

Wide Awake at 02:00 am

At two o'clock this morning, Sunday, November 22, I was wide awake. That wasn't supposed to happen. Yesterday I had the privilege of speaking at a remarkable addiction recovery conference in Cottonwood, Arizona, and it had gone beautifully. The audience was engaged, the conversations meaningful, and the experience deeply rewarding. After weeks of preparation and the considerable energy I pour into a presentation, I usually sleep like a baby. The work is done, the adrenaline settles, and I enjoy the rest. Not this morning.

My mind kept wandering back to the people I had met, the questions I had asked, and a nagging contradiction. We know so much more about addiction, trauma, the brain, and the possibilities of healing than we did a generation ago. Why does so much of that knowledge still seem absent from everyday recovery treatment? The question troubled me precisely because I had spent such a beautiful day with people whose hearts were so clearly in the right place.

By 4:14 a.m., the passion had so gripped me that I was on the old elliptical, trying to burn off a peculiar mixture of gratitude, inspiration, frustration, and discouragement. I work out six days a week, and Sunday is normally my exception. Church comes later this morning; the elliptical was never on the agenda. But there I was, pedaling before sunrise and composing sentences in my head. I was thankful for what I had seen at Steps to Recovery, encouraged by its leadership, frustrated by the shortcomings of our larger treatment system, and discouraged by how much suffering those shortcomings leave untouched. Quite a cocktail for an old psychologist on a Sunday morning.

So consider this an after-action reflection: a heartfelt tribute to a recovery community that gave me hope, and a candid challenge to a system that can and must do much better.

A Remarkable Day at Steps to Recovery

On November 21, 2026, I had the privilege of presenting ***The Wounds We Carry*** at the sixth annual *Erase the Stigma* conference hosted by Steps to Recovery Homes, a nonprofit recovery organization in Cottonwood, Arizona. My presentation grew from *The Wounds We Carry*, a book I coauthored with retired U.S. Army Colonel and psychiatrist Dr. Khris Peterson, a West Point graduate and combat veteran. The project also bears the contributions and stories of Sergeant Johnnie Griffitts, Major Salvatore Bitondo, Sergeant Jack Marion, and Dr. Stephanie Bowser. I wanted to bring those voices with me into the room, because their experiences give this work its heart. The event brought together recovery professionals, community leaders, first responders, advocates, and people whose lives have been profoundly affected by addiction. I was honored to share the program with five other notable speakers, including Erin Tawney, a regional leader with the U.S. Department of Health and Human Services, whose remarks challenged the recovery community to confront shortcomings and raise its standards. I appreciated her candor. We need leaders willing to say difficult things in rooms full of people doing difficult work.

The facility was beautiful, the hospitality generous, and the atmosphere genuinely welcoming. But what I carried home was an unexpected affection and admiration for the man helping make it all happen: **Damien Browning, CEO and cofounder of Steps to Recovery Homes.** I liked Damien almost immediately. Here is someone who has every reason to feel proud of what he and his colleagues have built, yet he did not strike me as someone resting on his accomplishments. He has a larger vision for people in recovery and for the professionals who care for them. He understands the political, regulatory, and financial pressures that weigh on nonprofit treatment organizations, and still he wants to raise the standard. His participation in an August 2026 SAMHSA workshop in Washington, D.C., addressing integrity and accountability in recovery housing, reflects the national conversation in which he is engaged. But the quality I admired most was much more personal.

Damien listens. I mean really listens. He brings in accomplished people who may challenge what his organization is doing, rather than surrounding himself with people who will simply tell him how wonderful everything is. He makes room for difficult questions and seems willing to act on good answers, wherever they come from. I have worked around enough executives who mistake a title for wisdom to recognize how uncommon—and how precious—that humility can be. I found myself thinking that this is exactly the kind of leader our profession needs more of: someone who cares enough about his mission to let others help him make it better. That takes confidence, courage, and, above all, heart.

My friend, Rage, provides a particularly meaningful example. Rage has lived through the devastation of addiction and emerged into recovery with hard-won wisdom, the courage to tell his story, and a desire to help others. He has written three books, including *Becoming the Change*, for which I had the privilege of writing the foreword. He also completed certification in

NeuroFaith®, deepening his understanding of trauma, neuroscience, identity, and spirituality. Rage does not have an advanced academic degree or professional licensure in addiction treatment. But he possesses the kind of lived wisdom no university can confer, and he has done the work of continuing to learn. Damien recognizes that. He listens to Rage's feedback, respects his perspective, and, from what I understand, makes changes when the ideas are good.

I was especially encouraged to hear that Steps to Recovery does not simply usher graduates of its treatment program straight into behavioral health technician roles. Damien understands why people need time to stabilize and consolidate the gains they have made in their own recovery before taking responsibility for the recovery of others. Elsewhere I have seen the opposite: the ink is scarcely dry on a person's treatment graduation certificate before an employment agreement is being signed and that person is preparing to lead groups or support other vulnerable patients. I find that practice deeply troubling. Early recovery deserves protection, not the immediate weight of a clinical helping role for which someone may be neither personally ready nor professionally prepared. Lived experience is an extraordinary asset, but it is not a substitute for sustained stability, training, supervision, and demonstrated readiness. I applaud Damien for respecting that distinction. After my presentation, he and I discussed the possibility of future conversations and collaboration. I found that openness genuinely encouraging. I would welcome the chance to keep exchanging ideas with someone who wants to strengthen care and is willing to listen.

Why I Couldn't Sleep

Before saying anything critical, let me make something abundantly clear: I love people who work in addiction recovery. Some of the finest human beings I have ever met devote their lives to helping others climb out of addiction. Many have battled their own demons, endured unimaginable suffering, and emerged determined to help people still trapped in darkness. They are often underpaid and overworked, yet they continue showing up. I have even greater admiration for those who summon the courage to seek recovery. These are among the bravest people I have known.

Imagine waking up with a brain that has learned to demand the very substance destroying your life. Imagine knowing another drink, pill, or injection could cost you everything, perhaps even your life, yet experiencing an overwhelming compulsion to use. Then imagine finding the courage to ask for help. People in addiction treatment are often fighting for their lives, carrying immense burdens of shame, trauma, broken relationships, and despair. They deserve the finest care we can provide.

During my presentation, I asked questions about addiction neuroscience, dopamine and reward circuitry, negative reinforcement, autonomic nervous system dysregulation, and the difference between incremental behavioral improvement and transformational healing. I was struck by how unfamiliar some participants—many working in recovery—seemed to be with these concepts. They were bright, compassionate, and interested. This is not an indictment of Steps to Recovery. It is a larger concern I have developed through decades of

clinical practice, teaching, and work in addiction treatment, particularly in Arizona: the science has moved forward, but clinical preparation has not consistently kept pace.

Judith Grisel, Ph.D., a behavioral neuroscientist and professor of psychology at Bucknell University, addresses the science powerfully in *Never Enough: The Neuroscience and Experience of Addiction* (2019). Grisel brings both rigorous research and a personal history of severe addiction and recovery to her work. She understands addiction from both sides of the microscope. Repeated substance exposure produces changes in reward, motivation, and stress regulation. Pleasure diminishes, distress intensifies, and the person who once used to feel good may eventually use primarily to stop feeling terrible. Positive reinforcement gives way, increasingly, to negative reinforcement. This is not merely a moral failure or a deficit in willpower. It is a vicious adaptation of the brain and nervous system, complicated by a person's psychological and social world.

The answer is not to belittle the workers who haven't been taught these things. It is to give them the education, supervision, and opportunities they deserve—and to expect treatment programs to build on what the science has taught us. Some centers are already doing excellent, neuroscience-informed and trauma-focused work. I applaud them. My point is that such preparation and accountability should be the expectation, not the pleasant surprise.

Incremental Improvement Is Not Transformational Healing

Much of addiction treatment depends upon approaches designed to stabilize patients, teach coping skills, recognize triggers, strengthen emotional regulation, and prevent relapse. Cognitive Behavioral Therapy, Dialectical Behavior Therapy, motivational interviewing, and related methods can be extremely helpful. I have used these approaches throughout my professional career. They can be essential in crisis intervention, stabilization, and early recovery, and for some people they help produce deep and lasting changes as well.

Yet I believe our ambitions often stop too soon. Teaching someone to manage suffering is not necessarily the same as helping that person heal its deeper sources. Someone can stop drinking and still be tormented by the same chronic shame, negative core beliefs, dissociated emotional pain, internal conflict, and fractured sense of identity that made escape so compelling. The substance is gone, but the suffering remains.

That is the distinction I draw between **incremental** and **transformational** care. Incremental interventions can help people survive a crisis, develop better habits, and function more effectively; they are often indispensable and can themselves produce lasting change. Transformational work deliberately reaches toward the deeper patterns through which a person experiences self, others, and the world: unresolved trauma, entrenched beliefs, attachment wounds, autonomic dysregulation, and the search for meaning. We need both. But a program that stops at teaching coping skills may never reach the very pain that made escape through substances so compelling in the first place.

Trauma Is Not a Footnote

Not everyone with an addiction has a history of trauma. But trauma and substance use disorders frequently coexist, and the relationship deserves far more clinical sophistication than I sometimes see. This is especially important among individuals with recurrent relapse, severe dysregulation, and complicated psychiatric histories. PTSD can involve intrusive memories, avoidance, persistent threat sensitivity, and changes in mood and cognition. Complex PTSD, recognized in the ICD-11, includes PTSD symptoms along with enduring difficulties in emotion regulation, self-concept, and relationships, often associated with repeated or prolonged interpersonal trauma.

For some patients, the substance functions as a temporary escape from frightening memories; for others, it may quiet the more pervasive agony of feeling defective, unlovable, worthless, or unsafe in their own skin. When addiction treatment never addresses co-occurring trauma, sobriety may arrive without relief from the internal world that gave the substance such power. Contemporary research supports integrated approaches to PTSD and substance use disorders, including evidence-based trauma-focused psychotherapy when appropriate.

Every addiction organization should be trauma-informed, and organizations treating patients with significant trauma-related disorders should have access to clinicians specifically trained to recognize and treat them. A weekend course doesn't make someone a trauma specialist. Neither does having personally experienced trauma. Recovery peers, behavioral health technicians, and licensed therapists each make valuable contributions, but their roles are not interchangeable. It is especially concerning when someone newly discharged from addiction treatment is recruited almost immediately into a BHT position, without adequate time to establish stability in their own recovery or acquire the skills that the work demands. We would never assign cardiac surgery to a compassionate cardiac laboratory technician, however experienced that technician may be. Why should we tolerate such mismatches between clinical responsibility and preparation in addiction treatment?

One Model, Not a Movement to Join

NeuroFaith® is one approach I have developed to encourage this deeper work. It draws together polyvagal-informed regulation, HeartMath® practices, Internal Family Systems, and spirituality or faith, while attending to trauma, identity, and the brain's self-referential networks. I tell my students, certified coaches, and therapists plainly: this is not a cult, and I am not running one. If you have found another thoughtful, evidence-informed transformational approach that helps your patients, use it. Learn from it. Stay with what works. I have no interest in turning a model into a brand people must pledge allegiance to. The point is not loyalty to NeuroFaith®. The point is healing.

I was encouraged by the conference discussion of faith and spirituality, including the perspectives Erin Tawney brought to the conversation. HHS leadership under Robert F. Kennedy Jr. has also expressed interest in the place of **faith and community** in health and recovery. I'm glad this dimension is receiving attention. Faith can offer belonging, meaning, forgiveness, and hope, and

for many people those are not ornamental extras; they are central to restoring a life. But faith should be integrated with clinical competence and respect for each person's beliefs, not used as a substitute for treatment. And calling a program 'Christian' should raise its standards of honesty and accountability, not lower them. A Christian sign on the building means little if Christian principles are absent from the boardroom.

Arizona's Unforgivable Betrayal

Few episodes demonstrate the consequences of financial exploitation more painfully than Arizona's sober-living fraud scandal. Fraudulent operators targeted vulnerable people, disproportionately Native Americans, recruiting them into purported recovery housing and treatment with promises of help and stability. Investigations exposed sham services, suspect billing, neglect, and harrowing accounts of people being abandoned, exploited, and sometimes prevented from freely leaving. The broader scandal involved approximately $2.8 billion in suspected fraudulent Medicaid billing. Investigative reporting documented at least 40 deaths among Native American residents of Phoenix-area sober-living homes and treatment facilities during 2022–2024. Attorneys representing affected families have alleged much larger numbers of people dead or missing, but those claims have not been independently confirmed as a comprehensive count.

These were human beings seeking help, not commodities. Their families were entitled to safety, truth, and care, not predation. The people responsible for such abuses represent an extreme, not the ordinary recovery worker. Yet the scandal exposed what can happen when financial incentives overwhelm morality, supervision, and oversight. This was not simply inadequate treatment. It was a profound betrayal.

When Profit Becomes the Clinical Director

I have come to dislike the phrase addiction treatment industry. Industry brings to mind assembly lines, efficiency, output, and the manufacture of nuts and bolts. But we do not manufacture human beings, and we cannot restore wounded identities on a production line. Yet in some organizations the priorities look disturbingly industrial: fill the beds, maximize occupancy, increase billable contacts, expand facilities, and advertise spectacular outcomes. I have nothing against ethical financial success. Stability allows organizations to hire excellent clinicians and sustain their mission. What I oppose is profit becoming the clinical director.

Several years ago, I was recruited from my hospital position to lead clinical services at a residential addiction treatment organization in Arizona. I hoped to implement an integrated, neuroscience-informed, trauma-focused model. Instead, I repeatedly experienced conflict between commercial priorities and clinical judgment. We developed a promising framework, but developing a framework is not implementing it. Implementation demands serious training, fidelity, supervision, and accountability. After my departure, I became concerned that elements of our work continued to be promoted without the corresponding preparation necessary to deliver what the marketing suggested. A model is not a brochure. A book is not

a clinical program. And a trademark is not evidence that a sophisticated treatment approach is actually being provided.

The same principle applies to astonishing recovery claims. Eighty percent success? Eighty-one percent effectiveness? Ninety percent recovery? Defined how? At discharge, after six months, after a year, or after five years? How many patients were lost to follow-up? Who verified the results? Extraordinary claims require transparent methods, not promotional arithmetic. A person seeking recovery deserves evidence, not an illusion sold as hope.

AHCCCS, Staffing, and Everyday Professionalism

Arizona's Medicaid program, AHCCCS, shapes much of the behavioral health landscape through its reimbursement arrangements. Peer workers and behavioral health technicians can be invaluable, but the system must also make it feasible to employ experienced licensed clinicians, provide high-quality trauma treatment, train and supervise staff, and evaluate meaningful long-term results. I want to see payment policies scrutinized for the incentives they create, not merely the services they reimburse. There are excellent centers already bringing neuroscience and advanced treatment into practice. Let's support that work and make rigorous training and accountability the norm instead of rewarding volume for its own sake.

And while we're talking about quality, let me address something far less complicated. Answer your damn phone. Return your emails. Respond to your messages. Give staff professional voicemail greetings that make it clear a patient has reached the right place. Make sure there is a reliable route to help after hours or in a crisis. I have seen a troubling casualness toward professional communication in some care settings, as though two-way contact were optional. It isn't when patients and families are depending on you. A person calling a recovery center may be frightened, withdrawing, or struggling to make it through another day. Professional communication is not a luxury or an administrative afterthought. It is part of patient care.

Why Steps to Recovery Gave Me Hope

My own experiences with addiction treatment in Arizona have not always been encouraging. I have encountered clinical decisions overshadowed by business priorities, underprepared personnel, and promotional claims that outpaced the care actually being delivered. I also know there are excellent treatment centers doing serious, compassionate work. This is not an indictment of everyone in the field. It is a plea to stop accepting the mediocre because it is familiar, or the profitable because it is convenient.

That is why Steps to Recovery touched me so deeply. I arrived hoping to give something through my presentation. I left feeling I had received something in return: renewed faith in the possibility of good leadership. Damien had assembled a thoughtful conference, welcomed tough messages, honored the wisdom of people like Rage, and shown a willingness to keep learning himself. He didn't need to impress me with claims of perfection. What I admired was precisely the opposite: he seemed to understand that none of us has arrived, that every program can improve, and that

people in recovery deserve leaders who are never finished learning. I left wanting to know him better and hoping our conversations might open the door to future collaboration. That possibility is energizing at this stage of my career. I would enjoy seeing where a shared commitment to better care might lead.

As I pedal away this morning, the emotion underneath all the others is hope. I want our recovery centers to bring in the best available neuroscience, the best evidence-based clinical methods, genuinely trauma-informed therapists, and the kind of staff training that makes compassion effective. I want honest outcomes, reliable communication, real supervision, and leaders willing to admit what they don't know. I also want room for faith and spirituality when patients welcome them—not as a slogan or an advertisement, but as a meaningful part of healing, identity, forgiveness, and belonging. Some programs already do this beautifully. I want many more to join them.

So, Damien, let me say this directly: thank you. Thank you for inviting me into something you have clearly poured so much of yourself into. Thank you for the beautiful setting, the warmth of your team, and the honor of presenting alongside Erin Tawney and the other gifted speakers. More than that, thank you for being approachable, for listening without defensiveness, and for believing your organization can grow even stronger. You gave this old psychologist something I didn't realize he needed that day—a fresh dose of hope. I also thank Rage, the recovery workers who keep showing up, and the courageous men and women seeking help. You are why this work matters. And Damien, I hope you know how much I admire what you're trying to build. The world of addiction recovery could use more of that spirit.

I have written a good many books, several available on Amazon, but I also give my work away because I want the knowledge to travel farther than I ever will. I tell people that I'm just an old dude riding life's conveyor belt; sooner or later it will drop me off into the next life. Before that happens, I want to throw the football back to the younger bucks. Take what I've learned over four decades. Catch it, improve on it, challenge it, and run farther with it than I ever could. That is not a surrender of what I've built; it is the whole point of building it. And if a place like Steps to Recovery can help that knowledge find its way into the hands of people who are fighting for their lives, then this rather unusual Sunday workout will have been worth every pedal stroke. These are not nuts and bolts on an assembly line. These are human beings. Let us give them our very best.

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