

NO APPARENT FEAR OF DEATH. A TENTATIVE INVESTIGATION INTO THE 'NAFOD' HYPOTHESIS

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'NAFOD' is a theoretical, psychological disorder seen as a genetic predisposition dominant in individuals undertaking professions categorized as being risky with calculation. The 'Nafodic' personality is reckless beyond the hard-wired risk taking profile of an adult male, is knowledgeable about death, is aware of its causes, takes risks not classified as calculated, is not a hero-type personality, is stubborn, and shares many traits of, but not nearly enough of, the disorders listed above.

Key words: *NAFOD, central intelligence, defense intelligence, military science, behavioral science, psychology, social psychology, defense resource management.*

1. INTRODUCTION

For some time, this author and colleagues at Capital Coaching and Research Group [1], a clinical coaching and theoretical psychology practice outside of Washington, DC have been tracking an acronym, 'NAFOD' from its verbal origin - a now retired One Star U.S Army General - to its current state which, as it appears is an acronym with no official military classification, designation, psychologically diagnosable criteria, or true root within the Psychological Sciences.

Available members of every branch of the United States Armed Forces and Coast Guard deny ever hearing of the term. This author has spoken with Public Affairs Officers (PAOs) at Navy Medical Center - San Diego, NAVAIR in Virginia, with Navy Personnel Command in Maryland and even The Bureau of Naval

Medicine at The Pentagon. However, the acronym, while representative of what this author theorizes as a legitimate Psychological Disorder, appears nowhere in particular.

If spoken of only once by a singular military Flag Officer, the acronym itself though interesting, should play no role in the practice and research of theoretical psychology except; there is a small, definable, yet unverifiable evolution of usage.

Open Source and Closed Source information gathering (e.g. Google, Bing, PubMed, and LexisNexis) offer only a small number of citations of either the acronym 'NAFOD' itself or its proposed definition 'No Apparent Fear of Death'. Two citations from Google are simply the recognition of the acronym itself, one citation is a presumably misused 'urban' definition, one citation is an unverifiable quip about a former Naval Aviator who lost his Flight Wings due to a 'NAFOD'

stamp and the last, a smaller but verifiable quip from another former Naval Aviator, Chris Cree (Former Lt. Chris. Cree, personal communication, November 17, 2012).

The former Lt. Chris Cree was quoted during the author's research as saying "he [former Marine flight school roommate] was one of those entertaining types who tended to do stupid stuff. He'd be first in line (or maybe the only one in line) to jump off the roof into the swimming pool at a party, stuff like that. So it made perfect sense that the Marine Corps was sending him home due to 'NAFOD'. I'd never heard the term before he said it to me. But it obviously stuck with me once he did".

2. 'NAFOD' AS A THEORETICAL CONCEPT AND HYPOTHESIS

As the author of this brief hypothesis I intend to be clear that, to essentially create a new and diagnosable psychological disorder, hundreds of steps need to be taken and that as of publishing, the plan is not to pursue that objective. This author plans instead to further understand the concept behind 'NAFOD' and the theoretical diagnosable criteria that may aid governments, militaries, law enforcement agencies or other risk pre-disposed employers in identifying either negative or positive behavioral characteristics (this is relative to an organization's mission statement) in an individual prior to employment or contracting.

2.1. 'NAFOD' as a theoretical concept

This paper's author has come to the conclusion that 'NAFOD' or, an

individual who could be categorized as such ('Nafodic') must be made into a personality profile or be categorized as having a disorder other than what the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) already suggests. To be 'Nafodic' a theoretical human case study must exhibit behavior short of being Suicidal or short of suffering from Sub-Clinical Suicidality [2], clinically unable to be diagnosed as suffering from Schizotypal or Anti-Social Personality Disorder, Borderline Personality Disorder, Narcissistic Personality Disorder or any other pre-classified stimulus seeking Axis II disorders [3]. Moreover; this person must be of at least above average intelligence and is clearly able to make logical and morally/ethically appropriate decisions - he or she just chooses not to. Also of note, while the theoretical human case study exhibits stimulus seeking behavior which, for the sake of full disclosure is in fact similar to other diagnoses within the DSM; the particular sub-type of stimuli seeking behavior alluded to in this paper precludes 'NAFOD' from in fact being classified alongside another more common disorders due to its unique diagnosis criterion or lack thereof.

The hypothesized 'NAFOD Disorder' candidate, or 'Nafodic' individual, is reckless beyond the hard-wired risk taking profile of an adult male, is knowledgeable about death, is aware of its causes, takes risks not classified as calculated, is not a hero-type personality, is stubborn, and shares many traits of, but not nearly enough of, the disorders listed above. A minor but important

acknowledgement should be pointed out: the theory also suggests this theoretical diagnosis is not learned behavior but is instead a genetic predisposition.

2.2. 'NAFOD' as a hypothesis

The hypothesis is: this individual is much like the late Bud Holland, USAF, who lost his life attempting to barrel-role a B-52 Bomber (Major Justin Silverman J.D. USAF, personal communication, November 17, 2012) which was physically and scientifically impossible to accomplish and, Captain Holland was aware of this limitation. It appears Captain Holland had nothing to prove as an aviator, no Id v Ego complexes, lived life short of a clinically manic state, understood the consequences of failing, and with all of this in mind, made his attempt at Fairchild AFB in Washington State and lost his life.

2.3. Theoretical Biological/ Personality Profile

The theoretical biological/ personality profile is as follows:

- Male;
- Has current or former relationship with military or other risk predisposed profession;
- Understands consequences of his actions yet chooses to take the risk;
- Has reckless ambivalence to death;
- No suicidal or sub-clinical suicidal ideation;
- Does not represent the "hero class", is not simply brave, is not a religious zealot, values life yet takes uncalculated risks;
- Is not clinically manic nor is he suffering from an 'other' or undiagnosed single manic episode;

- Exhibits recklessness without cause on an ongoing basis and likely has since childhood (≤ 13 y/o);
- Has been divorced or has failed to yield any singular, long-term, stable relationship.

2.4. Theoretical Criterion for 'NAFOD' Diagnosis

- Episodes are not initiated or defined by environmental factors;
- NAFOD candidate must show no signs of mania, psychosis, compulsivity regularly;
- Episodes are uncalculated stimuli seeking;
- Must not have been previously diagnosed as Major Recurrent Depressive or Dysthymic;
- Must not have recurrent and/or intrusive negative recollections of 'NAFOD' episodes;
- Has lost permission to drive, fly, etc., do to reckless or inappropriate behavior (see Figure. 1).

The data in **Figure 1** was compiled using an interview format. Participants were contacted by the author from open source data and US Freedom of Information Act (FOIA) Requests to the Federal Aviation Administration [4] and Virginia Department of Motor Vehicles [5] District Court Alexandria, VA [6] as it pertains to current or former licensed pilots as per US Federal Aviation Administration (FAA) requirements and current or former licensed drivers.

Additional data was compiled using an interview format. However, participants from former United States Navy and United States Marine Corps Aviators were contacted via word of mouth notification.

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Name	Profession or Former Profession?	Have You Ever Lost Permission to Fly?	Have You Ever Lost Permission to Drive?	Are You Now or Have You Ever Been Married?	Divorced?	Have You Ever Seen a Mental Health Professional?	Have You Ever Been Diagnosed?	Have You Purchased Sex Once Or More than Once In The Past?	As a Child, Do You Recall Being "the life of the party" Or Being The First To Experiment w/ Danger?
Jason O.	Fighter Pilot	Y	N	Y	Y	N	N	Y	Y
Roman S.	Law Enforcement	Y	N	Y	Y	N	N	Y	Y
James R.	Fighter Pilot	Y	N	Y	Y	N	N	Y	Y
Chris P.	Fighter Pilot	Y	N	Y	Y	N	N	N	Y
Mark L.M.	Fighter Pilot	Y	N	Y	Y	N	N	Y	Y
Ryan S.	Military Helicopter	Y	N	Y	Y	N	N	Y	Y
Jason T.	Fighter Pilot	Y	N	Y	N	N	N	N	Y
Abdul R.A.	Fighter Pilot	N	Y	Y	N	N	N	N	Y
Mackenzie T.	Medical Doctor	N	Y	Y	Y	N	N	Y	Y
Donnell P.	OGA*	Y	Y	N	N	Y	N	Y	Y
Robert L.	Fighter Pilot	Y	N	Y	Y	N	N	Y	Y
Miles B.	Fighter Pilot	Y	N	Y	Y	Y	N	Y	Y
Jonathan H.	Teacher	Y	Y	Y	N	Y	N	Y	Y
Isaac U.	Lawyer	Y	N	Y	Y	Y	Y	Y	Y
Mason W.	Professional Athlete	Y	Y	N	N	N	N	Y	Y
Marcel C.	Military Helicopter	Y	N	N	N	N	N	N	Y
Asa O.	Military Helicopter	N	Y	Y	Y	N	N	N	Y
Stephen F.	Military Helicopter	N	Y	Y	Y	N	N	Y	Y
Franklin F.	Law Enforcement	N	N	N	N	Y	N	Y	Y
Scott J.	Ret. USN Deck Sup.	Y	Y	N	N	Y	Y	Y	Y
Shawn L.	Marine Corps Officer	Y	N	N	N	N	N	Y	Y
Brian C.	OGA*	Y	N	N	N	N	Y	Y	Y
Floyd H.	Fighter Pilot	N	Y	N	N	N	N	Y	Y
Reid J.	Law Enforcement	Y	N	Y	N	N	N	Y	Y
Quinton A.	Lawyer	Y	Y	N	N	N	Y	Y	Y
Donald D.	Medical Doctor	Y	Y	N	N	N	N	Y	Y
Joshua P.	OGA*	N	Y	N	N	Y	N	Y	Y
Ryan F.	Construction	Y	N	Y	Y	N	N	Y	Y
James H.	Military Helicopter	N	Y	Y	Y	Y	N	N	Y
Clifford L.	Fighter Pilot	Y	N	Y	Y	N	N	N	Y
Randal D.	Fighter Pilot	Y	N	Y	Y	Y	N	N	Y
Theodore D.	Fighter Pilot	N	Y	N	N	Y	N	Y	Y

Figure. 1 Interview data

This poll and the data within it are without any implied relationship to the US Navy, United States Marine Corps and the aforementioned branches of the military were notified that such a poll was taking place.

Moreover, mention must be made that this is not a scientific poll.

3. 'NAFOD' AND OTHER DIAGNOSES: A DISCUSSION

Because 'NAFOD' is only a hypothesis, there are still a great number of alternative diagnoses that share diagnostic criteria with the theoretical criteria accompanying No Apparent Fear of Death. While diagnoses with shared criteria are plentiful, only a handful can truly be explored as an argument against a new diagnosis and in line with a more historic and scientifically proven disorder. Among the handful are Cyclothemia, Schizoaffective Disorder, Anti-Social Personality

Disorder and Sub-Clinical Suicidal Ideation.

The argument against a diagnosis of Cyclothemia is clear, according to the Diagnostic and Statistical Manual of Mental Disorder, Cyclothemia presents in a patient with chronic, parabolic mood fluctuations over the course of at least two years [7]. In the context as is presented here, that is, in the context of a Soldier, Marine, Airman, etc., such behavior would be nearly impossible for any third party to ignore and, with appropriate checks and balances in place, the Cyclothymic patient would be removed from danger immediately and stop-gaps would be put in place.

Just as is found with Cyclothemia, Schizoaffective Disorder presents with symptoms of mild to severe psychosis and episodes of mania but for a period of at least two weeks.

With the understanding that both disorders [Cyclothemia and Schizoaffective Disorder] present

with common 'NAFOD' traits of recklessness and a general ambiguity and ambivalence to risk, Schizoaffective Disorder would also be an extremely difficult disorder to hide, if even for only the two week [minimum] period suggested in the diagnostic criterion unless the patient began showing symptoms while on personal leave which, again, would still suggest that a responsible third party would recognize a dangerous pattern of behavior and take appropriate action.

'NAFOD' it seems, is best explained not by characteristics it shares with other disorders but in fact, the characteristics it does not. There is a particular uniqueness to the diagnostic criterion as a group defined most obviously by the word "not" or "no". To be "Nafodic", or someone who presents with 'NAFOD' symptoms and all criterion for diagnosis does not represent the "hero class", is not simply brave, is not a religious zealot, must not have recurrent negative recollections of past uncalculated risk taking behavior, and must not be diagnosed Depressed and/or Dysthymic.

4. CONCLUSIONS

To suggest that 'NAFOD' is, with an unparalleled amount of surety a ground breaking, novel diagnosis worth exploring for clinical use is an overstatement of great proportions but, to suggest that there is enough empirical evidence to expound on the theory for practical usage is not.

While the hypothesis is in its earliest stages, the basis beyond the hypothesis itself, the character traits of the theoretical subject of diagnosis

and the participants in the Figure 1 poll above can be utilized almost immediately to serve any number of purposes throughout the Public Sector and more notably, Military and Intelligence infrastructures.

While the initial objective was to separate any number of unique, albeit theoretical standards or criterion for diagnosis of the 'Nafodic' individual to use as a screening mechanism, more to the point, as negative characteristics to screen out of potential employment scenarios, the author has been struck by the potential use of the 'Nafodic' candidate should the candidate's symptoms be controlled. Based entirely on the idea that said symptoms are in fact not learned behavior but are present at the time of gestation the question remains, can we in turn utilize the previously thought dangerous behaviors for good? Can we control the symptoms of an otherwise dangerous disorder for use elsewhere, say, the Clandestine Services or Special Operations?

As the idea develops, it should be clear that the author is most certainly not referencing the fictional "Manchurian Candidate" concept or alluding to such fiction as the "Bourne" series of books and movies by Robert Ludlum but instead is making the suggestion that just as we can control, or at least moderate other types of Axis I behavioral disorders and psychosomatic personas through intense therapy and medication management, why could we not do the same with 'NAFOD', but for mildly more commercial reason.

To control an individual's behavior without their consent would be groundbreaking but also morally and ethically absurd but, to control

one's behavior with the participants knowledge and participation, to have a patient/employee recognize (alongside the practitioner/employer) that these 'Nafodic' symptoms exist and can be controlled, used for the greater good, used to protect our borders, to fight the War on Terror, to be deployed as needed to successfully operate in combat zones or less kinetic environments, would be among the greatest achievements in the Behavioral Sciences to date.

Learned Behavior can be stopped, can be controlled, but also has a considerably looser grip on the mind/body control spectrum.

Should agencies such as US Central Intelligence Agency and its military option the Special Activities Division (CIA/SAD), Defense Intelligence Agency (DIA), US Special Operations Command (SOCOM), or the Tier One option Joint Special Operations Command (JSOC) have the ability to profile, recruit, train, and offer medically necessary behavior control to an operative with the knowledge and skills to operate effectively without visible fear or stress and without reservation, perhaps our human capital management efforts from within the Clandestine Services will look differently in the years to come.

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ENDNOTES

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[2]*The term 'OGA' denotes "Other Governmental Agency", implying Intelligence, Federal Law Enforcement, Etc.