



WHY PEOPLE TURN TO ADDICTION

Stress, Trauma & Adverse Experiences

Understanding how difficult experiences can increase vulnerability without determining outcomes

The key idea

Stress, trauma and adversity can increase vulnerability to harmful substance use or other addictive patterns, particularly when they are prolonged, repeated or combined with limited support. They are important possible pathways - not universal causes. Many people experience adversity without developing addiction, and recovery is possible.

Stress, adversity and trauma are related - but not identical

Stress is the body's response to demands or threat. Adversity describes difficult circumstances or experiences that can place sustained pressure on a person. Trauma refers to experiences that overwhelm a person's ability to cope and can have lasting psychological or physiological effects. An adverse experience is not automatically traumatic, and people can respond very differently to similar events.

Why the distinction matters

Using the words interchangeably can flatten people's experiences. Someone may live with chronic poverty, discrimination, unsafe housing or caring pressures without describing themselves as traumatised, while another person may experience lasting trauma symptoms after a single event.

The stress response is protective

When danger is detected, the body can mobilise energy and attention to help a person respond. Heart rate, alertness and muscle readiness may increase, while functions that are less urgent in the moment receive less priority. Once safety returns, the system is designed to settle.

Chronic stress can change what feels manageable

When threat, uncertainty or pressure continues, opportunities to recover may be limited. Sleep, concentration, emotional regulation and decision-making can become harder. Fast-acting relief - including alcohol, drugs or repetitive rewarding behaviours - may therefore become more valuable in the short term.

In everyday language

If someone's nervous system spends much of its time dealing with threat or overload, something that quickly creates calm, numbness, energy or escape can become especially reinforcing. That helps explain a pathway into repeated use; it does not make addiction inevitable.

Trauma can affect more than memories

Trauma-related difficulties can include intrusive memories, avoidance, hypervigilance, sleep disturbance, emotional disconnection, irritability and dissociation. NHS information on PTSD also notes that symptoms may appear immediately or months or years after a traumatic experience.

Substances may become linked with regulation

For some people, alcohol or drugs temporarily reduce anxiety, numb difficult feelings, increase energy, help with sleep or create distance from intrusive memories. When relief follows use repeatedly, negative reinforcement can strengthen the pattern - the behaviour becomes more likely because distress decreases for a while.

Important distinction

Understanding the function of substance use is not the same as assuming every person is 'self-medicating'. Some people begin through curiosity, social use, availability or pleasure, while stress or trauma becomes relevant later - and others have no significant trauma history.

Adverse childhood experiences are associated with later risk

Research on adverse childhood experiences, often called ACEs, has found population-level associations between cumulative childhood adversity and later health and social harms, including substance use. Examples commonly studied include abuse, neglect, domestic abuse, household substance problems, parental mental ill-health and imprisonment.

An ACE count is not a personal forecast

An ACE score records exposure to a limited set of experiences; it does not measure their severity, timing, meaning, duration or the support available to the child. It also leaves out many forms of adversity. Associations found across populations cannot tell us what will happen to one individual.

Avoid deterministic language

A higher number of adversities may be associated with higher average risk across groups, but it does not mean a person is damaged, destined to develop addiction or unable to recover. Protective relationships, resources, individual differences and later experiences all matter.

Adult adversity matters too

Vulnerability is not confined to childhood. Domestic abuse, bereavement, homelessness, poverty, discrimination, serious illness, chronic pain, unsafe work, conflict, exploitation and repeated loss can all create or maintain distress. Current circumstances may be as clinically relevant as someone's early history.

Ongoing environments can keep the stressor active

Recovery is harder when the source of distress has not ended. A person may still be living with violence, unstable housing, financial insecurity, isolation or other threats. Asking someone to regulate differently without addressing their environment can overlook an important part of what maintains the pattern.

Protective factors can change the picture

Safe and reliable relationships, stable housing, meaningful activity, practical resources, culturally appropriate support, access to healthcare and opportunities for rest can reduce vulnerability. Protective factors do not erase trauma, but they can increase safety and expand the person's available choices.

For professionals

Trauma-informed practice does not require assuming trauma is present or asking for detailed disclosure. It means recognising that trauma may be relevant, prioritising emotional and physical safety, offering choice and collaboration, avoiding unnecessary re-traumatisation and responding to the person rather than reducing them to a history.

Trauma and substance-use needs can be addressed together

People may have PTSD or other trauma-related symptoms alongside harmful substance use. Assessment should consider both. Treatment sequencing depends on safety, dependence, withdrawal risk and the individual's needs; severe substance dependence may require specialist management alongside mental-health care.

Support should address what keeps the pattern going now

A trauma history may help explain vulnerability, but treatment also needs to consider present-day reinforcement, withdrawal, mental health, pain, relationships, housing, cues, routines and access to alternatives. Historical explanation alone does not tell us what will support change today.

A useful formulation question

Instead of asking 'What is wrong with this person?', consider: What has happened, what is happening now, how has the person adapted, what does the substance or behaviour provide, and what would increase safety and widen their options?

Recovery does not require a particular story

Some people find trauma-focused therapy important; others do not identify trauma as central to their addiction. Effective support should follow the person's formulation and goals rather than requiring them to adopt a trauma narrative.

Reflection

Which stressors are historical, and which are still active? What does the addictive behaviour change in the short term? What protective factors are already present? What practical, relational, psychological or medical support could reduce the need for immediate relief?

References & Further Resources

These sources provide current UK information on trauma, adverse experiences, substance-use vulnerability and treatment. Associations between adversity and addiction describe increased risk across populations; they should not be used to predict an individual's outcome.

NHS - PTSD (post-traumatic stress disorder)

Current NHS overview of traumatic experiences, PTSD symptoms, treatment and routes to support.

NICE - Post-traumatic stress disorder (NG116)

Guidance on recognising, assessing and treating PTSD, including considerations when substance misuse or dependence is also present.

GOV.UK - A whole-system response to drug prevention

UK evidence review discussing ACEs, chronic adversity, protective factors and population-level links with later drug use.

ACMD - Vulnerabilities and substance use

Independent UK review of risk and protective factors for substance-use problems, including adversity, socioeconomic disadvantage and ACE research.

UK clinical guidelines for alcohol treatment

Current clinical guidance describing biological, family, socioeconomic and adverse-experience factors that may predispose, precipitate or perpetuate problem alcohol use.

A note about ACEs

ACE research can be useful for understanding how adversity is distributed across populations and how cumulative exposure is associated with later outcomes. An ACE count is not a diagnostic test, a complete trauma assessment or a prediction of an individual's future. Good formulation considers the nature and context of experiences alongside strengths, relationships, resources and current circumstances.