# When the System Fails: A Veteran's Journey from Crisis to Advocacy

**A Personal Essay by Justin Vukelic**
***For Concerned Veterans for America*

## Introduction: The Promise and the Reality

When I first walked into the VA system seven years ago, I carried the same trust that most veterans bring to their healthcare: the belief that those who served would be served in return. I was emerging from the darkest period of my life---recently sober, recently divorced, and recently homeless. The New England Center for Homeless Veterans became my bridge to what I hoped would be healing.

I expected competency. Not perfection, but basic professional competency from a system designed to care for those who had cared for their country. What I encountered instead was something that has taken me years to fully understand: a system so insulated from accountability that it had lost touch with its fundamental mission.

This is not the story of a perfect patient meeting an imperfect system. I came to the VA with complex trauma, a misunderstood diagnosis, and the kind of assertiveness that some providers find challenging. But this is the story of what happens when legitimate advocacy for proper care is systematically reframed as pathology, when constitutional rights are treated as symptoms, and when the very act of seeking accountability becomes grounds for retaliation.

More importantly, it's a story about what we can do differently.

## The Foundation: False Certainty and Diagnostic Traps

The problems began with what I now recognize as epistemic overconfidence---the dangerous certainty that pervades much of mental healthcare. When I was transferred from a competent civilian psychiatrist to VA care, a bipolar diagnosis was "calcified" into my record in a way that wasn't helpful going forward. This single diagnostic decision created a cascade of treatment decisions that would dominate my care for years.

Dr. Arnold, my civilian provider, had maintained appropriate diagnostic humility. He understood that my sudden mental health crisis didn't fit neatly into bipolar or BPD criteria, despite the latter being the more likely explanation. He treated me with what I now understand was scaffolding---temporary medication support while we figured out what was actually happening. The VA system, however, operates on a different model: diagnostic certainty followed by algorithmic treatment protocols.

This false certainty is dangerous because it creates what I call diagnostic gravity wells---intellectual traps where all new evidence is interpreted to confirm pre-existing beliefs rather than challenge them. It's the same psychological mechanism that keeps people trapped in conspiracy theories, and it's endemic in institutional medicine. When you've committed to a diagnosis and treatment plan, acknowledging error requires not just intellectual humility but institutional vulnerability that many systems simply cannot tolerate.

The cost of this false certainty fell on me as a patient. Years of inappropriate medications, treatment approaches that didn't address my actual condition, and most damagingly, a therapeutic relationship built on the assumption that my reports of medication side effects and treatment concerns were symptoms rather than valid feedback.

# The Accountability Void: Where Good Faith Goes to Die

The deeper I got into the VA system, the more apparent it became that accountability mechanisms existed primarily as theater. Patient advocacy, quality assurance, and grievance procedures were elaborate processes designed to create the appearance of responsiveness while systematically insulating providers from consequences.

Ms. Thompson, the director of patient advocacy at Cincinnati VA, exemplifies this dysfunction. When I filed complaints about Dr. Stevens's care---documented concerns about medication abuse, boundary violations, and therapeutic coercion---they were either misdirected, lost, or dismissed without investigation. This isn't incompetence; it's institutional protection masquerading as process.

The result is predictable: providers who harm patients face no consequences, so they continue harming patients. Dr. Stevens's pattern of creating dependency relationships, dismissing patient concerns, and using his authority to override patient autonomy wasn't unique to our therapeutic relationship. Other veterans had complained. Those complaints were suppressed. The system that was supposed to protect me instead enabled my abuse by ensuring that patterns of harm never came to light.

This accountability void creates a toxic dynamic where providers who should be helping patients heal instead become invested in protecting themselves from scrutiny. When I began documenting concerning behaviors, requesting second opinions, and asking pointed questions about treatment decisions, I wasn't being difficult---I was being a competent consumer of healthcare services. But in a system without real accountability, competent consumers become threats.

# Constitutional Rights Don't End at the Hospital Door

The most surreal aspect of my VA experience was discovering that constitutional rights apparently become optional in healthcare settings. When I posted a flyer explaining Section 508 disability rights---my right to use assistive technology including AI tools that helped me communicate more effectively with providers---it was removed by Dr. Martinez with the explanation that veteran protection messaging was "hateful content."

This wasn't a policy disagreement; it was prior restraint censorship of educational material about federal law. When I documented this and asked for an explanation, the response was retaliation: removal from programs, disrupted care, and what can only be described as institutional gaslighting.

The irony is profound: veterans who took an oath to defend the Constitution find their constitutional rights suspended the moment they seek healthcare from the agency meant to honor their service. Freedom of speech, due process, equal protection---these become negotiable concepts when they conflict with institutional comfort.

Dr. Martinez's behavior exemplifies how constitutional violations can be hidden behind therapeutic language. When I objected to censorship of veterans' rights information, this was reframed as a mental health symptom. When I requested accountability for provider misconduct, this became evidence of "splitting" or "manipulation." The very act of advocating for constitutional compliance was pathologized.

This is dangerous beyond my individual case. When the VA can reframe constitutional rights as symptoms, it can justify any level of institutional abuse by claiming therapeutic necessity. Veterans become not citizens with rights but patients with pathologies, and any assertion of dignity or autonomy becomes grounds for increased control.

# The DBRS: Weaponizing Process Against Patients

The Disruptive Behavior Reporting System represents institutional dysfunction at its most insidious. Ostensibly designed to protect staff from genuinely threatening patients, it has become a tool for suppressing legitimate advocacy and feedback.

Over the course of my care, eight DBRS reports were filed against me. Not one cited an actual threat, aggressive behavior, or genuine safety concern. Instead, they documented the sin of sending "critical emails"---correspondence that was direct, factually accurate, and focused on documented provider misconduct. The reports themselves are kept secret from the veteran, creating a Kafkaesque situation where you know you're being accused but not of what.

The system's genius is its chilling effect. Once you know that any communication might trigger another report, self-censorship becomes inevitable. You stop asking pointed questions, stop requesting accountability, stop advocating for appropriate care. The system achieves its goal: veteran compliance through intimidation.

The practical consequences were severe. Three providers accompanied me to my cardiology appointment---a humiliating display that announced to everyone present that I was flagged as dangerous. I stopped seeking certain types of care rather than endure that humiliation. Veterans who served their country with honor shouldn't have to choose between dignity and medical care.

Most perversely, the DBRS operated without any meaningful feedback mechanism. When I asked what specific behaviors were problematic, I was told to file a Freedom of Information Act request---as if accessing basic information about accusations against me was equivalent to requesting classified documents. The message was clear: your role is to comply, not understand.

# When Therapy Becomes Persecution

The destruction of my therapeutic relationships reveals how institutional dysfunction cascades through individual interactions. Ms. Wilson had volunteered to submit my documented concerns about Dr. Stevens's care---a moment that felt like validation after months of dismissal. When I later asked about the status of this report, she laughed in my face and said, "Nobody's ever going to get back to me about that report."

This wasn't a miscommunication or scheduling conflict. It was deliberate cruelty disguised as therapeutic intervention. She had offered hope, then weaponized it. For someone with borderline personality disorder, this type of promise-breaking and invalidation is specifically triggering---which she, as a licensed therapist, would have known.

The timing wasn't coincidental. This occurred immediately after my clash with Dr. Martinez over the censored flyer, suggesting coordination between providers to maximize my distress. When I walked out of that session---a reasonable response to therapeutic abuse---this was documented as further evidence of my pathology.

The loss of DBT therapy was particularly devastating. I had maintained near-perfect attendance, contributed meaningfully to group discussions, and was making genuine progress in developing emotional regulation skills. DBT is the gold-standard treatment for borderline personality disorder---therapy specifically designed for my diagnosis. Its removal wasn't clinical judgment; it was punishment.

The broader pattern is clear: every time I advocated for appropriate care or accountability, therapeutic relationships were disrupted. Not because of clinical concerns, but because institutional protection required my isolation. Providers who might have supported me were warned away, creating a narrative of patient pathology to justify system dysfunction.

# Islands of Competence in a Sea of Dysfunction

Not every provider participated in this dysfunction, and their examples prove that the problems aren't inevitable. Dr. Jalynn Barnett, Jenn Moore, and Jessica Vandergriff demonstrated what competent, ethical care looks like even within a broken system.

Dr. Barnett approached our relationship with clinical objectivity rather than institutional defensiveness. She evaluated my medication needs based on my actual symptoms rather than documentary assumptions, supported my gradual medication reduction when clinically appropriate, and maintained professional boundaries without therapeutic coldness. Most importantly, she treated my reports as data rather than symptoms.

Our relationship proves that I'm not inherently difficult or impossible to treat. When approached with basic clinical competency and ethical integrity, I respond well to treatment and maintain appropriate therapeutic boundaries. The difference isn't my behavior---it's the provider's approach.

Jenn Moore exemplified what mental health nursing should look like. She worked harder than anyone else in the TRAC program, treated veterans with genuine respect, and focused on actual therapeutic goals rather than system compliance. When things weren't working correctly, she adapted her approach rather than demanding veteran compliance with dysfunction.

Jessica Vandergriff, despite being an intern, demonstrated the diagnostic competency that eluded senior providers. She listened to my self-reports, reviewed my history objectively, and corrected years of diagnostic error with appropriate clinical humility. She showed me what validation-first, trauma-informed care actually looks like rather than the hollow buzzwords that populate training materials.

These providers didn't perform miracles. They simply did their jobs competently and ethically. Their success highlights how much of my negative experience resulted from system dysfunction rather than patient pathology.

# The Academic Path: Understanding to Change

My pursuit of education in psychology and public health grows directly from my VA experience. Not out of bitterness, but from recognition that the problems I encountered are systemic, predictable, and ultimately solvable.

The field of mental health is caught between competing paradigms without acknowledging the tension. We operate on models that assume individual pathology while ignoring systems dynamics. We medicate symptoms without addressing causes. We pathologize reasonable responses to unreasonable situations. Most fundamentally, we avoid the accountability mechanisms that every other field accepts as necessary for improvement.

My educational goals focus on bridging these gaps. Cognitive psychology offers frameworks for understanding how diagnostic certainty traps develop and how they can be prevented. Public health provides population-level perspectives on mental health outcomes and system effectiveness. Research methodology offers tools for measuring what actually works rather than what we assume works.

The goal isn't to destroy the mental health system but to help it mature. Every other field---from aviation to medicine to engineering---has learned that safety requires systematic feedback mechanisms, error acknowledgment, and continuous improvement. Mental health remains trapped in models of infallibility that guarantee continued failure.

Veterans deserve better than this false choice between accepting abuse and being labeled difficult. The field deserves better than defensive insularity that prevents real improvement. And society deserves mental health systems that actually improve mental health rather than just managing symptoms.

# The Path Forward: Accountability and Bridge Building

This essay isn't an attack on the VA or individual providers---it's a call for the institutional maturity that veterans deserve. The providers who harmed me aren't monsters; they're professionals operating in a system that incentivizes the wrong behaviors and protects them from consequences.

Real reform requires several fundamental changes:

**Meaningful Oversight**: Patient advocacy must become genuinely independent, with authority to investigate complaints and impose consequences. The current system of institutional self-investigation guarantees continued dysfunction.

**Constitutional Compliance**: Veterans' rights don't become optional in healthcare settings. First Amendment protections, due process requirements, and equal protection guarantees must be actively preserved rather than therapeutically suspended.

**Feedback Integration**: The VA must develop actual mechanisms for incorporating patient feedback rather than defensive processes designed to deflect criticism. This includes making DBRS reports transparent to patients and creating appeals processes for disputed characterizations.

**Diagnostic Humility**: Providers must be trained to hold diagnoses provisionally rather than defensively. When patient reports consistently contradict treatment assumptions, the assumptions should be questioned rather than the patient pathologized.

**Professional Development**: Continuing education should include modules on power dynamics, constitutional rights in healthcare settings, and ethical use of therapeutic authority. Providers need skills for receiving criticism and acknowledging error without defensive retaliation.

The goal isn't perfection---it's progress. Systems that can acknowledge problems can solve problems. Systems that defensively deny problems are doomed to perpetuate them.

# Why This Matters Beyond My Case

My experience matters not because I'm unique, but because I'm not. Veterans across the country encounter similar patterns of institutional defensiveness, accountability avoidance, and rights violations. The difference is that my legal training, educational background, and communication skills gave me tools that other veterans lack.

The veteran who can't articulate why their medication makes them feel worse gets increased doses rather than decreased ones. The veteran who struggles to explain constitutional concerns gets pathologized rather than heard. The veteran who lacks social capital to navigate byzantine complaint processes simply gives up and walks away.

How many veterans have we lost to suicide not because their conditions were untreatable, but because the system responding to their distress was indistinguishable from the abuse that caused it? How many have turned to drugs or alcohol not because of moral failure, but because self-medication was the only relief available when legitimate medical care became a source of additional trauma?

The human cost of institutional dysfunction extends far beyond individual cases. When the VA fails veterans, it fails the communities those veterans would have served. It fails the families that depend on veteran stability. It fails the broader mission of honoring service through care.

# A Call for Partnership, Not Combat

This essay is written for multiple audiences, including VA leadership who might understandably feel defensive about institutional criticism. But criticism and partnership aren't mutually

exclusive. The most effective partnerships often begin with honest acknowledgment of problems followed by collaborative problem-solving.

I'm sharing my experience not to shame individual providers or destroy institutional credibility, but to create space for the accountability that enables genuine improvement. The providers who treated me poorly aren't evil people---they're professionals operating in systems that make ethical practice difficult and defensive practice safe.

Real reform requires acknowledging that the current system fails veterans and providers alike. Providers trapped in defensive postures can't practice the compassionate, effective care they entered the field to provide. Veterans subjected to institutional defensiveness can't access the healing they need and deserve.

The path forward requires mutual vulnerability. Veterans must acknowledge that some criticism will be harsh, some demands unreasonable, and some expectations unrealistic. VA leadership must acknowledge that some criticism will be accurate, some demands reasonable, and some expectations appropriate.

But this mutual vulnerability must be built on a foundation of genuine accountability rather than defensive deflection. When institutions can acknowledge error, apologize appropriately, and implement meaningful changes, they build trust rather than destroy it. When they respond to criticism with retaliation and gaslighting, they guarantee continued conflict.

# Conclusion: The Choice Before Us

Seven years after entering the VA system as a desperate, homeless veteran, I've learned that the choice isn't between perfect and imperfect care---it's between systems that can learn and systems that can't. Between institutions that treat accountability as threat and institutions that treat it as opportunity. Between providers who see patient advocacy as pathology and providers who see it as partnership.

The VA has a choice. It can continue operating as a defensive bureaucracy that protects itself from veteran feedback through retaliation and pathologization. Or it can mature into an accountable institution that uses veteran experiences---even difficult ones---as opportunities for improvement.

Individual providers have a choice. They can continue hiding behind institutional protection and therapeutic authority to avoid acknowledgment of error. Or they can model the professional courage that veterans demonstrated in service: the willingness to face uncomfortable truths in service of higher purpose.

And veterans have a choice. We can accept degraded care as the price of free healthcare, or we can demand the excellence that our service earned and our continued suffering deserves.

The system that failed me doesn't have to fail other veterans. The providers who harmed me don't have to harm other patients. The institutions that protected dysfunction don't have to perpetuate it.

But change requires more than good intentions. It requires systematic accountability, institutional humility, and the professional courage to acknowledge that serving veterans means more than processing them through predetermined protocols.

Veterans have already demonstrated our courage in service to country. Now we need our healthcare system to demonstrate comparable courage in service to healing.

The choice is ours---all of ours---to make.

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