

**Addiction as a Response to Complex Trauma:
The Role of Psychotherapy in Long-Term Recovery**

**By Max Yourell
Student No. 20006870**

Submitted in partial fulfilment of the requirements of the MA Psychotherapy at Dublin

Business School, School of Arts, Dublin.

Supervisor: Miriam Kavanagh

June 2025

Department of Psychotherapy

Dublin Business School

Contents	
Acknowledgement	2
Abstract	3
Introduction	5
Chapter 1: The Link Between Trauma and Addiction: A Biopsychosocial Perspective	10
1.1 Introduction	10
1.2 Addiction	11
1.3 Behavioural Addiction	12
1.4 Developmental Risk Factors	12
1.5 Adverse Childhood Experiences (ACEs)	13
1.6 PTSD and Substance Use Disorder Comorbidity	15
1.7 Trauma	16
1.8 Disturbances of Self-Organisation	17
1.9 Attachment in a Traumatic Environment	18
1.10 Psychological Defences	19
1.11 Affect Regulation and Addiction	20
1.12 Mentalisation, Alexithymia, and Epistemic Trust	22
1.13 Restoring Developmental Integrity in Addiction Recovery	24
1.14 Conclusion	25
Chapter 2: The Role of Psychotherapy in Addiction Treatment Systems.	27
2.1 Introduction	27
2.2 Historical Context and Theoretical Foundations	27
2.3 Overview of Addiction Treatment Approaches in Ireland	30
2.4 The Continuum of Care	31
2.5 Addiction as a Chronic, Relapsing Condition: A Trauma-Informed Perspective	34
2.6 Co-occurring Complex Trauma	34
2.7 Trauma-Informed Care	35
2.8 Recovery-Oriented System of Care (ROSCs): Potential and Limitations	36
2.9 Physicians' Health Programs	37
2.10 Barriers in Long-Term Treatment	38
2.11 Recovery Capital and the Window of Tolerance	38
2.12 Recovery Capital: Foundations of Sustainable Change	39
2.13 The Window of Tolerance: Navigating Emotional Regulation	40
2.14 Integration and Implications	40
2.15 Group Psychotherapy in the Treatment of Trauma and Addiction	41
2.16 Conclusion	43
Chapter 3: Integrating Psychotherapeutic Modalities Across the Stages of Addiction Recovery	44
3.1 Introduction	44
3.2 Transitional Phenomena and the Symbolic Function of Addiction	46
3.3 Humanistic Psychotherapy as a Foundational Stance	49
3.4 Somatic and Sensorimotor Psychotherapy: Reclaiming Bodily Safety and Regulation	50
3.5 Mentalisation and the restoration of reflective functions	53
3.6 Relational and Integrative Depth Work (Middle to Late Stage)	55
3.7 Recovery as Reconnection: Belonging, Meaning, and Integration	58
3.8 Conclusion	60
Conclusion	61
References	65

Acknowledgments

I want to acknowledge Miriam Kavanagh for supervising and providing support throughout the writing of this thesis. I want to thank the staff and students of the DBS MA in Psychotherapy.

I also want to thank all past and present staff and participants of Soilse, HSE Addictions Services. Special thanks to my Manager, Noel Murphy, for his support throughout this Master's and especially during the writing of this thesis.

I am grateful to the following people for their ongoing support and encouragement. Jimmy Judge, Gerry Cunningham, Alan McDonnell, Brian Kirwan, Dave Whelehan, Brian Somers, Brian Mitchel, Paddy McCormack, my co-sufferer Erika O'Brien, and Paddy Hogan for reminding me how well I'm doing. Everyone at MCDAR, special thanks to Cathy Whelehan.

Special thanks to my family and No. 2, Kerri, for being a legend, Barbara for feeding me, and very special thanks to my partner, Olivia Joyce, for putting up with me on this Master's. I know it was hard work; you can have your sitting room back (till the football starts).

This thesis is dedicated to my father, "Barney," who passed away on September 6, 2023, a week before I began this Master's program, and to my friend Terry Fagan, who died on January 5, 2024. *"There is no other of the other"*. Good stuff outta you, sick boy. You deserved better. Rest in Peace.

In the fourth step of the Narcotics Anonymous Step Working Guide, there is a section on abuse. At the bottom of the first paragraph, there is a sentence. *"We may need to seek additional help"*. If you don't know that you do, I sincerely hope someone cares enough to tell you. For anyone who does this thesis is for you.

Abstract

This thesis explores addiction in individuals with co-occurring complex trauma, framing it as a complex, relational, and developmentally rooted response to psychological distress. Moving beyond dominant biomedical and behaviourist models, it argues for an integrative biopsychosocial perspective in which addiction is understood not merely as compulsive behaviour, but as a survival strategy shaped by early adversity, disrupted attachment, and impaired emotional regulation.

Drawing on developmental psychology, attachment theory, and neurobiology, the work highlights how Adverse Childhood Experiences (ACEs), Complex PTSD (CPTSD), and Disturbances in Self-Organisation (DSOs) often underpin addictive patterns in this population. These insights suggest that, for individuals with significant trauma histories, addiction is deeply embedded in disrupted relational contexts and cannot be fully addressed without attending to the underlying psychological and interpersonal wounds.

The thesis makes the case for long-term, trauma-informed psychotherapy as central, rather than supplementary, to recovery. It critiques short-term, acute care responses that dominate many addiction treatment systems and advocates for recovery models that prioritise consistency, relational safety, and developmental repair. The evolving framework of Recovery-Oriented Systems of Care (ROSCs) is examined as a promising foundation for integrating psychotherapy into long-term addiction support.

Across three chapters, the thesis explores: (1) the developmental and relational links between trauma and addiction; (2) the role of psychotherapy within contemporary treatment systems; and (3) how diverse therapeutic modalities, such as psychodynamic, humanistic, somatic, and mentalisation-based approaches, can be integrated across the stages of recovery.

This thesis argues that sustained psychotherapeutic engagement offers the best opportunity to rebuild emotional and psychological resilience and personal agency in individuals affected by complex trauma and addiction. Addiction is not solely a clinical or public health issue; it is a profoundly human struggle rooted in the need for connection and meaning. Effective treatment must honour the relational nature and duration of recovery.

Introduction

Addiction is one of the most complex issues in mental health. Although significant advances have been made in understanding and treating addiction, many contemporary models still struggle to capture its contributory developmental and relational factors. This thesis offers a perspective that views addiction not merely as a pattern of compulsive behaviour but as a deeply embodied, psychologically embedded response to adversity. In doing so, it explores how early relational trauma, disruptions in attachment, and emotional dysregulation contribute to the development and maintenance of addiction, and how psychotherapy can serve as a vital resource in long-term recovery.

Emerging research on the brain disease model of addiction has advanced our understanding of the neurobiological changes associated with substance use disorders. This model has reframed addiction as a healthcare issue, contributing to reduced stigma and informing treatment approaches (Volkow et al., 2016). However, while this framework offers valuable insights, it often overlooks the relational, developmental, and psychosocial contexts in which addiction arises and persists (Heather et al., 2017). This thesis does not dispute the role of biology but contends that, to fully appreciate and address addiction, particularly from a therapeutic perspective, it is essential to consider the biopsychosocial dimensions that shape the experience of addiction.

A substantial body of research now connects addiction to early exposure to trauma, particularly through Adverse Childhood Experiences (ACEs) (Felitti et al., 1998). ACEs, including abuse, neglect, household dysfunction, and exposure to violence, disrupt a developing child's neurobiological systems and emotional regulation capacities. These disruptions often hinder the formation of secure attachments and impede the development of a healthy self-concept, as well as affect regulation (Anda et al., 2006). In the absence of safe relational environments,

individuals may turn to substances or compulsive behaviours to manage emotional distress or fragmented self-states.

In this context, addiction may function as a transitional phenomenon (Winnicott, 1971), temporarily regulating unbearable internal states or providing symbolic substitutes for unavailable attachment figures. Many individuals with addiction histories present with symptoms of Complex Post-Traumatic Stress Disorder (CPTSD) and Disturbances in Self-Organisation (DSOs), including chronic emotional dysregulation, negative self-concept, and interpersonal dysfunction (Cloitre et al., 2009) These presentations are often best understood not merely as comorbidities but as foundational elements in the aetiology and lived experience of addiction.

The development of core psychological functions, such as mentalisation, emotional regulation, and epistemic trust, is often impaired in contexts of early trauma (Fonagy & Luyten, 2009). Mentalisation refers to the ability to understand one's own and others' mental states and is central to navigating complex emotional and relational experiences. When disrupted, individuals may struggle to process affective experiences or trust others' intentions, which can leave them vulnerable to dissociation, hyperarousal, or compulsive self-soothing through substances or behaviours. It can also be instrumental in relapse (Suchman et al., 2018).

Psychotherapy, particularly when relational and trauma-informed, offers a crucial space where these disrupted capacities can begin to be restored. Unlike acute-care models, psychotherapy fosters a slower, deeper recovery process centred on safety, trust, and self-exploration. As Herman (1992) outlines in her seminal three-stage model of trauma recovery—safety and stabilisation, remembrance and mourning, and reconnection—psychotherapeutic healing unfolds over time, aligned with the client's developmental and relational needs.

However, in many addiction treatment systems, psychotherapy remains underutilised or marginalised, as resources are often directed toward more immediate interventions such as medication-assisted treatment (e.g., methadone or buprenorphine) or harm reduction strategies like needle exchanges and safe injection facilities. While these approaches are necessary and often life-saving, they rarely address the underlying psychological and relational wounds that sustain addiction. The framing of addiction as a chronic condition rather than an acute event (White, 2008) underscores the importance of long-term, integrative, and developmentally informed models of care, models in which psychotherapy plays a central, not supplementary, role.

This perspective is reflected in the evolution of Recovery-Oriented Systems of Care (ROSCs), which emphasise not only symptom reduction but also broader well-being and social inclusion (Sheedy & Whitter, 2009). Recovery is increasingly understood as more than abstinence; it involves the capacity to sustain emotional balance, engage in meaningful relationships, and reintegrate into society. Research by Hibbert and Best (2011) highlights the importance of recovery capital, noting that issues such as housing, employment, social connection, and stigma are not separate from clinical work; they form part of the ecology of recovery. This necessitates flexible, integrative responses that fuse depth with pragmatism, and relational attunement with systemic awareness.

Group psychotherapy also plays an important role in this broader landscape, offering clients opportunities to build relational capacity, practise affect regulation, and experience belonging (Yalom & Leszcz, 2020). While individual therapy supports profound personal exploration, group settings can replicate relational dynamics and provide corrective emotional experiences. In conjunction with formal therapy, mutual aid groups such as 12-step fellowships (e.g., Alcoholics Anonymous) offer a vital peer-led component of recovery. These fellowships foster

connection, accountability, and shared meaning-making, factors consistently associated with long-term recovery outcomes (Kelly, 2017). These fellowships have consistently been effective in conjunction with psychotherapy (Flores, 2001b).

The central thesis of this work is that addiction must be understood and treated through an integrative biopsychosocial lens, and that psychotherapy, rather than serving as a supplementary intervention, has a central role to play in recovery. In contrast to many current acute care systems that prioritise short-term episodic interventions, this thesis advocates for approaches that address the underlying psychological and relational wounds of addiction. It explores how trauma shapes the trajectory of addiction, how psychotherapy can address its developmental roots, and how diverse modalities can be effectively combined across the stages of recovery. Recovery from addiction in individuals affected by complex trauma is not short-term work; it requires long-term psychotherapeutic engagement. This thesis illustrates the need for a treatment paradigm that honours the duration and relational nature of the therapeutic process.

These questions are explored across three chapters, each addressing a core inquiry:

1. Is there a link between trauma and addiction?
2. What is the role of psychotherapy in contemporary addiction treatment systems?
3. How can different psychotherapeutic modalities be integrated at different stages of recovery?

Chapter One explores the role of trauma in addiction through developmental, attachment, and neurobiological frameworks. It presents evidence linking Adverse Childhood Experiences (ACEs), Complex PTSD (CPTSD), and Disturbances in Self-Organisation (DSOs) to increased vulnerability to addiction. It explores addiction as a regulatory adaptation to emotional and relational disconnection.

Chapter Two explores psychotherapy within the current addiction treatment system. It reviews the limitations of the acute care model and outlines the rationale for a shift toward a recovery-oriented, chronic care approach. The chapter also considers how psychotherapists can support long-term recovery through relational engagement and developmentally attuned care that extends beyond the formal treatment continuum.

Chapter Three presents a framework for integrating psychotherapeutic modalities across stages of recovery. It draws on Herman's trauma recovery model and incorporates theory from psychodynamic, humanistic, somatic, existential, Gestalt, and mentalisation-based traditions. The chapter emphasises the need for developmental sensitivity, symbolic understanding, and a relational stance capable of tolerating the complexity of each client's recovery journey.

In adopting this approach, the thesis does not seek to reduce addiction to a single explanatory model, but rather to integrate theory, clinical insight, and reflective practice in support of a more humane and effective response. Addiction is not merely about what people do; it encompasses what has happened to them, how they have learned to survive, and what becomes possible in the presence of safe, attuned, and long-term relational support.

Chapter 1: The Link Between Trauma and Addiction: A Biopsychosocial Perspective

1.1 Introduction

Addiction is one of the most complex and pervasive challenges in mental health, affecting individuals of all ages, cultures, and socioeconomic backgrounds. Traditionally viewed through a biomedical lens as a brain disease, contemporary understandings increasingly recognise addiction as a multifactorial condition shaped by biological, psychological, and social influences. Among these, trauma, particularly when experienced during early development, has emerged as a critical variable in understanding both the aetiology and maintenance of addictive behaviours.

This chapter explores the connection between trauma and addiction through an integrative biopsychosocial framework. It begins by outlining the predominant models of addiction and the diagnostic criteria that shape clinical understanding. The discussion then transitions to the developmental impact of trauma, including adverse childhood experiences (ACEs), and how these early disruptions in attachment, emotional regulation, and identity formation can lead to long-term vulnerabilities to addiction. By examining concepts such as complex post-traumatic stress disorder (CPTSD), disturbances in self-organisation (DSO), and affect dysregulation, the chapter underscores the psychological mechanisms that mediate the trauma-addiction connection.

Finally, it considers how trauma-informed approaches, grounded in attachment theory, mentalisation, and epistemic trust, can support recovery by addressing the underlying relational and emotional wounds that often precede substance use or compulsive behaviours. This inquiry establishes a foundation for understanding addiction not merely as a disorder of choice or neurochemistry but as a reaction to developmental injury and unresolved trauma. In doing so,

it prepares the ground for examining therapeutic models prioritising relational safety, psychological integration, and the restoration of developmental integrity.

1.2 Addiction

There are two primary models of addiction: the biomedical model and the biopsychosocial model. The biomedical model incorporates the brain disease concept of addiction, suggesting that repeated drug use affects the brain's reward system, impairs self-control, and increases compulsive drug-seeking behaviour (Volkow et al., 2016). In contrast, the biopsychosocial model views addiction as a multi-faceted condition influenced by biological, psychological, and sociological factors (Griffiths, 2005). These include genetic vulnerabilities and neurochemical changes (Volkow et al., 2016), psychological factors such as trauma and emotional dysregulation (Khantzian, 1997), and social determinants, including family environment and socioeconomic status (Griffiths, 2005). This model is considered a more comprehensive framework for understanding addiction (West, 2013; Kim & Hodgins, 2018; Griffiths, 2005).

Two major diagnostic frameworks contribute to our understanding of addiction: the International Classification of Diseases, 11th Revision (ICD-11; World Health Organisation, 2019), and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR; American Psychiatric Association, 2022). The ICD-11 categorises fourteen distinct substances that can lead to dependence and defines substance dependence as a strong internal drive to use a substance, resulting in impaired control, reduced prioritisation of other activities, and persistence of use despite harmful consequences (WHO, 2019). The DSM-5-TR conceptualises substance use disorder as “a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (APA, 2022, p. 545). The DSM-5-TR outlines eleven diagnostic criteria, including unsuccessful attempts to cut down or stop use, continued use

despite social or occupational problems, increased tolerance, and the presence of withdrawal symptoms (APA, 2022).

1.3 Behavioural Addiction

In terms of behavioural addictions, the DSM-5-TR (APA, 2022) includes gambling disorders in the substance-related and addictive disorder category. It identifies other behavioural addictions as requiring further evidence to be categorised as disorders. According to Griffiths (2005), addiction is synonymous with drug use. However, he identifies several behaviours that could be considered potentially addictive but do not involve drug consumption, such as gambling, sex, exercise, video gaming, and internet use. Kim and Hodgins (2018) propose that substance and behavioural addiction are “different expressions of a common underlying disorder” (p.1) and argue that treatment should address “underlying mechanisms common to both” (p.1). Grant et al. (2010) report that these mechanisms include impulse control, reward system dysregulation, and maladaptive coping mechanisms.

1.4 Developmental Risk Factors

Understanding addiction requires close attention to the developmental and environmental risk factors that shape a person’s life over time. Studies have shown that early exposure to traumatic experiences can interfere with healthy brain development and emotional regulation, increasing the likelihood of turning to maladaptive coping strategies such as substance use or compulsive behaviours (Anda et al., 2006). Moreover, adolescence represents a particularly sensitive developmental window, during which the brain’s reward and executive function systems are still maturing, making individuals more susceptible to risk-taking and the reinforcing effects of addictive substances and behaviours (Casey et al., 2008). Integrating these developmental insights enhances the biopsychosocial understanding of addiction by highlighting how early experiences and brain development contribute to lifelong addiction risk.

1.5 Adverse Childhood Experiences (ACEs)

Building on this developmental perspective, the role of early adversity in the development of both substance and behavioural addictions is effectively demonstrated by the Adverse Childhood Experiences (ACEs) framework. The original ACE study by Felitti et al. (1998) established a strong and graded relationship between the number of adverse experiences, such as abuse, neglect, or household dysfunction, and the likelihood of later substance use, mental health disorders, and chronic disease. These early experiences disrupt neurodevelopment, impair attachment formation, and compromise the development of core affect regulation capacities (Anda et al., 2006). Individuals with high ACE scores are more likely to engage in maladaptive coping behaviours, including substance use and compulsive behaviours, as attempts to manage persistent emotional dysregulation (Van der Kolk, 2014). Thus, the ACE framework offers a valuable perspective for understanding how early relational trauma and developmental disruption can shape vulnerability to addiction across the lifespan, emphasising the importance of trauma-informed care in both prevention and treatment contexts (Mahon, 2024).

Recent research further emphasises the impact of emotional neglect as a particularly potent form of trauma. A study on individuals in long-term opiate agonist treatment (OAT) in Dublin found that, while cumulative ACE scores were associated with earlier opiate use and greater PTSD symptoms, it was the specific experience of “feeling unloved” that most strongly predicted PTSD symptoms (McDonagh et al., 2023). This form of neglect, often termed trauma by omission, refers to the absence of critical emotional experiences such as love, validation, and attunement during childhood (Rosenberger & Feng, 2017). Unlike overt abuse, omission trauma is less visible. However, it can lead to profound emotional and psychological consequences, including difficulties in self-regulation, attachment insecurity, and a heightened risk of substance dependence. These findings underscore the clinical relevance of relational

and emotional neglect in the aetiology of addiction and further support the call for attachment-focused and trauma-informed treatment models in recovery care (McDonagh et al., 2023).

Given these developmental vulnerabilities, it becomes clear that when reliable emotional containment is missing in early life, individuals often turn to substances or compulsive behaviours as external ways to manage overwhelming emotions. Though ultimately harmful, these behaviours can temporarily stand in for the absent caregiver, offering short-lived relief from inner distress. In this way, addictive substances may function similarly to what Winnicott (1971) termed transitional objects: items or rituals that mediate between the self and others during vulnerable developmental phases. Taipale (2017) builds on this notion by suggesting that addiction serves as a form of externally assisted self-regulation, allowing individuals to create an illusory sense of control over internal chaos when affective self-mastery is compromised. This concept provides a valuable perspective for understanding how substance use may not only soothe dysregulated affect but also act as a psychological anchor in the aftermath of relational trauma. By viewing addiction as a compensatory mechanism for early failures in emotional holding, we enhance our appreciation of its complex developmental roots and establish a basis for considering how such symbolic dependencies intersect with trauma-related psychopathology.

1.6 PTSD and Substance Use Disorder Comorbidity

The ACE framework also helps clarify the high rates of comorbidity between post-traumatic stress disorder (PTSD) and substance use disorders (SUDs). Interpersonal trauma (e.g., abuse, assault) is more predictive of PTSD and symptom severity than non-interpersonal trauma (e.g., accidents, natural disasters) (Ullman et al., 2023). Furthermore, trauma has a cumulative effect; a greater number of exposures significantly increases the risk of psychopathology, a pattern known as the dose-response effect (Mollica et al., 1998). PTSD and SUD frequently co-occur, with approximately 46% of individuals with PTSD also meeting criteria for SUD, and 25–34% of those with SUD reporting comorbid PTSD (Lortye et al., 2021). This comorbidity is associated with elevated rates of suicidality, legal problems, relational violence, and reduced social and physical functioning (McCauley et al., 2012).

Although less studied, the relationship between complex PTSD (CPTSD) and substance use is emerging as clinically significant. CPTSD often results from prolonged developmental trauma involving caregivers, fostering profound emotional mistrust and the use of substances as maladaptive coping strategies (Briere et al., 2023). The self-medication hypothesis (Khantzian, 1997) suggests that substance use initially serves to dampen traumatic distress but ultimately worsens affect dysregulation and dependency. This view is reinforced by the ICD-11, which recognises substance use as a feature of PTSD symptomatology, particularly with avoidance (WHO, 2019). CPTSD research similarly highlights the role of chronic emotional dysregulation in driving addictive behaviour (Rossi et al., 2023).

Recent empirical work has begun to validate these theoretical and clinical insights. A systematic review and meta-analysis by Roberts et al. (2016), which analysed 14 randomised controlled trials involving individuals with co-occurring PTSD and SUD, found that trauma-focused psychological therapies, including cognitive processing therapy and exposure-based approaches, were effective in reducing PTSD symptoms without worsening substance use. In

several cases, modest reductions in substance use were also observed. These findings challenge longstanding concerns that trauma-focused therapy might destabilise recovery and instead support the safety and efficacy of integrated, trauma-informed approaches for comorbid presentations.

1.7 Trauma

In the context of psychotherapy, trauma is understood as an emotional or psychological injury resulting from distressing events that overwhelm an individual's ability to cope (Van der Kolk, 2014). Traumatic experiences occur when a person is overwhelmed by an event, a series of events, or conditions subjectively perceived as life-threatening (Ogden et al., 2006). Individuals with a history of trauma rarely experience a single event; instead, they are more likely to encounter repeated episodes of traumatic exposure (Kessler, 2000). Trauma can manifest in various forms depending on the nature, duration, and developmental timing of the exposure. Judith Herman (1992a) distinguishes between three types of trauma: acute, chronic, and complex. These forms of trauma, particularly when experienced during early development, can profoundly disrupt emotional regulation and increase vulnerability to later psychopathology, including addiction and relational disturbances.

Acute stress disorder involves the development of post-traumatic symptomatology that emerges within three days of a traumatic event and lasts for up to four weeks. If symptoms persist, the individual may develop post-traumatic stress disorder (Benedek & Wynn, 2016). The DSM-5-TR and the ICD-11 also assist in framing our understanding of PTSD. Post-traumatic stress disorder (PTSD) represents a more chronic pattern of trauma that occurs over time. According to the DSM-5-TR, it entails exposure to a threat or perceived threat of death, serious injury, or sexual violence. This manual describes PTSD using twenty symptoms categorised into four clusters: Intrusions, Avoidance, Negative Alterations in Cognition and Mood (NACM), and Hyperarousal (APA, 2022).

The ICD-11 identifies two related yet distinct trauma-related disorders: post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (CPTSD) (WHO, 2018). According to the ICD-11, “Exposure to repeated traumas, especially in early development, is associated with a greater risk of developing complex post-traumatic stress disorder rather than post-traumatic stress disorder” (WHO, 2018, p. 346). CPTSD typically arises from prolonged and inescapable interpersonal trauma, such as childhood abuse, domestic violence, torture, or institutional abuse (Cloitre et al., 2009). While CPTSD shares the core symptoms of PTSD, it is distinguished by additional diagnostic criteria of disturbances in self-organisation (WHO, 2018).

1.8 Disturbances in Self-Organisation

Disturbances in self-organisation typically arise in disrupted caregiving relationships that threaten the individual’s psychological integrity (Lawson et al., 2013). They manifest across three domains: (1) emotional dysregulation, including intense affect (terror, rage, shame) or a profound emotional collapse (emptiness, detachment, numbness); (2) interpersonal dysregulation in the form of conflicting, enmeshed, chaotic relationships; and (3) self-dysregulation characterised by self-loathing and viewing oneself as irreparably damaged or contaminated (Ford & Courtois, 2020). The inability to emotionally regulate, a depleted self-concept, and a debilitated ability to form relationships lay the foundation for the development of other comorbidities such as substance use disorder (Hein et al., 2020).

In her original writing on the syndrome of complex post-traumatic stress disorder, Herman (1992a) described the extraordinary psychological defences a child must adapt to survive in a traumatic environment. She identified DSOs as “deformations of personality” (p.388) that stemmed from a “betrayal-trauma” (Smith & Freyd, 2014) due to recurrent and extreme traumatic exposure. Children trapped in such an environment face developmental tasks complicated by their circumstances. One of the primary tasks of childhood, forming a primary

attachment to parents or an adult caretaker, is not merely important, but crucial for the child's survival. Their sense of self will ultimately be defined by its quality (Herman, 1992a).

Disturbances in self-organisation (DSO) have been recognised as a central mechanism linking early trauma to addiction. In a large-scale study of adolescents, Rossi et al. (2023) found that while both PTSD and CPTSD were associated with substance and behavioural addictions (SBAs), it was specifically the DSO symptoms, emotional dysregulation, negative self-concept, and interpersonal difficulties that accounted for most of the effect. DSO mediated 59% of the impact of intentional traumatic experiences (iTEs) on cannabis use and 66% on problematic internet use, surpassing the influence of core PTSD symptoms. These findings emphasise how prolonged interpersonal trauma disrupts self-regulation and fosters maladaptive coping strategies such as substance use and compulsive behaviours. Rossi et al. (2023) emphasise the clinical significance of DSO, advocating for trauma-informed interventions that focus on emotional regulation, identity integration, and relational functioning.

1.9 Attachment in a Traumatic Environment

Early caregiving relationships provide the relational context in which children develop their emotional regulation. When the child-caregiver relationship becomes a source of trauma, the attachment bond is severely compromised (Spinazzola et al., 2005). Attachment behavioural strategies are innate in children and designed to promote proximity and elicit caregiving responses. According to Main (1990), there are two primary attachment behavioural strategies. The optimal strategy supports the development of a secure attachment, fostering an adaptive and coherent sense of self (Wallin, 2007).

When a child's emotional needs go unmet, and a caregiver's responses discourage both proximity-seeking and autonomous exploration, the child is often forced to abandon the optimal attachment strategy in favour of a secondary one. This shift may lead to either

deactivation or hyperactivation of the attachment behavioural system (Cassidy & Kobak, 1988). Such adaptations represent the early formation of maladaptive psychological defences, as the child strives to survive within an emotionally insecure environment. In these contexts, children attempt to form bonds with caregivers who are unable to provide consistent emotional regulation, protection, or stimulation (Mikulincer & Shaver, 2003). As secure attachment fails to develop and secondary strategies take hold, defensive mechanisms become the child's primary tools for managing emotional and relational distress.

1.10 Psychological Defences

Children in traumatic environments face developmental tasks that can be confusing and contradictory. They must learn to trust caregivers who are untrustworthy or unsafe, develop a sense of safety in unpredictable and threatening conditions, and form an identity within the context of abusive or neglectful relationships (Herman, 1992). These impossible demands threaten the child's psychological integrity, and survival ultimately depends on preserving the primary attachment, regardless of the caregiver's ability to provide safety and nurturance (Siegel, 1999).

To maintain the attachment, the child must dissociate from intolerable emotional knowledge that could threaten the relationship. This results in a defensive splitting of experience, leading to a lack of integration across emotional, cognitive, and relational domains (Kernberg, 1984). Dissociation becomes a central strategy that manifests through psychological defences such as avoidance, depersonalisation, emotional numbing, constructing a false self, and the idealisation of caregivers (Kernberg, 1984; Kalsched, 1996). These defences protect the child from emotional annihilation but disrupt the consolidation of a coherent sense of self.

Over time, this defensive process leads to a lack of integration, resulting in fragmentation across various areas of development. Firstly, there is fragmentation in consciousness, which hinders the integration of memory, affect, and bodily experiences. Secondly, the internal

representation of the self becomes distorted, as the child internalises roles such as “evil” or “worthless”, or constructs compensatory identities such as the “good child” or “martyr” (Herman, 1992). Thirdly, the internalised representations of others are similarly fractured, characterised by persecutory or idealised images, as well as feelings of terror or rage. This undermines the developing ability to trust in relationships (Liotti & Farina, 2011; D’Andrea et al., 2012)

Although these strategies preserve a sense of relational safety in the short term, they come at a high cost for the protection they provide. The fragmentation of the self, the internalisation of a sense of badness and shame, and the failure to integrate memory and emotion create a foundation for numerous maladaptive coping mechanisms (van der Kolk & Fisler, 1994). Substance use, compulsive risk-taking, purging and vomiting, and compulsive sexual behaviour are employed to attempt to regulate distressing emotional states (Herman, 1992). Affect dysregulation is part of the symptom cluster involved in disturbances of self-organisation. It is often cited as a personality and temperamental trait inherent in the symptomatology related to PTSD, CPTSD, and SUD.

1.11 Affect Regulation and Addiction.

Affect regulation, the ability to modulate emotional responses adaptively, has emerged as a central mechanism in understanding addiction. Following the biopsychosocial model of addiction, emotional dysregulation is not merely a co-occurring symptom but a key etiological and maintaining factor (Khantzian, 1997; Griffiths, 2005). The notion that addiction arises as a form of self-medication for unmanaged affective states aligns with empirical findings and neurobiological models that emphasise the disruption of regulatory systems involved in emotion and reward (Koob & Le Moal, 2001; Schore, 2001).

According to Khantzian’s self-medication hypothesis, individuals who have difficulties modulating distress may resort to substances or behaviours as compensatory mechanisms to

manage overwhelming emotional states (Khantzian, 1997). These patterns are particularly evident in those with histories of trauma, early attachment disruptions, or mood disorders. Studies have consistently shown a strong correlation between substance use disorders (SUDs) and elevated levels of emotional dysregulation. Stellern et al. (2022) conducted a meta-analysis revealing significantly higher scores on the Difficulties in Emotion Regulation Scale (DERS) among individuals with SUDs compared to controls, with the most significant deficits in the “Strategies” and “Impulse” subscales.

Attachment theory provides a developmental framework for understanding how early relational experiences influence affect regulation. Secure attachment promotes right-brain development, vital for managing emotional arousal (Schore, 2001; Schore & Schore, 2007). When attachment is insecure or disrupted, primarily due to neglect or abuse, individuals may struggle to develop affective regulatory capacities. This developmental derailment heightens vulnerability to using substances or engaging in addictive behaviours as substitutes for inadequate internal regulation. 80% of abused infants exhibit a disorganised/disoriented attachment style (Van der Kolk et al., 1996).

The role of early trauma is also supported by Weiss et al. (2013), who found that childhood abuse, particularly emotional and physical, was significantly associated with emotional dysregulation and subsequent PTSD symptoms among substance users. Emotional dysregulation acted as a mediator between early trauma and addiction severity, suggesting that addictive behaviours often represent attempts to escape overwhelming emotional pain when intrinsic regulation strategies are lacking.

In addition to internal regulatory challenges, the ways individuals engage emotionally with others also contribute to addiction vulnerability. Dingle et al. (2017) emphasise that people with substance use disorders often struggle with interpersonal emotional regulation. They tend to show less flexibility in how they express emotions in social settings and can believe that

negative feelings should not be shared. This makes it harder for them to seek or receive support from others, reinforcing a pattern of managing emotions alone, often through substance use. When individuals struggle to put their feelings into words, it disrupts healthy coping and can lead to a range of harmful, self-defeating behaviours (Van der Kolk & Fisler, 1994).

Moreover, affect regulation deficits are not limited to substance addictions. Behavioural addictions, such as gambling or compulsive internet use, share similar underlying mechanisms involving poor impulse control, reward-seeking in response to negative affect, and reliance on maladaptive emotion regulation strategies (Kim & Hodgins, 2018; Grant et al., 2010). Affect regulation is fundamental to understanding addiction. Whether viewed through developmental, psychological, or neurobiological lenses, addiction often emerges as a maladaptive solution to persistent emotional dysregulation. Effective treatment must involve addressing the underlying regulatory deficits that drive addictive behaviour.

1.12 Mentalization, Alexithymia, and Epistemic Trust

From the beginning of life, the infant's relationship with the primary caregiver forms the foundation for affect regulation, mentalisation, and psychological resilience. Winnicott (1971) described how the infant's spontaneous gestures are met by an attuned maternal response that "gives back to the baby the baby's own self" (p. 118). This mirroring enables the infant to internalise a "subjective object", a version of the caregiver that exists within the infant's mind and provides ongoing emotional regulation and a stable sense of self (Winnicott, 1971; Schore, 2001). Similarly, Bion (1962) described the process of containment, whereby the caregiver receives, processes, and returns the infant's overwhelming affect in a tolerable form. This regulatory interaction is similar to Winnicott's holding environment and supports the development of the child's emerging self-regulatory capacities (Fonagy et al., 2002).

Through contingent and marked mirroring, caregivers convey a sense of being understood, which scaffolds secure attachment and the development of mentalizing capacities, the ability

to reflect on one's own and others' mental states (Fonagy et al., 2002; Wallin, 2007). This process shapes early self-development and underpins psychological resilience. A securely attached infant, who feels held in the caregiver's mind, is more likely to develop reflective functioning. This epistemic trust refers to the ability to perceive communication from others as trustworthy and personally relevant (Fonagy et al., 2017). Epistemic trust enables learning from social interactions and supports flexible adaptation to new environments. When early caregiving fails due to trauma, neglect, or chronic misattunement, these capacities may be compromised, leading to impaired mentalisation, disrupted epistemic trust, and reduced resilience (Fonagy et al., 2015; Luyten et al., 2020).

Mentalising enables individuals to make sense of social experiences and regulate emotions through reflection rather than reactivity. However, in the context of early trauma, this capacity may break down, resulting in maladaptive patterns such as hypermentalising, pseudomentlising, or mentalising collapse (Fonagy & Luyten, 2016). These disruptions are frequently observed in individuals with borderline personality disorder and substance use disorders (Bateman & Fonagy, 2016). When mentalisation fails, emotional regulation deteriorates, and epistemic vigilance, a defensive stance toward others' intentions, replaces trust, leading to social withdrawal and reduced benefit from relational or therapeutic interventions (Allen et al, 2012; Savov & Atanassov, 2013).

A related construct, alexithymia, reflects a breakdown in mentalizing and describes difficulty identifying, articulating, and processing emotions. It is marked by externally oriented thinking, diminished introspection, and limited imagination (Taylor et al., 1997). Alexithymia is particularly common in individuals with substance use disorders (SUDs) and post-traumatic stress disorder (PTSD), with significantly higher prevalence than in non-clinical populations (Thorberg et al., 2011). Emotionally neglected or traumatised individuals may not develop the emotional language or internal awareness necessary to understand and express their feelings,

contributing to a reliance on substances or compulsive behaviours to manage distress (van der Kolk & Fisler, 1995). Moreover, alexithymia is associated with poorer treatment outcomes, as it impairs engagement in therapy and limits the capacity to benefit from relational interventions (Evren et al., 2008).

1.13 Restoring Developmental Integrity in Addiction Recovery

In the context of addiction recovery, particularly within residential programmes, day treatment, and 12-step fellowships where group interaction is central, mentalising and epistemic trust are vital for meaningful engagement and sustained change. Individuals with early attachment disruptions may struggle to accurately interpret others' behaviours or intentions, leading to interpersonal mistrust and emotional isolation (Fonagy et al., 2015). When epistemic trust is compromised, group members may perceive therapeutic input or peer support as irrelevant or unsafe, hindering their openness to change (Fonagy et al., 2017). Conversely, epistemic trust can be restored when a safe and reflective group environment fosters mentalizing. This enables individuals to tolerate vulnerability, process emotional experiences, and form reparative relationships. Such relational experiences enhance psychological and emotional resilience, allowing participants to benefit from shared insight and community, which are critical components of long-term recovery (Luyten et al., 2020).

Recent research further illustrates the role of epistemic trust and mentalization in the development of trauma-related and addictive disorders. Kampling et al. (2022) demonstrated that adverse childhood experiences (ACEs) not only increase the risk of PTSD and complex PTSD (CPTSD) but also impair personality functioning, with epistemic trust mediating this relationship. Similarly, Savov and Atanassov (2013) argue that individuals with substance use disorders often exhibit deficits in affective mentalization, which are linked to early relational trauma and resemble the emotional challenges observed in borderline personality disorder.

These findings illustrate the need for trauma-informed therapeutic approaches that target the restoration of epistemic trust and strengthen reflective functioning.

Recovery from addiction must be understood as the repair of disrupted developmental processes. Psychotherapeutic recovery involves restoring psychological capacities frequently compromised by early trauma. Through therapeutic relationships that encourage secure attachment, mentalisation, and epistemic trust, individuals can begin to integrate fragmented self-states and develop healthier relational templates. These intersubjective processes are central to sustainable recovery and bridge the gap between trauma resolution and psychological integration.

1.14 Conclusion

This chapter has demonstrated that trauma, particularly when experienced during early developmental stages, plays a fundamental role in the emergence of both substance and behavioural addictions. While the biomedical model offers valuable insights into the neurochemical and compulsive aspects of addiction, it is the biopsychosocial perspective that provides a more comprehensive and empathetic understanding of addiction as it is lived, especially within the context of relational trauma.

When viewed through the lenses of attachment theory, mentalisation, and affect regulation, it becomes evident that disruptions in early caregiving relationships, such as those identified in ACEs, can hinder the development of key psychological capacities. As a result, individuals may become more susceptible to substance use or compulsive behaviours as maladaptive strategies for coping with emotional distress. Concepts such as Complex PTSD and Disturbances in Self-Organisation further illuminate how trauma can fragment the self, compromise emotional regulation, and obstruct the capacity for meaningful relationships.

The connection between alexithymia and addiction reinforces the need for trauma-informed and developmentally attuned treatment approaches. Recovery, from this standpoint, involves far more than simply achieving abstinence; it requires the gradual restoration of trust, emotional awareness, and a coherent sense of self, capacities that are frequently compromised by early trauma.

By building a clear theoretical and empirical foundation for the connection between trauma and addiction, this chapter opens the door to exploring how psychotherapy can begin to heal these deeper wounds. Meaningful and lasting recovery depends on approaches that truly recognise the developmental roots of addiction and respond to them with care and depth.

Chapter 2: The Role of Psychotherapy in Addiction Treatment Systems

2.1 Introduction

Addiction recovery is a multifaceted process that extends beyond abstaining from substance use. In recent decades, growing clinical and theoretical attention has been given to the psychological, emotional, and relational dimensions of addiction, particularly through the lens of psychotherapy. This chapter explores the evolving role of psychotherapy in addiction recovery, tracing its historical marginalisation to its status as a core component of recovery-oriented care. Drawing on diverse theoretical foundations, from psychodynamic and behavioural traditions to trauma-informed and neurobiological models, the chapter outlines how psychotherapy addresses the underlying emotional dysregulation, attachment trauma, and relational impairments often found at the heart of addictive behaviours.

In the Irish context, the development of addiction treatment has mirrored international trends, moving from abstinence-only approaches toward harm reduction, and now toward more integrative, person-centred recovery models. Psychotherapy has become a vital tool within these systems, particularly in supporting long-term recovery, emotional regulation, and relapse prevention. The chapter further explores the continuum of care, recovery capital, trauma-informed systems, and the growing use of group therapy as a developmental intervention. In doing so, it highlights the indispensable role psychotherapy plays in promoting meaningful, sustained recovery from addiction.

2.2 Historical Context and Theoretical Foundations

The role of psychotherapy in addiction recovery has evolved significantly over the past century, reflecting shifting understandings of the aetiology of addiction and the goals of treatment. Initially, addiction was conceptualised predominantly as a moral failing or a lack of willpower, leading to approaches that were often punitive or abstinence-driven, with little regard for

psychological complexity (White, 1998). Psychotherapeutic interventions were not initially prioritised in early addiction treatment models, which were often custodial or spiritually oriented, such as the early temperance movements or 12-step programmes rooted in the traditions of Alcoholics Anonymous (AA).

However, with the advent of psychoanalytic thought in the early 20th century, a psychological dimension of addiction began to emerge. Early psychoanalytic theorists such as Rado (1933) and Khantzian (1997) proposed that substance use acted as a defence against overwhelming affective states or unmet developmental needs. This psychodynamic framing suggested that addiction was less about the substance itself and more about its role as a psychological regulator, an early foreshadowing of modern self-medication hypotheses (Taipale, 2017). Although traditional analytic methods proved unsuitable for the often chaotic and dysregulated presentations of individuals with substance use disorders, psychodynamic insights laid important groundwork for recognising the internal conflicts and relational trauma that underpin many addictive behaviours.

During the mid-1900s, behaviourism became dominant, promoting a focus on observable behaviours rather than internal emotional states. Behavioural therapies sought to reduce substance use through reinforcement strategies but often overlooked the underlying emotional and relational drivers of addiction (White, 2015). Cognitive-Behavioural Therapy (CBT), developed in the 1970s and 1980s, adopted a more balanced approach. It integrated practical tools for managing behaviour with techniques to assist people in changing negative thinking patterns, building coping skills, and preventing relapse. CBT rapidly became a cornerstone in addiction treatment, mainly due to its robust empirical foundation and adaptability across treatment settings (Beck et al., 1993).

The limitations of strictly behavioural or cognitive models in addressing complex addiction presentations have led to a renewed interest in more holistic and relational approaches.

Humanistic approaches such as person-centred therapy (Rogers, 1951) introduced the importance of empathy, unconditional positive regard, and the therapeutic relationship. These elements are particularly crucial for individuals with trauma histories. These principles continue to inform contemporary trauma-informed care and relational psychotherapy approaches utilised in addiction recovery today (Najavits, 2002).

The 21st century has witnessed a growing convergence between neuroscience, developmental psychology, and psychotherapy in addiction research. Notably, attachment theory (Bowlby, 1969; Mikulincer & Shaver, 2007) and affect regulation theory (Schore, 2001; Fonagy et al., 2002) have significantly contributed to the current understanding of this concept. These models conceptualise addiction not merely as a response to craving or faulty cognition, but as a disorder rooted in early relational disruptions and impaired emotional regulation capacities. Psychotherapy addresses the impact of early developmental disruptions through corrective regulatory experiences that restore the capacity for intimacy and trust, emotional holding, and mentalising. These developmental skills are often compromised in individuals with histories of trauma and neglect.

Historically, the journey from moralism and behaviourism to medicalisation and affect regulation neuroscience illustrates an evolving understanding of the biopsychosocial issues inherent in addiction. It also highlights the pivotal role that psychotherapy plays in reducing symptoms, psychological reintegration and recovery. Following the evolution of treatment paradigms allows us to appreciate the profound contribution psychotherapeutic modalities have had in addressing the complex emotional and relational disturbances underlying the addictive experience.

2.3 Overview of Addiction Treatment Approaches in Ireland

The role of psychotherapy in addiction recovery must be understood within the broader historical evolution of addiction treatment systems in Ireland. There have been two main heroin epidemics: the first during the late 1970s and early 1980s, and again in the 1990s. During the first epidemic, the rapid increase in heroin use in cities led to a shift away from abstinence towards more adaptable responses (Strang et al, 2012). This change was reinforced by rising rates of overdose and HIV among intravenous drug users (O'Gorman, 1998). This crisis resulted in a paradigm shift towards harm reductionist responses that prioritised reducing the health consequences of drug use over abstinence (EMCDDA, 2013).

Harm reduction strategies, such as needle exchange programmes, acknowledged the reality that illicit drug use was a fact of life (Marlatt, 1996). Central to this shift was the introduction and widespread adoption of opioid substitution therapies like methadone maintenance treatment (MMT), which emerged as a cornerstone of the biomedical model of addiction (Comiskey et al, 2019). While this approach has been effective in reducing social and medical issues related to substance use, such as crime, mortality and transmission of infectious diseases, it has also been critiqued for downplaying the psychological, relational, and developmental dimensions of addiction (McDonagh et al, 2023).

Although both philosophies had the recovery of the substance user as the ultimate objective, the differing views on treatment led to a fragmented system (Futterman et al, 2004). In response to the perceived limitations of both abstinence-only and harm-reductionist paradigms, a more integrated framework, the recovery model, has emerged. This approach recognises recovery not as a singular, linear process, but as a personalised and dynamic journey encompassing various pathways, including harm reduction and abstinence (Best, 2019). The recovery model is grounded in the principles of person-centred care, empowerment, and holistic wellbeing, and

it aligns with international public health perspectives that advocate for flexible, inclusive treatment systems (White, 2008).

Rather than framing abstinence and harm reduction as mutually exclusive, the recovery model regards them as complementary strategies that can be tailored to individual needs and stages of change (Sheedy & Whitter, 2009). This paradigm shift reflects a broader cultural and clinical recognition that sustainable recovery often requires a combination of medical, psychological, and social interventions that honour the complexity of substance use and human behaviour. In doing so, the recovery model fosters a continuum of care that is more equitable, effective, and respectful of individual autonomy and dignity (Keane et al., 2014).

Over time, psychotherapy has shifted from the margins to the mainstream of addiction treatment, evolving alongside changing paradigms from abstinence to harm reduction to recovery. Once absent from early models, it is now regarded as a vital component of recovery-oriented systems. Psychotherapy encompasses a range of modalities designed to address the biopsychosocial aspects of addiction. It targets the emotional and psychological dimensions of substance use while reinforcing the holistic, person-centred ethos of the modern recovery model. Serving as a consistent thread throughout the continuum of care, psychotherapy supports individuals at all stages of recovery (Miller & Rollnick, 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).

2.4 The Continuum of Care

It is generally accepted that no single service or intervention can meet the complex needs of an individual entering addiction recovery. The complexity of these needs necessitates a multi-agency, stage-specific response that offers various interventions at different stages of the recovery journey. This is known as the continuum of care, and it typically follows the path of community engagement, stabilisation, detoxification, residential treatment, drug-free day

services, and ongoing aftercare. Each of these stages presents its own challenges, and research suggests that psychotherapy plays a central role in supporting the individual throughout the process.

A study by Ivers et al. (2017) evaluating post-detoxification outcomes in over 10000 opioid-dependent individuals found that transitioning from detoxification to structured aftercare, such as residential treatment or drug-free day programmes, was significantly associated with improved long-term outcomes. Counselling during and after detox was linked to increased retention and engagement. The authors highlight that patients who engaged with aftercare were more likely to remain abstinent and avoid relapse, concluding that “improving rates of transition from detoxification to aftercare is a vital goal for treatment providers” (p. 340). This research also established that a very low percentage of people on methadone completed detoxification, 143 people, which is 1.4% (Ivers et al, 2017).

This finding must be understood in the broader context of Ireland’s treatment landscape, where methadone has long served as the predominant biomedical response to opioid use disorder (Mayock & Butler, 2021). While methadone reduces harm and stabilises lives, recent critiques have underscored its limitations. According to the Health Research Board (HRB) (Lynch et al., 2025), there were 11075 people on methadone maintenance in 2022, many for prolonged periods without achieving full recovery.

McDonagh et al. (2023) argue that methadone, although medically effective, fails to address the psychological distress, emotional dysregulation, and early relational trauma that many clients continue to experience. Their research identified “feeling unloved in childhood” as the strongest predictor of PTSD among long-term opioid agonist therapy (OAT) patients, a finding that supports the need for attachment-focused, trauma-informed psychotherapy.

Evidence supports the role of emotional regulation difficulties in both the onset and maintenance of addiction. Estevez et al. (2017) found that deficits in emotional regulation and attachment difficulties were predictive of substance and behavioural addictions. These findings are echoed in qualitative research conducted within Keltoi, a drug-free residential programme in Dublin, which evaluated an emotional regulation skills training programme based on the “Window of Tolerance” model (Ogden et al., 2006; Siegel, 1999). Participants described the training as transformative, especially in helping them tolerate difficult emotional states without reverting to substance use (Sherry, 2013).

The importance of aftercare and therapeutic continuity is further reinforced by a longitudinal evaluation of Soilse, a drug-free day programme in Dublin’s inner city. Among 110 participants, those who maintained abstinence or successfully regained it after lapsing identified three consistent factors: 12-step fellowship involvement, counselling, and participation in psychotherapeutic aftercare groups (Soilse, 2011). These “Key Performance Indicators” were strongly associated with long-term recovery outcomes and resilience following lapses. Both Ivers et al. (2017) and Soilse (2011) emphasise that individuals who remain engaged in counselling and structured aftercare are significantly more likely to stabilise after relapse episodes, thereby avoiding a full return to substance dependence.

The continuum of care must address the evolving biopsychosocial needs of the client as they progress through the stages of their recovery. Access to and engagement with psychotherapeutic interventions at all stages enhance the likelihood of long-term, sustainable recovery. Research consistently reflects the vital role that psychotherapy plays in supporting recovery, cultivating epistemic trust, enhancing emotional regulation, and mitigating the risk of relapse.

2.5 Addiction as a Chronic, Relapsing Condition: A Trauma-Informed Perspective

Addiction treatment, as outlined in the continuum of care, is delivered in brief episodic stages. This is referred to in medicine as an acute-care model. A recovery paradigm advocates for a longer-term treatment model, akin to those for other health conditions, such as asthma or diabetes. This is commonly referred to as a chronic care model in primary care (White, 2008).

To thoroughly explore the role of psychotherapy in addiction recovery, it is essential to understand addiction as a chronic, relapsing condition that is deeply intertwined with complex trauma and co-occurring mental health challenges. Both the National Institute on Drug Abuse (NIDA, 2020) and the American Society of Addiction Medicine (ASAM, 2019) define substance use disorders not as episodic behavioural failures, but as long-term, relapsing health conditions possessing significant emotional, relational, and neurological dimensions. This chronicity demands sustained, flexible, and psychologically integrative approaches to care.

According to William White (2008), recovery from addiction, particularly in cases complicated by trauma, often spans years rather than months and requires “prolonged recovery management” that includes professional support, peer involvement, and community integration. Short-term interventions or detox episodes, while necessary, are insufficient on their own. White argues for a recovery-oriented system of care that supports individuals through repeated cycles of engagement, disengagement, and re-engagement. This model inherently values the consistent presence of psychotherapy across the lifespan of recovery.

2.6 Co-occurring Complex Trauma

The chronic nature of addiction is especially pronounced when it co-occurs with complex trauma, the cumulative impact of prolonged emotional neglect, abuse, or attachment disruption during childhood. Researchers such as Herman (1992), van der Kolk (2014), Courtois and Ford (2009), and Najavits (2002) have demonstrated that trauma is not simply a co-occurring issue

but often lies at the core of the addiction experience. These early disruptions impair the development of affect regulation, self-concept, and relational safety, domains that cannot be restored through medication or behavioural modification alone. Instead, they require attuned, sustained psychotherapeutic engagement, where the client can begin to reconstruct a coherent narrative of themselves and process overwhelming emotions in a safe, relational context.

When addiction is viewed through this lens, psychotherapy becomes essential not just for symptom management but for rebuilding internal psychological structures eroded by trauma. This includes reworking maladaptive coping mechanisms, addressing shame and grief, and forming new relational templates. As Najavits (2002) stresses in her trauma-informed model, *Seeking Safety*, clients often use substances to manage trauma symptoms, meaning that addressing trauma is not an adjunct to addiction treatment, but central to it.

2.7 Trauma-Informed Care

Recent research further reinforces the need for trauma-informed approaches within a chronic care model of addiction recovery. In a systematic review of trauma-informed care (TIC) in substance use settings, Mahon (2024) emphasises that trauma is not an ancillary concern but a core feature of addiction for many service users, particularly those with histories of emotional neglect, complex interpersonal trauma, and developmental disruption. TIC, as outlined in this review, is not a short-term technique but an organisation-wide, long-term framework that prioritises emotional safety, relational continuity, and empowerment at every stage of service delivery.

These systemic commitments mirror what psychotherapy offers on an individual level: a relational environment where traumatic adaptations, such as emotional numbing, mistrust, or compulsive self-soothing, can be explored and transformed. Mahon argues that trauma-informed principles must be embedded in the ethos of addiction services to improve

engagement, reduce retraumatisation, and support sustained recovery. This aligns closely with White's (2008) call for recovery-oriented systems of care and affirms that psychotherapeutic engagement is indispensable not just for addressing trauma, but for anchoring individuals in long-term healing.

2.8 Recovery-Oriented Systems of Care (ROSCs): Potential and Limitations

Recovery-Oriented Systems of Care (ROSCs) represent a transformative shift in the treatment of addiction and co-occurring mental health conditions. Moving beyond short-term or crisis-focused care, ROSCs aim to provide a person-centred, integrated network of services that encompass the multiple domains of recovery, health, housing, employment, and community connection. ROSCs are designed to extend recovery support over time and across multiple domains of life, acknowledging the chronic, relapsing nature of addiction and the need for long-term, holistic supports (White, 2008).

ROSCs prioritise flexibility, inclusion, empowerment, and dignity, placing the service user, not the service provider, at the centre of care. Davidson and White (2007) argue that recovery should be the "organising principle" for integrating mental health and addiction services, one that supports the restoration of agency, relationships, and a meaningful life. Similarly, SAMHSA (2023) identifies core components of ROSCs, including peer-based support, cultural responsiveness, and continuity of care across treatment settings. However, despite their promise, ROSCs have been critiqued for insufficient integration of trauma-informed psychotherapy, particularly for clients with complex trauma histories (SAMSHA, 2014).

2.9 Physicians Health Programs

Physicians' Health Programs (PHPs) in the United States exemplify the power of long-term, integrated recovery models that embed psychotherapy at their core. Designed to support healthcare professionals with substance use disorders, PHPs combine structured monitoring, counselling, and peer engagement to achieve some of the highest recovery rates recorded. DuPont et al. (2009) found that among 904 physicians enrolled in 16 PHPs, 78% remained abstinent over five years, and over 70% continued practising medicine. These outcomes were strongly linked to ongoing engagement in individual counselling, group therapy, and 12-step fellowships.

The success of PHP lies in its sustained, relational approach. Counselling is not regarded as a short-term intervention but as a vital, ongoing process addressing underlying issues such as shame, perfectionism, and identity loss. A meta-analysis by Geuijen et al. (2021) of 29 health professional monitoring programmes found pooled abstinence and work retention rates of 72% and 77%, respectively, with the most effective models incorporating psychotherapy and aftercare.

The chronic care model gains further support from research demonstrating that sustained therapeutic engagement yields long-term social and emotional benefits. Hibbert and Best (2011) found that individuals in recovery for over five years reported significantly higher levels of psychological well-being, quality of life, and social functioning, including increased employment and contributions to society. In some cases, exceeding general norms, a phenomenon they termed the "*better than well*" effect. Similarly, the Survivors Manchester SROI Report (2014) showed that trauma-informed therapy for highly marginalised men generated a social return of £5.84 for every £1 invested. Outcomes included reduced substance use, improved mental health, increased employability, and decreased reliance on welfare and

justice systems. These findings underscore the transformative and economic value of sustained, trauma-informed care.

2.10 Barriers to Long-Term Treatment

Staff and services do vital work supporting individuals in recovery from drug addiction. Acute care models, while essential for providing a solid foundation, typically offer structured support for up to two years, at a time when many clients are just beginning to develop the ego strength necessary for trauma processing. Specialist services such as One in Four, for example, require clients to be abstinent for at least 12 months before engaging in trauma therapy (One in Four, 2024). There can be an emphasis on short-term, manualised interventions. Although these can support early recovery, they are often insufficient for addressing the complex developmental trauma underlying many addiction presentations.

Long-term psychotherapy is labour-intensive and costly, necessitating extensive training, high-quality supervision, and smaller caseloads to support consistent, attuned care (Lambert, 2013; McLellan et al., 2014). In overstretched systems, high staff turnover and limited funding restrict service capacity (Mental Health Reform, 2022). As a result, those with the most complex needs do not receive long-term continuing care. Recovery-oriented systems, as emphasised in SAMHSA (2023), must be adequately resourced to support long-duration, trauma-informed care if they are to address the chronic and relational nature of addiction recovery meaningfully.

2.11 Recovery Capital and the Window of Tolerance

Addiction recovery is a complex process that affects every aspect of an individual's life. Two concepts that increasingly inform integrated, trauma-informed care are Recovery Capital and the Window of Tolerance. Although they originate from different disciplines, both models share a common goal of advocating for the effective use of resources to support individuals. Granfield and Cloud (2008) described recovery capital as the resources necessary to initiate

and sustain recovery. The Window of Tolerance, introduced by Siegel (1999), outlines the optimal arousal zone in which individuals can utilise their resources to regulate their emotions, remain present, and engage meaningfully. This section provides an overview of each concept and emphasises the interdependence between the availability of resources and psychophysiological regulation in addiction recovery.

2.12 Recovery Capital: Foundations of Sustainable Change

Recovery Capital provides a strengths-based framework that shifts the focus from pathology to potential. It occurs across four domains: social capital (relationships), physical capital (housing, employment), human capital (health, skills), and cultural capital (norms, values), each of which plays a crucial role in an individual's recovery journey (Granfield & Cloud, 1999; Cloud & Granfield, 2008). These resources collectively serve as a buffer against relapse and support sustained recovery. High levels of recovery capital are associated with improved quality of life and greater social integration (Best, 2019).

Recovery capital is influenced by social issues that traumatised substance users frequently encounter, including poverty, low educational attainment, and homelessness. Individuals who experience social exclusion will enter recovery with diminished levels of capital (Keane et al., 2013). This underscores the need for both structural and individual interventions. Supporting people in recovery beyond their acute clinical care has been challenging, as policies remain entrenched on focusing on short-term clinical care interventions (Best & Ivers, 2022). A significant gap in structural interventions is access to long-term psychotherapy for this cohort.

2.13 The Window of Tolerance: Navigating Emotional Regulation

The Window of Tolerance explains how individuals with trauma histories experience dysregulation, either hyperarousal (e.g., panic, rage) or hypoarousal (e.g., dissociation, numbness), in response to stress (Siegel, 1999). Addiction is often a maladaptive attempt to self-regulate these states. Substances become tools for modulating arousal, offering temporary relief at the cost of long-term dysregulation (Schore, 2001).

In early recovery, individuals must confront raw affective states without their familiar coping mechanisms. Psychoeducation concerning the Window of Tolerance enables clients to identify triggers, anticipate emotional shifts, and apply regulatory strategies. Evidence-based interventions, such as grounding, mindfulness, and somatic work, can expand the window, thereby fostering increased resilience (Ogden et al., 2006; Van der Kolk, 2014).

2.14 Integration and Implications

While Recovery Capital and the Window of Tolerance arise from different sociological and neurobiological paradigms, they are profoundly interconnected. A person's ability to remain regulated is influenced by the stability and safety of their environment. In turn, the capacity to utilise external supports often depends on internal regulation. For instance, individuals embedded in strong relational networks, one dimension of social capital, are more likely to experience co-regulation, a vital precursor to emotional resilience (Porges, 2011). Conversely, someone living in a homeless accommodation or without access to support may remain in a state of chronic arousal, impairing their ability to engage in recovery supports. Even when services are available, clients with unaddressed trauma may lack the regulatory capacity to benefit from them fully.

Similarly, emotional regulation can act as a gateway to building capital. Individuals with broader windows of tolerance are more likely to maintain employment, sustain relationships,

and engage in community life, thereby increasing human and social capital over time. In this context, interventions must be biopsychosocially integrated, addressing both the internal emotional system and the external social environment. This perspective has significant treatment implications. Programmes that combine practical support, such as housing and peer mentorship, with trauma-informed therapy that enhances regulatory capacity are more likely to yield positive outcomes. Such a dual-focus model acknowledges that recovery requires more than merely stopping substance use; it demands the re-establishment of safety, identity, and relational trust at both individual and systemic levels.

2.15 Group Psychotherapy in the Treatment of Trauma and Addiction

Group psychotherapy has become a cornerstone modality in addiction treatment, particularly within residential and community-based settings. It is arguably the predominant therapeutic form in most addiction services (SAMHSA, 2023). While group formats offer practical advantages such as scalability and peer support, their clinical utility runs much deeper. For individuals recovering from addiction and trauma, group therapy provides a powerful relational space where disrupted developmental processes, particularly trust, regulation, and self-coherence, can begin to be restored.

Yalom & Leszcz (2020) posit that all therapy groups inevitably echo the “primary group,” referring to the family of origin. This phenomenon is described as the “recapitulation of the primary family group,” in which early attachment dynamics, roles, and relational wounds are reactivated within the group setting. For those with complex trauma histories, this process can evoke profound distress. The very structure intended to foster healing can initially feel threatening, as it mirrors the context in which relational injury first occurred. Herman (1992) notes that trauma survivors often carry an internalised sense of difference and shame, leading them to fear exposure or rejection. Paradoxically, she also emphasises that “recovery can only take place within the context of relationships; it cannot occur in isolation” (p. 133).

What makes group therapy uniquely suited to trauma and addiction recovery is its potential to offer corrective relational experiences. Unlike the original “primary group,” therapeutic groups are intentionally structured to be safe, consistent, and non-hierarchical in nature. In this environment, clients are invited to move beyond defensive isolation and re-engage interpersonally. As participants witness their peers struggle with similar emotions, histories, and defences, they begin to internalise a sense of shared humanity, what Herman (1992) calls the “commonality of experience.” This shared recognition can dismantle the alienation and self-stigma often at the heart of both trauma and addiction.

Beyond this shared identification, group settings serve as rich environments for fostering epistemic trust (Fonagy et al., 2015). As discussed in chapter one, this trust is often compromised in individuals with complex trauma; however, within a well-facilitated group, repeated experiences of being seen, mirrored, and validated by others gradually reduce this vigilance. Over time, this nurtures the conditions for restoring mentalising (Fonagy et al, 2017).

This process is not merely interpersonal but neurobiological. As individuals begin to mentalise again in the presence of empathic peers and facilitators, their capacity for affect regulation improves. Fonagy and Luyten (2016) argue that the development of epistemic trust and mentalising capacities is essential for emotional regulation, especially in those with histories of neglect or trauma. In the group, clients gradually share previously unexpressed emotions, tolerate differences without collapsing, and reflect rather than react. The shift from epistemic vigilance to epistemic openness enables learning, growth, and the possibility of real relational change.

Moreover, the group context offers opportunities to repair attachment injuries through the therapeutic use of intersubjective processes. When facilitators and peers respond with curiosity and non-judgment, shame-laden parts of the self, often hidden in addiction, can be brought into awareness. This aligns with the mentalisation-based model of recovery, where affect

regulation, self-coherence, and interpersonal understanding are viewed as developmental achievements rather than solely cognitive skills (Bateman & Fonagy, 2016).

Empirical research supports these clinical observations. Marmarosh et al. (2013) found that group therapy can strengthen attachment security over time by providing a sense of safety and corrective relational experiences. Flores (2001b) highlights its role in increasing emotional awareness, dismantling defences, and rebuilding interpersonal trust. Taken together, these findings underscore that group therapy is not just a treatment format but a relational space for deep psychological repair. It fosters the epistemic trust and emotional resilience essential to long-term recovery.

2.16 Conclusion

Understanding addiction as a chronic, relapsing condition has shifted the focus of treatment away from short-term fixes and toward long-term, relational, and psychologically integrated care. Psychotherapy plays a central role in this shift, offering the kind of emotional support, trauma healing, and relational repair that recovery truly requires. As addiction is increasingly seen through developmental and neurobiological lenses, psychotherapy has moved to the centre of what effective, compassionate care looks like.

Recovery-oriented Systems of Care (ROSCs) provide a hopeful path forward. They prioritise flexibility, individual needs, and long-term support that spans multiple aspects of life. However, to truly fulfil their promise, these systems must centre trauma-informed psychotherapy in their approach, particularly for individuals with histories of complex trauma.

Chapter 3:

Integrating Psychotherapeutic Modalities Across the Stages of Addiction Recovery

3.1 Introduction

Addiction is increasingly understood not simply as a disorder of substance misuse, but as a complex, developmental, and relational adaptation to early emotional pain and trauma (van der Kolk et al., 1991). It is often a means of regulating unbearable affect, dissociation, and unmet relational needs (Khantzian, 1997). As such, recovery must be framed not as a return to normative functioning, but as a process of developmental repair, relational reintegration, and emotional transformation. This reflects the object relations-integrative stance that places relational repair and developmental reorganisation at the centre of therapeutic work (Nolan & Säfvestad-Nolan, 2005).

To provide a clinically meaningful framework for this chapter, Judith Herman's (1992) three-stage model of trauma recovery is adopted: (1) Safety and Stabilisation, (2) Remembrance and Mourning, and (3) Reconnection and Integration. Though originally developed to guide the treatment of survivors of interpersonal trauma, Herman's phases are highly applicable to addiction recovery, which often mirrors the emotional and relational injuries found in complex trauma. Clients in recovery typically require stabilisation and containment before they can process grief or build new relational and existential meaning.

While these phases offer a valuable heuristic, recovery is not a linear path. People often revisit earlier stages, move in and out of stability, or require different supports at different times. There is no single modality that fits neatly into one phase, nor should recovery be reduced to technique or protocol. Instead, this chapter argues for an integrative approach, one that centres the evolving needs of the individual and draws flexibly from diverse therapeutic traditions,

including humanistic, psychodynamic, sensorimotor, existential, and attachment-based modalities.

This chapter also positions recovery as a social and collective process, not merely an individual pursuit. It recognises the critical role of mutual aid, community, and relational belonging in supporting long-term integration. This aligns with broader frameworks of change, including the Transtheoretical Model (Prochaska & DiClemente, 1983), which views recovery as a cyclical process rather than a linear one, and the Scottish Recovery Consortium's stages of recovery, which emphasise the importance of connection, citizenship, and purpose (Bradstreet & McBrierty, 2012).

Emerging empirical evidence affirms the necessity of long-term, integrative psychotherapy for treating complex trauma, especially when addiction is also present. Complex trauma cannot be resolved through brief interventions or technique-driven protocols; it requires sustained, relationally attuned engagement across emotional, somatic, cognitive, and interpersonal dimensions (Herman, 2015). Phase-based models are more effective than single-phase interventions for complex PTSD, particularly when stabilisation precedes trauma processing (Darby et al., 2023). Juul et al. (2023) found that extended-duration mentalisation-based treatment yields better outcomes in individuals with developmental trauma, while Kline et al. (2018) reported durable symptom reduction following long-term trauma-focused therapy.

Discussing the need for longer-term treatment, Taylor (2014) notes, "trauma therapy is not quick work" (p. 221); consistency and continuity are essential in assisting clients to integrate dissociated parts of the self. Meta-analytic findings reinforce this view: Bisson et al. (2020) highlight the superior efficacy of long-term trauma therapy for chronic PTSD, while Simpson et al. (2021) demonstrate that integrated, phase-based interventions significantly reduce both PTSD and substance use symptoms. Furthermore, Flückiger et al. (2018) confirm that the therapeutic alliance, central to relational and integrative approaches, predicts more variance in

treatment outcomes than specific techniques. These findings support the integrative, trauma-informed framework presented in this chapter, which draws flexibly from humanistic, somatic, psychodynamic, and existential modalities.

3.2 Transitional Phenomena and the Symbolic Function of Addiction

Addiction is frequently framed in medical and behavioural terms, characterised by symptoms such as compulsion, craving, and withdrawal (APA, 2022; Volkow et al, 2016). However, for many individuals, substance use is not solely a means of altering consciousness or achieving pleasure, but a deeply symbolic and relational act, rooted in a developmental history of unmet emotional needs. To understand addiction psychotherapeutically, it is necessary to consider its function in the individual's psychic life: what it defends against, what it regulates, and what symbolic roles it may play (Potik et al., 2007; Taipale, 2017).

D.W. Winnicott's (1971) theory of *transitional phenomena* offers a powerful lens for this understanding. In healthy development, the child creates transitional objects, such as blankets or toys, or engages in repetitive behaviours to manage the emotional pain of separation and individuation. These objects are not simply inanimate things; they are imbued with psychic meaning and mediate between the child's internal world and the external reality. Critically, they provide comfort, predictability, and a sense of agency during vulnerable moments of change and instability.

In this light, substances and rituals surrounding their use can be understood as adult transitional objects, improvised tools for emotional regulation and psychic survival when the original developmental conditions for secure attachment were absent or inconsistent. As Potik et al. (2007) and Taipale (2017) note, substance use frequently develops in the wake of emotional neglect, relational trauma, or attachment rupture. The drug becomes a surrogate caregiver,

offering a sense of control, relief, or even identity, particularly in moments of internal chaos or interpersonal failure.

The rituals of addiction, preparation, procurement, and use may also serve important symbolic functions. For example, Miller (2002) describes the act of injecting heroin not simply as a pharmacological event, but as a structured, repetitive action rich in meaning, predictability, and affective charge. Such rituals echo earlier experiences of self-soothing and become embedded in the user's sense of safety and continuity. Even chaotic substance use patterns may reflect a compulsory search for relational containment, albeit one enacted through the body rather than the interpersonal field. In this light, Welsh (2014) argues that practices like needle fixation function as psychoanalytic fixations, developmentally arrested, symbolically charged behaviours through which the individual seeks psychic holding. The needle becomes not just a tool, but a transitional object offering a momentary illusion of integration and control.

This symbolic and regulatory function of addiction is not limited to the substances themselves. Treatment environments, such as methadone maintenance clinics, residential programmes, and 12-step meetings, can also take on transitional qualities (Potik et al., 2007). As Khan (1974) argued, the therapeutic space can serve as a substitute holding environment where the psychic work of mourning, integration, and reorganisation can occur. Methadone, for instance, is not just a medication; it becomes part of a stabilising ritual. Residential treatment centres and day programmes provide clear boundaries, predictable rhythms, and relational containment, temporarily standing in for the internal regulation the client has yet to develop.

Twelve-step fellowships, particularly Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), may also function as transitional communities, especially in the early and middle stages of recovery. Their structured formats and emphasis on shared language offer continuity and familiarity. Sponsorship models offer quasi-parental relationships, allowing clients to experience attunement, guidance, and accountability, often for the first time. These fellowships

offer a communal holding environment that can help internalise new models of relational safety and trust over time (Flores, 2001a).

From this perspective, addiction recovery is not simply about removing the transitional object (the substance) but about replacing it with more authentic and developmentally reparative forms of containment, connection, and regulation. This is where psychotherapy becomes critical. The therapeutic relationship, particularly when grounded in trauma-informed, attachment-based, and humanistic principles, offers a new transitional space (Winnicott, 1971; Khan, 1969; Ogden et al., 2006). In this space, the therapist becomes a consistent, attuned presence through whom the client can rework internalised relational patterns and gradually develop the capacity to self-regulate, mentalise, and trust again.

This reworking does not occur through insight alone. It requires the repetition of safe, emotionally resonant encounters that build new neural pathways and internal representations (Schoore, 2009; Ogden et al., 2006). Over time, the therapist's role as a transitional figure may diminish as the client internalises these experiences and begins to engage more flexibly in community life, intimate relationships, and broader recovery environments.

Thus, understanding addiction through the lens of transitional phenomena expands the psychotherapeutic task (Winnicott, 1971; Potik, 2006; Taipale, 2017). It moves us beyond symptom reduction and toward a deeper inquiry into the meaning, function, and relational logic of substance use. Mannion (2005) further illustrates this point in her clinical work with trauma survivors, where the therapeutic relationship functions as a reparative object, supporting clients to symbolically and emotionally separate from destructive internalised dynamics and develop healthier internal self-other representations. It also provides a rationale for integrating therapeutic modalities not based on diagnosis or protocol, but rather according to the client's developmental stage and what they are symbolically reaching for when they reach the drug.

3.3 Humanistic Psychotherapy as a Foundational Stance

In the aftermath of trauma and addiction, where experiences of betrayal, shame, and disconnection are often profound, the first task of psychotherapy is not to analyse, interpret, or reframe, but to relate. Humanistic psychotherapy, grounded in the values of empathy, congruence, and unconditional positive regard, offers a relational foundation upon which all other therapeutic modalities can be integrated (Rogers, 1961; Mearns & Cooper, 2005). This stance also reflects the broader integrative philosophy articulated by Nolan & Säfvestad-Nolan (2005, Ch. 1), who argue that relational attunement and humanistic values are prerequisites for safely applying other techniques, especially in trauma and addiction recovery work.

Clients entering addiction treatment frequently arrive with internalised messages of worthlessness, failure, and alienation, often reinforced by punitive systems, stigmatising language, and coercive treatment experiences (Maté, 2008; Flores, 2001b). Their difficulties are not only psychological but also interpersonal and existential in nature. For these individuals, the humanistic stance is both reparative and radical. It refuses to reduce the client to a diagnosis or behaviour and instead offers an experience of being genuinely seen and valued, perhaps for the first time.

Furthermore, humanistic psychotherapy offers a therapeutic space where ambivalence, shame, and not-knowing are allowed, experiences which often characterise the early stages of recovery. Rather than pressuring clients toward change, it meets them where they are, affirming their dignity even amid internal chaos or external relapse (Rogers, 1961; Mearns & Cooper, 2005). This approach reflects the non-linear nature of recovery itself, in which regression and contradiction are integral to the developmental process, rather than failures of will (Herman, 1992; Prochaska & DiClemente, 1983).

Importantly, the humanistic orientation is not incompatible with more structured or specialised modalities. Instead, it grounds them. A trauma-focused somatic intervention conducted without empathy or attunement can be overwhelming or even re-traumatising (Ogden et al., 2006; Fisher, 2017). A psychodynamic interpretation made in the absence of relational safety may feel shaming or intrusive. When guided by humanistic values, however, these techniques can become more attuned, responsive, and effective.

This integrative potential is especially relevant in addiction treatment, where clients may simultaneously struggle with bodily dysregulation, attachment injuries, existential distress, and social marginalisation. The humanistic stance enables therapists to respond to this complexity without defaulting to a singular framework. Whether drawing on Gestalt techniques for present-moment awareness, sensorimotor approaches for bodily regulation, or existential therapy for meaning-making, the therapist remains fundamentally oriented toward the person, not just the problem.

Finally, the humanistic model supports the re-humanisation of recovery itself. In contrast to approaches that focus narrowly on symptoms, it views healing as a process of becoming: a gradual reclaiming of voice, agency, and connection. For many clients, this is the real work of recovery, not just abstaining from substances, but re-establishing a sense of self that feels coherent, alive, and worthy of a meaningful life.

3.4 Somatic and Sensorimotor Psychotherapy: Reclaiming Bodily Safety and Regulation

In the early stages of addiction recovery, establishing a sense of internal safety is a prerequisite for all subsequent therapeutic work. For individuals with complex trauma histories, substance use often functions as a maladaptive form of physiological regulation, an attempt to manage overwhelming states of arousal, dissociation, or emotional numbness. In this context, recovery begins not with insight or memory work, but with the body. Somatic and sensorimotor

psychotherapies offer essential tools for stabilisation by addressing the physiological imprints of trauma and helping clients restore a tolerable range of emotional and sensory experience (Ogden et al., 2006; van der Kolk, 2014).

As explored in Chapter 2, the concept of the window of tolerance (Siegel, 1999) describes the optimal arousal zone in which individuals can process experience without becoming hyperaroused or dissociative. Re-establishing this window through grounding, breath awareness, and titrated body-based interventions remains vital in the early recovery process. By gently expanding clients' capacity to notice and regulate internal sensations, sensorimotor work supports the very conditions needed for reflective and relational therapies to take root later (Ogden et al., 2006; Fisher, 2017).

Sensorimotor Psychotherapy (SP) is particularly well suited to the first phase of recovery as described by Herman (1992), Safety and Stabilisation. This modality focuses on “bottom-up” processing, beginning with bodily experience rather than narrative content. For clients who may be flooded by affect or shut down due to chronic hyper- or hypoarousal, SP offers a non-verbal entry point into the therapeutic process. The goal at this stage is not to revisit traumatic memories but to increase present-moment awareness, build interoceptive tolerance, and begin to re-establish a felt sense of safety within the body (Ogden et al, 2006). Key techniques include grounding, breath regulation, titration, and somatic tracking, each designed to foster bodily presence and regulate arousal without overwhelming the client (Ogden & Fisher, 2015)

This work is vital for clients with high levels of dissociation or alexithymia, which is common in those with histories of developmental trauma and prolonged substance use. By focusing on physiological patterns of activation and deactivation, SP gently cultivates a foundation for later affective and narrative processing. Importantly, this body-based stabilisation is not separate from relational work but prepares the client to engage more fully in it (Ogden & Fisher, 2015).

The neurobiological framework underpinning sensorimotor work is supported by Schore's (2009) work on right-brain-to-right-brain attunement. Schore emphasises that early attachment relationships shape the developing right hemisphere, which governs affect regulation and bodily awareness. In this sense, somatic therapy can be seen as reparative attachment work, helping clients re-establish the capacity for co-regulation through the therapist's attuned presence and the safety of bodily containment.

Moreover, somatic therapies often function as an early corrective to epistemic mistrust. Clients whose relational systems have failed may initially find safety not in dialogue, but in the predictability of somatic experience. The therapist's non-intrusive guidance in these practices begins to offer a different kind of relationship, one in which bodily integrity and autonomy are respected. This reestablishes the groundwork for later development of trust, mentalisation, and affect regulation (Ogden & Fisher, 2015; Fonagy et al., 2017).

By helping clients re-inhabit their bodies and build tolerance for internal states, somatic and sensorimotor approaches enable what van der Kolk (2014, p.243) refers to as the "ownership of yourself." This is not just a clinical objective; it is a reclamation of the self as something that can be known, felt, and lived. In this way, Phase 1 of recovery becomes not only about containment but also the quiet emergence of possibility.

Epistemic trust must be cultivated from the very outset of recovery. Without a basic sense that others can be trusted, individuals are unlikely to engage meaningfully in therapy or benefit from social and relational support. This is particularly true in cases of developmental and betrayal trauma, where early experiences may have instilled deep mistrust of others' intentions and chronic hypervigilance (Smith & Freyd, 2014). Through a consistent, attuned, and non-coercive therapeutic relationship, grounded in humanistic values, clients begin to test whether the therapist is safe, emotionally available, and able to hold their experience without judgment (Rogers, 1961; Fonagy et al., 2017).

However, it is in this second stage of recovery, where traumatic memories are approached and grief is processed, that epistemic trust truly bears fruit. It takes enormous courage to allow another person to engage with experiences of shame, loss, or terror. The client's willingness to risk such vulnerability reflects a hard-won shift in relational worldview: from distrust and isolation to openness and intersubjectivity. This trust becomes the foundation from which mentalisation and affect regulation can grow meaningfully (Fonagy & Bateman, 2006; Herman, 1992).

Section 3.5 Mentalisation and the Restoration of Reflective Function

Once epistemic trust has been tentatively re-established in the therapeutic relationship, mentalisation can begin to flourish. In individuals with complex trauma and addiction histories, this capacity is often fragmented or collapses under emotional stress (Fonagy & Bateman, 2006). Clients may experience black-and-white thinking, projective identification, or dissociative disconnection, particularly when triggered by shame or perceived threat. However, when the therapeutic space is consistently perceived as safe and containing, clients gradually become able to stay present with their internal experience, tolerating ambiguity and developing a more integrated sense of self and other (Fonagy & Bateman, 2006; Ogden et al., 2006).

This unfolding mentalising capacity supports the emergence of affect regulation, the ability to tolerate, modulate, and express emotions in adaptive ways. For many in addiction recovery, emotional states have long been overwhelming or unavailable, either blunted by dissociation or numbed by substances. Substances may have functioned as rudimentary tools of affect regulation, used to manage what was otherwise unmanageable (Schore, 2003; Danylchuk & Connors, 2019). As clients internalise the regulating presence of the therapist, and begin to mentalise their emotional patterns, they develop alternative strategies for emotional containment, ones that do not involve compulsive behaviours or self-abandonment.

This work is not quick. It is iterative and relational. As affect regulation improves, clients become more capable of engaging in reparative interpersonal experiences, both within and beyond therapy (Schoore, 2012). These may include reconnecting with estranged family members, participating in group therapy, or finding grounding within 12-step fellowships or recovery communities (Flores, 2001b). While these collective spaces offer invaluable opportunities for mirroring, modelling, and shared vulnerability, they can feel initially threatening, especially for those with histories of betrayal trauma (Smith & Freyd, 2014). For such individuals, the therapeutic relationship remains a vital holding environment, where social anxieties can be worked through, and relational confidence gradually built (Winnicott, 1965).

In many ways, the journey from epistemic distrust to trust, from dysregulation to regulation, and from alienation to connection is a developmental arc, not unlike that of early attachment (Fonagy & Allison, 2014). Therapy serves as a kind of corrective emotional environment, where the psychological structures necessary for recovery are not merely taught, but co-created and developed (Wallin, 2007). Mentalisation and regulation are not imposed from the outside, and they are modelled, invited, and supported within the safety of a trusted relationship (Fonagy & Bateman, 2006).

By this stage of recovery, the client is not only abstinent but is developing the internal architecture required for long-term psychological resilience: the capacity to reflect, regulate, and relate. These are the hallmarks of meaningful change. They signal not simply the cessation of substance use, but the beginning of a deeper, more integrated way of being (van der Kolk, 2014).

3.6 Relational and Integrative Depth Work (Middle to Late Stage)

As clients deepen into the second and third phases of recovery, Herman's (1992) "remembrance and mourning" and "reconnection and integration" psychotherapy often expands into more nuanced emotional and relational territory. This work involves not only processing traumatic memory but also repairing internal working models, integrating disowned or fragmented self-states, and gradually constructing a coherent and meaningful sense of self and story. It is in this phase that relational, psychodynamic, existential, and gestalt modalities find particular relevance, offering diverse but complementary paths for deep psychological repair and identity reconstruction.

For clients with early attachment disruptions or chronic relational trauma, their internal world is often shaped by templates of disconnection, abandonment, and shame. These become internalised object relations, parts of the self relating to internalised others in ways that are distorted, punitive, or fragmented (Gomez, 1997; Kernberg, 2004). Psychodynamic therapy, particularly when informed by object relations and attachment theory, provides a relational holding environment that allows these inner dynamics to emerge. Through careful attention to transference and countertransference, the therapist becomes both a container and interpreter of affectively charged enactments (Clarkin et al., 2006).

By the time clients reach this stage of recovery, what is required is not quick symptom management but deep and sustained therapeutic engagement. The integration of traumatic memory and identity is not a short-term task; it unfolds gradually through repeated relational encounters and the slow reworking of internal dynamics. At this stage, the duration of therapy is not simply about the amount of treatment delivered but about creating the conditions in which emotional depth and lasting transformation can develop. Integration is not achieved in a single breakthrough; it is a developmental process built on repeated experiences of safety, resonance,

and relational repair (Mannion, 2005). For this reason, sustained and integrative therapeutic work becomes not just beneficial but often indispensable.

This process is not simply insight-oriented. As new relational experiences accumulate, experiences of being seen, held, and not abandoned, the client begins to internalise new self-other representations. These slowly supplant earlier patterns, enabling greater emotional coherence and relational flexibility. In this way, the therapeutic relationship functions as a corrective emotional experience, but also as a developmental process in which the client begins to mentally and emotionally integrate what was once fragmented or disowned (Wallin, 2007; Fonagy & Bateman, 2006).

Gestalt therapy adds an important dimension by grounding this process in the present moment. Its focus on somatic cues, relational immediacy, and choices in the present moment can help clients move from dissociation to embodied presence (Taylor, 2014). Existential therapy, meanwhile, aids clients in confronting the often-overlooked questions of meaning and identity that arise in later recovery: “Who am I without the drug?” or “What is worth living for now?” These questions, once numbed by substance use, must now be embraced with curiosity and compassion, not hurried but explored (Yalom, 1980).

In this integrative space, self-states previously kept apart due to trauma, shame, or survival needs can begin to meet. As Fisher (2017) observes, therapy at this stage involves facilitating communication between these parts, rather than eliminating or correcting them, but rather creating a compassionate internal dialogue. Affect storms that once overwhelmed the client can now become understood, metabolised, and eventually integrated. This process requires not only affect regulation, but a trusting relationship in which such intense material can be safely brought forward.

It is also here that the fruits of earlier work on epistemic trust and mentalisation become apparent. As trust in the therapist and one's own emotional experience grows, the client becomes increasingly able to mentalise previously dissociated states. This relational security enables them to reinterpret emotional experiences not as threats but as meaningful signals, fostering the conditions for deeper self-ownership and relational intimacy (Fonagy & Bateman, 2006).

An integrative therapeutic approach is essential at this stage, as it enables the therapist to respond to the client's shifting developmental needs, drawing on psychodynamic depth at times and existential presence or embodied Gestalt awareness at others. The complex and intersecting effects of trauma necessitate a framework that is both flexible and comprehensive. By incorporating psychodynamic, somatic, cognitive, and relational modalities, integrative psychotherapy allows interventions to be tailored to the unique and evolving needs of each individual (Norcross & Goldfried, 2019).

Erskine (2008) emphasises that unconscious experience often originates in preverbal or dissociative processes, which require non-linear, relationally attuned engagement to be meaningfully addressed. This becomes particularly crucial in work with dissociation, addiction, and complex trauma, where rigid, manualised protocols often prove insufficient (Herman, 2015). As Norcross and Wampold (2019) contend, the quality of the therapeutic relationship and the clinician's responsiveness, core tenets of integrative practice, frequently exert greater influence on outcomes than technique alone. No singular modality can meet the complex, evolving needs of trauma-informed addiction recovery; integration must remain grounded in the humanistic, attuned therapeutic stance that has supported the client from the beginning.

Ultimately, this stage is not about "fixing" the past, but about reconnecting and reinhabiting the self, with greater coherence and emotional flexibility. It marks a turning point: from surviving to living; from fragmentation to integration.

3.7 Recovery as Reconnection: Belonging, Meaning, and Integration

As individuals progress into the later stages of addiction recovery, what Herman (1992) identifies as "reconnection and integration", the therapeutic focus increasingly turns toward rebuilding a coherent self, re-establishing meaningful relationships, and engaging with life beyond the narrow confines of survival. At this point, recovery is no longer primarily about abstinence or symptom management; it becomes a process of reclaiming agency, constructing meaning, and forming durable, life-affirming connections with others and with one's own values.

This phase invites existential questions that are often submerged or suspended during earlier stages: *Who am I without the addiction? What is the point of all this suffering? Where do I belong now?* These are not pathological concerns; they are valid questions and signs of healing. As clients gain stability and emotional capacity, the loss of their former identity as "addict" or "survivor" creates a necessary space for something new. However, that space can feel terrifying if it is not held and supported through relational integration and narrative coherence (Yalom, 1980).

Psychotherapy remains essential here, not to offer answers, but to provide a steady, reflective space in which clients can explore and construct meaning from their lived experience. This often involves integrating disparate self-states that were previously dissociated, shamed, or inaccessible. Fisher (2017) describes how recovery requires not simply the cessation of harmful behaviours, but the reintegration of "fragmented selves", parts of the psyche that developed to survive trauma and were later pathologised or suppressed. Therapy can support a

compassionate dialogue between these parts, creating an internal environment of acceptance and wholeness.

In this integrative phase, clients may also begin to re-engage with community in more authentic ways. Where early recovery may have involved cautious participation in 12-step fellowships or therapeutic groups, later recovery offers the opportunity for more mutual, sustaining relationships. Belonging becomes more than a strategy for avoiding relapse; it becomes an existential anchor. The recovery community, in this sense, is not just a support structure but a crucible for transformation, offering clients a sense of being seen, needed, and valued. Such social reintegration stands in direct opposition to the social exclusion and marginalisation often experienced by people with histories of addiction and trauma (Bradstreet & McBrierty, 2012).

This is also a time when creative and spiritual modalities may emerge as powerful sources of integration. Clients might engage in service through fellowships, “doing chairs” (personal storytelling), stepwork, journaling, creativity, and various physical activities, as ways to author their recovery narratives and metabolise meaning from suffering. Existential and humanistic therapies can hold space for this, validating the client’s yearning for coherence and transcendence without offering false closure or reductive answers (Bugental, 1987; Schneider & Krug, 2017). For survivors who go on to work in services or help others in recovery, this can represent what Herman (1992) referred to as a symbolic act of triumph, meaning it signifies gaining mastery over the trauma.

Importantly, integration is not about arriving at a perfected or fully healed self. Instead, it involves developing a flexible and compassionate relationship with the self, including its wounds and unfinished business (Fisher, 2017; Herman, 1992). Clients are not “cured,” or “recovered,” but are more deeply connected to themselves, to others, and to the world. This process is inherently developmental and ongoing. As such, integrative psychotherapy honours

the complexity of recovery by allowing room for ambivalence, humility, and the lifelong work of relational living (Bugental, 1987; Rogers, 1961).

Ultimately, the final stage of recovery is less about completing a journey than about becoming capable of continuing it. Through the therapeutic process, clients come to experience themselves not as broken or disordered, but as whole, evolving persons, capable of love, connection, creativity, and meaning (Yalom, 1980; Schneider & Krug, 2017). That, perhaps, is the most profound outcome psychotherapy can offer.

3.8 Conclusion

Recovery from addiction is not a linear path nor a singular event; it is a profoundly human process of re-establishing safety, reclaiming identity, and reconnecting with life. This chapter has proposed an integrative, trauma-informed approach to psychotherapy grounded in Judith Herman's (1992) three-phase model of recovery. Rather than assigning specific modalities to fixed stages, it has emphasised the importance of flexibility, relational depth, and developmental attunement across the therapeutic arc.

From the humanistic foundation that establishes safety and dignity, through the restoration of epistemic trust and the capacity to mentalise, to the later work of relational integration and existential meaning-making, psychotherapy can offer a holding environment capable of meeting the full complexity of the recovery journey. Recovery is not merely about abstaining from substances; it is about re-entering life with the emotional resilience, relational capacity, and symbolic resources needed to thrive.

In this sense, integrative psychotherapy is not simply a method; it is a commitment to staying with the person in all their complexity, walking with them through the ruptures and repairs that make healing possible. It is an act of trust, of presence, and ultimately of hope.

Conclusion

This thesis has argued that addiction is not merely a biomedical issue but a complex, embodied, and relational adaptation to psychological distress, disconnection, and developmental trauma. While contemporary treatment models have made valuable strides in neurobiological research and the evolution of the recovery model, they often fall short in addressing the emotional, interpersonal, and symbolic dimensions that underpin addiction. Central to this work has been the assertion that psychotherapy, particularly when trauma-informed, relational, and developmentally sensitive, holds a vital and often underutilised role in long-term addiction recovery.

The first chapter laid the theoretical groundwork for this position, establishing the deep and multifaceted relationship between trauma and addiction. Drawing on developmental, attachment, and neurobiological frameworks, the chapter demonstrated how early relational trauma, such as Adverse Childhood Experiences (ACEs), chronic emotional misattunement, or neglect, can impair an individual's capacity to regulate affect, form secure attachments, and develop a cohesive sense of self. Addiction, viewed through this lens, emerges not simply as a set of harmful behaviours but as a survival strategy. This regulatory adaptation attempts to soothe unbearable internal states or symbolically replace missing relational experiences. The inclusion of diagnostic constructs such as Complex PTSD (CPTSD) and Disturbances in Self-Organisation (DSOs) further underscores the extent to which addiction is often a symptom of deeper psychological and relational wounds. These insights challenge narrow biomedical or behavioural understandings and demand a more holistic, psychodynamically-informed view.

Building on this foundation, Chapter Two examined how psychotherapy fits within the current addiction treatment landscape, with a particular focus on the Irish context. The analysis

revealed a system still primarily oriented around harm reductionist and acute-care responses such as methadone maintenance and acute interventions such as stabilisation, detoxification, and short-term residential and day services. While such interventions are necessary and often life-saving, they rarely provide the sustained relational depth or developmental repair that long-term recovery requires.

The chapter traced the emergence of the recovery model and recovery-oriented systems of care (ROSCs), both of which signal a growing awareness that recovery is not simply the cessation of substance use, but the rebuilding of a meaningful life. Within this paradigm shift, psychotherapy offers more than symptom reduction; it supports the reconstruction of relational capacity, emotional resilience, and personal agency. The chapter also introduced the concept of an integrated model of recovery capital and the window of tolerance, arguing that psychotherapists are well-positioned to attend to both the intrapsychic and systemic conditions that shape clients' journeys. Recovery does not occur in a vacuum, and an awareness of contextual resources and relational environments is essential for lasting change.

Chapter Three moved toward clinical integration, proposing a framework for psychotherapeutic engagement across the stages of recovery. Drawing on Herman's trauma recovery model—safety and stabilisation, remembrance and mourning, and reconnection—the chapter offered a flexible but structured approach to long-term healing. It synthesised insights from psychodynamic, humanistic, somatic, existential, Gestalt, and mentalisation-based modalities, each offering different tools for addressing the complexity of trauma and addiction. The emphasis on symbolic understanding and developmental attunement reflects a commitment to meeting clients not as problems to be fixed, but as individuals whose addictions are entangled with the layers of their histories and identities. This chapter illustrated how

diverse modalities, when integrated thoughtfully, can create the conditions for real and lasting transformation.

Across all three chapters, a common thread has been the centrality of relationship, both as a source of wounding and as a medium for healing. This thesis illustrated that addiction often arises in contexts where secure attachments were disrupted or unsafe. Psychotherapy offers a corrective relational experience, one in which safety and attunement form the foundation for emotional integration and recovery. Importantly, this is not a quick or linear process. Unlike acute-care models, psychotherapy acknowledges that healing takes time and that relational wounds are healed through consistent, compassionate presence rather than technique alone.

The implications of this thesis extend beyond individual clinical practice. At a systems level, it calls for a shift away from narrow, short-term models of addiction treatment toward long-term, trauma-informed, and relationally grounded care. For policymakers and service providers, this means investing in long-term psychotherapy as a core component of recovery-oriented systems of care. This is especially relevant to Irish addiction services that are still evolving and face significant gaps in psychological resources. Training programmes for addiction professionals should incorporate deeper engagement with developmental trauma, attachment theory, and relational psychotherapeutic approaches. At the same time, clinical supervision and support structures must be enhanced to sustain practitioners working at this depth.

Addiction is a complex experience, shaped by many personal and social factors. This thesis does not claim to offer a prescriptive model or universal solution. The integrative approach advocated here is meant to be flexible, client-centred, and responsive to each person's unique history and needs. While this thesis does not present original empirical research or lived-

experience narratives, it draws extensively on emerging empirical findings and practice-informed insights that reflect the clinical realities of those in long-term recovery. Recent outcome studies and meta-analyses (e.g., Darby et al., 2023; Simpson et al., 2021; Bisson et al., 2020) affirm the efficacy of long-term, trauma-informed psychotherapy for co-occurring PTSD and substance use disorders, reinforcing the need for sustained, relational engagement. Future studies, particularly those incorporating qualitative data and service-user perspectives, would offer valuable validation and expansion of the integrative model proposed here. Further research is also needed to assess the long-term impact of trauma-informed psychotherapy in community and public health settings.

Despite these limitations, this thesis contributes to an ongoing dialogue about what it means to support recovery. It places psychotherapy at the centre of addiction care, serving as a space where trauma can be acknowledged, processed, and relational trust rebuilt. Addiction is not solely a public health concern; it is a profoundly human struggle, rooted in the need for connection, meaning, and belonging. Ultimately, addiction is not simply about what people do, but about what has happened to them, how they have adapted to survive, and what becomes possible when they receive sustained, attuned relational support. When psychotherapy is offered in this spirit, not as a service to be delivered, but as a relationship to be co-created, it becomes a powerful medium for healing, growth, and enduring recovery.

References

- Allen, J. G., Fonagy, P., & Bateman, A. W. (2012). *Mentalizing in clinical practice*. American Psychiatric Publishing.
- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders (5th ed., text rev.; DSM-5-TR)*. American Psychiatric Publishing.
<https://doi.org/10.1176/appi.books.9780890425787>
- American Society of Addiction Medicine (ASAM). 2019. Public Policy Statement: Definition of Addiction. <https://www.asam.org/quality-care/definition-of-addiction>
- Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3), 174–186. <https://doi.org/10.1007/s00406-005-0624-4>
- Bateman, A. W., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide*. Oxford University Press.
- Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse*. The Guilford Press.
- Benedek, D. M., & Wynn, G. H. (2016). Acute stress disorder and posttraumatic stress disorder. In R. J. Ursano, C. S. Fullerton, & L. Weisaeth (Eds.), *Textbook of disaster psychiatry (2nd ed., pp. 101–116)*. Cambridge University Press.
<https://doi.org/10.1017/9781316481424.008>
- Best, D. (2019). *Pathways to desistance and recovery: The role of the social contagion of hope*. Policy Press.

- Best, D., & Ivers, J. (2022). Inkspots and ice cream cones: A model of recovery contagion and growth. *Addiction Research & Theory*, 30(3), 155–161.
<https://doi.org/10.1080/16066359.2021.1986699>
- Bion, W. R. (1962). *Learning from experience*. Heinemann.
- Bisson, J. I., Roberts, N., Geddes, J. R., & Cipriani, A. (2020). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews*, 12, CD003388.
<https://doi.org/10.1002/14651858.CD003388.pub4>
- Bowlby, J. (1969). *Attachment and loss: Volume 1. Attachment*. Basic Books.
- Bradstreet, S., & McBrierty, R. (2012). Recovery in Scotland: beyond service development. *International Review of Psychiatry*, 24(1), 64–69.
<https://doi.org/10.3109/09540261.2011.650158>
- Briere, J., Kaltman, S., & Green, B. L. (2008). Accumulated childhood trauma and symptom complexity. *Journal of Traumatic Stress*, 21(2), 223–226.
<https://doi.org/10.1002/jts.20317>
- Bugental, J. F. T. (1987). *The art of the psychotherapist*. Norton.
- Casey, B. J., Jones, R. M., & Hare, T. A. (2008). The adolescent brain. *Annals of the New York Academy of Sciences*, 1124, 111–126. <https://doi.org/10.1196/annals.1440.010>
- Cassidy, J., & Kobak, R. R. (1988). Avoidance and its relation to other defensive processes. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment* (pp. 300–323). Lawrence Erlbaum Associates.
- Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2006). *Psychotherapy for borderline personality: Focusing on object relations*. Wiley.

- Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress, 22*(5), 399–408. <https://doi.org/10.1002/jts.20444>
- Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use & Misuse, 43*(12–13), 1971–1986. <https://doi.org/10.1080/10826080802289762>
- Comiskey, C., Galligan, K., Flanagan, J., Deegan, J., Farnann, J., & Hall, A. (2019). Clients' views on the importance of a nurse-led approach and nurse prescribing in the development of the Healthy Addiction Treatment Recovery Model. *Journal of Addictions Nursing, 30*(3), 169–176. <https://doi.org/10.1097/JAN.0000000000000290>
- Courtois, C. A., & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. The Guilford Press.
- D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & van der Kolk, B. A. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *American Journal of Orthopsychiatry, 82*(2), 187–200. <https://doi.org/10.1111/j.1939-0025.2012.01154.x>
- Danylchuk, L. S., & Connors, K. J. (2019). *Treating complex trauma and dissociation: A practical guide to navigating therapeutic challenges*. Routledge
- Darby, A., Roberts, N. P., & Wild, J. (2023). A systematic review of phase-based treatments for complex PTSD. *Journal of Affective Disorders Reports, 12*, 100628. <https://doi.org/10.1016/j.jadr.2023.100628>

Davidson, L., & White, W. (2007). The concept of recovery as an organizing principle for integrating mental health and addiction services. *The journal of behavioral health services & research*, 34(2), 109–120. <https://doi.org/10.1007/s11414-007-9053-7>

Dell'Aquila, A., & Berle, D. (2023). Predictors of alcohol and substance use among people with post-traumatic stress disorder (PTSD): Findings from the NESARC-III study. *Social Psychiatry and Psychiatric Epidemiology*, 58(10), 1509–1522. <https://doi.org/10.1007/s00127-023-02472-6>

Dingle, G. A., Neves, D. D. C., Alhadad, S. S. J., & Hides, L. (2017). Individual and interpersonal emotion regulation among adults with substance use disorders and matched controls. *British Journal of Clinical Psychology*, 56(1), 106–122. <https://doi.org/10.1111/bjc.12126>

Dube, S. R., Anda, R. F., Felitti, V. J., Edwards, V. J., & Croft, J. B. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *JAMA*, 286(24), 3089–3096. <https://doi.org/10.1001/jama.286.24.3089>

DuPont, R., McLellan, A., White, W., Merlo, L. J., & Gold, M. (2009). Setting the standard for recovery: Physicians' health programs. *Journal of Substance Abuse Treatment*, 36(2), 159–171. <https://doi.org/10.1016/j.jsat.2008.01.004>

European Monitoring Centre for Drugs and Drug Addiction. (2013). *Drug policy profiles: Ireland* (EMCDDA Papers, ISSN 1977-2246). Publications Office of the European Union. <https://doi.org/10.2810/75991>

Erskine, R. G. (2008). Psychotherapy of unconscious experience. *Transactional Analysis Journal*, 38(2), 128–138.

- Estévez, A., Jáuregui, P., Sánchez-Marcos, I., López-González, H., & Griffiths, M. D. (2017). Attachment and emotion regulation in substance addictions and behavioral addictions. *Journal of behavioral addictions*, 6(4), 534–544.
<https://doi.org/10.1556/2006.6.2017.086>
- Evren, C., Cinar, O., Evren, B., & Celik, S. (2008). Relationship of alexithymia and temperament and character dimensions with depression and anxiety symptoms in patients with alcohol dependency. *Psychiatry and Clinical Neurosciences*, 62(4), 371–378. <https://doi.org/10.1111/j.1440-1819.2008.01820.x>
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245–258.
[https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8)
- Fisher, J. (2017). *Healing the fragmented selves of trauma survivors: Overcoming internal self-alienation*. Routledge.
- Flores P. J. (2001a). Addiction as an attachment disorder: implications for group therapy. *International journal of group psychotherapy*, 51(1), 63–81.
<https://doi.org/10.1521/ijgp.51.1.63.49730>
- Flores, P. J. (2001b). *Group psychotherapy with addicted populations: An integration of twelve-step and psychodynamic theory* (2nd ed.). Haworth Press.
- Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta analytic synthesis. *Psychotherapy*, 55(4), 316–340.
<https://doi.org/10.1037/pst0000172>

- Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*. Advance online publication. <https://doi.org/10.1037/a0036505>
- Fonagy, P., & Bateman, A. W. (2006). Mechanisms of change in mentalization-based treatment of borderline personality disorder. *Journal of Clinical Psychology*, 62(4), 411–430. <https://doi.org/10.1002/jclp.20241>
- Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. Other Press.
- Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2017). What we have changed our minds about: Part 2. Borderline personality disorder, epistemic trust and the developmental significance of social communication. *Borderline Personality Disorder and Emotion Dysregulation*, 4, Article 9. <https://doi.org/10.1186/s40479-017-0062-8>
- Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of Personality Disorders*, 29(5), 575–609. <https://doi.org/10.1521/pedi.2015.29.5.575>
- Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology*, 21(4), 1355–1381. <https://doi.org/10.1017/S0954579409990198>
- Fonagy, P., & Luyten, P. (2016). A multilevel perspective on the development of borderline personality disorder. In D. Cicchetti (Ed.), *Developmental psychopathology* (3rd ed., Vol. 3, pp. 726–792). Wiley.
- Ford, J. D., & Courtois, C. A. (Eds.). (2020). *Treating complex traumatic stress disorders in adults: Scientific foundations and therapeutic models* (2nd ed.). The Guilford Press.

- Futterman, R., Lorente, M., & Silverman, S. (2004). Integrating harm reduction and abstinence-based substance abuse treatment in the public sector. *Substance Abuse*, 25(1), 3–7. https://doi.org/10.1300/J465v25n01_02
- Geuijen, P. M., van den Broek, S. J. M., Dijkstra, B. A. G., Kuppens, J. M., de Haan, H. A., de Jong, C. A. J., Schene, A. H., Atsma, F., & Schellekens, A. F. A. (2021). Success rates of monitoring for healthcare professionals with a substance use disorder: A meta-analysis. *Journal of Clinical Medicine*, 10(2), 264. <https://doi.org/10.3390/jcm10020264>
- Gomez, L. (1997). *An introduction to object relations theory*. Free Association Books.
- Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York University Press.
- Grant, J. E., Potenza, M. N., Weinstein, A., & Gorelick, D. A. (2010). Introduction to behavioral addictions. *The American journal of drug and alcohol abuse*, 36(5), 233–241. <https://doi.org/10.3109/00952990.2010.491884>
- Griffiths, M. (2005). The biopsychosocial approach to addiction. *Psyke & Logos*, 26(1), 9-26.
- Heather, N., Best, D., Kawalek, A., Field, M., Lewis, M., Rotgers, F., Wiers, R. W., & Heim, D. (2017). Challenging the brain disease model of addiction: European launch of the addiction theory network. *Addiction Research & Theory*. <https://doi.org/10.1080/16066359.2017.1399659>
- Hein, D. A., Schwartz, A. C., & Ford, J. D. (2020). Treating co-occurring complex PTSD and substance use disorders. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in adults: Scientific foundations and therapeutic models* (2nd ed., pp. 333–352). The Guilford Press.

- Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377–391.
<https://doi.org/10.1007/BF00977235>
- Herman, J. L. (1992a). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror*. New York: Basic Books.
- Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence, from domestic abuse to political terror* (Revised and updated ed.). Basic Books.
- Hibbert, L. J., & Best, D. W. (2011). Assessing recovery and functioning in former problem drinkers at different stages of their recovery journeys. *Drug and Alcohol Review*, 30(1), 12–20. <https://doi.org/10.1111/j.1465-3362.2010.00190.x>
- Ivers, J.-H., Zgaga, L., Sweeney, B., Keenan, E., Darker, C., Smyth, B. P., & Barry, J. (2018). A naturalistic longitudinal analysis of post-detoxification outcomes in opioid-dependent patients. *Drug and Alcohol Review*, 37(S1), S339–S347.
<https://doi.org/10.1111/dar.12597>
- Juul, S., Jakobsen, J. C., Hestbaek, E., Jørgensen, C. K., Olsen, M. H., Rishede, M., Frandsen, F. W., Bo, S., Lunn, S., Poulsen, S., Sørensen, P., Bateman, A., & Simonsen, S. (2023). Short-Term versus Long-Term Mentalization-Based Therapy for Borderline Personality Disorder: A Randomized Clinical Trial (MBT-RCT). *Psychotherapy and psychosomatics*, 92(5), 329–339.
<https://doi.org/10.1159/000534289>
- Kalsched, D. (1996). *The inner world of trauma: Archetypal defenses of the personal spirit*. Routledge.
- Kampling, H., Gander, M., Boecking, B., & Mertens, M. (2022). Personality functioning and epistemic trust mediate the association between adverse childhood experiences and

complex PTSD. *Journal of Clinical Psychology*, 78(5), 902–919.

<https://doi.org/10.1002/jclp.23306>

Keane, M., McAleenan, G., & Barry, J. (2014). *Addiction recovery: A contagious paradigm. A case for the re-orientation of drug treatment and rehabilitation services in Ireland.* Soilse/Health Research Board.

Kelly, J. F. (2017). Are societies paying unnecessarily for an otherwise free lunch? Final musings on the research on Alcoholics Anonymous and its mechanisms of behavior change. *Addiction*, 112(5), 791–797. <https://doi.org/10.1111/add.13652>

Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies.* Yale University Press.

Kernberg, O. F. (2018). *Treatment of severe personality disorders: Resolution of aggression and recovery of eroticism.* American Psychiatric Association Publishing.

Kessler, R. C. (2000). Posttraumatic stress disorder: The burden to the individual and to society. *The Journal of Clinical Psychiatry*, 61(Suppl 5), 4–14.
<https://pubmed.ncbi.nlm.nih.gov/10761674/>

Khan, M. M. (1974). *The privacy of the self: Papers on psychoanalytic theory and technique.* London: Hogarth Press.

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry*, 4(5), 231–244. <https://doi.org/10.3109/10673229709030550>

Kim, H. S., & Hodgins, D. C. (2018). Component model of addiction treatment: A pragmatic transdiagnostic treatment model of behavioural and substance addictions. *Frontiers in Psychiatry*, 9, Article 406. <https://doi.org/10.3389/fpsy.2018.00406>

- Kline, A. C., Cooper, A. A., Rytwinski, N. K., & Feeny, N. C. (2020). The effect of concurrent depression on PTSD outcomes in trauma focused psychotherapy: A meta analysis of randomized controlled trials. *Behavior Therapy*. Advance online publication. <https://doi.org/10.1016/j.beth.2020.04.015>
- Koob, G. F., & Le Moal, M. (2001). Drug addiction, dysregulation of reward, and allostasis. *Neuropsychopharmacology*, 24(2), 97–129. [https://doi.org/10.1016/S0893-133X\(00\)00195-0](https://doi.org/10.1016/S0893-133X(00)00195-0)
- Lambert, M. J. (2013). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 169–218). Wiley.
- Lawson, K. M., Back, S. E., Hartwell, K. J., Moran-Santa Maria, M., & Brady, K. T. (2013). A comparison of trauma profiles among individuals with prescription opioid, nicotine, or cocaine dependence. *The American Journal on Addictions*, 22(2), 127–131. <https://doi.org/10.1111/j.1521-0391.2013.00319.x>
- Liotti, G., & Farina, B. (2011). *Suffering, pain, and trauma: Attachment and dissociation*. Routledge.
- Lortye, S. A., Will, J. P., Marquenie, L. A., Goudriaan, A. E., Arntz, A., & de Waal, M. M. (2021). Treating posttraumatic stress disorder in substance use disorder patients with co-occurring posttraumatic stress disorder: Study protocol for a randomized controlled trial to compare the effectiveness of different types and timings of treatment. *BMC Psychiatry*, 21(1), 442. <https://doi.org/10.1186/s12888-021-03366-0>
- Luyten, P., Campbell, C., Allison, E., & Fonagy, P. (2020). The mentalizing approach to psychopathology: State of the art and future directions. *Annual Review of Clinical Psychology*, 16, 297–325. <https://doi.org/10.1146/annurev-clinpsy-071919-015355>

- Lynch, T., Tierney, P., & Lyons, S. (2025). National Drug Treatment Reporting System: 2024 drug treatment demand. Health Research Board.
- Mahon, D. (2024). A systematic review of trauma-informed care in substance use settings. Preprints.org. <https://doi.org/10.20944/preprints202409.1775.v1>
- Main, M. (1990). Cross-cultural studies of attachment organization: Recent studies, changing methodologies, and the concept of conditional strategies. *Human Development*, 33(1), 48–61. <https://doi.org/10.1159/000276502>
- Mannion, D. (2005). Sexual abuse, post-traumatic stress and object relations: An integrative way of working. In I. Säfvestad-Nolan & P. Nolan (Eds.), *Object relations and integrative psychotherapy: Tradition and innovation in theory and practice* (pp. 143–156). John Wiley & Sons.
- Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors*, 21(6), 779–788. [https://doi.org/10.1016/0306-4603\(96\)00042-1](https://doi.org/10.1016/0306-4603(96)00042-1)
- Maté, G. (2008). *In the realm of hungry ghosts: Close encounters with addiction*. Knopf Canada.
- Marmarosh, C. L., Markin, R. D., & Spiegel, E. B. (2013). *Attachment in group psychotherapy: Bridging theories, research, and clinical practice*. Routledge.
- Mauritz, M. W., Goossens, P. J. J., Draijer, N., & van Achterberg, T. (2013). Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology*, 4(1), 19985. <https://doi.org/10.3402/ejpt.v4i0.19985>
- Mayock, P., & Butler, S. (2021). Producing recovery: Methadone, subjectivity and politics in the Irish drug treatment system. *International Journal of Drug Policy*, 88, 103041. <https://doi.org/10.1016/j.drugpo.2020.103041>

- McCauley, J. L., Killeen, T., Gros, D. F., Brady, K. T., & Back, S. E. (2012). Posttraumatic stress disorder and co-occurring substance use disorders: Advances in assessment and treatment. *Clinical Psychology: Science and Practice*, 19(3), 283–304.
<https://doi.org/10.1111/cpsp.12006>
- McDonagh, D., de Vries, J., & Comiskey, C. (2023). The role of adverse childhood experiences on people in opiate agonist treatment: The importance of feeling unloved. *European Addiction Research*, 29(1), 1–10. <https://doi.org/10.1159/000532005>
- McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA*, 284(13), 1689–1695. <https://doi.org/10.1001/jama.284.13.1689>
- Mearns, D., & Cooper, M. (2005). *Working at relational depth in counselling and psychotherapy*. SAGE Publications.
- Mental Health Reform. (2022). Annual report and financial statements 2022.
<https://mentalhealthreform.ie/wp-content/uploads/2023/07/MHR-2022-Annual-Report.pdf>
- Miller, J. (2002). Heroin addiction: The needle as transitional object. *Journal of the American Academy of Psychoanalysis*, 30(2), 293–304.
<https://doi.org/10.1521/jaap.30.2.293.21955>
- Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change* (3rd ed.). Guilford Press.
- Mikulincer, M., & Shaver, P. R. (2003). The attachment behavioral system in adulthood: Activation, psychodynamics, and interpersonal processes. In M. P. Zanna (Ed.), *Advances in experimental social psychology* (Vol. 35, pp. 53–152). Academic Press.
[https://doi.org/10.1016/S0065-2601\(03\)01002-5](https://doi.org/10.1016/S0065-2601(03)01002-5)

- Mollica, R. F., McInnes, K., Poole, C., & Tor, S. (1998). Dose–effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *The British Journal of Psychiatry*, 173(6), 482–488.
<https://doi.org/10.1192/bjp.173.6.482>
- Najavits, L. M. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. The Guilford Press.
- Najavits, L. M., Gastfriend, D. R., Barber, J. P., Reif, S., Muenz, L. R., Blaine, J., ... & Crits-Christoph, P. (1998). Cocaine dependence with and without PTSD among subjects in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *American Journal of Psychiatry*, 155(2), 214–219.
<https://doi.org/10.1176/ajp.155.2.214>
- National Institute on Drug Abuse. (2020, July 6). Drug misuse and addiction.
<https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction>
- Nolan, P., & Säfvestad-Nolan, I. (2005). Tradition and innovation in theory and practice: An orientation. In I. Säfvestad-Nolan & P. Nolan (Eds.), *Object relations and integrative psychotherapy: Tradition and innovation in theory and practice* (pp. 1–7). John Wiley & Sons.
- Norcross, J. C., & Goldfried, M. R. (Eds.). (2019). *Handbook of psychotherapy integration* (3rd ed.). Oxford University Press.
- Norcross, J. C., & Wampold, B. E. (Eds.). (2019). *Psychotherapy relationships that work: Evidence-based therapist contributions and responsiveness* (Vols. 1–2, 3rd ed.). Oxford University Press.

- O’Gorman, A. (1998). Illicit Drug Use in Ireland: An Overview of the Problem and Policy Responses. *Journal of Drug Issues*, 28(1), 155-166.
<https://doi.org/10.1177/002204269802800109>
- Ogden, P., & Fisher, J. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment*. W. W. Norton & Company.
- Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. W. W. Norton & Company.
- One in Four. (2025). Therapy [Webpage]. <https://www.oneinfour.ie/therapy>
- Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self regulation*. W. W. Norton & Company.
- Potik, D., Adelson, M., & Schreiber, S. (2007). Drug addiction from a psychodynamic perspective: methadone maintenance treatment (MMT) as transitional phenomena. *Psychology and psychotherapy*, 80(Pt 2), 311–325.
<https://doi.org/10.1348/147608306X164806>
- Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51(3), 390–395. <https://doi.org/10.1037/0022-006X.51.3.390>
- Radó, S. (1933/1984). The psychoanalysis of pharmacothymia (drug addiction). *Journal of Substance Abuse Treatment*, 1(1), 59–68. [https://doi.org/10.1016/0740-5472\(84\)90055-2](https://doi.org/10.1016/0740-5472(84)90055-2)
- Roberts, N. P., Roberts, P. A., Jones, N., & Bisson, J. I. (2015). Psychological interventions for post-traumatic stress disorder and comorbid substance use disorder: A systematic review and meta-analysis. *Clinical psychology review*, 38, 25–38.
<https://doi.org/10.1016/j.cpr.2015.02.007>

Rogers, C. R. (1951). *Client-centred therapy: its current practice, implications, and theory*.

Houghton Mifflin.

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Houghton

Mifflin.

Rosenberger, J., & Feng, H. (2017). Trauma by omission: Treating complex attachment dynamics in a Chinese woman. *International Forum of Psychoanalysis*.

<https://doi.org/10.1080/0803706X.2017.1333139>

Rossi, R., Reda, F., Federico, I., Jannini, T. B., Socci, V., D'Aurizio, G., Pettorruso, M.,

Pacitti, F., Rossi, A., Martinotti, G., & Di Lorenzo, G. (2023). The association

between traumatic experiences and substance and behavioral addictions in late

adolescence: A role for PTSD and cPTSD as potential mediators. *Journal of*

psychiatric research, 168, 82–90. <https://doi.org/10.1016/j.jpsychires.2023.10.023>

Säfvestad-Nolan, I., & Nolan, P. (2002). Tradition and innovation in theory and practice: An

orientation. In I. Säfvestad-Nolan & P. Nolan (Eds.), *Object relations and integrative*

psychotherapy: Tradition and innovation in theory and practice (pp. 1–7). Whurr

Publishers.

Savov, S., & Atanassov, N. (2013). Deficits of affect mentalization in patients with drug

addiction: theoretical and clinical aspects. *ISRN Addiction*, 2013, 250751.

<https://doi.org/10.1155/2013/250751>

Schore, A. N. (2001). The effects of early relational trauma on right brain development,

affect regulation, and infant mental health. *Infant Mental Health Journal*, 22(1–2),

201–269. [https://doi.org/10.1002/1097-0355\(200101/04\)22:1%3C201::AID-](https://doi.org/10.1002/1097-0355(200101/04)22:1%3C201::AID-)

[IMHJ8%3E3.0.CO;2-9](https://doi.org/10.1002/1097-0355(200101/04)22:1%3C201::AID-IMHJ8%3E3.0.CO;2-9)

- Schore, A. N. (2003). *Affect dysregulation and disorders of the self*. W. W. Norton & Company.
- Schore, A. N. (2009). Relational trauma and the developing right brain: An interface of psychoanalytic self-psychology and neuroscience. *Annals of the New York Academy of Sciences*, 1159(1), 189–203. <https://doi.org/10.1111/j.1749-6632.2009.04474.x>
- Schore, A. N. (2012). *The science of the art of psychotherapy*. W. W. Norton & Company.
- Schore, A. N., & Schore, J. R. (2007). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal*, 36, 9–20. <https://doi.org/10.1007/s10615-007-0111-7>
- Schneider, K. J., & Krug, O. T. (2017). *Existential-humanistic therapy: A guide for integrative practice*. American Psychological Association.
- Sheedy, C. K., & Whitter, M. (2009). *Guiding principles and elements of recovery-oriented systems of care: What do we know from the research?* U.S. Department of Health and Human Services. https://archive.samhsa.gov/sites/default/files/ros_c_resource_guide_book.pdf
- Sherry, P. (2013). *Emotional regulation skills training for substance dependent individuals: The clients' experience [Unpublished master's thesis]*. Keltoi, HSE Addiction Services.
- Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. Guilford Press.
- Simpson, T. L., Goldberg, S. B., Loudon, D. K. N., Blakey, S. M., Hawn, S. E., Lott, A., Browne, K. C., Lehavot, K., & Kaysen, D. (2021). Efficacy and acceptability of interventions for co-occurring PTSD and SUD: A meta-analysis. *Journal of anxiety disorders*, 84, 102490. <https://doi.org/10.1016/j.janxdis.2021.102490>

- Smith, C. P., & Freyd, J. J. (2014). Institutional betrayal. *American Psychologist*, 69(6), 575–584. <https://doi.org/10.1037/a0037564>
- Social Value UK. (2014). Survivors Manchester SROI report [PDF]. Social Value UK. <https://socialvalueuk.org/wp-content/uploads/2016/04/Survivors-Manchester-SROI-2014.pdf>
- Soilse. (2013). Soilse interview results [Unpublished internal report]. Health Service Executive.
- Spinazzola, J., van der Kolk, B., & Ford, J. D. (2018). When Nowhere Is Safe: Interpersonal Trauma and Attachment Adversity as Antecedents of Posttraumatic Stress Disorder and Developmental Trauma Disorder. *Journal of traumatic stress*, 31(5), 631–642. <https://doi.org/10.1002/jts.22320>
- Stellern, J., Xiao, K. B., Grennell, E., Sanches, M., Gowin, J. L., & Sloan, M. E. (2023). Emotion regulation in substance use disorders: a systematic review and meta-analysis. *Addiction (Abingdon, England)*, 118(1), 30–47. <https://doi.org/10.1111/add.16001>
- Substance Abuse and Mental Health Services Administration. (2014). Trauma-informed care in behavioral health services (Treatment Improvement Protocol [TIP] Series 57; HHS Publication No. SMA14-4816). U.S. Department of Health and Human Services. <https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>
- Substance Abuse and Mental Health Services Administration. (2023). TIP 65: Counseling approaches to promote recovery from problematic substance use and related issues. U.S. Department of Health and Human Services.
- Suchman, N. E., DeCoste, C., Borelli, J. L., & McMahon, T. J. (2018). Does improvement in maternal attachment representations predict greater maternal sensitivity, child

attachment security, and lower rates of relapse to substance use? A second test of Mothering from the Inside Out treatment mechanisms. *Journal of Substance Abuse Treatment*, 85, 21–30. <https://doi.org/10.1016/j.jsat.2017.11.006>

Strang, J., McCambridge, J., Best, D., Beswick, T., Bearn, J., Rees, S., & Gossop, M. (2003). Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. *BMJ (Clinical research ed.)*, 326(7396), 959–960. <https://doi.org/10.1136/bmj.326.7396.959>

Taipale, J. (2017). Controlling the uncontrollable: Self-regulation and the dynamics of addiction. *Scandinavian Psychoanalytic Review*, 40(1), 29–42. <https://doi.org/10.1080/01062301.2017.1343546>

Taylor, M. (2014). *Trauma therapy and clinical practice: Neuroscience, Gestalt and the body*. Open University Press.

Taylor, G. J., Bagby, R. M., & Parker, J. D. A. (1997). *Disorders of affect regulation: Alexithymia in medical and psychiatric illness*. Cambridge University Press.

Thorberg, F. A., Young, R. M., Sullivan, K. A., & Lyvers, M. (2011). Alexithymia and alcohol use: A critical review. *Addictive Behaviors*, 36(5), 337–349. <https://doi.org/10.1016/j.addbeh.2010.12.012>

Ullman, S. E., Relyea, M., Peter-Hagene, L., & Vasquez, A. L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addictive Behaviors*, 38(6), 2219–2223. <https://doi.org/10.1016/j.addbeh.2013.01.027>

van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

- Van der Kolk, B. A., Hostenler, A., Herron, N., & Fisler, R. (1996). Trauma and the development of borderline personality disorder. *Psychiatric Clinics of North America*, 19(4), 791–806.
- Van der Kolk, B. A., & Fisler, R. E. (1994). Childhood abuse and neglect and loss of self-regulation. *Bulletin of the Menninger Clinic*, 58(2), 145–168.
- Van der Kolk, B. A., & Fisler, R. E. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress*, 8(4), 505–525. <https://doi.org/10.1007/BF02102887>
- Van der Kolk, B. A., MacFarlane, A. C., & Weisaeth, L. (Eds.). (1996). *Traumatic stress: The effects of overwhelming experience on the body, mind, and society*. Guilford Press.
- van der Kolk, B. A., Perry, J. C., & Herman, J. L. (1991). Childhood origins of self-destructive behavior. *The American Journal of Psychiatry*, 148(12), 1665–1671. <https://doi.org/10.1176/ajp.148.12.1665>
- Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic Advances from the Brain Disease Model of Addiction. *The New England journal of medicine*, 374(4), 363–371. <https://doi.org/10.1056/NEJMra1511480>
- Wallin, D. J. (2007). *Attachment in psychotherapy*. The Guilford Press.
- Weiss, N. H., Tull, M. T., Lavender, J., & Gratz, K. L. (2013). Role of emotion dysregulation in the relationship between childhood abuse and probable PTSD in a sample of substance abusers. *Child Abuse & Neglect*, 37(11), 944–954. <https://doi.org/10.1016/j.chiabu.2013.03.014>
- Welsh, S. (2014). Fixation and needle fixation. *Language and Psychoanalysis*, 3(1), 23–38. <https://vuir.vu.edu.au/38332/1/1586-Article%20Text-5911-1-10-20160730.pdf>

- West, R. (2013). Models of addiction (EMCDDA Insights Series, No. 14). Publications Office of the European Union.
https://www.emcdda.europa.eu/publications/insights/models-of-addiction_en
- White, W. L. (1998). Slaying the dragon: The history of addiction treatment and recovery in America. Chestnut Health Systems/Lighthouse Institute.
- White, W. L. (2008). Recovery management and recovery oriented systems of care: Scientific rationale and promising practices (Addiction Technology Transfer Monograph No. 5). Great Lakes Addiction Technology Transfer Center; Northeast Addiction Technology Transfer Center; Philadelphia Department of Behavioral Health and Mental Retardation Services.
- Winnicott, D. W. (1965). The maturational processes and the facilitating environment: Studies in the theory of emotional development. International Universities Press.
- Winnicott, D. W. (1971). Playing and reality. Tavistock Publications.
- World Health Organization. (2019). International statistical classification of diseases and related health problems (11th ed.). <https://icd.who.int/>
- Yalom, I. D. (1980). Existential psychotherapy. Basic Books.
- Yalom, I. D., & Leszcz, M. (2020). The theory and practice of group psychotherapy (6th ed.). Basic Books.