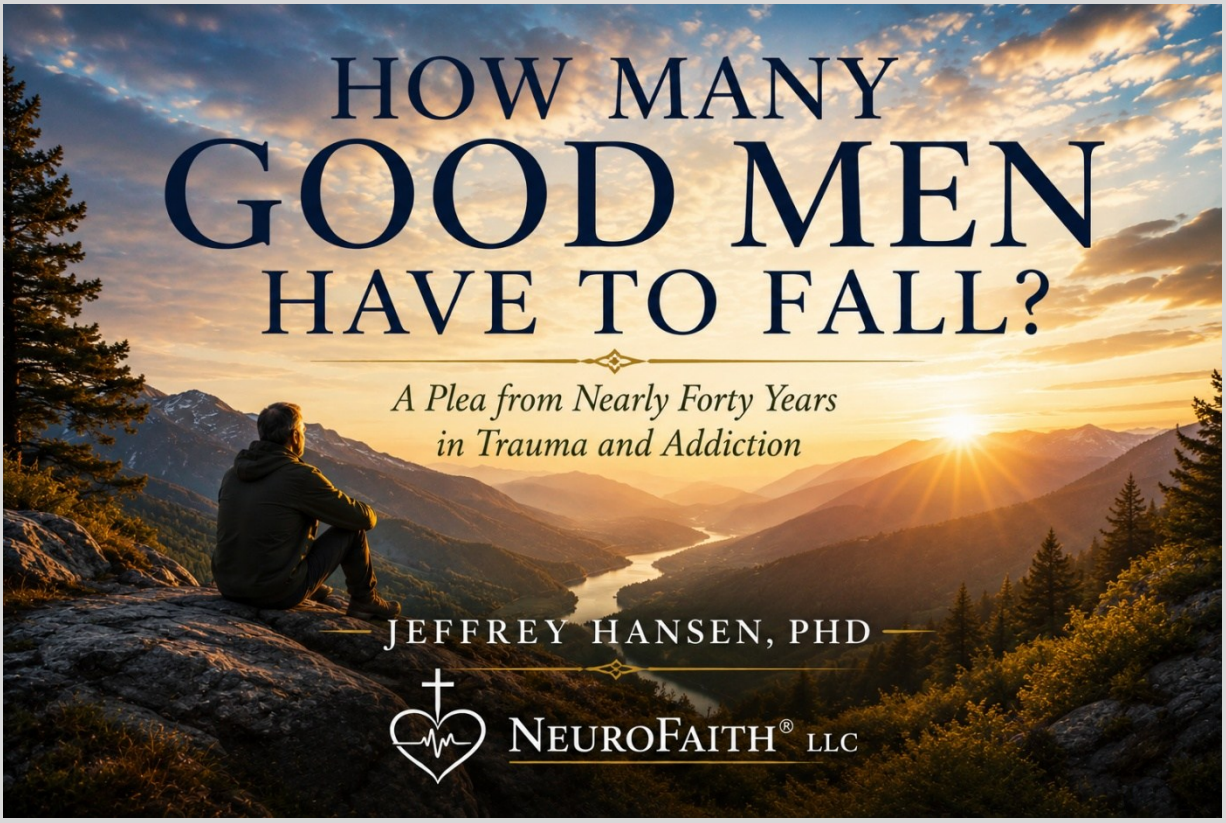

Why I Had to Write This

For nearly forty years, I have devoted my professional life to the treatment of trauma and addiction. During that time, I have worked with children, adolescents, adults, military service members, veterans, first responders, and countless individuals whose lives have been profoundly affected by trauma. More recently, I have had the privilege of working directly within residential, partial hospitalization, and intensive outpatient addiction treatment programs. That experience has only deepened my admiration for those who dedicate their lives to helping others recover. At the same time, it has left me with a growing concern that I can no longer keep to myself.

This essay is not written to criticize the addiction treatment community. It is written because I care deeply about it. I have witnessed extraordinary healing in these programs. I have watched men reclaim their marriages, reconnect with their children, rediscover their faith, and begin building lives they once believed were beyond their reach. Addiction treatment changes lives every single day, and for that I am profoundly grateful.

Yet loving something also means being willing to ask difficult questions when we see patterns that concern us.

One question has weighed heavily on my heart.

How many good men have to fall?

The Men Who Carry the Weight

My admiration belongs to the Behavioral Health Technicians.

Over the years, I have come to believe they are the heavy lifters of addiction treatment. They are the men who spend countless hours walking alongside clients through withdrawal, cravings, fear, shame, anger, grief, discouragement, and hope. They are present during the long nights when anxiety becomes overwhelming. They celebrate victories that others never see, and they quietly absorb heartbreak when relapse threatens to erase months of hard-earned progress. Their work is demanding, emotionally exhausting, and often underappreciated.

Most of these remarkable men came out of addiction themselves.

That is one of their greatest strengths.

They know the territory because they have lived there. They recognize the rationalizations because they once used them. They understand denial because they have battled it. They know the seductive pull of addiction because they have felt it in their own bodies and minds. While many may not possess advanced academic degrees, they have graduated from what I sometimes call the academy of life. Their education was earned through suffering, perseverance, humility, and grace.

As a psychologist, I have learned a great deal from graduate school, clinical training, research, and nearly four decades of practice. But I would be less than honest if I did not acknowledge how much I have also learned from these men. Their authenticity, compassion, wisdom, and uncanny ability to recognize defenses have made me a better clinician. They have sharpened my understanding of addiction in ways no textbook ever could.

That is precisely why writing these words is so difficult.

I love these men.

I respect them deeply.

And I have watched too many of them struggle after stepping into roles that I believe ask more of them than their own recovery is yet prepared to sustain.

Recovery Begins at Graduation

One of the most beautiful aspects of residential treatment is the environment itself.

For perhaps the first time in years, many men find themselves surrounded by people who genuinely understand their struggle. They eat together, attend groups together, challenge one another, pray together, encourage one another, and refuse to let another brother fight alone. They discover accountability without condemnation and compassion without enabling. In many ways, they become a family united by a common purpose: helping one another reclaim their lives.

It is a remarkable environment. But it is also a protected environment. Nearly every graduate I have spoken with has expressed the same realization. The real work begins after graduation.

Once treatment ends, the structure that supported recovery begins to fade. The daily schedule disappears. The constant accountability diminishes. Financial pressures return. Relationships become complicated again. Old neighborhoods, old friends, familiar triggers, and unfinished pain all begin waiting at the front door. The individual who felt strong inside the safety of treatment must now learn to practice recovery in the unpredictable realities of everyday life.

That is why continuing care is not an optional recommendation.

It is essential.

These are not separate components competing with one another. They are all part of the same healing process, each reinforcing the others as the recovering person slowly develops a new way of living. Recovery is not simply about stopping the use of alcohol or drugs. Recovery is about building an entirely new life.

Why Recovery Takes So Long

One of the greatest misunderstandings in addiction treatment is the assumption that sobriety and healing occur on the same timetable. They do not. Sobriety may begin today. Healing continues long afterward.

Modern neuroscience has taught us something that should fundamentally change how we think about recovery. The human brain possesses extraordinary capacity for healing, but that healing requires repetition, consistency, and time. For many individuals, meaningful neurological recovery continues for twelve to eighteen months after sobriety begins, and in some cases even longer.

The recovering brain is rebuilding itself.

Years of chronic stress, trauma, and substance use leave lasting effects on the autonomic nervous system. The hypothalamic-pituitary-adrenal, or HPA, stress system often remains chronically overactivated, leaving the individual unusually sensitive to stress and easily propelled into survival mode. Others find themselves slipping into what polyvagal theory describes as dorsal vagal shutdown, a state characterized by emotional numbness, withdrawal, hopelessness, and collapse. Many individuals oscillate between these two extremes, never fully experiencing the calm, connected state that accompanies healthy ventral vagal regulation.

The prefrontal cortex is also affected. This remarkable region of the brain allows us to plan, regulate emotions, delay impulses, solve problems, consider consequences, and make thoughtful decisions. During addiction, however, these executive functions often become compromised, a phenomenon commonly referred to as hypofrontality. The result is not simply poor decision-making; it is a diminished neurological capacity to consistently access the very brain systems responsible for wise judgment. Recovery therefore involves far more than telling someone to make better choices. The neurological machinery that supports those choices is itself recovering.

Neurochemistry also requires time to normalize. Dopamine systems that were repeatedly overwhelmed by artificial stimulation must gradually recalibrate. GABA, one of the brain's primary calming neurotransmitters, slowly regains healthy functioning, while excessive glutamatergic activity begins settling toward healthier balance. Endocannabinoid systems recover. Ion channels gradually function more efficiently. Countless interconnected neural networks begin reorganizing themselves in ways that restore resilience, flexibility, and emotional regulation. None of these changes occur overnight. They unfold gradually as the brain repeatedly experiences healthy patterns of living.

Canadian neuropsychologist Donald Hebb's famous observation remains as true today as when he first proposed it: *neurons that fire together wire together.* Every healthy choice strengthens healthy neural pathways. Every day of regulated living reinforces the architecture of recovery. Healing occurs through thousands of repetitions that gradually become the brain's preferred way of functioning.

Recovery, in other words, is not merely a decision.

It is a process of neurological reconstruction.

The Body Recovers Alongside the Brain

The brain never heals in isolation.

The body heals with it.

One of the most exciting developments in neuroscience over the past several decades has been our growing understanding of the intimate relationship between the brain, the heart, and the autonomic nervous system. We now recognize that resilience is not simply a psychological concept. It is a physiological reality.

As vagal regulation improves, individuals gradually develop greater flexibility in responding to stress. Heart rate variability, one of the clearest indicators of autonomic resilience, begins improving as the brain and body learn once again to function as an integrated system rather than remaining trapped in chronic survival states. This is one reason approaches such as HeartMath® and other evidence-informed regulation strategies have become such valuable components of treatment. They provide practical methods for strengthening the body's natural capacity to return to physiological balance.

This does not happen because someone attends a few sessions. It happens because new patterns are practiced repeatedly until they become increasingly automatic. The nervous system learns. The body remembers.

Resilience gradually becomes embodied rather than merely understood.

Psychological Healing Requires the Same Patience

The psychological dimension of recovery unfolds with similar complexity.

Trauma rarely disappears simply because substance use has stopped. In many cases, addiction functioned as an attempt to manage overwhelming emotional pain that had never been adequately processed. As sobriety develops, that pain often becomes more accessible, making psychological work not less important, but more important than ever.

Internal Family Systems has given us a remarkably compassionate framework for understanding this process. The protective parts that once relied upon substances were not trying to destroy the individual. They were attempting, however imperfectly, to protect him from unbearable suffering. Lasting recovery requires those protective parts to develop trust that they no longer have to carry those burdens alone. Gradually, the Self emerges with greater calmness, curiosity, confidence, compassion, courage, creativity, clarity, and connectedness. Those qualities cannot be forced. They mature through repeated experiences of safety, relationship, and healing.

Like the brain itself, the inner psychological system reorganizes slowly.

Growth cannot be hurried.

Healing Is Also a Spiritual Journey

There is one final dimension of recovery that deserves equal attention. Human beings are not merely biological and psychological organisms. We are also spiritual beings.

Within the NeuroFaith® model, lasting recovery rests upon the integration of four complementary pillars: neuroscience, nervous system regulation, psychological healing, and

spiritual formation. None of these dimensions stand alone. Each strengthens and reinforces the others.

Spiritual maturity requires time just as neurological maturity does. Prayer gradually becomes less of a crisis response and more of a daily conversation with God. Scripture slowly reshapes patterns of thinking that were once dominated by shame, fear, and hopelessness. Worship softens a heart that has often been hardened by years of pain. Healthy Christian community provides accountability, encouragement, correction, forgiveness, and belonging. Identity gradually shifts away from being defined by addiction toward the deeper truth of being a beloved son of God.

These transformations cannot be microwaved. They are cultivated through faithful practice over many months and years.

When the brain is healing, the nervous system is becoming more regulated, the psychological system is becoming more integrated, and the spiritual life is becoming more deeply rooted, genuine transformation begins to emerge. Recovery is no longer merely about avoiding relapse. It becomes the gradual restoration of the whole person.

So Why Are We Rushing Them?

This brings me to the question that has troubled me for quite some time. If everything we have learned over the past several decades about the neuroscience of addiction and recovery is true, then why are we so often placing men directly out of treatment into one of the most emotionally demanding positions in behavioral health? That question is not intended as an accusation. It is an invitation to think more carefully about what genuine recovery actually requires.

Please hear what I am saying, because this point is critically important.

I am not questioning the sincerity of these men. I am not questioning their integrity, their commitment, or their desire to serve. In fact, it is precisely because of their compassion that they are so vulnerable. Most of them desperately want to give back. They remember the Behavioral Health Technician who sat with them during a panic attack, who challenged them when they were minimizing their addiction, who encouraged them when they wanted to quit treatment, or who simply believed in them when they could not believe in themselves. It is only natural that they would want to become that person for someone else.

There is something profoundly beautiful about that desire.

But there is also something profoundly dangerous about confusing compassion with readiness.

The brain does not know that a person has accepted a new job. The autonomic nervous system does not suddenly become resilient because someone has been hired. The prefrontal cortex does not fully recover because graduation day has arrived. Dopamine systems do not finish recalibrating because a certificate has been handed to someone. Psychological defenses do not disappear because a person has accepted Christ or experienced a powerful emotional breakthrough. Even spiritual maturity, as beautiful as it may begin, continues to deepen through years of faithful practice, testing, surrender, and growth.

Healing continues long after employment begins.

That reality should give every treatment program pause.

When a newly recovering individual steps into a full-time Behavioral Health Technician position, he is no longer responsible only for protecting his own recovery. He now spends his days absorbing the fear, grief, anger, manipulation, despair, and trauma of dozens of other people.

He is expected to remain emotionally available while witnessing relapses, family crises, psychiatric emergencies, interpersonal conflict, and the relentless emotional intensity that accompanies addiction treatment. Those experiences place tremendous demands upon a nervous system that may itself still be learning how to remain regulated under ordinary stress.

That is an enormous burden for anyone.

It is an even greater burden for someone whose own recovery architecture is still under construction.

I often think about how differently we approach visible injuries. If a patient underwent open-heart surgery, no responsible physician would discharge him from the hospital and encourage him to begin training for a marathon the following week. If a young man suffered a fractured femur, no orthopedic surgeon would remove the cast and recommend that he immediately begin climbing mountains. We instinctively understand that tissues require time to heal before they are capable of bearing prolonged stress.

Yet we often fail to apply that same wisdom to addiction recovery.

The reason, I suspect, is because neurological and psychological healing are largely invisible. We cannot see a recovering prefrontal cortex. We cannot observe dopamine pathways gradually finding equilibrium. We cannot watch vagal regulation strengthen or measure, with our eyes alone, the slow development of healthier heart rate variability. We cannot easily recognize the quiet work of psychological integration or the gradual deepening of spiritual maturity. Because these processes occur beneath the surface, it becomes tempting to assume they have already been completed simply because someone appears to be functioning well.

That assumption, I believe, is one of the greatest mistakes we make.

Recovery is not finished because someone looks healthy.

Recovery continues because the brain, the body, the mind, relationships, and the spirit are still being transformed. Like the construction of a beautiful building, the structure may appear complete from the outside while skilled craftsmen continue strengthening the foundation, completing the wiring, reinforcing the support beams, and preparing the building to bear the weight it will eventually carry. No wise builder removes the scaffolding before the structure is ready.

Neither should we.

When Good Intentions Need Greater Understanding

I want to speak directly to the men and women who own treatment centers, serve as executive directors, supervise programs, or make hiring decisions. I hope you will hear these words in the spirit in which they are written.

I believe most of you genuinely care.

I believe you entered this profession because you wanted to rescue people whose lives had been devastated by addiction. I believe many of you have sacrificed financially, emotionally, and personally to build programs that have literally saved lives. Some of you have your own stories of recovery. Others have watched addiction affect people you deeply love. Whatever your journey, I do not begin with the assumption that your motives are selfish or uncaring.

In fact, I suspect many of you hire recent graduates because you sincerely believe you are helping them. Employment provides dignity. It creates financial stability. It offers purpose, responsibility, and an opportunity to give back. Those are all worthy goals, and I understand why they seem attractive.

I also recognize that many administrators are not trained in clinical psychology, neuroscience, or trauma physiology. They may never have been exposed to the growing body of research describing the remarkable complexity of neurological recovery. They may simply assume that because someone has completed treatment successfully, the major work has been accomplished.

If that is the case, then my purpose is not to condemn.
My purpose is to educate.
But education carries responsibility.

Once we understand that meaningful recovery involves the gradual restoration of the brain, the autonomic nervous system, executive functioning, neurochemistry, psychological integration, relational health, and spiritual formation, our hiring decisions should reflect that knowledge. We cannot unknow what modern neuroscience has taught us. Nor can we ignore what we have repeatedly observed in the lives of men whose recoveries were placed under extraordinary strain before they had become firmly established.

That is why I believe this conversation is so important.
It is not about questioning anyone's heart.
It is about asking whether our systems reflect what we now know to be true.

Only then can we begin building programs that protect not only the people seeking recovery, but also the remarkable men and women who dedicate their lives to helping them find it.

As the Apostle Paul reminds us, *"Let perseverance finish its work so that you may be mature and complete, not lacking anything"* (James 1:4).

Healing has always been God's work.
And God has rarely been in a hurry.

Recovery Should Come Before Responsibility

Please do not misunderstand what I am saying.

I am not suggesting that men in early recovery should be isolated from meaningful service. Quite the opposite. One of the most powerful aspects of recovery is discovering that our pain can eventually become a source of hope for someone else. Sponsoring another man in a Twelve Step program, sharing one's testimony, mentoring someone who is just beginning the journey, volunteering at a recovery meeting, serving in a church, or simply walking alongside another brother can all become important milestones in the healing process.

Those opportunities should be encouraged.

What concerns me is something altogether different.

There is a profound difference between serving another person and assuming full-time responsibility for the emotional care of dozens of people whose lives are in crisis. The first can strengthen recovery. The second may place demands upon a recovering brain and nervous system that they are simply not yet prepared to sustain. Good intentions cannot substitute for neurological readiness, psychological maturity, or spiritual rootedness.

My concern has not arisen from theory alone. It has arisen from experience. Over the years I have watched remarkable men enter this profession with tremendous enthusiasm, deep compassion, and an authentic desire to give back. Some have done extraordinarily well. Others have not. I have watched gifted men relapse. I have watched others become emotionally overwhelmed. I have watched men whose hearts were unquestionably in the right place discover that they had accepted responsibilities their own recovery could not yet support. Every one of those situations has broken my heart.

Perhaps those outcomes would have occurred anyway. Recovery is complex, and no one can reduce relapse to a single cause. But after witnessing similar stories unfold repeatedly, I believe we have an obligation to ask whether we are contributing to the problem by asking too much, too soon.

Recovery deserves patience.

The remarkable work taking place within the recovering brain, body, mind, and spirit deserves time to mature before it is asked to carry extraordinary emotional weight. That is not lowering expectations. It is honoring the healing process.

A Challenge to Those of Us Who Lead

If you are an administrator, owner, executive director, or clinical leader, I hope you will receive these thoughts in the spirit in which they are offered.

I am not your adversary.

I am your colleague.

Like you, I want to see people recover. Like you, I want treatment programs to flourish. Like you, I want Behavioral Health Technicians who are compassionate, resilient, wise, and capable of serving others for many years. My concern is simply that our desire to help someone rebuild his life may unintentionally lead us to place him into a role before the foundations of his own recovery have become sufficiently established.

Some decisions are undoubtedly made out of compassion. Others may be influenced by staffing shortages, financial realities, or organizational pressures that those outside leadership rarely appreciate. I recognize those realities, and I do not pretend they are easy. Nor do I presume to

judge the motives of any individual. Scripture reminds us that only God truly knows the human heart.

What I am asking is something much simpler.

I am asking us to allow what we now know about neuroscience, trauma, and recovery to reshape the way we think about staffing. Once we understand that healing continues long after discharge, once we appreciate the slow restoration of executive functioning, autonomic regulation, neurochemistry, psychological integration, and spiritual maturity, we can no longer make decisions as though graduation marks the completion of recovery.

Knowing these things changes our responsibility.

For that reason, I have chosen a phrase that I recognize is strong. When we repeatedly place men, whose own recovery remains under construction into one of the most emotionally demanding positions in behavioral health, despite what we now understand about the science of recovery, I believe we are approaching what I would call **administrative malpractice**.

I do not use those words to condemn.

I use them because I believe the stakes are too high for polite silence.

If those words make us uncomfortable, perhaps that discomfort is worth exploring. Sometimes the most important conversations begin when we are willing to ask whether long-standing practices deserve to be reexamined in the light of new understanding.

We Can Do Better

I remain deeply hopeful.

Every day I witness lives transformed by men and women who have dedicated themselves to addiction treatment. I have seen marriages restored, families reunited, fathers return to their children, and men discover a relationship with Christ that has completely changed the direction of their lives. I have also seen outstanding Behavioral Health Technicians whose own recovery had become deeply rooted over time. Their wisdom, steadiness, humility, and compassion make them invaluable members of every treatment team. They are exactly the kind of people our profession needs.

My plea is simply that we give more men the opportunity to become that kind of clinician.

Let recovery become something that is no longer merely being maintained but has become woven into the very fabric of a person's character.

I believe we will ultimately produce stronger Behavioral Health Technicians, healthier treatment programs, and better outcomes for the people entrusted to our care. More importantly, I believe we will protect some very good men from carrying burdens they should never have been asked to bear so early in their own recovery.

If you have read this essay all the way to the end, I hope you have heard my heart. I have not written these words to criticize an industry that I love. I have written them because I believe we are capable of something even better. We have been given extraordinary insights into the neuroscience of recovery, the regulation of the nervous system, the psychology of trauma, and the transforming power of authentic faith. Those insights should not remain confined to textbooks or conference presentations. They should shape the way we build our programs, support our staff, and care for those who have answered the noble calling of helping others heal.

In the end, this is not simply about staffing.

It is about stewardship.

It is about protecting the people who have devoted themselves to protecting others.

As the Apostle Paul wrote with confidence, *"He who began a good work in you will carry it on to completion until the day of Christ Jesus"* (Philippians 1:6).

God is not in a hurry.

Perhaps we should not be either.