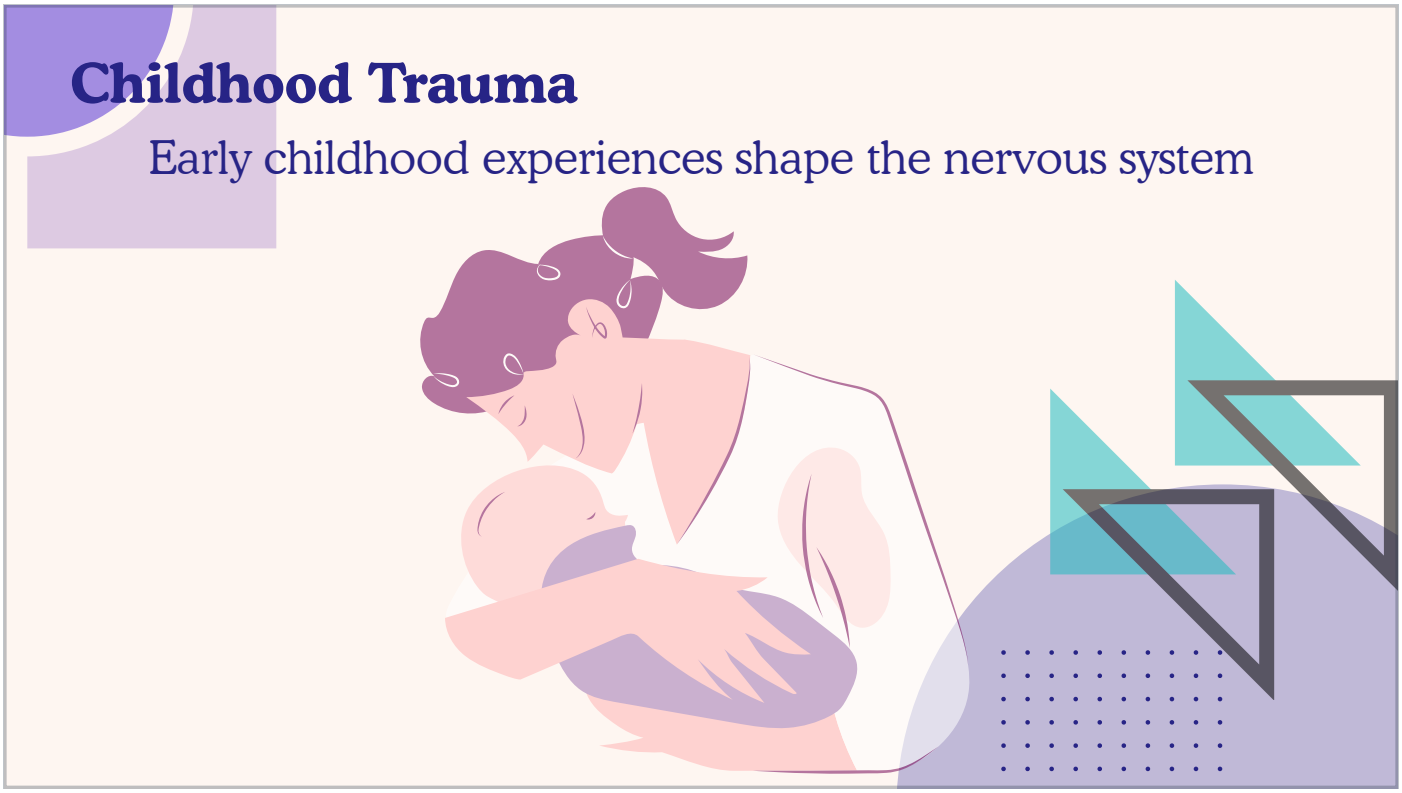
Exaggerated startle response — jumping at sounds or sudden movement

Difficulty with physical touch or intimacy

Dissociation — feeling disconnected from the body, floating, unreal

Numbness or tingling without medical explanation

Rapid heart rate or chest tightness in the absence of physical exertion



What do we know to be true when it comes to childhood trauma?

Early childhood experiences shape the nervous system: The First Three Years Are the Foundation

The brain develops from the bottom up.
When a young child experiences chronic stress, fear, neglect, or chaos during this period, the stress response system gets calibrated to a world that is dangerous and unpredictable.

The brain essentially concludes — that high alert is the appropriate setting. And it builds accordin gly.

Research showed that the brains of children raised in chronically stressful environments showed measurable differences in the development of the prefrontal cortex and the stress response systems compared to children raised in safe, nurturing environments. These are not subtle differen ces.

The Role of the Primary Caregiver:

The nervous system of a young child co-regulates with the nervous system of their primary caregiver. This is called co-regulation — the child literally borrows the parent's regulated nervous system to learn how to manage their own internal states.

A calm, attuned caregiver teaches the child's nervous system: the world is safe, distress is

temporary, someone will come.

When that caregiver is absent, unpredictable, frightening, or themselves dysregulated — the child has no external regulator to borrow from. They cannot learn what they are never shown. The nervous system develops without a template for safety or self-regulation.

The attachment system got wired in a fundamental contradiction: the person I need for survival is also the person I am afraid of.

That contradiction becomes the blueprint for adult relationships.

Familiarity feels like safety. The nervous system orients toward what it knows — even when what it knows is painful. Chaos, intensity, emotional unavailability — these can feel like home to someone whose early environment was defined by them. The brain isn't seeking pain. It's seeking the familiar.

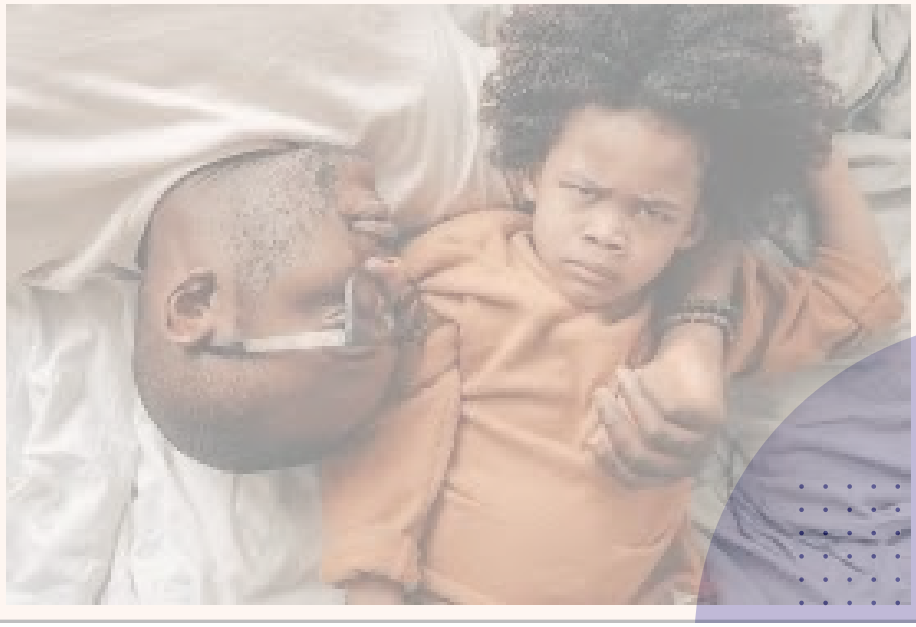
Unfinished business. We have this unconscious drive to return to situations that mirror early wounds in an attempt to finally get a different outcome. To finally be chosen. To finally be enough. To finally get the love that was withheld.
This is sometimes called the repetition compulsion and it shows up powerfully in love and relationship addiction.

The window of tolerance gets narrow. When regulation was never modeled, calm and stability can actually feel threatening — boring, unsafe, too quiet. The dysregulated nervous system can unconsciously create or seek drama and intensity because that is what it learned to recognize as n ormal.

Shame loops. Early experiences of neglect or abuse often produce a core belief of I am fundamentally defective. That shame belief drives behavior that tends to recreate the very relational dynamics that produced it — seeking validation, tolerating mistreatment, losing self in relationship.

Childhood Trauma: Role of the Caregiver

Relational patterns formed in childhood serve as a blueprint for adult relationships



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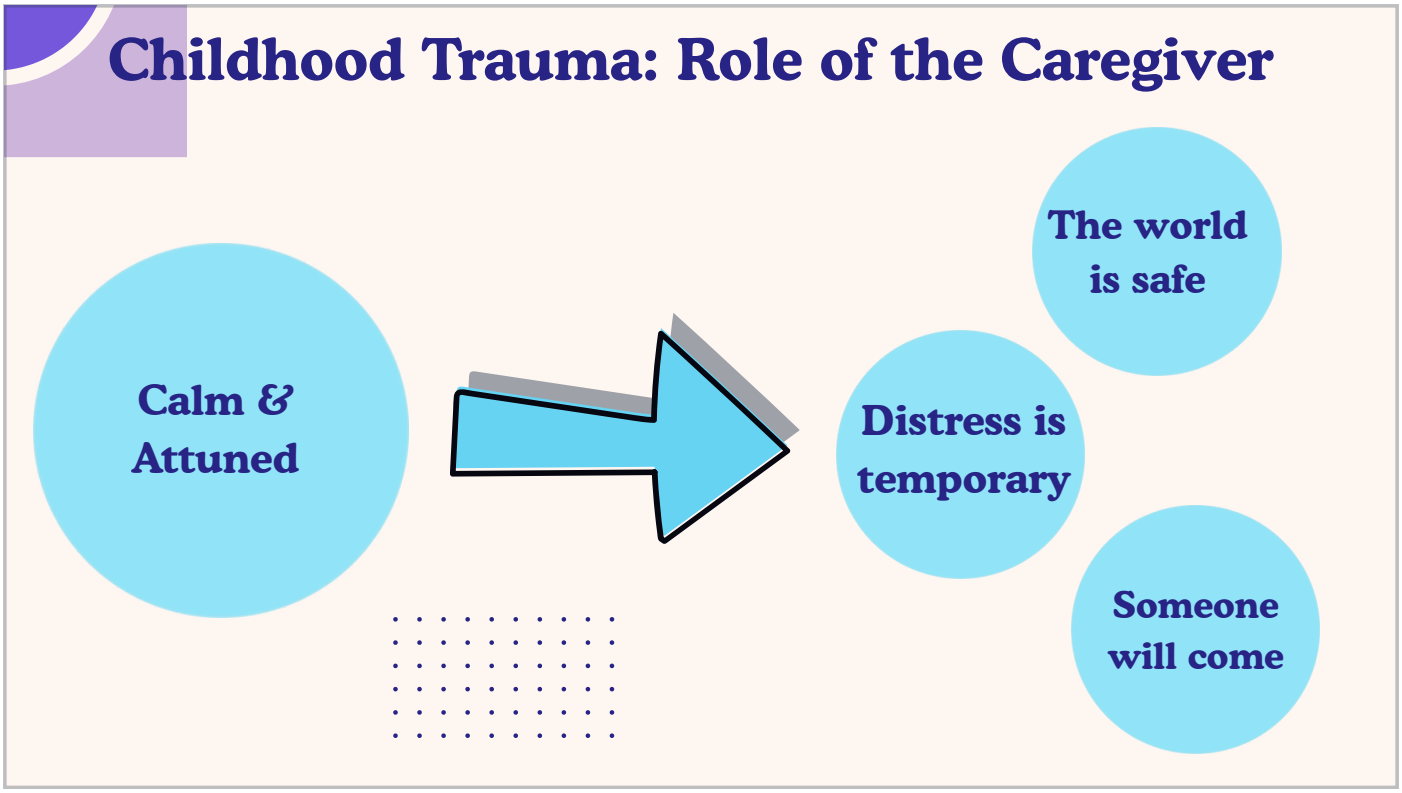

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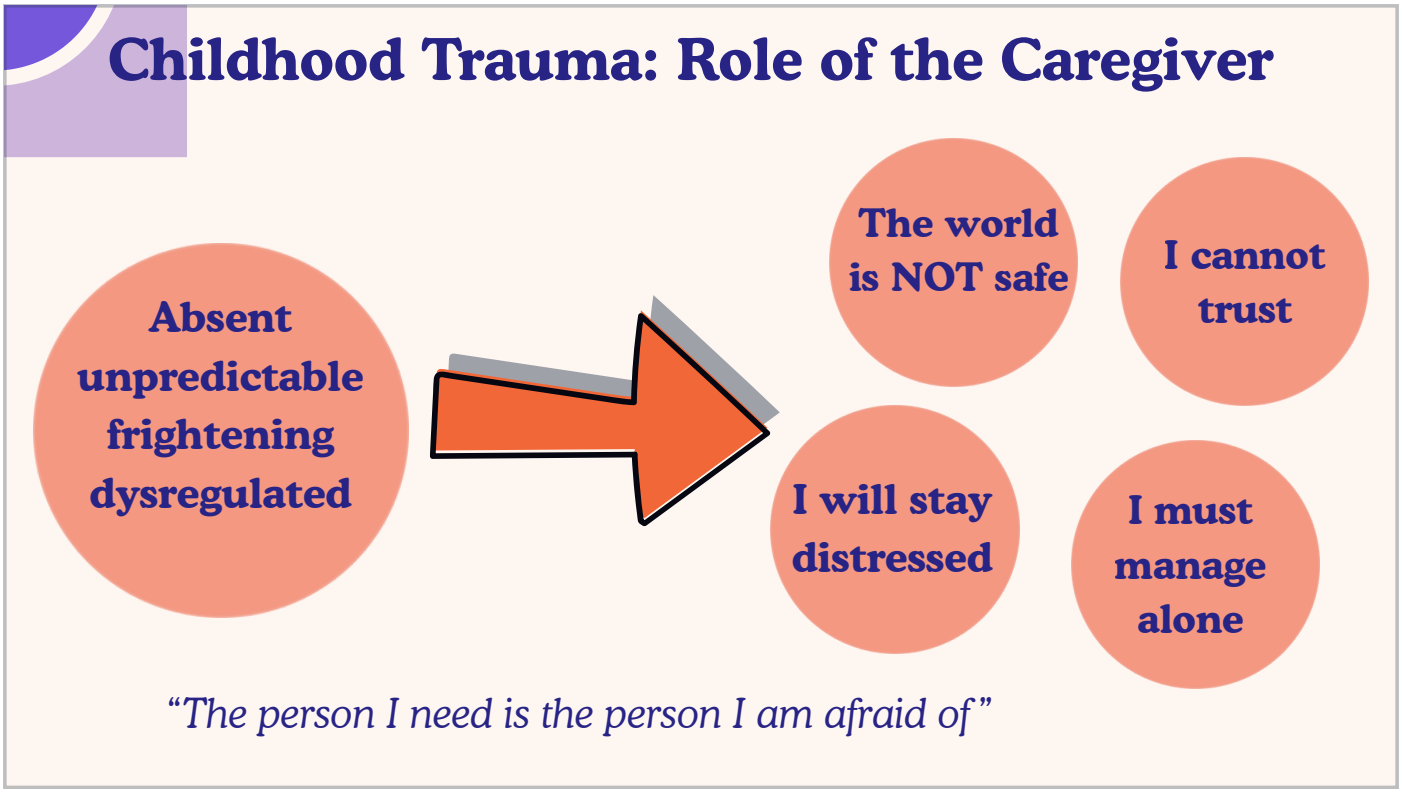

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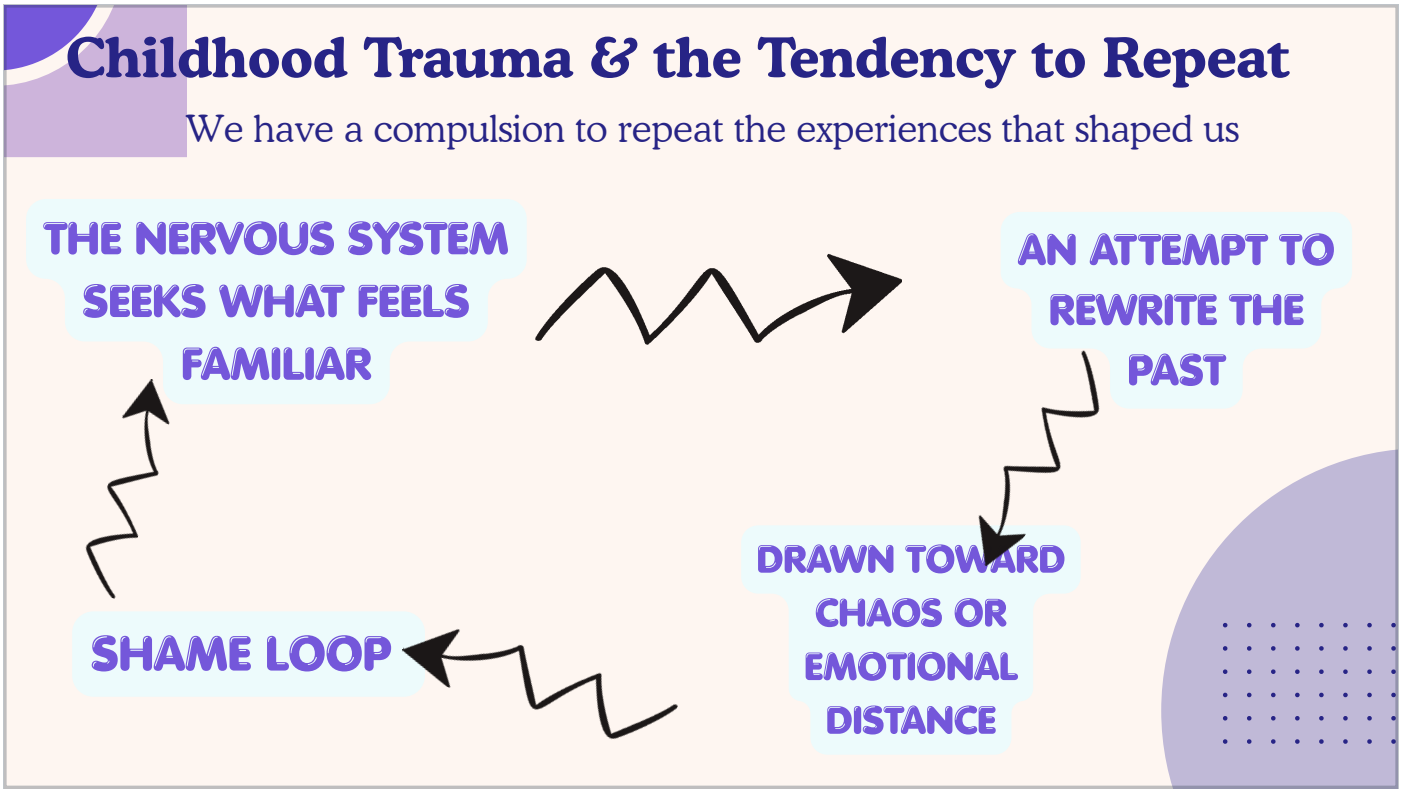

The nervous system seeks what feels familiar — early relational experiences create a template for what "home" feels like, even when home was unsafe. The system doesn't seek what's good; it seeks what it knows. An attempt to rewrite the past" — unresolved wounds create an unconscious drive to return to the original painful dynamic, this time hoping for a different outcome. It's the psyche trying to finally "win" the scenario it never resolved.

"Drawn toward chaos or emotional distance" — without a model for secure connection, the nervous system registers calm as suspicious and gravitates toward intensity or numbness — the only register it was trained on.
"Shame as confirmation" — when the pattern repeats and pain follows, the wound interprets it as evidence: this is what I deserve. The shame deepens, reinforcing the original belief and pulling the cycle back to the start.

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Let's talk about Dana...

Meet "Dana"
Dana grew up with a mother who was loving in moments but frequently cold, critical, and emotionally unpredictable.

Affection was earned, never guaranteed. Dana learned early that love comes with conditions, that she has to work for connection, and that when someone pulls away, the right response is to try harder — not to let go.

Dana meets Marcus...

Dana is 34 and starts dating Marcus. Marcus is charming, attentive in the beginning, then gradually harder to reach.

He runs hot and cold. Dana's friends notice it immediately and feel uneasy. Dana feels something different: alive. Energized. Invested in a way she hasn't been with the "nice guys" who were consistent and available.

The men who were kind and consistent? Dana described them as "boring" or said she just "didn't feel a spark." That absence of a spark was actually the absence of hypervigilance — and her nervous system had never learned to read calm as safe.

Stage 1 *The nervous system seeks what feels familiar*

She doesn't consciously think this feels like my mother. What she feels is pull. Chemistry. Depth.

What's actually happening is that her nervous system has scanned Marcus's emotional signature and found it legible. The withholding, the intermittent warmth, the need to earn his attention — it's a pattern her body already knows every step to. It doesn't feel dangerous. It feels like home.

The men who were kind and consistent? Dana described them as "boring" or said she just "didn't feel a spark." That absence of a spark was actually the absence of hypervigilance — and her nervous system had never learned to read calm as safe.

Stage 2: *An attempt to rewrite the past*

The relationship with Marcus unfolds, and Dana pours herself into it. She becomes more attuned to his moods than her own.

She adjusts herself — softer when he seems irritable, more impressive when he seems distant, less needy when she's actually falling apart.

Underneath the conscious effort is an unconscious wager: if I can just get this right, if I can just be enough, he'll choose me consistently. She's not really trying to win Marcus. She's trying to finally win her mother. To get the ending the child in her never got.

This is why clients in this stage often feel a near-compulsive intensity about the relationship — it doesn't feel optional. It feels like something is at stake, something older and more essential than the current relationship. Because it is.

Stage 3: *Drawn toward chaos or emotional distance*

There's a period, around month four, where Marcus is actually more present. He's going through something at work and leans on Dana. She's good at this — caretaking is her fluency.

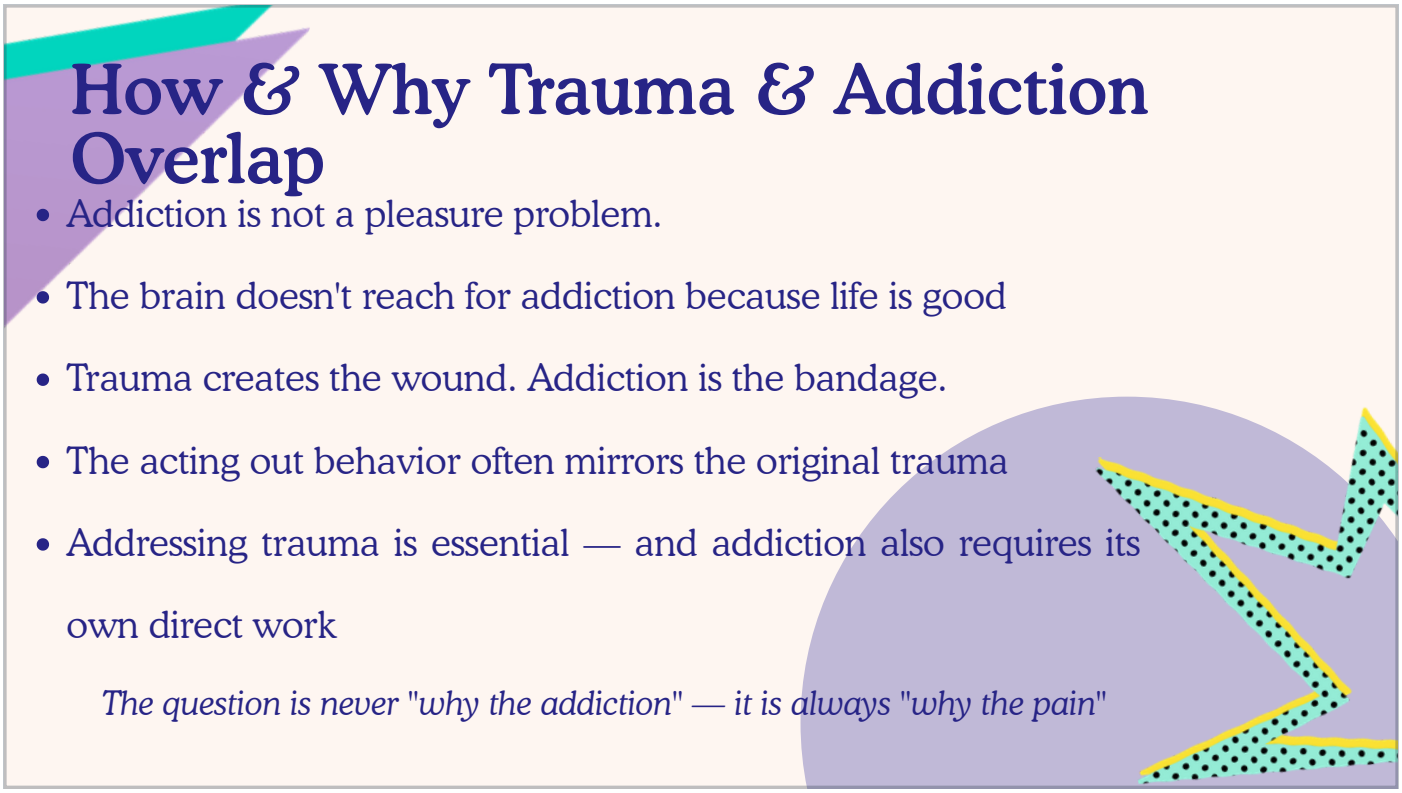
For a few weeks, things feel close.
And Dana starts to feel... itchy. Vaguely anxious. She can't name why. She picks a fight over something small. She becomes critical of things she'd previously overlooked. She pulls back a little herself, then watches to see what he does.
She isn't doing this consciously. Her nervous system has registered the sustained closeness as a threat signal — this isn't the script I know. The lack of push-pull, the steadiness, has actually dysregulated her more than the chaos did. She introduces turbulence because turbulence is the state in which she knows how to function.
When Marcus eventually retreats again — stung by her criticism, back to his familiar distance — Dana feels the anxiety lift. She also hates herself for it. Which brings us to Stage 4.

***Stage 4**: Shame as confirmation*

The pattern has repeated. Dana is alone on a Sunday, Marcus hasn't texted, and the familiar ache is back. But this time it's layered with something heavier: I did this. I always do this. There's something wrong with me.

The shame isn't just about Marcus. It reaches back — to every relationship that followed this shape, to the little girl who couldn't make her mother stay warm, to every time she was told she was "too much" or "not enough." The repetition feels like evidence. Like a verdict.
And here is exactly where the cycle closes and resets: shame is an inward collapse, and an inward collapse increases the nervous system's need for external regulation. So Dana finds herself, days later, responding warmly when Marcus resurfaces — relieved, grateful, re-engaged — and the whole architecture re-assembles itself.


Session Two
The Trauma-Addiction Connection + Shame



Addiction is not a pleasure problem. It is a pain management problem. The relationship between trauma and addiction is not coincidental — it is neurological, psychological, and deeply relational.

The brain doesn't reach for addiction because life is good — it reaches because something is unbearable.

Trauma creates the wound. Addiction is the bandage. Recovery means finally treating the injury. Those wounds are never fully healed. Addiction is the behavior the nervous system developed to manage the pain of that wound. But here is the cruel irony — most addictive behaviors don't just soothe the wound, they reopen it

The acting out behavior often mirrors the original trauma — seeking intensity because intensity feels like connection, seeking unavailable people because unavailability feels like home.

Acting out sexually, chasing love, numbing with substances — these behaviors temporarily relieve the pain while simultaneously recreating the very conditions that caused it.

The cycle continues until someone names what is actually happening underneath.

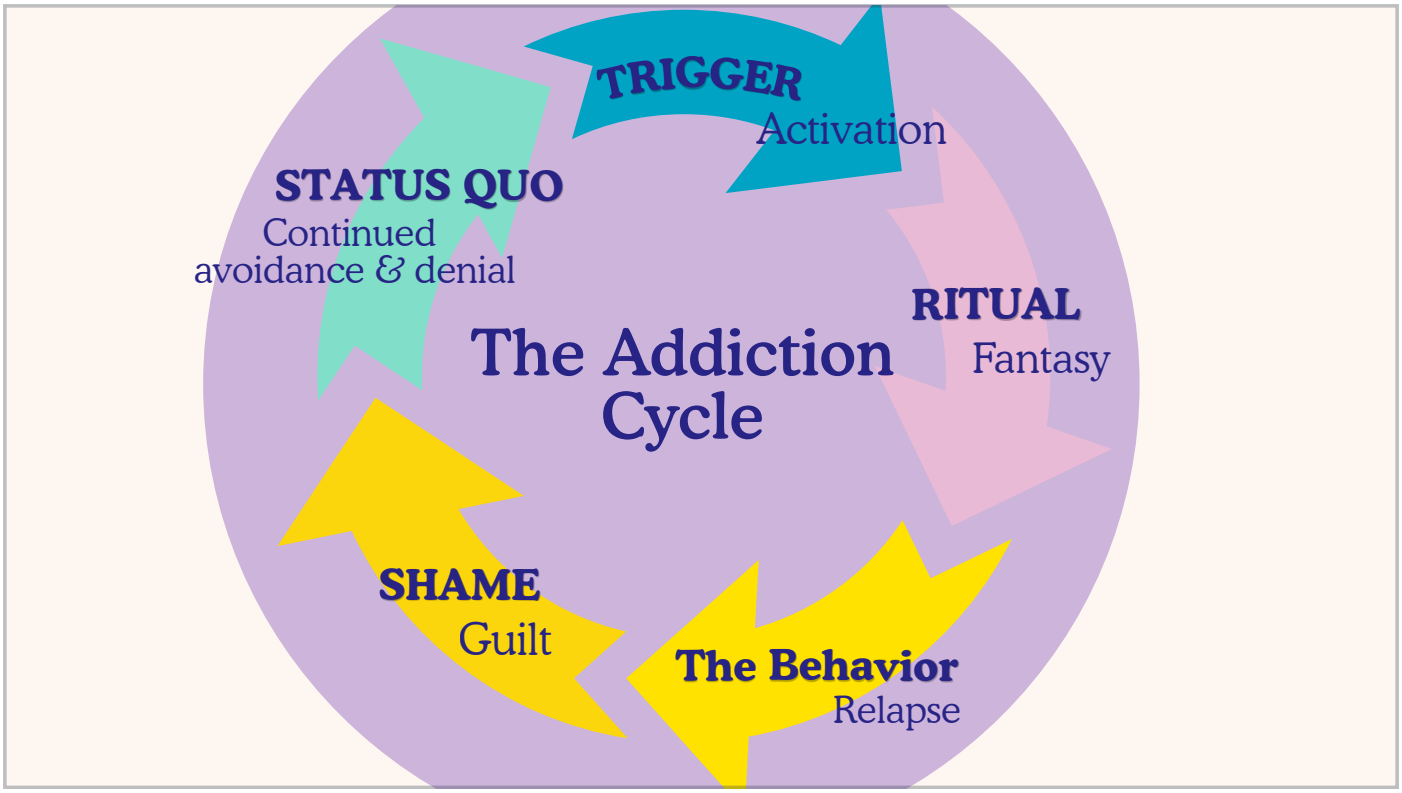
Trauma rarely produces just one coping strategy — the nervous system is resourceful.

Cross-addiction is extremely common — when one behavior is removed without addressing the underlying wound, the nervous system finds another. This is why people get sober from alcohol and develop a shopping addiction, or stop acting out sexually and start overeating — the substance changes, the function stays the same

In SLAA specifically, sex, love, relationship, food, substances, and work addiction frequently appear together

The addictions are not independent problems — they are interdependent expressions of the same unmet need
Treating one without the others is like treating one symptom while the root cause continues to generate new ones

This is not a character flaw — it is a nervous system doing exactly what it was designed to do



Trigger/Activation — something external or internal activates the nervous system. A feeling, a memory, a tone of voice, a rejection, an empty Friday night

Ritual/Craving — the brain signals urgency. This is not a want — it feels like a need. The survival brain has taken over. The craving is not for the behavior — it is for relief from the feeling that preceded it. What the craving is really seeking: regulation, connection, relief from pain, a return to safety

Ritual process begins. Planning, imagining, rehearsing. This stage can feel almost pleasurable — it is actually the first hit. often where the most energy lives — interrupting it there is more effective than waiting until acting out

Acting out/Relapse — the behavior. Brief relief. The alarm quiets temporarily

Shame/guilt — almost immediately the shame floods in. "Why did I do that again." "I am broken." "I will never change."
Recommitment — "I will never do that again." Shame does not stop the cycle — it fuels it. Shame is one of the most reliable triggers there is

We return to a "status quo state" by utilizing continued avoidance, denial, distraction, etc until the next trigger fires

Then we repeat

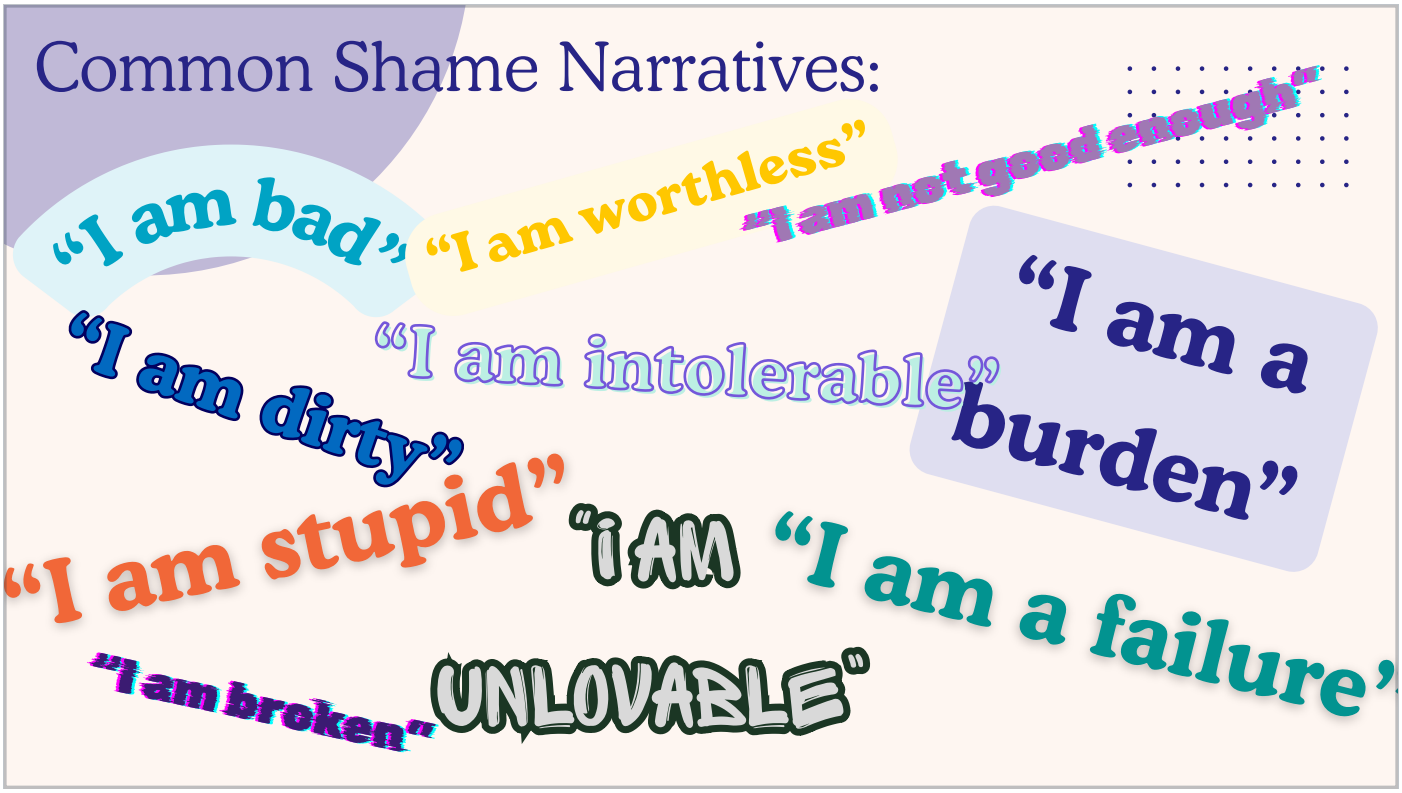
Recovery doesn't mean the triggers stop — it means the response to them changes.

The question is not "Do I have shame?" it is "What is the shame narrative telling me?"

Guilt says "I did something bad." Shame says "I am bad." That distinction is everything

Shame narratives are the stories we carry about our fundamental worth and identity — formed earliest in childhood through the messages we received from caregivers, peers, institutions, and culture. Trauma forces us to wrestle the truth of our "goodness" or "badness".

This bad thing happened to me. I must have done something to cause this. I must be bad.


Common Shame Narratives:
“I am bad”
“I am worthless”
“I am not good enough”
“I am a burden”
“I am dirty”
“I am intolerable”
“I am stupid”
“I AM UNLOVABLE”
“I am a failure”
“I am broken”

Shame repetition is the way unaddressed shame keeps recreating the conditions that produced it. It is one of the most misunderstood dynamics in recovery.

Shame Repetition Looks Like:

- In Relationships
- Addiction patterns, especially sex and love addiction
- In daily behavior and self-talk
- In recovery

In relationships:
Repeatedly choosing partners who are emotionally unavailable, critical, or withholding — and interpreting their distance as confirmation that "I am not lovable enough"

Over-giving, over-explaining, and over-apologizing in every relationship to manage the constant fear that they are "too much" or "not enough"

Ending relationships before the other person can — beating them to the rejection they are certain is coming

In sex and love addiction:
Pursuing someone who is unavailable — already in a relationship, emotionally closed off, or clearly not interested — and interpreting the chase as the only kind of love that feels real

Disclosing deeply personal information to someone very early in a relationship — skipping the outer layers of the relationship onion entirely — then feeling exposed and ashamed when the relationship cannot hold the weight of that vulnerability

In Daily Behavior and Talk:
Minimizing accomplishments immediately after achieving them — "it wasn't that big a deal," "anyone could have done that" — because accepting praise feels dangerous or undeserved
Volunteering for criticism by over-sharing mistakes or flaws before anyone else can point them out — if I humiliate myself first, you can't humiliate me

In Recovery:
Not telling their sponsor, therapist, or group about a slip because the shame of having slipped feels more unbearable than the slip itself — and the secrecy keeps the shame alive

Getting close to a breakthrough in therapy and then suddenly canceling sessions, ghosting the therapist, or picking a fight that ends the therapeutic relationship — right at the moment healing was becoming real

The question is not "Do I have shame?" it is "What is the shame narrative telling me?"

Shame cognitions are thoughts, not truths — but they have been rehearsed so many times they feel indistinguishable from reality.

The first step is simply noticing — catching the thought in real time rather than just living inside it

Naming a shame cognition reduces its power neurologically

Labeling an emotion decreases amygdala activation and restores prefrontal cortex access

You cannot think your way out of a shame cognition — but you can learn to identify it, name it, and choose not to act from it.

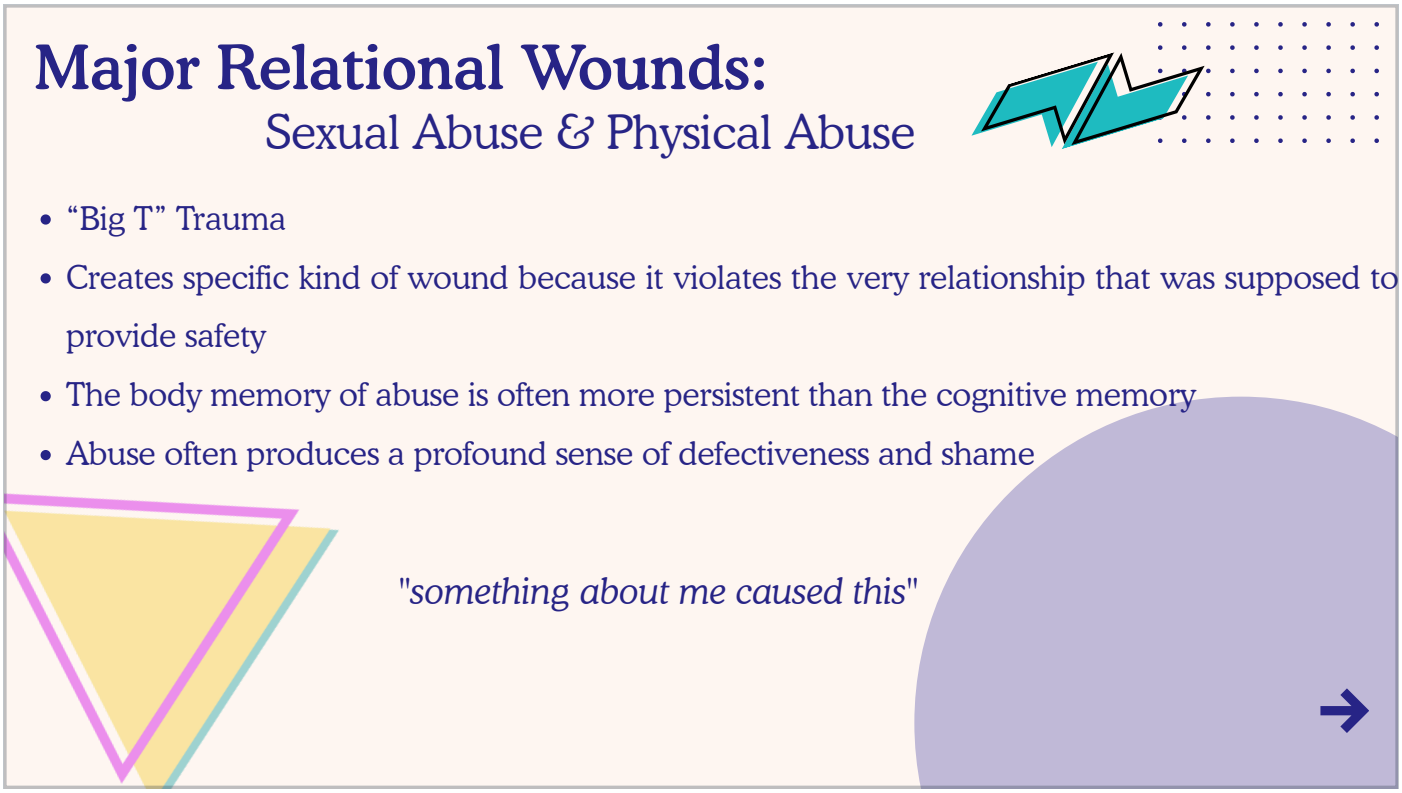
Breaking shame repetition requires more than willpower — it requires updating the core belief itself, which is the work of trauma-informed therapy

Shame and relapse are deeply connected — shame about past behavior becomes a trigger for more behavior. The cycle feeds itself

Session Three

Relational Wounds & Breaking the Cycle

Before we go here, I want to remind you that you are in charge of yourself today. If this section asks more than you have right now, stepping out or simply sitting with your feet on the floor is always okay.



It's big T trauma. It's THE most significant predictor of both trauma and addiction outcomes.

Abuse within a relationship — especially a caregiving relationship — creates a specific kind of wound because it violates the very relationship that was supposed to provide safety

The body memory of abuse is often more persistent than the cognitive memory — people may not remember specific events clearly but their body responds as if the threat is still present

Major Relational Wounds:

Sexual Abuse & Physical Abuse

- Sexual abuse specifically is deeply connected to sex and love addiction
- The importance of naming and SAFE disclosure
- Important to acknowledge: not everyone in the room will identify as an abuse survivor

Sexual abuse specifically is deeply connected to sex and love addiction — it creates distorted templates for intimacy, safety, power, and worth in relationships.

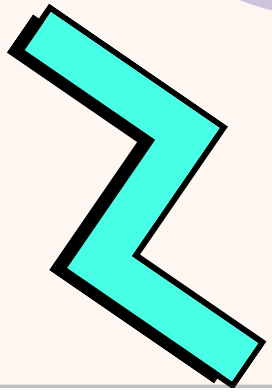
The importance of naming and disclosure — speaking what happened out loud in a safe context is one of the most powerful steps toward reducing its hold.

Important to acknowledge: not everyone in the room will identify as an abuse survivor — but many will, and some won't know it yet

Intimacy Disorders:

Addiction is an intimacy disorder

- An intimacy disorder is not an inability to feel — it is an inability to feel safely in connection with another person
- Rooted in early relational experiences where intimacy was either dangerous, conditional, unavailable, or overwhelming
- Two primary patterns:
  - Intimacy avoidance
  - Intimacy anxiety



Two primary patterns:
Intimacy avoidance — closeness feels threatening. Distance is managed through work, fantasy, addiction, or emotional unavailability
Intimacy anxiety — closeness is desperately sought but destabilizing when found. Clinging, intensity, fear of abandonment