Introduction

In my last blog, *When One of Us Falls*, I wrote about the fall of our dear brother Drew, who relapsed while working in an addiction treatment center where I once served as clinical director.

I wrote from a place of sadness, but also from concern. And now, after sitting with that sadness, I believe we have a responsibility to do something more. We need to ask the hard questions, not to assign blame, not to find villains, and not to pretend that any one person or system is responsible for another person's choices, but because honest questions are how we learn, how we grow, and ultimately, how we do better.

We cannot change what happened to Drew. We cannot go backward and rewrite his story. But surely, the least we can do in honor of his struggle is to learn from it, and to learn from ourselves. We can examine the systems in which we work, the cultures we create, the people we place in positions of responsibility, and the ways we support, or sometimes fail to support, those who are still healing while trying to help others heal.

That is the purpose of this reflection. Not blame. Not condemnation. But courage: the courage to look honestly at what happened, to ask what we might have done differently, and to make meaningful changes so that perhaps another person, another family, and another community will be spared the pain we are witnessing now.

My concern, then, is not simply about one man, one relapse, or one treatment center. It is about a broader pattern I have witnessed throughout the addiction treatment industry: men and women who are still relatively early in their own recovery are sometimes moved too quickly from treatment into positions of responsibility because they are motivated, eager to please, hardworking, and deeply committed to giving back.

Those are beautiful qualities. But sometimes our greatest strengths can also become our defenses.

When Our Strengths Become Our Defenses

Internal Family Systems, or IFS, helps us understand this through the language of parts. Many people who have experienced trauma develop strong manager parts. These parts work tirelessly to keep life under control. They achieve. They perform. They please. They serve. They work harder. They become indispensable. And often, beneath all that activity, they are protecting deeply wounded exile parts carrying shame, fear, loneliness, grief, rejection, and painful core beliefs such as:

I am not worthy. I am not lovable. I am never truly safe. I have no value. If I fail, I will be rejected.

The manager system can be extraordinarily effective. In fact, it may help a person survive for years. But if the underlying pain remains unhealed, the manager eventually becomes exhausted. The pressure grows, the defenses begin to crack, and the firefighters may emerge.

In IFS, firefighters are the parts of us that rush in when emotional pain becomes overwhelming. They do not carefully reason through consequences. They act urgently to extinguish the fire through addiction, rage, anger, compulsive behavior, isolation, sexual acting out, or anything else that promises immediate escape from unbearable internal pain.

Most of us move among these defensive states to some degree. We manage, suppress, overwork, withdraw, become angry, or seek distraction. These are human defenses. The goal is not to shame them, but to understand them, appreciate how they once protected us, and help them step back so that we can return to what IFS calls the Self.

The Self is characterized by the eight Cs: curiosity, compassion, calm, clarity, courage, confidence, creativity, and connectedness.

For those of us who approach healing through faith, there is a beautiful resonance with the fruit of the Spirit: love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control.

Different language, perhaps, but both point us toward something profound: healing requires more than controlling symptoms. It requires helping people return to the deepest, healthiest, most grounded center of who they are.

Understanding Is Not Exoneration

I want to be very clear about something. Although I have raised serious concerns about systemic problems within the addiction treatment industry, Drew is ultimately responsible for his actions. Trauma does not exonerate us from responsibility. A difficult childhood does not exonerate us. An unhealthy workplace does not exonerate us. Our defenses do not exonerate us.

But understanding matters.

Understanding helps us see why people do what they do. It allows us to intervene earlier. It replaces simplistic judgment with informed compassion. And when a person begins to understand what is happening within the body, brain, heart, psyche, and soul, that understanding can become the beginning of genuine healing.

Drew now has a long journey ahead of him, and I grieve that deeply. But this blog is not about pointing fingers or finding villains. It is not about absolving anyone of responsibility.

It is about asking a harder and, I believe, more important question:

What can we do better?

How can we better protect and support the behavioral health technicians, recovery coaches, peer support specialists, young therapists, and other helping professionals who enter this field with their own histories of addiction, trauma, and pain? How can we honor their desire to serve without exploiting it? How can we help them give back without asking them to give more than their own healing can yet sustain?

And how can treatment centers create cultures in which asking for help is seen not as weakness or failure, but as wisdom?

Healing Must Come Before Helping

I believe we must begin with a fundamental principle: Before we ask people to carry the pain of others, we must make certain they have had sufficient opportunity to understand and heal their own.

This requires more than sobriety alone. Sobriety is essential, but abstinence and healing are not the same thing. A person can stop using drugs or alcohol while still carrying profound autonomic dysregulation, unresolved trauma, deeply embedded negative core beliefs, exhausted manager defenses, and firefighter parts waiting for the next moment of overwhelming distress.

This is why deep therapy matters.

CBT and DBT can be enormously valuable. They help people challenge problematic thoughts, tolerate distress, regulate emotions, navigate crises, and develop healthier coping skills. I consider these important resilience-building therapies.

But resilience and transformation are not identical.

Transformational healing asks us to go deeper. It asks us to understand the wounds that shaped our beliefs about ourselves, our relationships, and the world. It asks us to explore why the nervous system continues to respond to present-day stress as though an old danger were still happening now.

This is where the NeuroFaith® model seeks to bring the pieces together.

We begin with the body, understanding how trauma and chronic negative emotional states can dysregulate the autonomic nervous system. Some people become trapped in chronic sympathetic activation: hypervigilance, anxiety, irritability, anger, and relentless striving. Others collapse into dorsal vagal states of withdrawal, numbness, disconnection, and hopelessness. Many move back and forth between the two.

As the body becomes more regulated, we can begin deeper work with our psychological defenses, including the manager, firefighter, and exile parts described by Internal Family Systems. We begin to approach those defenses not as enemies to be defeated, but as survival adaptations to be understood and healed.

And ultimately, through faith, spirituality, relationship, meaning, and identity, we begin rewriting the deepest beliefs about who we are. We discover that the old story does not have to remain the final story.

That is transformational healing.

And if we are going to place people with histories of addiction and trauma in positions where they are exposed every day to the pain, chaos, crises, relapses, anger, grief, and trauma of others, then we have an ethical responsibility to make sure their own foundation is strong enough to carry that weight.

Recovery Requires Time to Consolidate

Healing also requires something our culture does not always value enough: Time.

I believe treatment centers must resist the temptation to move people too quickly from early recovery into helping roles. As a general principle, I believe a person should have at least one solid year of stable sobriety before entering a professional role in an addiction treatment environment.

Even then, time alone is not enough. One year of white-knuckling is not the same as one year of genuine recovery.

Recovery requires consolidation.

Hebb's Law is often summarized simply: neurons that fire together wire together. The brain changes through repeated experience. New ways of thinking, relating, responding, regulating, and living must be practiced again and again before they become sufficiently established to guide us when life becomes difficult.

One good day does not rewire a brain. Neither does one week, one month, or one therapeutic insight.

We need many repeated experiences of facing distress without escaping, receiving correction without collapsing, experiencing failure without concluding that we are worthless, asking for help before reaching the breaking point, and discovering that painful emotions can be survived without returning to addiction.

Over time, those repeated experiences help create and strengthen new neural pathways. What once required enormous conscious effort gradually becomes more available and more automatic. The brain learns new possibilities. The nervous system develops greater flexibility. Old survival pathways may still exist, but they no longer have to dominate behavior.

And this consolidation cannot happen only in the brain. The heart must heal too.

From a NeuroFaith® perspective, genuine recovery involves the whole person: body, brain, heart, relationships, identity, and spirit. A person may intellectually understand trauma and still carry shame in the heart. Someone may know all the right therapeutic language and still feel fundamentally unworthy

of love. A person may develop excellent coping skills and still be disconnected from meaning, belonging, faith, and genuine human connection.

Healing takes time because trust takes time. Identity takes time. Relationships take time. Spiritual growth takes time. The body and brain need repeated experiences of safety, while the heart needs repeated experiences of love, grace, truth, belonging, forgiveness, and connection.

This is why I believe we must be extraordinarily careful about placing people too quickly into demanding helping roles within addiction treatment. Every day, they may be exposed to stories, behaviors, crises, relapses, anger, grief, and trauma that activate their own unresolved wounds. The desire to give back may be beautiful and sincere, but desire alone is not yet readiness.

Our responsibility as leaders is not merely to admire someone's desire to help.

Our responsibility is to make sure that the person who wants to help others is sufficiently supported, sufficiently healed, and sufficiently grounded to survive the helping.

Healing Cannot End at Discharge

Treatment centers should provide excellent care while a person is in treatment, but our responsibility cannot simply end at the discharge door.

Good discharge planning must include thoughtful attention to what happens next.

Twelve-step programs, sponsors, recovery communities, faith communities, prayer, and spiritual practices can all be beautiful and essential parts of sustained recovery. But for many people, they are not substitutes for ongoing therapy.

I am a man of deep faith. I believe profoundly in the power of prayer. But I do not believe we can simply pray away trauma any more than we would tell someone with a broken leg to pray instead of receiving medical care.

Prayer and therapy are not enemies. Faith and psychological healing do not have to compete with one another. For many people, the deepest healing occurs when they work together.

If treatment centers are going to hire former clients or others with histories of addiction and trauma, then we should actively support their continued healing. We should encourage ongoing therapy when needed, help connect them with appropriate resources, and create a culture in which continuing to work on oneself is regarded as a sign of maturity and wisdom rather than weakness.

Do Not Overwhelm the Person Who Wants to Serve

Once someone is ready to enter the treatment environment as a behavioral health technician, recovery coach, peer support specialist, or other helping professional, we should bring that person in thoughtfully.

Not too much responsibility too quickly. Not an immediate leap from being cared for to carrying the care of everyone else. Not endless demands simply because someone is eager, hardworking, available, and has difficulty saying no.

The very qualities that make someone an appealing employee can sometimes be the same qualities that place that person at risk. The manager parts described earlier through Internal Family Systems may quickly return to doing what they have always done: achieving, pleasing, performing, rescuing, overworking, and proving one's worth.

Those defenses do not simply disappear because someone has completed treatment or achieved sobriety. They remain part of us. Under excessive pressure, old wounds can become activated, the exiled pain can intensify, and eventually the system can become overwhelmed. When that happens, firefighter defenses may return with enormous force.

That can mean relapse, rage, withdrawal, compulsive behavior, or other desperate attempts to escape unbearable pain.

We saw what happened to Drew.

That does not mean we could necessarily have prevented it. I do not know that we could have. But it does mean we have a responsibility to ask whether we could have done more.

Supervision Must Be About More Than Performance

I would propose that employees with histories of addiction and significant trauma, particularly those relatively early in their professional development, receive thoughtful and consistent supervision that goes beyond job performance.

Someone needs to have a genuine pulse on how they are doing.

That might be the clinical director, program director, or another appropriately qualified and trusted leader. The exact title matters less than the quality of the relationship. There should be regular opportunities to ask: How are you really doing? Are you becoming overwhelmed? Are old patterns reemerging? Are you becoming increasingly irritable or withdrawn? Are you taking on too much? Are you still connected to the people and practices that support your recovery?

This is not about treating employees like patients or invading their privacy. Nor is it about creating a second-class category of employees who are constantly viewed with suspicion because of their history.

It is about recognizing reality.

People who work in addiction treatment are exposed daily to trauma, crisis, relapse, anger, grief, manipulation, despair, and tremendous emotional intensity. For someone with a personal history of addiction or trauma, that work can touch old wounds in powerful ways.

There must also be freedom to speak honestly.

An employee should be able to say, I am struggling. I am overwhelmed. Something is happening inside me, and I need help, without immediately fearing punishment, humiliation, rejection, or the loss of everything he or she has worked to rebuild.

Of course, accountability and appropriate professional boundaries remain essential. Safety matters. Competence matters. Patient care matters. But a healthy organization should create pathways for people to ask for help before they reach the point of collapse.

If the first honest admission of struggle comes only after a relapse, an explosion, or a crisis, we have waited too long.

The Environment Itself Must Be Healthy

We cannot ask staff members to become healthy inside an unhealthy system.

A truly therapeutic treatment center must embody the very principles it teaches. There must be good communication, genuine trust, appropriate boundaries, reasonable workloads, meaningful supervision, and leadership that listens.

Clinical directors must also be genuinely empowered to do their jobs. They are often closest to the clinical health of the organization and are frequently among the first to see when a staff member is struggling, when workloads are becoming unsustainable, or when the culture is beginning to deteriorate.

Their concerns must carry real weight.

Of course, treatment centers have financial realities. Payroll must be met. Beds must be filled. Bills must be paid. No organization survives for long by ignoring its financial responsibilities. But when financial pressures consistently override clinical judgment, staff wellness, and patient care, the organization may remain financially alive while becoming therapeutically unhealthy.

We need balance. We need leadership teams willing to listen when clinical leaders say, This person is carrying too much. This staff member needs support. This workload is becoming unsafe. We need more training. We need to slow down.

Sometimes the wisest thing a treatment center can do is resist the pressure to produce, produce, produce.

People are not production units. And people who spend their days carrying the pain of others cannot endlessly pour from an empty cup.

When the Metrics Begin to Matter More Than the Person

There is another concern I believe we must name, and it extends beyond any one treatment center. I have been increasingly struck by how much the addiction treatment industry has become driven by metrics, numbers, levels of care, ASAM criteria, documentation requirements, utilization reviews, and the constant need to justify treatment. I understand why these things exist. We need standards. We need accountability. We need measurable outcomes. We need to demonstrate medical necessity, and we need responsible documentation. I am not arguing against any of that.

But somewhere along the way, I fear we have allowed the metrics to become the master rather than the servant.

We have become so busy feeding the model of the metrics that we sometimes forget to feed the soul of the person.

I saw this firsthand in working with Kipu, the electronic medical record system widely used in addiction treatment. Kipu may serve many important administrative and documentation functions, but in my experience, its treatment-planning structure tends to reflect an incremental approach to care: identify a

problem, establish a measurable objective, assign an intervention, document progress, repeat. There is certainly value in that structure, particularly for accountability and demonstrating medical necessity. But as a tool for guiding truly transformational treatment, I found it deeply limited.

Transformational healing does not always fit neatly into a checkbox.

How do we adequately capture the moment when a man who has spent his entire life believing I am worthless begins, perhaps for the first time, to experience that he has value? How do we document the gradual transformation of a nervous system that has lived for decades in survival mode? How do we reduce to a numerical scale the moment when someone finally understands that the rage, addiction, withdrawal, or relentless achievement that has dominated his life was not evidence that he was fundamentally defective, but an adaptive attempt to survive pain he never learned how to carry?

Of course, we can—and should—measure symptoms, behaviors, functioning, substance use, cravings, treatment participation, and progress toward specific goals. But those measures are not the whole person, and they are certainly not the whole story of healing.

The danger comes when clinicians begin treating to the documentation system rather than using the documentation system to support treatment. The record begins driving the therapy instead of the therapy driving the record. We become more concerned with whether every box has been checked, every objective has been made sufficiently measurable, and every level of care has been adequately justified than with whether the person sitting across from us is actually changing at the deepest levels of body, brain, heart, relationship, identity, and spirit.

That needs to change.

Our electronic medical records and treatment-planning systems should be redesigned to support both accountability and transformation. Whether we are using Kipu or any other EMR, the treatment plan should be capable of capturing not only symptom reduction and behavioral compliance, but deeper therapeutic processes: autonomic regulation, attachment, trauma healing, defensive patterns, negative core beliefs, identity, meaning, relationships, spiritual well-being when appropriate to the individual, and the person's growing capacity to live from a healthier and more integrated sense of self.

I tried, during my time as a clinical director, to move treatment planning more in this direction, with only marginal success. The existing structures were simply not designed to easily accommodate the kind of transformational work I believed our clients needed.

But that experience only strengthened my conviction that we have to do better.

Documentation should serve treatment. Treatment should never become a servant of documentation.

Metrics matter. Accountability matters. Standards matter. Medical necessity matters. But the person matters more.

If our systems can tell us everything about a person's ASAM level of care, diagnoses, attendance, measurable objectives, and discharge date, yet fail to capture whether that person is becoming more regulated, more connected, more whole, more capable of carrying pain, more able to love and be loved, and more deeply grounded in a life of meaning and purpose, then our systems may be measuring a great deal while still missing what matters most.

We must stop feeding only the model of the metrics. We must begin feeding the soul of the person.

A Transformational Model Must Begin With the Staff

Staff training is essential, and I believe far too many treatment centers underestimate what genuine training requires.

Again, I am not dismissing incremental therapies such as CBT and DBT. These approaches can be enormously valuable for building coping skills, increasing distress tolerance, challenging problematic thinking, and helping people navigate moments of crisis.

But a treatment center that seeks transformational healing must have a transformational therapeutic philosophy.

And that philosophy cannot exist only in a manual, a PowerPoint presentation, or a mission statement hanging on the wall.

The staff must embody it.

Behavioral health technicians are generally not psychotherapists, nor should they be expected to function as psychotherapists. Their role may involve coaching, encouragement, psychoeducation, modeling healthy behavior, maintaining boundaries, supporting regulation, and helping clients navigate the daily challenges of treatment.

But if we expect BHTs to do those things well, we must teach them how.

We cannot simply hand someone a radio, give them a schedule, tell them where the clients are, and expect them to understand trauma, autonomic dysregulation, psychological defenses, addiction, shame, therapeutic boundaries, de-escalation, and relational healing.

Education alone is not enough either.

Training must be experiential.

Staff members need opportunities to understand their own autonomic states, recognize their own defenses, experience healthy regulation, examine how they respond under stress, and understand how their personal history may enter the therapeutic environment. They need to experience the very principles they are being asked to model for others.

A treatment center's therapeutic model should first live within its staff. Only then can it authentically reach its clients.

The Hard Question I Must Ask Myself

As I think about Drew, I have to ask hard questions of myself as well.

I was a clinical director. I cared deeply about Drew. I saw his enormous heart for service, his desire to help, his drive, and also some of his vulnerabilities. I tried at times to raise concerns about the larger system and about the pressure being placed on people who were still healing themselves.

But looking back, I still have to ask: Could I have done more? Could we have done more? Could we have created more space for honest conversation, more meaningful supervision, better training, a healthier

pace, a stronger therapeutic culture, and more opportunity for staff members to do their own healing while helping others heal?

I do not know. And I refuse to pretend that I do.

Had these things been more fully implemented, Drew may have had a different outcome. Or perhaps he would not have. We cannot rewrite history, and we cannot know with certainty what would have happened under different circumstances.

But we can learn. We can ask harder questions. And we can do better.

We Can Do Better. We Will Do Better.

We do not need any more Drews. We do not need any more lives tragically broken while the rest of us look back afterward and wonder whether there were signs we missed, concerns we minimized, burdens we failed to see, or opportunities to intervene that quietly passed us by. Drew remains responsible for his choices. I remain responsible for mine. Leaders remain responsible for theirs. Organizations remain responsible for the cultures they create. Responsibility does not require blame; it requires courage—the courage to look honestly at what happened, to examine ourselves before examining everyone else, to acknowledge what we might have done differently, to listen when someone says, I am struggling, before the whisper becomes a scream, and to change the systems, cultures, and practices that are within our power to change.

We will never prevent every relapse. We will never save every person. We will never create a world without pain, trauma, failure, or human frailty. But that cannot become our excuse for doing nothing. We can create treatment centers where healing is more than a program delivered to clients, where the people doing the healing are cared for too, where asking for help is seen as wisdom rather than weakness, where clinical judgment is heard, and where staff members are trained not merely to recite a therapeutic model but to embody it. We can create environments where people are given time to heal, time to consolidate, time to grow, and time to become ready before we ask them to carry the pain of others. We can create places where faith and science are not enemies, where prayer and therapy walk together, where accountability and compassion can share the same room, and where understanding a person's wounds never excuse destructive behavior but helps us intervene before those wounds contribute to another tragedy.

I cannot change what happened to Drew. I cannot go backward and answer every question differently, see every sign more clearly, or make every decision better than I did at the time. But I can learn, I can listen, I can ask harder questions, and I can do better. And so can we. Perhaps that is how we truly honor those who fall—not by pretending we could have saved everyone, not by finding someone to blame, and not by washing our hands of responsibility and moving on, but by refusing to learn nothing from their fall. We become wiser because we have grieved, more compassionate because we have hurt, more courageous because we have seen what silence can cost, and more determined because another person, somewhere, may be standing closer to the edge than anyone realizes.

For that person, and for every person who will come after Drew, we must keep asking the hard questions. We must keep listening, learning, and changing. I can do better. We can do better. And together, we will do better.