Warfighter Advance: The ADVANCE 7-Day

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Abstract

The author describes her early acquaintance with Adlerian practice while studying for clinical practice as a U.S. Navy officer. She describes the impact on her by juxtaposing it to the heavily burdened medical model of therapy she found herself in as she completed studies. She also describes her experience of providing psychological care during military service, which led her, upon completion of duty assignment, to develop Warfighter Advance. The author describes the effort to create a non-medicine-oriented psychological support program to bring sufferers from military trauma back to their best selves. She portrays the program as an amalgam of her Adlerian upbringing, U.S. Navy core values, and undergraduate training in theater "to build a viable and life-saving alternative" to medicinal dependence for dealing with war trauma.

Keywords: Warfighter Advance, Adler, alternative mental health programs, war trauma, PTSD, veteran suicide, alternative to the medical model

Influences on Adlerian Identity

It was 27 years ago, in 1993, that I was introduced to Adlerian Individual Psychology while completing an internship at the 97th General Hospital in Frankfurt, Germany. I was a master's student at Boston University's Overseas Programs for the Military. For my psychotherapy practicum, I was placed in the hospital's department of Social Work Services under the supervision of an Adlerian named Cathy Sisson. Through this placement, I was introduced to a group of Adlerians who met over lunch to "staff cases" as only Adlerians would. There were presentations of early recollections, family constellations, and issues of belonging. The conversations were thoughtful and stimulating, and the formulations were useful in conceptualizing and working with people.

After graduating from BU, I was accepted into a doctoral program at Southern Illinois University at Carbondale. Current psychotherapies were presented and examined in the coursework, and while many of them borrowed from Adler's Individual Psychology, none of them presented a compelling alternative to the Adlerian identity I had formed in Frankfurt. As with many graduate schools, cognitive behavioral and other formulaic approaches were favored by the SIU faculty, so I was grateful for the training I had received in Frankfurt and leaned on it heavily during that time.

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For my predoctoral internship in psychology, I joined the U.S. Navy. Soon, the demands of being an officer and a clinician, requiring me to make high-stakes decisions in a stressful environment, made the luxury of case conceptualization and thoughtful formulations a distant memory. People quickly became "patients."

I was indoctrinated into a medical model for patient care, expected to memorize the categories and criteria presented in the 4th edition (and later 4th revised and 5th editions) of the *Diagnostic and Statistical Manual of Mental Disorders*. I became proficient at interviewing and dispositioning patients. I learned how to explain to patients that they were "mentally ill," and I learned how to write elaborate medical-sounding psychological evaluations that through the power of language could either save or terminate military careers. Somehow, perhaps as a result of the pace and stress, I swallowed the medical model whole and adapted to it. It was, in a way, mesmerizing. However, I never stopped thinking of people in Adlerian terms: their context, their sense of belonging and contributing, their goals and their striving to achieve them, and their agency.

For my second duty station, about five years into my military career, I was stationed at Roosevelt Roads, Puerto Rico. It was there, while practicing the medical model, as required, that I began to observe and understand the human toll of that model. After bearing witness to addiction to psychiatric medications and suicides, I began to extensively research the psychopharmacology that was so casually prescribed to patients as a result of the medical model. What I learned was that the poor (and sometimes disastrous) outcomes were actually predictable and well documented. I was shocked. Nowhere in my graduate or naval training had this been presented, even tacitly.

With dozens of warfighters returning to Puerto Rico from Iraq, traumatized by combat, grieving, and struggling to reintegrate, I knew that the medications were harmful and potentially deadly, and I, as a diagnostician and referrer to prescribers, was part of the problem. For a few years, I was operating under the assumption that overprescribing—and later, "any" prescribing—was the only culprit. A chance meeting with Allen Francis, chairman of the DSM-IV task force, at an International Society for Ethical Psychology and Psychiatry conference in 2014 woke me up to the scientific reality of the DSM (Frances, 2013) and the fact that DSM mental illnesses are not illness at all but rather ill-defined linguistic constructs. I was left without a paradigm.

It took many years to extricate myself from the necessity of adhering to the medical model, an adherence that remains an economic reality for practitioners even if they realize the harm, because they rely on third-party reimbursement. But needing an ethical and scientific paradigm set in motion what would become Warfighter Advance, a 501(c)3 dedicated

to nonmedical warfighter reintegration, and the ADVANCE 7-Day, its premier program. As Warfighter Advance developed, I drew on my Adlerian upbringing, my U.S. Navy core values, and my undergraduate training in theater to build a viable and life-saving alternative. Many of my military colleagues provided support, good ideas, hard work, and encouragement during this process.

Incorporating Individual Psychology

As a team of post-deployment warfighters ourselves, all of whom had experienced the adverse effects of the medical model, we developed a demonstrably effective program that is completely extricated from the medical model for warfighter reintegration. Adler's Individual Psychology was a natural fit for Warfighter Advance and the ADVANCE 7-Day program. Adlerian concepts enable warfighters to understand their predicaments, their longings for affiliation, their discouragement, and their responsibility. With these, the warfighter is able to replace illness-based language and the patient identity with a new and more fitting paradigm.

Humans exist within various, often overlapping contexts, and healing or personal growth therefore occurs in these contexts as well. Isolating and targeting a "symptom" does not result in healing, because it ignores context and social influences on human problems. In some cases, a context itself may need to heal. At Warfighter Advance, we are very deliberate about creating, re-creating, and honoring context (elaborated on in the next section). In other words, we (re)create the *Gemeinschaftsgefühl* that exists naturally in the military. For warfighters, the military context, which is part culture and part extended family, is rivaled only by actual family for importance in their lives. Warfighters need to understand how they relate to the layers of greater context (e.g., family, culture, society) and how they contribute to it, as well as how it contributes to them. For many warfighters, sudden removal from the military context (through injury, discharge, or retirement), and the demand that they identify as civilians or patients rather than professional warfighters, is demoralizing and discouraging. When their existing context is forcefully broken down, and they no longer understand or feel comfortable in the world, they become discouraged, and discouragement is at the root of every reintegration problem that has been operationally defined as mental illness and relegated to the realm of psychiatry.

At Warfighter Advance, we understand that all behavior is goal oriented and that failure to achieve goals may also cause discouragement. An example of discouragement we often see is the warfighter trying to achieve symptom "remission" via means that are more likely to increase or add to their symptoms (e.g., medical model treatments, drugs, electroconvulsive

shock treatments or ECT) and when they do not get better, they are labeled "treatment failures," or when they do not accept the heavy-handed treatments, they are labeled "noncompliant." Failure and noncompliance are chilling concepts within the military mind-set. At Warfighter Advance, we educate about what the medical model calls our symptoms (sleeplessness, nightmares, hypervigilance, a need for order and control, to name but a few) and help the warfighter to understand them as a warfighter's adaptations and as the valuable warning system that they are. Our expectation is that warfighters pay attention to the warning system, understand the information that is being conveyed, and act accordingly. We educate and allow each warfighter to develop his or her own smorgasbord of options for responding to the signs of chronic stress or trauma. We emphasize the infinite variety of options, preferences, and accessibility issues and encourage a thoughtful process from stated goal to selected behavior.

Basic to any team endeavor, war fighting included, is the fact that misalignment of goals causes failure to achieve goals. Many treatment programs, and even many nonprofit veterans programs, preconceive what successful post-deployment outcomes should look like, and this may not align with the goals or the contextual realities of the individual, naturally resulting in resistance. At Warfighter Advance, we understand that it is not our place to determine the goals (e.g., what constitutes a valid goal, what healing looks like) for any individual warfighter. While we have general expected outcomes, we believe that it is arrogant to define success for our warfighters. We have what we call the $N = 1$ concept: every warfighter is the subject and the control in their own life experiment. To put it another way, "If you've seen one warfighter, you've seen one warfighter." Therefore, generalizations or one-size-fits-all approaches are doomed to fail. The individual is the best judge of what is right for him or her. It is the program's job to assist individual participants in achieving the goals they have set for themselves and in determining what healing and success looks like for them, as well as how they want to relate to their contexts.

Warfighters, like all human beings, are growth oriented and benefit when they are contributing to the growth and well-being of others. For this reason, growth and community cannot end after seven days. We provide a robust alumni association (not "aftercare," which is a medical concept) and many ways for warfighters to support one another, to support Warfighter Advance, to become program mentors, or to contribute as their individual talents indicate. In addition, we strongly encourage alumni to engage with their communities when they return home. We have alumni contributing as firefighters, police officers, emergency medical technicians, elected public officials, and all types of volunteers. Additionally, most of our graduates, with their "greatest weapon back"—their brains are clear of neurotoxins,

and their minds are clear of false paradigms—return to school, return to work, or advance in their careers. We celebrate these accomplishments as a community.

Finally, at Warfighter Advance, there is no doctor–patient hierarchy. We, the staff, are just like them. We wear the same uniform. We do not employ mental health professionals to treat warfighters. We employ post-deployment mentors and volunteers who facilitate the warfighter's journey of reintegration through the passing of critical knowledge, normalization and support, and the development of a new and supportive layer of context. We use the metaphor, often repeated on social media, that the warfighter starts out in a deep hole. Many pass the hole and hear the plea for help: the attorney throws down his business card, the chaplain offers a prayer, the psychiatrist a prescription. We, however, jump into the hole with the warfighter, who is quite alarmed, but we explain that we know the way out. In military terms, we have the "field manual," the instructions, the guidance, and we are there simply to pass on what we have been fortunate to learn.

Area of Professional Contribution: Program Overview

Warfighter Advance hosts the ADVANCE 7-Day, an in-person training program located in rural Maryland, throughout the year and welcomes 20 new participants to each evolution. We welcome warfighters who are struggling with what is typically referred to as post-traumatic stress disorder, or PTSD, although no formal diagnosis is required. Other post-deployment "mental illness" labels or problems (anxiety, depression, adjustment disorder, anger, mTBI, military sexual trauma, psychosis, to name a few) are also considered. All referrals are self-referrals. No paperwork documenting mental illness is required or accepted. Warfighter Advance welcomes warfighters who have been treated by traditional psychiatric methods, as well as warfighters who have been struggling on their own to reintegrate or deal with their operational traumas. Warfighter Advance welcomes warfighters who are discouraged because nothing that has been offered to them has been helpful, as well as those who have self-medication or substance abuse problems.

The ADVANCE 7-Day is, at its core, a seven-day program that uses a variety of means to change the trajectory of the warfighter's post-deployment life, so that rather than an existence characterized by an endless cycle of mental illness diagnoses, medications, medical appointments and disappointments, the warfighter has a life characterized by pride, productivity, healthy relationships, continued service, and advocacy for the same outcomes for their fellow service members.

The 7-Day achieves this goal through a carefully orchestrated week of experiences. Every moment of the week-long experience is designed and timed for maximum empowerment, growth, and change. Warfighters are told, from the first contact, that they will be among peers, treated as adults, treated with respect, and trusted to manage themselves. They are asked to entrust us with a week of their time and to arrive with high expectations for themselves and for the program. Medical or mental illness terminology is never used by the staff. We refer to ourselves as hosting warfighters or participants. To re-create a familiar context, a uniform (service branch–specific polo and fleece, embroidered with name and rank) is issued to each participant. Staff members dress in exactly the same way so that no distinction or hierarchy is created. All questions regarding the program and its philosophy are answered openly and with full disclosure, and scholarly references are also made available to participants.

Upon arrival, participants, who are generally anxious, are met by alumni of the program who assist them in finding their room assignments and settling in. There is instant rapport and friendly and familiar military banter. They are welcomed in the evening with a gala-style opening dinner attended by new participants, alumni, fellow veteran supporters, community leaders, donors, and well-wishers. The warm and dignified welcome and dinner—opened with a traditional "missing man" table ceremony—bears no resemblance to any hospitalization or treatment experience that the warfighter has previously encountered to address their deployment traumas or reintegration difficulties and alerts them immediately that this is not the medicalized treatment they have come to expect. Warfighters are provided with their own books and scholarly articles to assist them in evaluating the content of the lectures they receive, as well as necessary equipment to continue many of the wellness activities they learn. There is never any cost for transportation, room, board, tuition, or materials to the warfighter, whether active duty, reservist, veteran, or retired. By week's end, warfighters learn that their outcome is their own responsibility; however, they are no longer bewildered as to how to achieve their desired outcome. They have the knowledge, references, tools, relationships, and support necessary to move forward as warfighters (past or present) rather than patients.

Core Tenets of Warfighter Advance

Warfighter Advance is committed to five core tenets relative to scientific integrity, knowledge of the state of the art, fully informed consent, and individual outcomes. Much of what is typically presented to our warfighters, and to the public at large, as patient education, is bad intelligence (the same

bad intelligence I received in my medical model training) and precludes them from achieving their goal or desired outcome. When warfighters leave the ADVANCE 7-Day, they are fully informed of the science supporting our core tenets.

With the first tenet, Warfighter Advance acknowledges that there is a direct cause-and-effect relationship, well documented in the scientific literature, between the rates of post-deployment suffering and suicide and the use of psychopharmaceuticals to treat a variety of psychiatric labels. To be clear, it is the treatment, and not an underlying clinical or medical condition, that is causing suffering and unprecedented rates of suicide (Admin., Council for Evidence-Based Psychiatry, 2019; Food and Drug Administration, FDA, 2004). In response to this scientific and data-driven conclusion, the FDA requires a black-box warning, the highest level of warning, indicating that a drug is known to cause death in patients treated with it.

Second, a careful review of the literature and analysis of scientific merit has led us (and many other scientists, including those at the National Institute of Mental Health) to conclude that the categories of mental disorder as defined by the DSM-5 are scientifically invalid and diagnostically unreliable (Greenberg, 2013; Jayson, 2013; Kutchins & Kirk, 1997), and therefore, it is unethical for us to use them or to convince warfighters that they "have" them. Warfighter Advance rejects all mental illness labels for warfighters and for their reintegration experiences.

In a powerful way, warfighters come to understand that the DSM-5 classification system has no practical meaning for their trauma and reintegration journey, and indeed may be unnecessarily harmful, as it weights them down with mental illness labels and implications.

Third, after a careful analysis of the science, the available literature, and the risk–benefit ratio, Warfighter Advance rejects the use or usefulness of psychiatric medications and ECT in the process of warfighter reintegration or trauma response. We also acknowledge the devastating implications and harmfulness of these treatments for traumatized individuals in general (Breggin & Cohen, 2007; Jackson, 2005, 2009; Kirsch, 2010; Read et al., 2019). Many of the treatments they have been prescribed carry the potential for great harm or even death and are being used to treat a symptom that, while distressing, is physically harmless. Warfighters are introduced to sources of carefully vetted information for medication tapering and encouraged to share those with their prescriber.

Fourth, warfighters are educated on the parameters of fully informed consent, which, for the reader's review, include, at a minimum, being informed of the risks and benefits of any proposed treatment or intervention; being informed of the alternative treatments or interventions and their risks and benefits; and being allowed to make the treatment decision without

coercion. Most Warfighter Advance participants were not fully informed before accepting potentially harmful treatments, and many were, in fact, coerced. Many suffer from devastating injuries.

Finally, the fifth tenet states that a warfighter must be allowed to determine his or her own successful outcome. Again, it appears to us as arrogant that we should determine for another person what a good outcome looks like, or that we should determine that another person's suffering, bereavement, response to trauma, or reintegration is "abnormal" or "pathological."

References

Admin. (2019, June 25). *New study: Antidepressants significantly raise the risk of suicide in the treatment of depression for adults*. Council for Evidenced-Based Psychiatry. http://cepuk.org/2019/06/25/new-study-antidepressants-significantly-raise-risk-suicide-treatment-depression-adults/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Breggin, P. R., & Cohen, D. (2007). *Your drug may be your problem: How and why to stop taking psychiatric drugs*. DaCapo Press.

Food and Drug Administration. (2004). *Revisions to product labeling*. https://www.fda.gov/media/77404/download

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma, and the medicalization of ordinary life*. William Morrow.

Greenberg, G. (2013). *The book of woe: The DSM and the unmaking of psychiatry*. Penguin.

Jackson, G. E. (2005). *Rethinking psychiatric drugs: A guide for informed consent*. AuthorHouse.

Jackson, G. E. (2009). *Drug induced dementia: A perfect crime*. AuthorHouse.

Jayson, S. (2013, May 14). NIH official clarifies criticism of diagnostic manual. *USA Today*. http://www.usatoday.com/story/news/nation/2013/05/14/dsm-5-mental-health-diagnosis/2159345/

Kirsch, I. (2010). *The emperor's new drugs: Exploding the antidepressant myth*. New Basic Books.

Kutchins, H., & Kirk, S. A. (1997). *Making us crazy: DSM the psychiatric bible and the creation of mental disorders*. Free Press.

Read, J., Kirsch, I., & McGrath, L. (2019). Electroconvulsive therapy for depression: A review of the quality of ECT vs. sham ECT trials and meta-analysis. *Ethical Human Psychology and Psychiatry, 21*(2), 64–103.

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