

DEPARTMENT OF DEFENSE BLOGGERS ROUNDTABLE WITH GENERAL LOREE SUTTON, DIRECTOR OF THE CENTER FOR PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY (VIA TELECONFERENCE FROM ROSSLYN, VIRGINIA) SUBJECT: PSYCHOLOGICAL AND TRAUMATIC BRAIN INJURY TIME: 4:30 P.M. EST DATE: THURSDAY, JANUARY 15, 2009

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CHARLES "JACK" HOLT (Chief, New Media Operations, Office of the Secretary of Defense for Public Affairs): I think we can go ahead and get started. We've got 4:30 so we'll move right along here. Welcome to the Bloggers Roundtable. With us on the line this afternoon is Army Brigadier General Loree Sutton. She was the director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

General Sutton, thanks for joining us today.

GEN. SUTTON: Thanks so much. This is a real privilege.

MR. HOLT: Thank you. The floor is yours. If you've got an opening statement to get us started, we're ready when you are. GEN. SUTTON: Well, thank you so much for the opportunity to join you today. I appreciate your interest in this area. Clearly, this is an historic time. We're really at a point where we are supporting our warriors and their loved ones, recognizing that never in the history of our republic has so much been borne on the shoulders of so few on behalf of so many for so long.

And so every possible support, every possible measure that we can take to support warriors and their loved ones, whether you're on the battlefield, whether you're on the homefront, whether you're suffering from injuries seen or invisible, that's what we're all about.

So it's a joy to be here and to share what we're doing and to learn from each other.

MR. HOLT: Okay, very good. Thank you very much.

And Carla, since you were first on the line, why don't you get us started.

Q I guess my question is, how many have been treated for PTSD and TBI in terms of raw numbers? Do we know?

GEN. SUTTON: You know, in terms of raw numbers, you know, over the last five now going on six years, there have been 1.8 million warriors who have been deployed to either Iraq or Afghanistan. And of those, about anywhere

ranging from 15 to 20 percent, but 20 percent is kind of a round number, who have screened positive, meaning that when they come back through the post-deployment screening, you know, they've had a significant level of distress, as is not at all to be unexpected from this being the most corrosive environment known to warfare, and that is protracted urban counterinsurgency operations.

And so what that means is that those, roughly, probably 300,000 who, you know, are experiencing significant distress, such as anxiety, depression, maybe sleep problems or post-traumatic stress issues, of those, approximately 40(,000) to 50,000 across the services have been actually diagnosed with, for example, post traumatic stress disorder.

So you know, we don't get, you know, too hung up in the diagnoses. We just know that what we've got to do is we've got to help our warriors and their loved ones know that there is a transition for everyone coming back from war. This is as old as war itself.

And so our challenge is to reach out and help folks understand, what are the normal human responses to trauma? How can we help you adapt? How can we recognize that, for example, you know, the skills that are necessary to survive on the streets in Baghdad are very different than those which allow one to drive here on the homefront?

So we're, you know, really keeping our arms around every single warrior. You know, we are our brother's keepers, we are our sister's keepers, and that's our commitment. Q Thank you.

MR. HOLT: All right.

Okay, Bruce.

Q Hi, General. Bruce McQuain with QandO and Blackfive.

I was reading an Army Times article the other day. It was entitled "PTSD Victim Booted for Misconduct." And essentially, what it boiled down to was this was a sergeant that had had a couple of tours, was diagnosed with post traumatic stress disorder, had gone through the medical process and ended up being administratively discharged for a pattern of misconduct, even while the diagnosis said that, you know, it may have been the medicine he was on and that type of thing.

And his main complaint was, although he went to all his counseling sessions and did all this stuff, it wasn't enough. And I can certainly see the commander's side of this, you know. He's got a deployable unit, he's got to make sure he has as many deployable warriors as he can to take over there. It seems like a catch-22 for this sergeant. How are we getting more and more help to these PTSD cases that we have within the Army?

GEN. SUTTON: Sure. I mean, you know, just take a step back and for us to remind ourselves that these young men and women, you know, the majority of them have come into our services -- Army, Navy, Air Force, Marines -- since 9/11. They've known that our country is at war, they've raised their hands, and they've said, here I am, send me.

And so our obligation, our sacred commitment to them is to give them every bit of support we possibly can. And we know that, for example, for folks like this sergeant, we, as leaders, we simply must -- and in fact, there's been

a great attention that's been paid to this issue over the last several months and in fact a couple of years -- understand that, you know, if you've been a good troop before and you go downrange, whether it be your first, second or third time, and you come back and you're having difficulties, if you get into disciplinary problems, whether it be for substance abuse or, you know, maybe you had a fit of anger or, you know, you got yourself into some difficulties, our leaders now are very much attuned to the fact that they've got to look at the whole picture. You know, really take a holistic, comprehensive view to see, you know, is this a troop who really needs to get some help?

And it sounds like this soldier actually, you know, was able to step forward and say, hey, you know, I need to get some help, which is an act of great courage and strength.

But we also know that we've got to bring more tools to bear. So for example, one of the things this very year, we're bringing forward what we call the Warrior Wellness Innovation Network. It's a win-win network which will be a series of a type of studies across 15 to 16 sites, across the Department of Defense, all four services.

And what this will be, building upon the foundational treatments of cognitive behavioral therapy and prolonged exposure therapy which we know are, you know, fundamental for reaching out and addressing post traumatic stress issues.

For example, we also have clinical practice guidelines for depression and anxiety and substance abuse. We just finished up some of the practice guidelines for concussion of mild traumatic brain injury both in a deployed as well as a non-deployed setting.

This is all necessary, but we also believe that to be wholly sufficient, we've got to reach out to those complimentary alternative forms of therapy as well. So that's what this win-win network will be about is to put some performance metrics and outcome measures against treatments and approaches such as yoga and acupuncture and tai chi and, you know, (qigong ?) and meditation and biofeedback.

So we're very excited about this, and the troops are excited. You know, they look at it first and sort of say, you know, this sounds kind of flaky to me. (Laughs.) But once they try it -- for example, we've got a reiki program that's going on at Fort Bliss right now -- the troops love it. It helps them to sleep. It calms them down. It gives them a sense of mastery. And it engages both sides of the brain, left brain, right brain, as well as their mind, body and spirit.

So it's a very holistic approach that we will be launching just within the next few weeks.

Q Can I ask a follow up?

MR. HOLT: Yeah, sure. Go ahead.

Q More to a different point, General. Or not really to the same point, you know, more succinctly. Commanders are sitting out there right now looking at these warriors that they have. And they're asking themselves this question, do I rehabilitate him, or do I get rid of him as expeditiously as I can so I can replace him with someone who can deploy? That to me is the catch-

22, and that to me is what concerns me because the guy caught in the middle is the guy with PTSD.

GEN. SUTTON: Well, and here's the thing. And in fact, if you want to talk to the most enlightened commander that I know of in our services today it's Major General Mark Graham who is the commanding general at Fort Carson, Colorado. And he has really taken the lead in recognizing that, you know, I've got to prepare my leaders to, what we would say, get to the less of the crisis. In other words, you know, start building resilience from the very first day of a session and to keep regular contact with troops and their families and find out, you know, what's going on. How's your stress level? What have you got going on in your life? Do you have legal problems, financial problems, maybe one of your children is ill? You know, do you have pain? Do you have physical pain, emotional pain, spiritual pain?

It's important for every single leader to make sure that his or her troops coming back from combat, you know, really come to claim a war story that they can live with. And that means taking some pretty raw, pretty tough, pretty, at times, shocking experiences and talking it through to get the bigger picture and to really come to terms with whatever feelings of perhaps guilt, maybe you've lost a buddy and you've got survivor guilt or whatever feelings of inadequacy or concern that you may have had so you can really understand the whole context of your experience and learn from it.

And so, for example, Major General Graham, before he ever takes any sort of disciplinary action on one of his troops, he has his lawyers work with the docs, work with the command sergeant major to pull together the entire packet and to tell him the story which he reviews personally and then talks with the servicemember to determine really what's going on here and is this a servicemember, whether it be a soldier, sailor, airman, Marine -- in the case of General Graham, it would be a soldier; he's an Army general -- to determine, you know, is there something that we can do for this troop to get him or her back on track? And if there is, great, let's do it.

But certainly, none of us are in favor of, you know, deploying someone who has an illness or has a condition that really needs some attention. So there's so much effort that is being towards exactly the situation that you identify so that we make sure that, you know, we bring our troops back, and we help them reset their total fitness -- mind, body, spirit -- get with their families and then determine whether they're going to stay in uniform and continue to serve or whether perhaps they're going to continue their service as civilians on the outside.

Most of these troops, though, I will tell you, despite the toughness that they've been through -- I mean, two, three and sometimes four or more deployments -- they want to stay on the team. And so our commitment, our sacred duty is to give them the tools that they need and they want that will allow them to continue to serve.

Q So it sounds to me that General Graham has raised the visibility of the problem, he is personally taking charge of these cases and reviewing them himself.

GEN. SUTTON: Absolutely. And that has now become policy, actually.

Q Okay.

GEN. SUTTON: You cannot discharge a troop for a disciplinary chapter or a personality chapter without having that kind of review. And in fact, it goes up to the general-officer level before that can be approved just so that we make sure that we are not leaving any warrior behind, that we are taking every single factor into account and that we're making sure that we keep our arms around them to get them on track, no matter whether they're staying on active duty or whether they're going on to civilian life.

Q Last question, I promise. (Laughs.)

GEN. SUTTON: Sure.

Q The complaint about not having enough, I want to say, doctors or counselors or whatever to address those with PTSD that I found in this article, essentially saying, you know, I needed to go more than once a month, I needed to go more than what I was scheduled to go. Is in fact there a problem with the number of counselors that can help with this particular problem? And is there a plan to increase that?

Q Can I just jump on that? This is Carla. And whether there's been an improvement in in-house capabilities as opposed to using outsourcing for, you know, crisis intervention.

GEN. SUTTON: Certainly. No, that's a great question. Let me take sort of a big-picture view to begin with. First of all, within the VA system over the last three, three and a half years, they've actually added several thousand, 4,000 new mental health professionals to their ranks.

The TRICARE network which, of course, you know, TRICARE is our partner in terms of being able to supplement as we deploy our health care team downrange, TRICARE is the network that teams up with us outside the post. And they've added about 3,000 mental health professionals to their team which, of course, is part of our team. We're all in this together.

And within the Department of Defense, the various services have likewise correspondingly been working very hard. We're at about 75 percent of the identified new professionals that we need to bring onboard. So we're making progress.

We've got 200, for example, public health service professions, several of whom are working on my team right now with the Centers of Excellence. And they're just fantastic, I mean, they're just so proud to be part of the team, and they're doing wonderful, wonderful work.

But we're not going to be satisfied with simply bringing on more folks. We also want to be in a position to reach to next-generation solutions. And so for example, one of the things we're doing right now is we are moving out like fury to develop what we're calling a sim coach. If you can imagine, if every troop, every warrior, every family member had the opportunity to access an online coach from the privacy of their own home, their own laptop, their own smart phone and to harness the best of artificial intelligence, expert learning, voice recognition, simulated conversations and, of course, the best of neuroscience and experts who are willing to come forward and be part of our toolkit, you know, that is coming onboard.

We are developing that right now, leaning forward and pressing the technologists, the designers, the engineers and, you know, really industry to

help us reach that goal because we think that that's going to be an essential function, not a clinical, not a medical function but a (couch ?) function that would allow a troop or a family member to engage in conversation with an online coach.

And that coach then could help bring in every possible tool imaginable, whether it be, you know, cognitive training tools, whether it be online de-stress exercises, whether it be the opportunity to talk to a peer who has gone through treatments, let say, for post traumatic stress and who's come out on the other side and is eager to share lessons. Or if you want to talk with one of the world's leading experts on traumatic brain injury or depression or, you know, you name it, I mean, the sky is really the limit on this.

So we are moving out like fury so that we can develop this tool in addition to all of the other things that we're doing, which include screening before a troop goes downrange. It includes, you know, use of the MACE, the military acute concussion evaluation, if one is exposed to trauma or to blast through the course of one's deployment. It includes a pre-deployment, cognitive baseline assessment which is good to have a baseline assessment of brain function.

And then, of course, when one comes back, the post-deployment health assessment. And then three to six months later, once the honeymoon is kind of over, to be able to check back in again with troops and say, hey, how are you doing? Have a conversation with a health care professional, and if you need some help, whether it be for a, you know, a bad knee, a bad back or let's say that you're having trouble sleeping or having problems with nightmares or flashbacks or whatever the case may be, maybe you're having trouble at home, and we can help get you plugged into the resources that we have.

So it's really a full-court-press effort that we continue to improve upon. And you know, today's best isn't good enough. We've got to keep making it better every single day.

MR. HOLT: All right. Did anybody else join us?

Okay, any other follow-up questions? Bruce?

Q No, I actually got all my questions answered, thank you.

MR. HOLT: All right. Okay.

Well, General Sutton, do you have any closing thoughts for us or closing comments?

GEN. SUTTON: Well, again, I would just like, you know, so much on behalf of all of our troops and family members, I'd just like to thank you for your interest. You know, the critical messages to get out there right now is to, you know, to help our troops, our family members understand, you know, we are not alone. There's a whole nation of folks, like yourselves, like others around this country, who are interested in being part of the solution. They're interested in speaking truth to power. They're interested in transforming this culture, you know, from what has been a very medically illness-focused culture to one that is focused upon performance and wellness and resilience, you know, that allows folks to stay on the team.

And so I think that, you know, as we go down this road, I would invite you to continue to check in with us because we're just moving out and drawing fire. I'll tell you, you know, today's briefing is tomorrow's paperweight because there's so much to learn, so much to draw from science, from the field of technology, from neuroscience.

I mean, I would just use as an example, you know, I'm a psychiatrist. And when I went to medical school back in the early to mid '80s, you know, they taught us what they thought was really true at the time, and that was, you know, you're born into this world with all of the brain cells you're ever going to get. And so it was because of that, you know, that assumption -- that's what we thought was true at the time -- that, you know, this whole area of brain injury and rehabilitation, it really kind of developed kind of an era of doom and gloom.

And folks thought, well, you know, if you got a brain injury, you're just stuck. And now we know, over the last 10 to 15 years, we know now that the brain can and does grow new cells and axons and dendrons and dendrites and neurons and makes new connections. And in fact, that this takes place at the hippocampus which is the seat of memory and learning and emotions. And that there are things that we can do that can foster and absolutely enhance that kind of growth. And there are things certainly that can, you know, discourage that kind of growth. So of course, we want to encourage and we want to maintain as absolutely healthy a nutrition and, you know, the kind of cognitive and holistic approach that will allow us to maintain mind, body and spiritual fitness.

You know, the plasticity, for example, neuroplasticity, I would recommend you to a book that I recently ran across. It's called "The Brain That Changes Itself." Every chapter is devoted to a new renegade scientist who's, you know, learned about different ways the brain, you know, it rewires itself to adapt. And there are things that we can do to encourage that.

So for example, you know, one of the problems our troops have had has been with phantom limb pain. And this is not just a military problem. Anyone who's lost a limb is subject to this. And it can be so severe that, you know, it can drive someone to just absolutely, you know, just desperate ends and at times even suicide.

So there was a scientist in San Diego who, you know, was thinking about this. And he thought, you know, what if? He hypothesized, what if the brain has an image that it carries with it, you know, sort of a body image, and when it loses part of that body that it communicates with, that it continues to try to communicate with that part -- let's say it's an arm -- and it's no longer getting feedback from that limb? And so it becomes distressed, if you will. It can kind of get into a (dual-loop ?) of electrical impulses that then can lead to just absolutely intractable pain.

So on this basis, he goes down to, you know, sort of a hobby shop and gets a box and gets a mirror and starts doing research where, you know, you put the mirror in the middle of the box and had his patients then lean into the box so that, for example, let's say that they were missing their left arm. So they put their face then in and their right arm on the right side of the mirror and, you know, they would look into the mirror and see their right arm that was moving. But of course, in the mirror, that looks like their left arm.

And lo and behold, what he found was that indeed he could fool the brain into thinking that it again had a left arm. And he found that that indeed

did calm that series of distress signals. And in so doing, it absolutely helped with pain. And of course, the earlier we can intervene, the better.

So we're using that technique, for example, at Walter Reed and Bethesda and at Balbo and across the military right now. And we'll continue to learn because this is such an exciting, dynamic time. We're really on the frontier of what I would call, you know, innerspace.

I mean, in the '60s when President Kennedy summoned us all, challenged us to, you know, get to the moon in 10 years, and now here we are absolutely plumbing the frontiers of innerspace. And so I would just be delighted to stay in touch with you all and keep you posted on what we learn as we learn it.

MR. HOLT: That's fascinating. And yes, ma'am, we would love to have you back to join us again for another one of our DOD live Bloggers Roundtables. That would be great.

GEN. SUTTON: That would be just great. You know, let me just close with just a quick little tool that we developed this last year, if you don't mind. This is something that came out of tragedy. A Marine who was discharged with PTSD and ended up, you know, killing himself and his brother. It was just, you know, tragedy on top of tragedy.

And as we always do after, you know, a loss, we pull ourselves together, and we look at every detail of what's happened and try to learn everything that we possibly can so that this loss will not be in vain.

So one of the officers there, you know, one of the senior Marines there, you know, looked at me and said, hey, you know, doc, can't you just develop a simple tool, you know, none of this psychobabble stuff? Can't you just give us a tool that even our front-line troops, our front-line sergeants can use to figure out who of their troops might be most at risk?

And so what we've done -- we're just at the end of a whole series of focus groups with warriors and families and different generations -- we've developed what we've called a toolkit for life. And it's just seven simple questions but, you know, reinforcing every once of these questions is a whole body of science and knowledge that supports the validity of these areas of concern and endeavor.

So here goes, the toolkit for life.

Number one, got stress?

Number two, got pain?

Number three, got sleep?

Number four, got fuel?

Number five, got friends?

Number six, got heart?

Number seven, got hope?

Now, to be sure, you know, there are other risk factors, resilience factors that you could point to. But I will tell you that if every soldier, sailor, airman, Marine knew the answer to those questions, not only about themselves but about those, their brothers and sisters in arms, and knew how to engage each other in dialogue to kind of, you know, dig into it and unpack what the issues are and then knew how to link each other up with resources, you know, we'd be a step ahead in terms of our current challenges with suicide. So we're just, you know, leaving no stone uncovered. It's not just about one tool, it's not about a silver bullet. It's about a whole array of tools that we can pack into our toolkit. And this is just one simple one that we'll be developing with the gaming and design and technology industries so that we can, you know, we can make learning fun. And you know, that's what it's all about is to keep learning as we go to understand that, you know, we're all in this together. And try and navigate this journey alone will put any of us at greatest risk. And that's why I'm just so heartened that you all are interested in this. And I look forward, as we go down this road together, I look forward to staying in touch and keeping you posted on progress.

MR. HOLT: All right, ma'am. Thank you very much. And Army Brigadier General Loree Sutton, the director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, thanks for being with us. And we do look forward to chatting with you again.

GEN. SUTTON: Likewise. Thank you so much. Hoo-ah!

MR. HOLT: Hoo-ah!

GEN. SUTTON: Take care.

MR. HOLT: Thanks.

END.