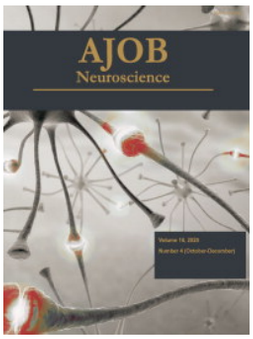

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TARGET ARTICLE: SOCIAL REINTEGRATION

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Reintegration Beyond the Medical Model: The Case of Warfighter Advance

Mary Neal Vieten

Warfighter Advance

ABSTRACT

All military members are "enhanced" relative to civilians counterparts roughly in three levels (original to author). Regardless of the level of enhancement, learning and cumulative experience permanently change in the individual warfighter creating specific challenges when faced with reintegration to garrison life, civilian communities, and their families. At this point, warfighters are encouraged to seek medical assistance, an approach that does not come without a high toll on the individual. Warfighter Advance was developed by a cohort of experienced warfighters who found the psychiatric paradigm of reintegration to be inadequate, reductionistic and doomed to fail on the individual level, with some aspects flatly unethical. Warfighter Advance is not an alternative treatment, but an alternative to treatment full stop. Warfighter Advance is an alternative to the medical model, and a normative blueprint for how the Department of Defense, the Department of Veterans Affairs, and others should view and approach warfighter reintegration.

KEYWORDS

DoD; enhanced soldier; ethical treatment; medical model; military members; psychopharmacology; reintegration; suicide; super soldier; VA; veteran; warfighter

The "enhancement" of military members begins immediately upon enlistment or commissioning and continues systematically as the member is molded into the warfighter that is required. It may be helpful to divide the enhancement of warfighters into levels (original to author), as there are a wide variety of roles in the military. At the lowest and universal level, military members receive advanced physical conditioning, training in advanced critical thinking skills, and additionally are molded by a deliberate process to adopt a new and cohesive identity consistent with the objectives of national defense. They are no longer civilians, a fact that by itself will cause some struggle at the point of reintegration. At the next level, military members are trained in the tools, weapons, and machinery of their military occupational specialty. They may be trained in anything from the obvious combat and flight roles, to defuzing bombs, to mortuary duties, to cooking, to driving or repairing trucks, to playing in a military band. Their specialty and related operational experiences will draw them further into community with other warfighters, and increase the distance between them and the civilian population. Finally, based on specific mission requirements, individual soldiers, airmen, sailors, or marines may be elevated to a role of individual advantage or dominance through drugs, medical procedures such as SGB or implants, exoskeletons, and advanced tools and weapons.

Up to this point, it is clear that what happens to each warfighter is a process of learning, adaptation, and sometimes interference in biological processes. This is not only obvious, it is also intentional in order that the defense mission is accomplished and the fewest lives possible are lost. In this process, the individual warfighter may also be psychologically overwhelmed by the realities of the job they have been tasked to do (some like to use the word "traumatized"). They may also be so dramatically altered by the things s/he has learned or the ways in which s/he has adapted, that he or she can no longer function well (as defined by civilians and or psychiatry) in "normal" settings. Both of these scenarios are *normal and predicable* responses to military life, despite their being uncomfortable and undesirable.

If these outcomes are normal and predictable, and the result of adaptation, learning, and experience, and in no way indications of the onset of illness or disease, our institutional response to these outcomes becomes illogical and disconnected at best. However, the road from warfighter to psychiatric patient has been normalized and made efficient, without any scientific or medical justification, and much to the detriment of our warfighters' post-military lives. Over

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the course of the wars in Iraq and Afghanistan, warfighters have been systematically trained to "ask your doctor," if they have any uncomfortable lingering feelings about their military experiences. If a warfighter has somehow made it to the point of being discharged from active duty and has not reported his or her inevitable emotions and changes in behavior to a doctor, the discharge physical has been reinvented and married up with the Veterans Administration compensations and pensions process, and a the instruments of screening have become a fine net, so that almost any warfighter will be detected and identified as having a mental illness. Complicating this, responding with full disclosure of ones feelings and behaviors has been incentivized by the potential for monetary compensation. Many warfighters are emotionally uncomfortable or suffering tremendously, and the promise of quick pharmaceutical and financial relief is enticing, while the scientistic rhetoric that has become part of the military vernacular makes it all seem logical.

The impact of military service and war on the individual warfighter has been acknowledged in various ways by cultures throughout history, but only recently, with the inclusion of the construct of Post-traumatic Stress Disorder (PTSD) in the Diagnostic and Statistics Manual of Psychiatric Disorders – III (DSM-III) in 1973, have we seen this impact transformed, through negotiation and language (Kutchins and Kirk 1997), into a mental illness that falls into the realm of psychiatry and psychiatric treatments. As with all "mental disorder," PTSD is ill defined, and the sum of it's own definition (criteria). There are literally thousands of ways to recombine the current diagnostic criteria and still reach an "diagnosis" of PTSD. No one who has served in the military will dispute the suffering and anguish that may result as we accomplish our missions, nor will they pretend that the reintegration to civilian life is an easy transition. However, medical model labeling and "treatment" of this suffering, along with the problems that accompany the learning and adaptations that make reintegration difficult, makes little sense, and for many warfighters it adds considerably to their suffering.

Warfighter Advance was developed from the ground up by post deployment veterans with a wide variety of military occupational specialities to offer an alternative to treatment for warfighters looking to assuage the normal and predicable outcomes of military service and participation in war. It is worth underscoring, Warfighter Advance is not an alternative treatment. It is an alternative to treatment. Convincing warfighters that they have a "mental illness" which is chronic and progressive and will require some level of psychiatric intervention for the rest of their lives is/was found to be demoralizing and to have profound negative impacts on the warfighter. The "treatments" proposed for the "mental illness" are frequently heavy handed, even dangerous, unpredictable, and reductionistic (Jackson 2005, 2009; Kirsch 2010; Read, Kirsch, and McGrath 2019). Warfighters may be left injured, unable to work, unable to function in family or community settings and chronically suicidal. To be clear, the treatments, and not any underlying "mental disorder," have led to these outcomes (Admin 2019). Many of the "treatments" can be argued to be far outside of the boundaries of medical ethics, in particular the mandate to do no harm (Vieten 2022).

HOW WE ACHIEVE OUR OUTCOMES

The main product offered by Warfighter Advance is the "Advance 7-Day." It is a residential training model that has been honed during the past ten years for maximum impact in a short period of time. The training curriculum has been designed and developed around five core tenets (Vieten 2022) that articulate our scientific integrity, our commitment to knowledge of the scientific state of the art, to fully informed consent, and to respect for individual warfighters. Ongoing outcome research into our methods, as well as the core tenants, can be reviewed on our website.

Participation in the Advance 7-Day is voluntary and all participation is through self-referral. Participants in the Advance 7-Day program, many of whom have been through prolonged psychiatric treatment prior to attending, and many of whom are heavily and visibly medicated, are surprised when no medical referral is required, no medical-seeming documentation is required or collected, and no opportunity is missed to provide them with a dignified experience. The week opens with a gala dinner, well attended by alumni, local officials, financial supporters, and others, with the intention of setting a tone that breaks free of the medical model. There is great detail placed on military traditions and on honoring their service, as well as the dignity of each person who has served. Alumni are enthusiastic about returning to meet the newest participants and to encourage them with their own stories. Many alumni drop in throughout the week to reiterate their support, and many become mentors or volunteers in other capacities which serves the program, but also enhances that individual alumni's outcome. Each day includes didactic training, experiential learning, exercise, nutrition,

social support and speakers. As part of our ethical commitment, every aspect of the programming is offered with full transparency with regard to why it is part of the program and offered in the way it is offered.

INFORMED CONSENT

Education begins with a complete remediation of the informed consent that each and every warfighter is or was entitled to before receiving psychiatric or psychological intervention. To remind the reader, informed consent requires at a minimum that the patient be informed of the potential risks as well as benefits, and the alternatives to the proposed "treatment" (American Medical Association, 2017). It also requires that the patient be allowed to chose among the proposed treatments and alternatives without coercion. The information passed in this lecture is almost universally new to the participants, despite informed consent being a fundamental part of the ethics codes of all practitioners, as well as the Patients Rights documents of the Department of Defense (Instruction 6000.14) and the Veterans Administration. It is our belief that a truly ethical encounter, and truly informed consent, requires full disclosure of underpinnings of the mental health industry, this disclosure occurring prior to the patient making any type of disclosure to the provider. Therefore, fundamental to the didactic is a review of the history of psychiatry and the history of the Diagnostic and Statistics Manual, as well as a thorough breakdown of the process by which American Psychiatric Association committees examine common human experiences like sadness, grief, or fear, as well as how they interpret human variation or behavior, and then determine that those things have gone beyond what should be considered normal and should be defined as mental illness (Greenberg 2013). Participants come to understand that the diagnostic categories are loosely defined constructs and not discrete, objectively identifiable medical illnesses, even according to NIMH officials (Jayson, 2013). Most participants arrive under the misapprehension that they have an actual brain dysfunction, abnormality, or illness and that strict compliance to treatment would cure that illness and lead them back to their post-deployment mental state. Learning that this is not in fact the case, opens up the warfighter to new possibilities. Additionally, the social consequences of receiving a mental illness label, which can subject any labeled person, and has subjected many of our participants, to forced hospitalization, forced drugging, loss of specific rights, loss of security clearances, and loss of FAA licenses to name a few are presented. We do not consider these consequences as a natural and unfortunate result of having a mental illness, because mental illness is (as discussed above) a euphemism and a value-driven linguistic construct. More subtle consequences in the behavior and assumptions of friends, relatives, or in the public are reviewed. The warfighter is left to determine for themselves if this is a valid lens through which to view their reintegration or suffering.

Naturally, the education on informed consent also includes an in-depth review of the research on the risks and benefits of current treatment modalities and methods. This includes current psychotherapies, technology based interventions, drugs, procedures, and psycho-surgeries. There is no attempt to influence the participants regarding their eventual consent to any of these treatments. Our focus in on remediating the informed consent for the purpose of empowering the warfighter to make the best decision for themselves. Because presenting the alternatives, we believe, includes presenting that which is not medically based or under the purview of a licensed provider, we also present the science and efficacy research on a wide variety of alternatives to treatment. Naturally, we can not be exhaustive during a one week course, however, our participants graduate with the tools they need to evaluate alternatives for themselves.

CRITICAL THINKING

Clearly, critical thinking is encouraged and emphasized in the informed consent presentations, but critical thinking is encouraged and fostered throughout the program. Military members know that knowledge is power and that good information can make or break a mission. We encourage them to apply this concept to their lives and their relationship with their medical providers. We provide (at no cost) a wide variety of books and scholarly articles to the participants. We encourage them to research rather than believe. We help them to identify signs that "research" may be corrupted by a conflict of interest, and we help them to understand how research can be designed to produce a researchers desired outcome. We provide them with basic knowledge of how screening instruments can be designed to be almost zodiac-like, and we encourage them to consider who this will benefit. We ensure that they understand that these screening tools are always optional. We explore drug advertising and point of care deception used to increase "patient compliance." Again, we are emphatic with our participants that our goal is not to produce our own type of "patient compliance," but rather to demonstrate that it is possible to apply the critical thinking skills one already possesses, such as the ability to evaluate a risk benefit ratio, to one's decisions about reintegration. Indeed, many of the interventions that are proposed to our warfighters include a risk of injury or death, when the problem being targeted, while uncomfortable or even emotionally devastating, is also normal and self limiting (Francis 2103).

PHILOSOPHICAL AND INTELLECTUAL CHALLENGE

Throughout the week, we highlight the philosophical debate on the problem of consciousness, the difference between mind and brain, the difference between medical and medical-model, and role of morality, values, language and culture in medicine and psychiatry (Ruby 2020). Rather than try to minimize or ignore these issues, we dive into the DSM text on language, culture, and religion (American Psychiatric Association 2013). We discuss the obvious issues with these playing a part in diagnostic conclusions. It is noted that in physical medicine, these do not play a role. Scientific reliability and validity of DSM constructs is

explored. Intellectual debate on these topics is encouraged. We encourage debate on the arrogance of a system in which another human being is allowed to pass judgment on your emotions, suffering, behavior, or variations, and create a "treatment plan" to make you more like what they have determined to be normal (Caplan 1995). Conversely, we discuss the process by which a warfighter is brought to that encounter prepared to accept it (Lacasse and Leo 2005). Again, the goal is to demonstrate to the warfighter that there is a debate to be had, and that they are capable of participating in the debate, not to steer them to a particular conclusion.

OPPORTUNITIES FOR EXPERIENCE

Throughout the week warfighters are given the opportunity to explore and experience various means of improving their daily lives, their fitness, their emotional experience, and their overall reintegration. Some of these opportunities, such as increased social support and regular nutritional meals, are built into the program, and other opportunities are by choice. All of the opportunities are vetted and included because they are extremely low to non-risk, and carry a potential for extremely good outcomes. We attend to the spiritual needs of participants and offer 12-step meetings as part of the choices available to participants. Through mentorship and through speakers who share their reintegration journeys, experience is passed on, while the wide variety of right answers is underscored. Participants and mentors are encouraged to create a lived "pharmacy" of tools and support based on their knowledge and experience of what has worked for them.

Individual Outcomes

At Warfighter Advance we are intentionally resistant to faceless metrics and to the poo-pooing of anecdotal data. I the words of Huffington Post investigative journalist Art Levine, "at some point, enough anecdotes are evidence" (personal communication, 2015). Participants are, therefore, encouraged to abandon a one-size-fits-all solution in favor of a completely unique solution that fits their lives, and their desired outcomes, culture, and context. Part of every warfighter's individual identity is that they are a warfighter. Trying to become a civilian after years of systematic learning, adaptation and experience is doomed to lead to discouragement and failure (and messages to "ask your doctor"). Learning to be a warfighter, living peacefully among civilians, is an attainable goal. The 7-Day begins a process by which the warfighter evaluates his or her reintegration options. S/he gathers information and tools that will work for them, rejects what does not work with their lifestyle, values, or other individual needs, and now feels confident in doing so. The warfighter is encouraged to abandon the "professional patient" mentality that comes with mental illness models, and re-embrace the power and the responsibility that comes with being a warfighter, whether past or present. Reductionism is replaced with holism, a true state of reintegration.

It is worth noting that, as we are not a treatment program, no after-care model applies. Participants in our training program graduate on the last day and become members of our alumni association, which provides life-long support and cohesion through a network of alumni volunteers and modern communication platforms. As mentioned previously, many alumni choose to participate in the program after graduation in a variety of ways including volunteering, serving in various roles during events, or becoming staff or board members.

Warfighter Advance has made a deliberate decision to remain small, agile, and responsive to individual warfighter needs. It is our mission to provide a method by which any and every warfighter can be successfully reintegrated without reference to the medical model. While it is not our mission to franchise or wade into public debate, we do believe that the Warfighter Advance reintegration model and philosophy should become a normative blueprint for the Department of Defense, the Department of Veterans affairs, and other organizations committed to humane warfighter reintegration. Additionally, this model has clear applicability to other high risk occupations such as aviation and public safety. Personnel from these fields frequently complete the Advance 7-Day training with stunning individual results.

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