REPORT DOCUMENTATION PAGE		Form Approved OMB No. 0704-0188

Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0188), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.**

1. REPORT DATE (DD-MM-YYYY) 17-05-2016	2. REPORT TYPE FINAL	3. DATES COVERED (From - To)

4. TITLE AND SUBTITLE Show No Weakness: Post-Traumatic Stress Disorder at the Tip of the Spear	5a. CONTRACT NUMBER
	5b. GRANT NUMBER
	5c. PROGRAM ELEMENT NUMBER
6. AUTHOR(S) Derek D. Price, Lt Col, USAF Paper Advisor: Dr. William Bundy and Mr. Walter Bonilla	5d. PROJECT NUMBER
	5e. TASK NUMBER
	5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Gravely Naval Research Group Naval War College 686 Cushing Road Newport, RI 02841-1207	8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)	10. SPONSOR/MONITOR'S ACRONYM(S)
	11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION / AVAILABILITY STATEMENT
Distribution Statement A: Approved for public release; Distribution is unlimited. Reference: DOD Directive 5230.24

13. SUPPLEMENTARY NOTES
A paper submitted to the Naval War College faculty in partial satisfaction of the requirements of the Gravely Naval Research Group. The contents of this paper reflect my own personal view and are not necessarily endorsed by the NWC or the USN.

14. ABSTRACT

War is hell…on the men and women fighting America's wars around the world, especially upon the mental health of them and their families. In SOCOM, this reality has created a rising trend in PTSD diagnoses' along with many other combat stress related issues, to include suicide and suicidal ideations. With rising rates, comes recognition and preventative measures, yet little head way has been made to date. This research aims to reverse that trend by creating a different model for diagnosing and treating PTSD along with many other mental health and combat stress related issues. It focuses on the realities of combat that every soldier faces and the coping mechanisms available to them, instead of whether or not the soldier has a disorder or doesn't. In addition, this research pushes for a different leadership development model within USSOCOM to ensure warriors have adequate support for the realities they face in combat.

15. SUBJECT TERMS

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON Dr. William F. Bundy Director, Gravely Naval Research Group
a. REPORT UNCLASSIFIED	b. ABSTRACT UNCLASSIFIED	c. THIS PAGE UNCLASSIFIED		35	19b. TELEPHONE NUMBER (include area code) 401-841-2674

Standard Form 298 (Rev. 8-98)

NAVAL WAR COLLEGE
Newport, R.I.

Show No Weakness: Post-Traumatic Stress Disorder at the Tip of the Spear

by

Derek D. Price

Lieutenant Colonel, USAF

A paper submitted to the Faculty of the Naval War College in partial satisfaction of the requirements of Gravely Naval Research Group.

Signature: _____

17 May 2016

Contents

Preface

Before delving into this research on Post-Traumatic Stress Disorder, it is critical to understand the motivations behind the author's desire to study this topic as well as the background which led him here. As a pilot in the US Air Force, Lieutenant Colonel Derek D. Price has spent the previous 14 years flying, planning, and leading within Air Force Special Operations Command (AFSOC). As an aircrew member on AC-130U aircraft, Lt Col Price has accumulated nearly 3,000 hours of flight time, including more than 1,000 hours in combat, supporting special operations forces ground units within Afghanistan and Iraq. Over the span of 13 combat deployments, he has directly witnessed the struggles and triumphs of soldiers deploying to war as well as redeploying and reintegrating with their families and friends. As a squadron commander from 2013 to 2015, Lt Col Price led an organization of 300 airmen in training and combat, as well as supporting the needs of an additional 300 family members. During this time, he witnessed a significant number of personnel in his unit succumbing to various symptoms of combat related stress, from alcohol abuse, to depression, family break-ups, emotional distress, and several suicide attempts or ideations. It was the cumulative effects of these issues on his airmen and their families that led him down the path of researching PTSD.

Early in this process, after entering the US Naval War College curriculum, Lt Col Price discovered USSOCOM's interest in the same subject. In its annual publication of Special Operations Research Topics, USSOCOM identified "preserve our force and families"

as a priority topic for 2016.[1] In this document, USSOCOM identifies numerous specific topics of interest, to include PTSD, resiliency, suicide, and the stigma associated with seeking mental health care.[2]

Lt Col Price then took his interest in the subject and combined it with USSOCOMs desire for research to develop the topic of this report. It is important though, to understand ahead of time, that this research is developed from an operational point of view. That is, it attempts to answer the research questions from a warfighters perspective; through the eyes of the men and women who are suffering from the symptoms, instead of the medical and mental health professional's perspective. While this difference may seem minimal on the surface, it can have significant impacts from the training, education, resources, and insurance perspectives. In short, an operational perspective may be too simplistic for medical diagnosis, but the author believes those differences are an important consideration in why despite national focus on PTSD and suicide, the rates of occurrence continue to climb and appear as though that trend will continue well into the future.

The goal then of this research, is to conceptualize a new way of thinking about the root causes of combat stress in all its forms; that is the willingness of special operations troops to seek medical and mental health counseling early enough in the life cycle of PTSD to control the problem before it begins affecting USSOCOM warriors, their families, and their organizations.

---

[1] Joint Special Operations University, *Special Operations Research Topics 2016*, 2015 (MacDill AFB, Florida: Joint Special Operations University Press) 33-34.
[2] Ibid, 33.

Abstract

Show No Weakness: Post-Traumatic Stress Disorder at the Tip of the Spear

War is hell…on the men and women fighting America's wars around the world, especially upon the mental health of them and their families. In SOCOM, this reality has created a rising trend in PTSD diagnoses' along with many other combat stress related issues, to include suicide and suicidal ideations. With rising rates, comes recognition and preventative measures, yet little head way has been made to date. This research aims to reverse that trend by creating a different model for diagnosing and treating PTSD along with many other mental health and combat stress related issues. It focuses on the realities of combat that every soldier faces and the coping mechanisms available to them, instead of whether or not the soldier has a disorder or doesn't. In addition, this research pushes for a different leadership development model within USSOCOM to ensure warriors have adequate support for the realities they face in combat.

"War is Hell…"

-William Tecumseh Sherman

Introduction

Not many quotes seem to capture the totality of war like this short but complete

statement. War is hell on the men and women tasked with carrying it out. War is hell on the

people afflicted by its violence. War is hell on the enemy, ravaged in its wake. War is hell on

the families devastated by deployments, injuries, and death. War, in all its forms, devastates

everything and everyone in its wake. It also devastates the warrior's mind. Despite the most

sophisticated weaponry and technology that our scientists can develop, the mind of our

soldier's is still the heart and soul of the United States' ability to wage war, and will remain

so into the future. Short of a revolution in military affairs which replaces the human brain

with artificial intelligence, our ability to win and even participate in combat will fall on the

men and women in uniform and their mental ability to retain humanity.

United States Special Operations Command (USSOCOM) puts this concept at the

forefront with its five special operations forces (SOF) truths:[3]

1. People are more important than hardware.

2. Quality is better than quantity.

3. SOF cannot be mass produced.

4. Competent SOF cannot be created after emergencies occur.

5. Most special operations require non-SOF support.

---

[3] United States Special Operations Command, *SOF Truths*, n.d. Retrieved 30 January 2016, from http://www.socom.mil/Pages/SOFTruths.aspx.

These truths encapsulate the understanding that it is people and not things that fight and win wars, and at the heart of those people, is their ability to think and act rationally, and make decisions. Whether as a Major General making strategic decisions or as a Private First Class pulling the trigger on the frontlines in Afghanistan, the mental capacity and health of the individual soldier, sailor, airman or marine is the critical link that gives the US an advantage over its enemies. While it's easy to say that "people are more important than hardware" and talk about how SOF warriors are better trained and more capable of using the mind as a weapon, it can be a much more complicated concept in execution, and that's where this research will focus.

This report will focus on sharpening the blade at the very tip of the spear. The mental health of USSOCOM's warriors is the most vital link in the commands ability to carry out its mission, yet it has largely been ignored over the last 25 years. Despite numerous efforts to remove the stigma associated with mental health support or counseling, that stigma is still present, and provides a major hurdle to the overall health and resilience of SOF personnel. This report then will focus on a multi-pronged approach which attempts to remove the stigma of seeking mental health counseling, and therefore increasing the resiliency and efficiency of USSOCOM's elite warriors. This will be accomplished by developing a new model for diagnosing and treating combat stress related disorders and then using a transformational leadership style to institute the new model through a top-down (leadership-first) approach. Before this concept can be developed though, it is important to understand the "why" for seeking change and then "what" is actually being changed. Therefore, this essay will begin with a simulated scenario which develops the situation that SOF operators face on a daily basis, followed by an historical understanding of how the concept of PTSD started and turned

into the diagnosis it is today. With these tasks complete, the groundwork for the new model will be laid, along with discussions of a transformational leadership style which should be fostered in order to cement the significant changes being proposed.

Background Scenario[4]

The date is 27 November 2013 and you are the commander of an organization deployed to Afghanistan in order to provide fire support and close air support to SOF throughout the area of responsibility. One of your best aircrews has just been alerted to launch for a troops in contact situation on the outskirts of Kandahar. As the crew brief and mission preparation briefs conclude, the aircraft commander approaches you and says he has an issue which he needs to discuss in private. He then explains that his navigator pulled him aside and with the look of fear and pain in his eyes, admits that he has not slept in several days and is having significant mental issues, to the extent that he doesn't know if it will affect his ability to carry out the mission. Upon further questioning, the navigator divulged that he is having marital problems, anger issues when he talks to his children, financial problems, and other unspecified concerns.[5]

As the commander, you are now faced with the dilemma of launching the crew on an emergency mission to support ground forces or cancelling the mission and risk significant consequences for the ground forces if they cannot get additional close air support coverage. In this situation, the commander elected to launch the crew and accept some risk to the

---

[4] Derek D Price, "PTSD: Strategic Implications and a New Approach for USSOCOM," February 1, 2016; An essay to fulfill the requirements for the National Security Decision Making course at the United States Naval War College, Newport, RI.
[5] Ibid. This is a realistic scenario based on similar circumstances the author faced on deployment to Afghanistan in 2013.

navigator's mental state in order to protect the ground force, while coordinating for a chaplain to meet the crew after landing and sit down with the navigator to see where and if he could help. As the crew arrives over the target, they begin engaging numerous enemy positions and conducting flawless fire support, allowing the ground force an opportunity to withdraw from a position they have been pinned down in for several hours. Towards the end of the mission, on their last engagement, the navigator inadvertently inputs one wrong coordinate into the fire control system and when the crew shoots the onboard weapons, several rounds land on a house across the street from the previous target, engulfing the building in flames.

After the engagement, the crew elects to cease firing and coordinates for another aircraft to continue providing fire support, while they thoroughly check their weapons systems for malfunctions and return to base. Upon landing and reviewing the footage from the engagement, you determine that the error was induced by the navigator incorrectly putting the wrong coordinates into the computers. The crew also indicates that though the navigator made no other errors throughout the night; he did not appear to be on his "A" game and seemed distracted on several occasions. As the commander, you are now faced with the decision: if and how to discipline the navigator for his actions. You also understand that due to the likelihood of media attention, an investigation will probably take place, and the events leading up to the mission, including your decision to launch the crew, will come under significant scrutiny.

So how does this scenario relate to the broader discussion of resiliency, PTSD, and leadership? For that, one should look no further than the more recent incident where a special operations aircraft accidentally engaged a Doctors Without Borders hospital building in

Kunduz, Afghanistan. On 3 October, 2015, the tragic event led to the death of at least 22 patients, doctors, and staff in a building which was mistakenly targeted, very much like the scenario described above[6]. In the immediate aftermath, North Atlantic Treaty Organization (NATO) and US Central Command (USCENTCOM) leadership feverishly worked the media outlets in an attempt to prevent international outrage.[7] Within days, the US president and other civilian leadership were apologizing on television and radio broadcasts around the world.[8] Several international organizations, along with Doctors Without Borders staff began calling the airstrikes an act of war crimes and demanding outside investigations into the killing of so many civilian personnel. In time, the fallout from this strike would significantly affect US policy inside Afghanistan through stricter controls on the use of force and a more strained relationship between the US and Afghan governments, along with significantly hurting the trust and confidence of US military interactions with numerous non-governmental organizations.

SOF Deployments

The root causes of this latest tragedy are still not yet clear, but the operators who carried out the mission are. They are SOF personnel operating on the ground, in the air, and

---

[6] United States Central Command, *USCENTCOM FOIA Library: Airstrike on the MSF Trauma Center in Kunduz Afghanistan - 3 Oct 2015*, (MacDill AFB, FL). https://www6.centcom.mil/foia_rr/FOIA_RR.asp?Path=/5%20USC%20552%28a%29%282 %29%28D%29Records&Folder=1.%20Airstrike%20on%20the%20MSF%20Trauma%20Ce nter%20in%20Kunduz%20Afghanistan%20-%203%20Oct%202015.
[7] Ibid.
[8] British Broadcasting Corporation, "Obama Apologizes to MSF President for Kunduz Bombing," *BBC News,* October 7, 2015. http://www.bbc.com/news/world-us-canada-34467631.

over cyberspace, integrating together to form a team that can carry out precise targeting over thousands of miles with relatively little oversight due to their intensive training and the trust placed in them. What is also clear is that these same forces are deploying at a rate unheard of in previous wars. Whereas in Vietnam or Korea, the average soldier would deploy for a year or less and then return home for several years, today's SOF personnel are deploying 5 to 10 times on average over a 2 to 3-year span. This frequent addition of multiple deployments adds tremendous stress on the operator, their families, and their teams. Most SOF personnel deploying with USSOCOM have deployed several times before even getting selected for SOF and after several SOF deployments can easily accrue 400-500 days in combat. In fact, just within Air Force Special Operations Command (AFSOC) there are crews with 15-20 deployments and 3+ years of combat time. Given these numbers and the way SOF deploys, it is surprising that there is not a significant majority of SOF operators with significant signs of combat stress or medically diagnosed PTSD symptoms. Therefore, prior to discussing the symptoms of PTSD or offering up a new model for diagnosis, it is important to understand the history of the disorder and how the term came into being.

History of PTSD and Combat Stress

Though the term has become a common lexicon in the media over the last few years, PTSD and its predecessor terminology have been around as long as war itself. This next portion of research will look at the historical context of what is now termed PTSD, from the most basic historical writings detailing combat related stress to the current medical dictionary which distinctly defines PTSD and the specific symptoms that characterize the disorder. This

analysis will then provide a backdrop to why a new model is needed that breaks from the traditional definition.

To begin with, the term PTSD is actually a relatively new name, coined in 1980 in the Diagnostic and Statistical Manual of the American Psychiatric Association's third edition which is termed DSM-III.[9] This recent terminology though follows a long history of combat related stress reactions. In researching the historical records, it appears the first characterized use of combat related psychosocial disorder appears in Homer's Greek epic poem, *The Iliad.*[10]Many works reference the tragic battle for Troy, centered on the infamous King Agamemnon and the warrior Achilles, as they battle for many years over lust and betrayal. The years of war turn Achilles from heroic warrior to a bloodthirsty savage, at many times animalistic in nature and treatment of his enemies.[11] Lisa Schiller spends an entire research report chronicling the episodes of Achilles and his battles and how he frequently exudes the classic signs of combat stress or what we would now call PTSD.[12]

Advancing into the late 1500's, the poet William Shakespeare in *Henry IV, part 1,* told a compelling story in the words of Lady Percy about her husband Sir Henry Percy's emotional and psychosocial toll from many years of war and conflict. She accurately describes many of the symptoms of PTSD and combat stress, yet the story is almost 400 years before the first known actual definition of PTSD.

---

[9] Matthew J. Friedman, *PTSD History and Overview*, United States Department of Veterans Affairs, n.d. http://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp.
[10] American Institute of Stress, "Post Traumatic Stress Disorder and Politics," *The Newsletter of the American Institute of Stress*, February 2007, 3.
[11] Ibid, 3.
[12] Lisa Schiller, *PTSD and a Reevaluation of Homer's Achilles*, 3 May 2003. http://stripe.colorado.edu/~fredrice/schiller.achilles.doc.

40 O' my good lord, why are you thus alone?
41 For what offense have I this fortnight been
42 A banish'd woman from my Harry's bed?
43 Tell me, sweet lord, what is't that takes from thee
44 Thy stomach, pleasure
45 and they golden sleep
46 Why dost though bend thine eyes upon the earth,
47 And start so often when thou sit'st alone?
48 Why has though lost the fresh blood in thy cheeks,
49 And given my treasures and my rights of thee
50 To thick-eyed musing and cursed melancholy?
51 In thy faint slumbers I by thee have watch'd,
52 And heard thee murmur tales of iron wars,
53 Speak terms of manage to thy bounding steed,
54 Cry "Courage! To the field!" And thou has talk'd
55 Of sallies and retires, of trenches, tents,
56 Of palisades, frontiers, parapets,
57 Of prisoner's ransom, and of soldiers slain,
58 And all the currents of a heady fight.
59 Thy spirit within thee hath been so to war
60 And thus hath so bestirr'd thee in thy sleep.
61 That beads of sweat have stood upon thy brow,
62 Like bubbles in a late-disturbed stream:
63 And in thy face strange motions have appear'd,
64 Such as we see when men restrain their breath
65 On some great sudden haste.

Henry IV, Part 1, Act 2, Scene 3[13]

What's even more interesting than the compelling chronicle of PTSD above, and was not discussed in any historical readings, is that the author who wrote these musings is clearly making a case for a man who has seen significant time in conflict and was quite visibly moved and shaken from those conflicts. To date, no study has researched whether Shakespeare himself was dealing with many of these same attributes that he bestowed upon King Henry, or whether his knowledge of the subject developed from stories he heard from other warriors. This would make a fascinating research topic in itself.

Moving on from Shakespeare, the next collection of literature that falls into the historical realm of PTSD occurs during and after the American Civil War. In 1876 Dr.

---

[13] American Institute of Stress, "Post Traumatic Stress Disorder", 3.

Mendez DaCosta published an article that would become the first known medical diagnosis of combat related psychosocial conditions, which he labeled "soldiers heart."[14] He used the term to describe veterans who came from the front lines with a startle response, hyper vigilance, and disturbances in heart rhythm.[15] This is also the first time that research shows a pattern of removing soldiers from the battle due to the condition, and suggests leaving them off the front lines for a little while but then returning them to combat as soon as possible. Though this would be frowned upon by the medical community today, it is likely the first instance where the soldiers began to feel shame for their symptoms and due to this stigma, there were likely many more soldiers with similar issues who never spoke up.

After the civil war, very little on the topic is discussed until the first World War, where initial diagnoses of "soldiers heart" are coined under the new term of "shell shock".[16] This is also the first time statistics were kept to explain the effect of the disorder by the British, who estimated that 60,000 soldiers were diagnosed with shell shock, and of those, nearly 44,000 were retired from military service due to the symptoms.[17] After World War I, the next major world war would become the catalyst that began a study of the symptoms and efforts to screen soldiers prior to entry. At the onset of America's entry into World War II, significant efforts were made to screen out soldiers who showed signs of weakness or emotional difficulties, in an effort to reduce the number of casualties from shell shock.[18] Though a valiant effort, the results proved a failure on this effort as approximately 300

---

[14] American Institute of Stress, "Post Traumatic Stress Disorder", 4.
[15] Ibid, 4.
[16] Ibid, 4.
[17] Ibid, 4.
[18] Ibid, 5.

percent more troops suffered psychosocial injuries or complaints compared to World War I.[19] It is clear as well that military leadership did not understand the symptoms or how to deal with this new phenomenon. In fact, one of the greatest military heroes of this war, General George Patton, derailed his career and was punished for an incident where he slapped two soldiers in an Allied hospital for what he referred to as cowardice.[20] The provocation earned him a rebuke from General Eisenhower and likely cost him the opportunity to lead the D-Day invasions.[21]

As World War II closed, much research and thought was spent on shell shock and a newer term of "battle fatigue," but as the war drew to conclusion and the victors returned home, the emotional consequences of combat lost favor within the medical and political arenas.[22] The next era for PTSD began in the late 1960's and early 70's with the Vietnam conflict. Vietnam is the first war that thrust combat related psychiatric conditions into regular conversation. Leaning on lessons from previous wars, military leaders began to believe that susceptibility to battle fatigue or shell shock was significantly related to the length of time that a warrior was exposed to combat conditions. Based on this information, tours of duty were typically limited to a maximum of 13 months, followed by a mandatory redeployment back home.[23] This is the first indication that combat related emotional fatigue may not be directly related to a single event but a buildup of stress over time. Even though this is a

---

[19] American Institute of Stress, "Post Traumatic Stress Disorder", 5.
[20] Ibid, 5.
[21] Carlo D'Este, "The Triumph and Tragedy of George S. Patton, Jr.: The Slapping Incidents in Sicily," *The Armchair General*, May 4, 2005. http://www.armchairgeneral.com/the-triumph-and-tragedy-of-george-s-patton-jr-the-slapping-incidents-in-sicily.htm.
[22] Sally Satel, "The Battle Over Battle Fatigue," *The Wall Street Journal,* July 17, 2010. http://www.wsj.com/articles/SB10001424052748704913304575371130876271708.
[23] American Institute of Stress, "Post Traumatic Stress Disorder", 5.

breakthrough of sorts, it still proved a failed concept on its own as the Vietnam conflict produced an estimated 30% psychosocial casualty rate for veterans.[24]

Based on the extreme rates of veterans returning with significant mental health problems and growing evidence that World War II and Korean veterans were experiencing problems related to their conflicts, the American Psychological Association included PTSD in its Diagnostic and Statistical Manual III (DSM-III), which was released in 1980. This manual serves as the "bible" for mental health and psychological disorders and was the first to officially designate PTSD as a mental disorder.[25] In addition to gaining a definition, diagnosis, and treatment options, inclusion in the DSM-III brought significantly greater recognition and acceptance of the disorder into the mainstream medical community. Though this would not end all controversy associated with PTSD, it allowed a more open dialogue based on physical and mental conditions instead of the perception of weakness and cowardice in line with how General Patton viewed the condition some 40 years earlier.

With inclusion of the DSM-III, PTSD gained a renewed emphasis and became common lexicon among military leaders as the US entered the modern era of warfare, starting with the first Gulf War and finally with the ongoing Global War on Terrorism (GWOT). The statistics from the first Gulf War do not lend much insight due to the rapid conflict and relatively few actual skirmishes among ground combatants. In the GWOT though, PTSD has become a significant concern at every level of military rank. For frontline soldiers experiencing the new phenomenon of suicide attacks, roadside bombs, and remote controlled attacks, there is no longer the safety of being behind the forward line of troops and

---

[24] American Institute of Stress, "Post Traumatic Stress Disorder", 5.
[25] Friedman, *PTSD History and Overview*.

operating within relatively safe confines. The new style of terrorist warfare creates a zone of conflict which is inclusive of supply routes, forward operating bases, and even attacks against military bases within relative safe zones as well as within the United States' borders.

PTSD and the Problem

It is these same soldiers then, which are fighting a near endless war, that tie back into the original scenario discussed in this report. The fact is they have been fighting for up to 15 years and will continue to do so for many more. It is no coincidence then that USSOCOM has experienced skyrocketing rates of PTSD, suicide, and marital failures and these are occurring in both active and veteran populations.[26] USSOCOM recognized this trend in 2012 and began a program called Preservation of the Force and Family (POTFF) which aimed to identify warriors at risk earlier in the process and create avenues for them to seek help with less "stigma" than just walking into the base mental health clinic.[27] While the concept is noble and the efforts behind POTFF are gaining some momentum among the troops, funding has become a significant hurdle as pouring money into a "touchy-feely" developmental concept can be tough to justify compared to budget woes in acquiring the latest weapons and technologically advanced gear. Therefore, the author believes that a significant effort should be placed into changing the discussion and diagnosis of mental health problems within the

---

[26] Terron Sims, II., "Why Congress Is Wrong for Shutting Down SOCOM Proposed Budget to Curb Suicide Rate," *Task and Purpose Blog*, May 23, 2014. http://taskandpurpose.com/congress-wrong-shutting-socom-proposed-budget-curb-suicide-rate/.
[27] United States Special Operations Command. *Preservation of the Force and Family.* United States Special Operations Command Homepage. Accessed January 12, 2016. http://www.socom.mil/POTFF/default.aspx.

force; one that does not require significant sums of resources and personnel, but that would require a concerted effort from leadership and the medical community to get at the heart of the problem.

Upon inclusion in DSM-III in 1980, PTSD quickly became a catch-all phrase for numerous mental health symptoms that had no other more relevant diagnoses. The problem with establishing a diagnosis of PTSD though, for military members and especially SOF warriors, is that it goes against everything that makes them who they are. The last thing SOF operators want is to have the stigma of a disorder attached to them for the rest of their careers. Not only does the stigma of a disorder affect their mental state, but it has real and direct effects on their ability to function as a SOF warrior in several ways. First, leadership is much less likely to let them deploy and operate with their units. Mental health concerns are typically seen as a risk to the mission and other friendly forces. Second, with any significant mental health concerns will come the question of whether or not the member's security clearances should be suspended. For SOF personnel, their security clearance typically includes several special access categories that are critical to their ability to execute the mission, so any risk of losing them is a deterrent. Finally, most SOF personnel are what would be referred to as the prototypical type-A personality. They thrive on the ability to withstand situations and risks that ordinary citizens cannot. To them, seeking mental health counseling is seen as a weakness and an inability to complete their mission. If they can avoid these risks by keeping their issues to themselves, then they often will.

The risk in keeping mental health problems inside and not discussing them with proper personnel is that the stress and tension are still building up within the soldier. Eventually, they will boil over and if it happens to be while deployed, scenarios like the ones

mentioned earlier are likely. So the intent then of this research is to come up with an alternative solution that allows the soldiers to express their concerns and talk to professionals yet also try to prevent the concerns over stigma, helplessness, security risks, and many other negative side effects of seeking help.

A New Model

The author is proposing a concept of removing the label of PTSD from the medical records of service members and replacing that diagnosis with a numerical score which relates to metrics along a sliding scale, as can be seen in Figure 1 below. These scores would replace the current diagnosis of PTSD or similar stress-related conditions within the SOF community, and as the program matures, expansion to include the military as a whole. As will be discussed within the implementation phase, every member assigned to a SOF specialty code would then be evaluated and assigned a score during their annual physical checkup. Within their medical records, this Personal Stress Index (PSI score) would then provide insight to caregivers and commanders within the Health Insurance Portability and Accountability Act (HIPAA) guidelines. Before continuing to discuss this process though it is important to understand the scales themselves.
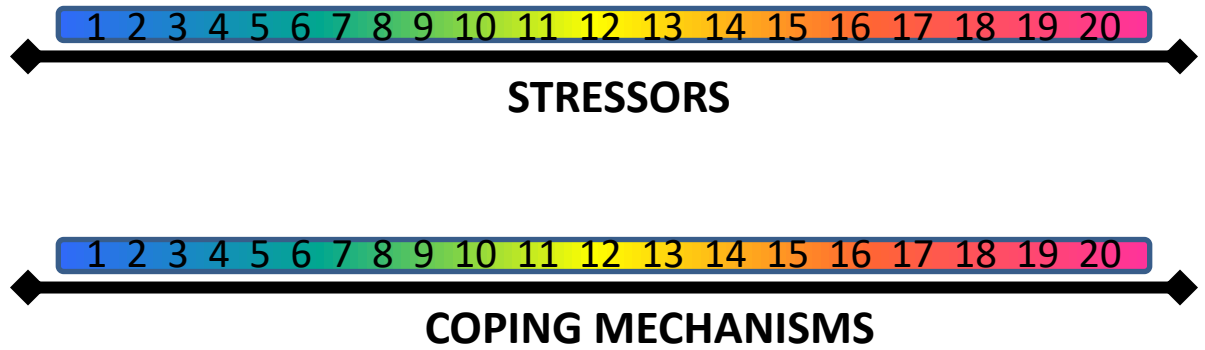
Scales

The first scale provides an acute and chronic stress score, which essentially equates to a numerical score along the scale, coinciding with the buildup of stressors that member is dealing with at any one time. This would be a single score which encompasses many aspects of the mental state of an individual. Specific scoring guidelines would need development

within the medical and psychological communities to ensure consistency among numerous professional services, but the score would theoretically be a "0" for individuals with no stressors currently ongoing and on the other end of the scale, a score of "20" would indicate the most severe cases of chronic and acute stress buildup. In reality, your average military member not on a deployment or dealing with significant stress in their life would probably score out around a "2-5" whereas an SOF operator overseas who has been assaulted or experienced a recent IED blast would likely score out in the "10-15" range. What this index allows then is the ability to identify not just specific extreme instances of stress, but also how the buildup of other stressors could increase a member's composite stress score, before it reaches a crisis level.

For the coping mechanisms score, much like the stressors score, every member of the SOF community would be analyzed on an annual basis for their ability to deal with emotional and physical stress in their lives. Commanders, medical professionals, and operational psychologists would each have the capacity to engage with one another and identify characteristics about the member that help in their coping ability. For those who are very well educated and suited to dea.3ling with stress in chronic and acute situations, they would likely score out in the "2-3" range, whereas individuals keep their emotional pain inside, frequently turn to alcohol or other substances to cope, or have other issues in coping with their stress, the score would be much higher.

Figure 1. Stress Indicator and Coping Mechanisms Scale. [28]

---

[28] Price, "PTSD: Strategic Implications."

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

STRESSORS

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

COPING MECHANISMS

The are several keys which would allow a system like this to succeed where so many other diagnoses have failed. First is the fact that every member within the given community would be somewhere along the scale. It is no longer a system that assigns a disorder to certain members because they can't seem to thrive like fellow members of the unit. Second, is the ability to maneuver up and down on the scale as environmental factors change for the individual. This accounts for standard trauma such as a blast or casualty but also allows that score to adjust upward, incrementally, as other financial, marital, or multiple deployment stressors accumulate. On the contrary, it also accounts for the member's stress score to decrease as they spend time at home post-deployment or start receiving medical or mental health care after a significant event. The third benefit is that by ensuring an annual evaluation along with the physical checkup, the mental checkup becomes a routine and is not seen as the dreaded "visit to the mental health clinic" that nearly every combat operator is forced to endure. Additionally, the medical, mental health, and command team could still make adjustments to the score outside of the annual requirement, just as the medical community can still change their deployment readiness based on short term illnesses. The fourth benefit to discuss is that it provides an opportunity for a team of experts to engage the members one on one and discuss mental health and stress factors without the stigma of whether or not they are going to assign you a disorder based on what you say.

The intent behind a scale that starts with a "1" as the lowest level is that every military member then falls somewhere on the scale. This will help de-stigmatize the fact that all individuals have stressors which they deal with daily. Some have more stressors and some have less. Some have better coping mechanisms than others and some need additional resources to prop up their ability to cope. What this creates though is an environment where everyone, including SOF leadership, aligns somewhere on the scale and the ability to move up and down in score is a function of the environments they warriors operate in instead of a diagnosis that they have a disorder or they do not.

As has been seen in many other aspects of the military organizational bureaucracy though, changing a major system or function alone does not solve problems at the operational and tactical level. For true change to take hold and survive in a dynamic fiscally constrained system, simply directing a change by the organizational leadership is not enough. Leaders absolutely must believe and buy into the concept and how it can dramatically increase the effectiveness of their organization. They must inspire their subordinates through passion, or what Bernard Bass would label "charisma."[29] But to get there, a new discussion of leadership and how it is developed within USSOCOM must be considered.

Leading Trough Change[30]

---

[29] Bernard M. Bass, "From Transactional to Transformational Leadership: Learning to Share the Vision," *Organizational Dynamics*, Vol 18 (1990). Quoted on the *Strand Theory* website. http://strandtheory.org/images/From_transactional_to_transformational_-_Bass.pdf.
[30] Price, Derek D, "Transformational Leadership in USSOCOM: A PTSD Case Study," February 9, 2016; An essay to fulfill the requirements for the National Security Decision Making course at the United States Naval War College, Newport, RI.

This portion of the essay is about leading in the trenches. Leading USSOCOM's elite warriors and taking the first SOF truth to heart: *"People are more important than hardware."*[31] That means putting soldier's lives, health, mental concerns, and families in front of the leader's own well-being and toughness. It means having the guts to admit that everyone faces difficult times and all need help from time to time. It means understanding that being at the tip of the spear is even more of a reason to do everything possible to keep soldiers in the fight and allow them to focus on completing the mission. That leadership trait and style is not taught at any school, nor is it what we train for at JADED THUNDER, RED FLAG, or any other joint combat training exercise. To lead SOF in this era of continuous deployment cycles and a never ending war on terrorism, USSOCOM needs to develop and promote transformational leaders.

"People – not equipment – make the critical difference. The right people, highly trained and working as a team, will accomplish the mission with the equipment available. On the other hand, the best equipment in the world cannot compensate for a lack of the right people." *SOF Truth #1: People are more important than hardware.*[32]

The previous quote is at the heart of USSOCOM's focus on people as opposed to equipment and technology to accomplish the mission. The latest equipment and technologically advanced weapons systems are absolutely critical to establishing a marked advantage over the enemy, but they are useless without highly trained individuals capable of understanding when to use that weaponry and when to use the mind as a tool to accomplish the mission. In order to take care of people though and allow them to accomplish their mission, leaders are needed who are just as adept at knowing their troops as they are at

---

[31] United States Special Operations Command, *SOF Truths*.
[32] Ibid.

knowing their enemy. For the men and women leading USSOCOM, "leadership from the front" and leading in combat what SOF does best. They thrive on being on the front lines and deploying with their troops to the latest hot spot and into partner countries to train and develop their own militaries so they can root out terrorism from within. This leadership style is what they are trained for and how they expect to accomplish the mission. It is what defines leadership at the "Tip of the Spear".

What they are not prepared for and do not thrive on is leading warriors as they redeploy home and reintegrate with their families and lives that they left months earlier. There are no leadership courses focused on how to deal with airmen and soldiers suffering from PTSD or combat stress nor how to focus those warriors on getting the right assistance so that they can recover and become a functional member of their unit once again. But that is not the glamorous style of leadership USSOCOM is known for, at least not in the movies, books, television shows, or other media where SOF have gained their current fame. All that touchy-feely stuff is for the medical community and social workers to use on those soldiers who are too weak to cut it on the front lines, where heroes are born! Right? Or is it?

Transformational Leadership

Transformational leadership is a term first coined by James M. Burns in 1978. He defined leadership as"…leaders inducing followers to act for certain goals that represent the values and motivations-the wants and needs, the aspirations and expectations-of both leaders and followers".[33] To take that leadership to the transformational level, he believed that the

---

[33] J.M. Burns, *Leadership*, (New York, NY: Harper and Row), 1978.

critical attributes were the ability to "motivate" and appeal to the values and aspirations of those being led. Burns' discussions were then expanded upon by James Keagen and then most notably by Bernard Bass, a distinguished academic who published numerous articles on leadership styles, especially the difference between transactional and transformational leadership. He stated that transformational leadership occurs when "leaders broaden and elevate the interests of their employees…and when they stir their employees to look beyond their own self-interest for the good of the group."[34] Bass believed that transformational leaders were characterized by four traits:[35]

1. Charisma: Provides vision and a sense of mission, instills pride, gains respect and trust.

2. Inspiration: Communicates high expectations, uses symbols to focus efforts, and expresses important purposes in simple ways.

3. Intellectual Stimulation: Promotes intelligence, rationality, and careful problem solving.

4. Individualized Consideration: Gives personal attention, treats each employee individually, coaches, and advises.

Based on these traits, it appears that Bass focused the concept of transformational leadership on how the leader relates to those being led and whether or not they felt connected to their leader. A sense of shared purpose and mutual trust is critical to the ability to define a relationship as transformational. In applying these characteristics to military leadership,

---

[34] Bass, "From Transactional to Transformational Leadership", 21.
[35] Ibid, 22.

Colonel Mark Homrig noted in an essay for the US Air Force's Air University in 2001 that applying transformational leadership in the military leads to "professionals leading inspired subordinates through tough budgets, difficult deployments, the rigors of combat and ultimate victory."[36] Similarly, Dr. Mary Raum, a PhD Professor at the US Naval War College described the transformational leader as one who has larger than self, inspirational approaches to leading an organization and at the same time assist those being lead in fulfilling their maximum potential.[37] Given an understanding of these descriptions of transformational leadership, this essay will use a case study to show what transformational leadership looks like in action.

A Case Study: Nelson Mandela

Nelson Mandela epitomized the values of a transformational leader. Though at times he represented many leadership styles to include transactional and even great man or trait leadership theory, it was his ability to motivate those around him to greatness and inspire followers that made him the exceptional leader he was. While in captivity and rarely heard from across his country, Mandela continued to inspire the people of South Africa, prompting mass demonstrations and outpourings of support. Upon release from an unbelievable 27 years in prison, the clashes between white elitists and the African National Congress continued and reached all-time highs in violence, yet Mandela was able to persevere and

---

[36] Mark A. Homrig, *Transformational Leadership*. United States Air Force: Air University. Maxwell AFB, AL. 21 December, 2001, 1. http://leadership.au.af.mil/documents/homrig.htm.

[37] Mary Raum, PhD., "Ideas About Leadership: A Short History and Description of Modern Leadership Theories," August 10, 2012, 3. Published in the *National Security Decision Making Course* Syllabus. United States Naval War College. Newport, RI. 2015.

continue making the case for reconciliation. He never lost sight of the greater good, even at the country's darkest times. He espoused Bernard Bass' four traits of transformational leadership and used them to rally a people and a nation behind him to accomplish a greater good. One of the defining moments in labeling Mandela as a transformational leader came in 1995 when he very publicly attended the Rugby World Cup finals, wearing the jersey of the white South African captain.[38] This symbolic gesture showed how much he espoused the transformational qualities of reconciliation of his nation and mutual trust among whites and blacks. So what then can Nelson Mandela teach us about resiliency and leadership in special operations?

Transforming Through Resilience

As discussed earlier, transformational leadership is about relating to followers. It involves not only key characteristics such as charisma and intellect, but also much more difficult traits like inspiring, mentoring, and cultivating greatness from those being led. These leadership traits were clearly evident in Nelson Mandela. USSOCOM needs to cultivate these same characteristics in its leaders so that they can continue to thrive in a complex strategic environment while still maintaining focus on the individualistic needs of our warriors and leaders.

In the background scenario of this essay, we are asked to examine a brief description about how one person can have so many personal issues piling up that it affects their ability

---

[38] Joan Johnson-Freese, PhD., "And the 1993 Nobel Peace Prize Goes to …" August 2008. Edited by Reginald R. Smith, Lt Col, USAF, July 2010, 11. Published in the *National Security Decision Making Course* Syllabus, United States Naval War College, Newport, RI, 2015.

to complete a mission, while his chain of command remained unaware of the problem or the root causes. This is due to a squadron culture at the time focused on transactional leadership and not on leading people in order to accomplish the mission, without regard for their future development, their family's welfare, or whether they were inspired to be in the unit. It was about the leader getting the next promotion, the squadron killing the next enemy or winning the next unit award. This was a textbook case of transactional leadership at work and how it can fail without a solid mixture of transformational leadership to offset the negative characteristics of that task and reward system.

SOF soldiers are fighting a long war; one that has been ongoing for nearly 15 years and will continue far into the future. The personnel that have been leading this fight for many years are the same ones who will continue to lead in more senior positions for the foreseeable future. SOF by nature are a small group, highly specialized, and highly trained to accomplish specific missions so we need to focus on keeping them physically and mentally fit for the long haul. That means leaders need to get to know their troops at the most basic levels. Spend the time to understand their uniquely individual situations, where they are from, how the family is coping with deployments, and what issues the troops are worried about. These most basic questions are the building blocks of trust and mentoring that allows leaders to know when their troops are showing signs of stress without needing to ask. We need to inspire a culture in units that promotes open dialogue about mental health issues and spend the extra time to become more familiar with our troops on a deeper level. But how do they get there? How do they break the cycle of "showing no weakness" in a culture where that weakness can cause a loss of confidence or ultimately the tragic death of civilians in combat? That is where a culture of transformational leadership comes in.

Leading from the Front

USSOCOM needs to focus on teaching its leaders to lead from the front at all times, not just in combat. This means being the first to step in front of a unit and admit weakness. Every great leader is human, and humans have issues dealing with the realities of war. If killing and combat did not affect soldiers in a negative way, they would lose the humanity that defines them. Greg Grossman, author of "On Combat" states that human-on-human aggression is what he called the Universal Human Phobia, and that 98% of the population is utterly opposed to human violence. If that is true, then it is certain that most of the military, including SOF, are composed of men and women who oppose violence as the means to accomplish a mission. Yet leaders ask them routinely to engage in violence and kill their enemies on a regular basis; essentially forcing them and even training them to contradict their basic humanity. If this cycle of violence is continued over time, then leaders need to show their troops that it is not normal to routinely engage in violence and then move on as if nothing happened. Instead, they need to show them, by setting the example, that seeking help from the medical and mental health communities is a natural and even expected reaction to the human aggression.

This is exactly why transformational leadership styles are needed, which promote leaders who are willing to admit weakness in front of their people. They are willing to throw out their pride and positional power in order to foster trust and a sense of belonging across their organization. This is the epitome of what transformational leadership looks like, especially in a community which prides itself on attracting the prototypical type-A personality.

With an understanding now of how transformational leadership is needed in order to change the way USSOCOM thinks about, manages, and develops leaders, this report will transition into a couple of the friction points which will present significant challenges to such a sweeping overhaul.

Friction Points

Upending a mainstay of mental health diagnosis' which affects a likely population in the hundreds of thousands does not come without significant friction. With 26 years of development and evolution on the concept of PTSD and its definition, this easily qualifies as a mainstay in the medical community. Understanding the friction points could easily be the topic of another 100+ page report, but for the purpose of establishing this argument, a quick discussion of the primary friction points is adequate.

First, and likely foremost, is that within medical and insurance organizations, a diagnosis of PTSD provides an easy understanding of what treatment options will be provided and therefore makes the insurance coverage issues fairly straightforward. Yes, each case will be different and require different methods of treatment depending on severity, but the insurance industry is familiar with PTSD and the range of services it will need to cover. Removing the label of PTSD, will likely cause a significant hiccup in what, how, and why they would cover follow up costs. Especially when making diagnoses along a sliding scale that can frequently change. This will not be an insurmountable friction point, but will take some significant research to create a smooth transition.

Second, with thousands of PTSD diagnoses already made, swapping all of them over with personal consultations will take years to accomplish. This is true however it will need to

be managed in phases, not as an all at once program. The first priority should be on training the practitioners and then on new diagnoses. As time and severity allows, services will need to develop plans to slowly transition the current members diagnosed with PTSD. Also, one reason for starting with a smaller population such as USSOCOM is that it allows for testing and working kinks in the system out before adopting it for the larger military and/or civil populations.

There are likely hundreds of other friction points to address with such a massive transformation, but those are better addressed in future research and development on this topic. As stated in the beginning, the intent of this research is not to fully develop a system which can be implemented in the short term, rather it is an operational perspective which deserves further research. To wrap up this effort, lets focus back on why this project started and its intent

Conclusion

The original scenario in this research is not an isolated event which is unlikely to occur again in the near future. Rather, it is representative of situations and decisions which are made each and every day by commanders and warriors, reacting to an ever-increasingly complex battlefield. Life and death decisions are made at every level on a recurring basis in today's fight against terrorism, and many times those decisions are made by war-weary SOF operators on their fifth, tenth, or even twentieth deployment. They may not outwardly show the signs of emotional or mental exhaustion, combat stress, or mounting family and financial issues, but the data shows that a significant and increasing number of them are suffering. Therefore, it is up to the leadership that entrusts them with these strategic military decisions

to also ensure they are mentally prepared for the rigors of continuous combat. As Lieutenant Colonel Grossman hinted, it would be abnormal for these warriors to not be affected by what they are seeing and doing in war. [39] It is essential then that USSOCOM develop a system which removes the stigma associated with seeking the help they need, and move to a new model which not only encourages seeking help, but also makes it a regular and recurring discussion topic between warriors and their health care providers. The model introduced in this research is a step in the right direction towards embracing the reality that SOF are exposed to in this new type of conflict.

As has been stated prior, this research is understandably vague and simplistic in many aspects related to the specific medical or mental health diagnosis associated with PTSD. Significant additional research is required before implementing any of the concepts introduced, however, the author believes that effort is well worth the cost in time and resources. PTSD is just one of many psychological concerns that military members are facing today, yet it appears to be one of the leading consistent factors associated with failing family, financial, and professional stressors. Even more concerning is the rise in suicide and suicide attempts by active and retired military members. Again, the author believes that a model based on or similar to the one presented in this research, which encourages and even demands active discussions among leaders, medical professionals, and SOF warriors, will significantly help remove the stigma associated with seeking help when it is needed and before it snowballs into a situation where poor decisions are made on the battlefield or in the personal lives of operators.

---

[39] David Grossman, and Loren W. Christensen, *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace*, Millstadt, IL, Warrior Science Publications, 2008.

Bibliography

American Institute of Stress. "Post Traumatic Stress Disorder and Politics." *The Newsletter of the   American Institute of Stress*. February 2007.

Bass, Bernard M. "From Transactional to Transformational Leadership: Learning to Share the Vision." *Organizational Dynamics*. Vol 18 (1990). Quoted on the *Strand Theory* website. http://strandtheory.org/images/From_transactional_to_transformational_-_Bass.pdf.

British Broadcasting Corporation. "Obama Apologizes to MSF President for Kunduz Bombing." *BBC News.* October 7, 2015. http://www.bbc.com/news/world-us-canada-34467631.

Burns, J.M. *Leadership*. New York, NY. Harper and Row. 1978.

D'Este, Carlo. "The Triumph and Tragedy of George S. Patton, Jr.: The Slapping Incidents in Sicily." *The Armchair General*. May 4, 2005. http://www.armchairgeneral.com/the-triumph-and-tragedy-of-george-s-patton-jr-the-slapping-incidents-in-sicily.htm.

Friedman, Matthew J. *PTSD History and Overview*. United States Department of Veterans Affairs. n.d. http://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp.

Grossman, David, and Loren W. Christensen. *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace*. Millstadt, IL. Warrior Science Publications. 2008.

Homrig, Mark A. *Transformational Leadership*. United States Air Force: Air University. Maxwell AFB, AL. 21 December, 2001. http://leadership.au.af.mil/documents/homrig.htm.

Johnson-Freese, Joan, PhD. "And the 1993 Nobel Peace Prize Goes to …" August 2008. Edited by Smith, Reginald R., Lt Col, USAF. July 2010. Published in the *National Security Decision Making Course* Syllabus. United States Naval War College. Newport, RI. 2015.

Joint Special Operations University, *Special Operations Research Topics 2016*. MacDill AFB, FL: The Joint Special Operations University Press, 2015.

Price, Derek D. "PTSD: Strategic Implications and a New Approach for USSOCOM." February 1, 2016. An essay to fulfill the requirements for the National Security Decision Making course at the United States Naval War College. Newport, RI.

Price, Derek D. "Transformational Leadership in USSOCOM: A PTSD Case Study." February 9, 2016. An essay to fulfill the requirements for the National Security Decision Making course at the United States Naval War College. Newport, RI.

Raum, Mary, PhD. "Ideas About Leadership: A Short History and Description of Modern Leadership Theories." August 10, 2012. Published in the *National Security Decision Making Course* Syllabus. United States Naval War College. Newport, RI. 2015.

Satel, Sally. "The Battle Over Battle Fatigue." *The Wall Street Journal.* July 17, 2010. http://www.wsj.com/articles/SB10001424052748704913304575371130876271708.

Schiller, Lisa. *PTSD and a Reevaluation of Homer's Achilles*, 3 May 2003. http://stripe.colorado.edu/~fredrice/schiller.achilles.doc.

Sims, Terron, II. "Why Congress Is Wrong For Shutting Down SOCOM Proposed Budget To Curb Suicide Rate." *Task and Purpose Blog*. May 23, 2014. http://taskandpurpose.com/congress-wrong-shutting-socom-proposed-budget-curb-suicide-rate/.

United States Central Command. *USCENTCOM FOIA Library: Airstrike on the MSF Trauma Center in Kunduz Afghanistan - 3 Oct 2015*. MacDill AFB, FL. https://www6.centcom.mil/foia_rr/FOIA_RR.asp?Path=/5%20USC%20552%28a%29%282%29%28D%29Records&Folder=1.%20Airstrike%20on%20the%20MSF%20Trauma%20Center%20in%20Kunduz%20Afghanistan%20-%203%20Oct%202015.

United States Special Operations Command. *Preservation of the Force and Family.* United States Special Operations Command Homepage. Accessed January 12, 2016. http://www.socom.mil/POTFF/default.aspx.

United States Special Operations Command. *SOF Truths.* N.d. Retrieved 30 January 2016, from http://www.socom.mil/Pages/SOFTruths.aspx.