



CDP Research Update -- March 15, 2012

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<http://www.ncbi.nlm.nih.gov/pubmed/22402895?dopt=Abstract>

Occup Med (Lond). 2012 Mar 7. [Epub ahead of print]

Military hierarchy, job stress and mental health in peacetime.

Martins LC, Lopes CS.

Source: Department of Epidemiology, Institute of Social Medicine, State University of Rio de Janeiro (IMS/UERJ), Rua São Francisco Xavier 524, 7^o andar, Rio de Janeiro, RJ 20550-900, Rio de Janeiro, RJ 20550-900, Brazil.

Abstract

Background

Most studies of mental health in the armed forces focus primarily on post-traumatic stress disorders among military personnel in combat situations. Aims To evaluate the prevalence of common mental disorders (CMD) and job stress, and the association between the two, among military personnel in peacetime. Additionally, it sought to identify occupational subgroups with higher prevalences of CMD.

Methods

The study participants were 506 military personnel from a Brazilian army directorate in Rio de Janeiro City. CMD were evaluated using the 12-item version General Health Questionnaire. Job characteristics were measured using the effort-reward imbalance (ERI) model and by categories of military rank. Prevalence ratios (PRs) were estimated by Poisson regression to obtain robust (95%) confidence intervals (CIs).

Results

The prevalence of CMD was 33% (95% CI 29-37). After adjusting for age, education, income, lifestyle and other occupational characteristics, ERI was associated with CMD (PR = 2.03; 95% CI 1.3-3.1).

Overcommitment proved to be an important component of job stress. Independently of socio-economic, demographic, lifestyle and job stress variables, the rank of lieutenant associated strongly with CMD (PR = 2.02; 95% CI 1.2-4 0.1).

Conclusions

This study found that job stress among armed forces personnel is associated with CMD. In addition, the specific occupational characteristics of the military environment can lead to a higher prevalence of CMD among those holding the rank of lieutenant.

<http://www.ncbi.nlm.nih.gov/pubmed/22401487?dopt=Abstract>

J Clin Psychiatry. 2012 Feb;73(2):e264-70.

The stressor criterion for posttraumatic stress disorder: does it matter?

Roberts AL, Dohrenwend BP, Aiello AE, Wright RJ, Maercker A, Galea S, Koenen KC.

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Abstract

OBJECTIVE:

The definition of the stressor criterion (DSM criterion A1) for posttraumatic stress disorder (PTSD) is hotly debated with major revisions being considered for DSM-5. We examine whether symptoms, course, and consequences of PTSD vary predictably with the type of stressful event that precipitates symptoms.

METHOD:

We used data from the 2009 PTSD diagnostic subsample (N = 3,013) of women from the Nurses' Health Study II. We asked respondents about exposure to stressful events that qualified under DSM-III or DSM-IV or did not qualify under DSM criterion A1. Respondents selected the event they considered worst and reported subsequent PTSD symptoms. Among participants who met all other DSM-IV PTSD criteria, we compared distress, symptom severity, duration, impairment, receipt of professional help, and 9 physical, behavioral, and psychiatric sequelae (eg, physical functioning, unemployment, depression) by precipitating event group. Various assessment tools were used to determine fulfillment of PTSD criteria B through F and to assess these 14 outcomes.

RESULTS:

Participants with PTSD from DSM-III events reported, on average, 1 more symptom (DSM-III, mean =

11.8 symptoms; DSM-IV, mean = 10.7 [P < .001]; non-DSM, mean = 10.9 [P < .01]) and more often reported that symptoms lasted 1 year or longer compared to participants with PTSD from other groups (DSM-III vs DSM-IV, P < .01; DSM-III vs non-DSM, P < .001). However, sequelae of PTSD did not vary systematically with precipitating event type.

CONCLUSIONS:

Results indicate the stressor criterion as defined by the DSM may not be informative in characterizing PTSD symptoms and sequelae. In the context of ongoing DSM-5 revision, these results suggest that criterion A1 could be expanded in DSM-5 without much consequence for our understanding of PTSD phenomenology. Events not considered qualifying stressors under the DSM produced PTSD as consequential as PTSD following DSM-III events, suggesting PTSD may be an aberrantly severe but nonspecific stress response syndrome.

<http://www.ncbi.nlm.nih.gov/pubmed/22403572?dopt=Abstract>

Front Neurol. 2012;3:32. Epub 2012 Mar 5.

Assessment of the effects of acute and repeated exposure to blast overpressure in rodents: toward a greater understanding of blast and the potential ramifications for injury in humans exposed to blast.

Ahlers ST, Vasserman-Stokes E, Shaughness MC, Hall AA, Shear DA, Chavko M, McCarron RM, Stone JR.

Source: Department of Neurotrauma, Operational and Undersea Medicine Directorate, Naval Medical Research Center Silver Spring, MD, USA.

Abstract

Mild traumatic brain injury (mTBI) resulting from exposure to improvised explosive devices (IEDs) has fueled a requirement to develop animal models that mirror this condition using exposure to blast overpressure (BOP). En route to developing a model of repeated exposure to BOP we sought to initially characterize the effects of acute BOP exposure in rodents, focusing specifically on the levels of BOP exposure that produced clinical mTBI symptoms. We first measured BOP effects on gross motor function on a balance beam. Separate groups of unanesthetized rats were exposed (in different orientations) to 36.6, 74.5, and 116.7 kPa BOP exposure inside a pneumatically driven shock tube. Results demonstrated that rats exposed to 116.7 kPa demonstrated transient alterations or loss of consciousness indicated by a transient loss of righting and by increased latencies on the balance beam. The 116.7 kPa exposure was the threshold for overt pathology for acute BOP exposure with approximately 30% of rats presenting with evidence of subdural hemorrhage and cortical contusions. All animals exposed to 116.7 kPa BOP manifested evidence of significant pulmonary hemorrhage. Anterograde memory deficits were observed in rats exposed to 74.5 kPa facing the BOP wave and rats exposed to 116.7 kPa in the lateral (side) orientation. We next assessed repeated exposure to either lateral or frontal 36.6 kPa BOP in anesthetized rats, once per day for 12 days. Results showed that repeated exposure in the frontal, but not side, orientation to the BOP wave produced a transitory learning deficit on a Morris water maze task

as shown by significantly longer latencies to reach the submerged platform in the second and third blocks of a four block session. Implications of these data are discussed in relation to the manifestation of mTBI in military personnel exposed to IEDs. Finally, we suggest that there are multiple types of long-term brain injury from blast exposure.

<http://www.ncbi.nlm.nih.gov/pubmed/22402485?dopt=Abstract>

Neuroscientist. 2012 Mar 8. [Epub ahead of print]

Genetic Polymorphisms Influence Recovery from Traumatic Brain Injury.

Weaver SM, Chau A, Portelli JN, Grafman J.

Source: Traumatic Brain Injury Research Laboratory, Kessler Foundation Research Center, West Orange, NJ.

Abstract

Traumatic brain injury (TBI) is a major public health concern in both civilian and military populations. Recently, genetics studies have begun to identify individual differences in polymorphisms that could affect recovery and outcome of cognitive and social processes following TBI. This review considers the potential for polymorphisms to influence six specific cognitive and social functions, which represent the most prominent domains of impairment following TBI: working memory, executive function, decision making, inhibition and impulsivity, aggression, and social and emotional function. Examining the influence of polymorphisms on TBI outcome has the potential to contribute to an understanding of variations in TBI outcome, aid in the triaging and treatment of TBI patients, and ultimately lead to targeted interventions based on genetic profiles.

<http://www.ncbi.nlm.nih.gov/pubmed/22403039?dopt=Abstract>

Curr Psychiatry Rep. 2012 Mar 9. [Epub ahead of print]

Advances in Psychotherapy for Generalized Anxiety Disorder.

Garfinkle EJ, Behar E.

Source: Hunter College, Regulation of Emotion in Anxiety and Depression Laboratory, 695 Park Avenue, Hunter North, Room 738, New York, NY, 10065, USA, egarfinkle@hotmail.com.

Abstract

Since the introduction of generalized anxiety disorder into the diagnostic system for psychiatric conditions, scientists have worked to develop effective treatments for the amelioration of chronic,

excessive worry. In addition to traditional cognitive-behavioral therapy, more recent advances have focused on treatments targeting intolerance of uncertainty, meta-cognitions, emotion dysregulation, lack of acceptance of internal experiences, and emotional contrasts. This article reviews these therapeutic approaches and summarizes recent publications relevant to the psychological treatment of worry and generalized anxiety disorder.

<http://www.ncbi.nlm.nih.gov/pubmed/22398269?dopt=Abstract>

Psychoneuroendocrinology. 2012 Mar 5. [Epub ahead of print]

Is there a biological difference between trauma-related depression and PTSD? DST says 'NO'

Savic D, Knezevic G, Damjanovic S, Spiric Z, Matic G.

Source: Vinca Institute, Belgrade, Serbia; International Aid Network, Belgrade, Serbia.

Abstract

The use of the low-dose dexamethasone suppression test (DST) as a potentially discriminative marker between post-traumatic stress disorder (PTSD) and depression is still under discussion. In order to compare the influence of these psychopathologies on the DST results, we examined suppression in war-traumatized subjects with one or both of these disorders, as well as in healthy controls. Based on our previous findings, we hypothesized that subjects with any disorder would exhibit higher dexamethasone suppression than healthy controls due to traumatic experiences. This study was a part of a broader project in which simultaneous psychological and biological investigations were carried out in hospital conditions on 399 male participants: 57 with PTSD, 28 with depression, 76 with PTSD+depression, and 238 healthy controls. Cortisol was measured in blood samples taken at 0900h before and after administering 0.5mg of dexamethasone (at 2300h). Group means±standard deviation of cortisol suppression were: 79.4±18.5 in the PTSD group, 80.8±11.6 in the depression group, 77.5±24.6 in the group with PTSD+depression, and 66.8±34.6 in healthy controls. The first three groups suppressed significantly more than the fourth. When the number of traumas was introduced as a covariate, the differences disappeared. The hypothesis was confirmed: in respect to DST, the examined trauma-related psychopathologies showed the same pattern: hypersuppression, due to multiple traumatic experiences.

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<http://www.ncbi.nlm.nih.gov/pubmed/22397917?dopt=Abstract>

Psychiatry Res. 2012 Mar 5. [Epub ahead of print]

Social cognition disorders in military police officers affected by posttraumatic stress disorder after the attack of An-Nasiriyah in Iraq 2006.

Mazza M, Giusti L, Albanese A, Mariano M, Pino MC, Roncone R.

Source: Department of Science of Health, University of L'Aquila, L'Aquila, Italy.

Abstract

Emotional numbness in individuals affected by posttraumatic stress disorder (PTSD) may be a result of the depletion of emotional capacities. The ability to process emotions in a social context is a part of social cognition, which is still an under-explored topic in PTSD. The present study investigated deficits in social cognition, such as emotion recognition and theory of mind, and their relationship to emotional numbing in 35 military police officers, who were in Iraq in April 2006, during a terrorist attack in An-Nasiriyah. Our results indicated that individuals suffering from PTSD showed deficits in social cognition when compared with healthy subjects. These disorders seemed to involve emotional numbing rather than clinical symptoms such as anxiety and depression. Future research directions are suggested to improve the measurement of emotional functioning in PTSD.

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<http://www.ncbi.nlm.nih.gov/pubmed/22397913?dopt=Abstract>

Psychiatry Res. 2012 Mar 5. [Epub ahead of print]

Decreased suicidal ideation in depressed patients with or without comorbid posttraumatic stress disorder treated with selective serotonin reuptake inhibitors: An open study.

Sher L, Stanley BH, Posner K, Arendt M, Grunebaum MF, Neria Y, Mann JJ, Oquendo MA.

Abstract

Comorbidity of posttraumatic stress disorder (PTSD) and major depressive disorder (MDD) is associated with higher morbidity including suicidal ideation and behavior. Selective serotonin reuptake inhibitors (SSRIs) are a known treatment for PTSD, MDD and comorbid PTSD and MDD. Since the patients with comorbid MDD and PTSD (PTSD-MDD) are sicker, we hypothesize a poorer response to treatment compared to patients with MDD only. Ninety-six MDD patients were included in the study: 76 with MDD only and 20 with PTSD-MDD. Demographic and clinical parameters at baseline were assessed. We examined clinical parameters before and after 3 months of open SSRI treatment in subjects with PTSD-MDD and compared this group to individuals with MDD only. At baseline, PTSD-MDD patients had higher Hamilton Depression Rating Scale and Buss-Durkee Hostility Scale scores compared with MDD only subjects. There was a significant decrease in scores on the Hamilton Depression Rating Scale, Beck Depression Inventory, Beck Hopelessness Scale, and Beck Scale for Suicidal Ideation after 3 months of treatment with SSRIs in both groups. The magnitude of improvement in Beck Scale for Suicidal Ideation scores was greater in the PTSD-MDD group compared to the MDD only subjects. Symptoms of depression including suicidal ideation improved in MDD patients with or without comorbid PTSD after

3months of treatment with SSRIs but improvement in suicidal ideation was greater in the PTSD-MDD group. Our finding has not supported the hypothesis that a response to treatment is poorer in the PTSD-MDD group which may indicate that sicker patients benefit more from the treatment.

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<http://www.ncbi.nlm.nih.gov/pubmed/22397911?dopt=Abstract>

Psychiatry Res. 2012 Mar 5. [Epub ahead of print]

Behavioral inhibition and PTSD symptoms in veterans.

Myers CE, Vanmeenen KM, Servatius RJ.

Source: Department of Veterans Affairs, VA New Jersey Health Care System, East Orange, NJ, USA; Department of Psychology, Rutgers University-Newark, NJ, USA; Stress and Motivated Behavior Institute, University of Medicine and Dentistry of New Jersey-New Jersey Medical School, Newark, NJ, USA.

Abstract

Behavioral inhibition (BI), a temperamental bias to respond to novel stimuli with avoidance behaviors, is a risk factor for posttraumatic stress disorder (PTSD). It is unclear whether BI accounts for additional variance in PTSD symptom severity beyond that accounted for by general anxiety. Here, 109 veterans (mean age 50.4years, 9.2% female) provided self-assessment of PTSD symptoms, state and trait anxiety, combat exposure, and current (adult) and retrospective (childhood) BI. Adult BI was correlated with anxiety and PTSD symptom severity, especially cluster C (avoidance) symptoms, but not with combat exposure. A regression model including adult BI, state and trait anxiety, and combat exposure was able to correctly classify over 80% of participants according to presence or absence of severe PTSD symptoms. Because avoidance behaviors are a core component of PTSD, self-assessments of BI may be an important tool in understanding PTSD and potentially assessing vulnerability to the disorder.

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<http://www.ncbi.nlm.nih.gov/pubmed/22397543?dopt=Abstract>

Psychiatry. 2012 Spring;75(1):76-97.

Bereavement and mental health after sudden and violent losses: a review.

Kristensen P, Weisæth L, Heir T.

Abstract

Abstract This paper reviews the literature on the psychological consequences of sudden and violent losses, including disaster and military losses. It also reviews risk and resilience factors for grief and mental health and describes the effects and possible benefit of psychosocial interventions. The review shows gaps in the literature on grief and bereavement after sudden and violent deaths. Still, some preliminary conclusions can be made. Several studies show that a sudden and violent loss of a loved one can adversely affect mental health and grief in a substantial number of the bereaved. The prevalence of mental disorders such as post-traumatic stress disorder (PTSD), major depressive disorder (MDD), and prolonged grief disorder (PGD, also termed complicated grief) varies widely, however, from study to study. Also, mental health disorders are more elevated after sudden and violent losses than losses following natural deaths, and the trajectory of recovery seems to be slower. Several factors related to the circumstances of the loss may put the bereaved at heightened risk for mental distress. These factors may be differentially related to different outcomes; some increase the risk for PTSD, others for PGD. Given the special circumstances, bereavement following sudden and violent death may require different interventions than for loss from natural death. Recommendations for future research and clinical implications are discussed.

<http://www.ncbi.nlm.nih.gov/pubmed/22397541?dopt=Abstract>

Psychiatry. 2012 Spring;75(1):49-59.

Leadership, Cohesion, Morale, and the Mental Health of UK Armed Forces in Afghanistan.

Jones N, Seddon R, Fear NT, McAllister P, Wessely S, Greenberg N.

Abstract

Abstract UK Armed Forces (AF) personnel deployed to Afghanistan are frequently exposed to intense combat and yet little is known about the short-term mental health consequences of this exposure and the potential mitigating effects of military factors such as cohesion, morale, and leadership. To assess the possible modulating influence of cohesion, morale, and leadership on post-traumatic stress disorder (PTSD) symptoms and common mental disorders resulting from combat exposure among UK AF personnel deployed to Afghanistan, UK AF personnel, during their deployment to Afghanistan in 2010, completed a self-report survey about aspects of their current deployment, including perceived levels of cohesion, morale, leadership, combat exposure, and their mental health status. Outcomes were symptoms of common mental disorder and symptoms of PTSD. Combat exposure was associated with both PTSD symptoms and symptoms of common mental disorder. Of the 1,431 participants, 17.1% reported caseness levels of common mental disorder, and 2.7% were classified as probable PTSD cases. Greater self-reported levels of unit cohesion, morale, and perceived good leadership were all associated with lower levels of common mental disorder and PTSD. Greater levels of unit cohesion, morale, and

good leadership may help to modulate the effects of combat exposure and the subsequent development of mental health problems among UK Armed Forces personnel deployed to Afghanistan.

<http://www.ncbi.nlm.nih.gov/pubmed/22397177?dopt=Abstract>

Med Law. 2011 Dec;30(4):517-27.

Psychiatric diagnoses in legal systems: an issue of validity.

Mellsop GW, Diesfel K.

Source: Waikato Clinical School of the University of Auckland, New Zealand.
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Abstract

When considering psychiatric evidence, justice systems from many countries are frequently presented with diagnostic labels from official psychiatric classificatory systems. A lack of validity in much of these classificatory systems is receiving increasing attention. Illustrative examples include post-traumatic stress disorder, various personality disorders and dissociative identity disorder. The courts and review bodies from many jurisdictions place tremendous faith in the present categorical classifications (e.g., DSMIV and ICD10). This paper questions whether the reliance on these classifications systems is appropriate in legal proceedings.

<http://www.ncbi.nlm.nih.gov/pubmed/22394292?dopt=Abstract>

J Neurosurg. 2012 Mar 6. [Epub ahead of print]

Is aggressive treatment of traumatic brain injury cost-effective?

Whitmore RG, Thawani JP, Grady MS, Levine JM, Sanborn MR, Stein SC.

Source

Departments of Neurosurgery.

Abstract

Object The object of this study was to determine whether aggressive treatment of severe traumatic brain injury (TBI), including invasive intracranial monitoring and decompressive craniectomy, is cost-effective. Methods A decision-analytical model was created to compare costs, outcomes, and cost-effectiveness of 3 strategies for treating a patient with severe TBI. The aggressive-care approach is compared with "routine care," in which Brain Trauma Foundation guidelines are not followed. A "comfort care" category, in which a single day in the ICU is followed by routine floor care, is included for

comparison only. Probabilities of each treatment resulting in various Glasgow Outcome Scale (GOS) scores were obtained from the literature. The GOS scores were converted to quality-adjusted life years (QALYs), based on expected longevity and calculated quality of life associated with each GOS category. Estimated direct (acute and long-term medical care) and indirect (loss of productivity) costs were calculated from the perspective of society. Sensitivity analyses employed a 2D Monte Carlo simulation of 1000 trials, each with 1000 patients. The model was also used to estimate these values for patients 40, 60, and 80 years of age. Results For the average 20-year-old, aggressive care yields 11.7 (\pm 1.6 [SD]) QALYs, compared with routine care (10.0 \pm 1.5 QALYs). This difference is highly significant ($p < 0.0001$). Although the differences in effectiveness between the 2 strategies diminish with advancing age, aggressive care remains significantly better at all ages. When all costs are considered, aggressive care is also significantly less costly than routine care (\$1,264,000 \pm \$118,000 vs \$1,361,000 \pm \$107,000) for the average 20-year-old. Aggressive care remains significantly less costly until age 80, at which age it costs more than routine care. However, even in the 80-year-old, aggressive care is likely the more cost-effective approach. Comfort care is associated with poorer outcomes at all ages and with higher costs for all groups except 80-year-olds. Conclusions When all the costs of severe TBI are considered, aggressive treatment is a cost-effective option, even for older patients. Comfort care for severe TBI is associated with poor outcomes and high costs, and should be reserved for situations in which aggressive approaches have failed or testing suggests such treatment is futile.

<http://www.ncbi.nlm.nih.gov/pubmed/22408635?dopt=Abstract>

Front Neurol. 2012;3:31. Epub 2012 Mar 7.

Perspectives on creating clinically relevant blast models for mild traumatic brain injury and post traumatic stress disorder symptoms.

Brenner LA, Bahraini N, Hernández TD.

Source: Veterans Integrated Service Network 19, Mental Illness Research Education and Clinical Center Denver, CO, USA.

Abstract

Military personnel are returning from Iraq and Afghanistan and reporting non-specific physical (somatic), behavioral, psychological, and cognitive symptoms. Many of these symptoms are frequently associated with mild traumatic brain injury (mTBI) and/or post traumatic stress disorder (PTSD). Despite significant attention and advances in assessment and intervention for these two conditions, challenges persist. To address this, clinically relevant blast models are essential in the full characterization of this type of injury, as well as in the testing and identification of potential treatment strategies. In this publication, existing diagnostic challenges and current treatment practices for mTBI and/or PTSD will be summarized, along with suggestions regarding how what has been learned from existing models of PTSD

and traditional mechanism (e.g., non-blast) traumatic brain injury can be used to facilitate the development of clinically relevant blast models.

<http://www.ncbi.nlm.nih.gov/pubmed/22406920?dopt=Abstract>

Clin Psychol Rev. 2012 Feb 10;32(3):202-214. [Epub ahead of print]

Psychological treatments for concurrent posttraumatic stress disorder and substance use disorder: A systematic review.

van Dam D, Vedel E, Ehring T, Emmelkamp PM.

Source: Department of Clinical Psychology, University of Amsterdam, Weesperplein 4, 1018 XA, Amsterdam, The Netherlands; Jellinek Substance Abuse Treatment Centre/Arkin, Amsterdam, The Netherlands.

Abstract

This article gives an overview of research into psychological treatments for concurrent posttraumatic stress disorder (PTSD) and substance used disorder (SUD), with a special focus on the effectiveness of treatments addressing both disorders compared to treatments addressing one of the disorders alone. In addition, a distinction is made between trauma-focused versus non-trauma-focused therapies for concurrent PTSD and SUD. The databases Embase, Psychinfo, Medline and Web of science were searched for relevant articles. In total, seventeen studies were identified evaluating ten treatments protocols (six trauma-focused and four non-trauma-focused treatment approaches). In general, the studies showed pre-post reductions for PTSD and/or SUD symptoms. Although most treatments for concurrent PTSD and SUD did not prove to be superior to regular SUD treatments, there are some promising preliminary results suggesting that some patients might benefit from trauma-focused interventions. However, the lack of methodologically sound treatment trials makes it difficult to draw firm conclusions. Methodological limitations are discussed, along with recommendations for future research.

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<http://www.ncbi.nlm.nih.gov/pubmed/22404747?dopt=Abstract>

Headache. 2012 Mar 8. doi: 10.1111/j.1526-4610.2012.02112.x. [Epub ahead of print]

Chronic Daily Headache in U.S. Soldiers After Concussion.

Theeler BJ, Flynn FG, Erickson JC.

Source: From the AMEDD Student Detachment, 187th Medical Battalion, Fort Sam Houston, Texas, Medical Corps, United States Army, TX, USA (B.J. Theeler); Madigan Traumatic Brain Injury Program, Fort Lewis, Washington, USA (F.G. Flynn); Madigan Army Medical Center, Department of Medicine, Neurology Service, Medical Corps, United States Army, USA (J.C. Erickson).

Abstract

Objective

To determine the prevalence and characteristics of, and factors associated with, chronic daily headache (CDH) in U.S. soldiers after a deployment-related concussion

Methods

A cross-sectional, questionnaire-based study was conducted with a cohort of 978 U.S. soldiers who screened positive for a deployment-related concussion upon returning from Iraq or Afghanistan. All soldiers underwent a clinical evaluation at the Madigan Traumatic Brain Injury Program that included a history, physical examination, 13-item self-administered headache questionnaire, and a battery of cognitive and psychological assessments. Soldiers with CDH, defined as headaches occurring on 15 or more days per month for the previous 3 months, were compared to soldiers with episodic headaches occurring less than 15 days per month.

Results

One hundred ninety-six of 978 soldiers (20%) with a history of deployment-related concussion met criteria for CDH and 761 (78%) had episodic headache. Soldiers with CDH had a median of 27 headache days per month, and 46/196 (23%) reported headaches occurring every day. One hundred seven out of 196 (55%) soldiers with CDH had onset of headaches within 1 week of head trauma and thereby met the time criterion for posttraumatic headache (PTHA) compared to 253/761 (33%) soldiers with episodic headache. Ninety-seven out of 196 (49%) soldiers with CDH used abortive medications to treat headache on 15 or more days per month for the previous 3 months. One hundred thirty out of 196 (66%) soldiers with CDH had headaches meeting criteria for migraine compared to 49% of soldiers with episodic headache. The number of concussions, blast exposures, and concussions with loss of consciousness was not significantly different between soldiers with and without CDH. Cognitive performance was also similar for soldiers with and without CDH. Soldiers with CDH had significantly higher average scores on the posttraumatic stress disorder (PTSD) checklist compared to soldiers with episodic headaches. Forty-one percent of soldiers with CDH screened positive for PTSD compared to only 18% of soldiers with episodic headache.

Conclusion

The prevalence of CDH in returning U.S. soldiers after a deployment-related concussion is 20%, or 4- to 5-fold higher than that seen in the general U.S. population. CDH following a concussion usually resembles chronic migraine and is associated with onset of headaches within the first week after concussion. The mechanism and number of concussions are not specifically associated with CDH as compared to episodic headache. In contrast, PTSD symptoms are strongly associated with CDH, suggesting that traumatic stress may be an important mediator of headache chronification. These

findings justify future studies examining strategies to prevent and treat CDH in military service members following a concussive injury.

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<http://psycnet.apa.org/journals/tra/4/2/152>

Disturbances of emotional awareness and expression in posttraumatic stress disorder: Meta-mood, emotion regulation, mindfulness, and interference of emotional expressiveness.

Frewen, Paul A.;Dozois, David J. A.;Neufeld, Richard W. J.;Lanius, Ruth A.

Psychological Trauma: Theory, Research, Practice, and Policy, Vol 4(2), Mar 2012, 152-161.

doi: 10.1037/a0023114

Demonstrations of deficient emotional awareness (EA) in posttraumatic stress disorder (PTSD) measured by alexithymia were extended to trait metamood, difficulties in emotion regulation, and trait mindfulness in 55 women with PTSD related to history of interpersonal/familial maltreatment. Perceived causes of interference of emotional expression were also identified that fully mediated the association between PTSD diagnostic status and alexithymic difficulty describing feelings, but only partially mediated the association between PTSD diagnosis and alexithymic difficulty identifying feelings. Such causes of interference of emotional expression correlated with history of childhood physical and emotional neglect. Clinical implications and future research directions are discussed. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

<http://psycnet.apa.org/journals/tra/4/2/221>

Changes in mindfulness skills and treatment response among veterans in residential PTSD treatment.

Owens, Gina P.;Walter, Kristen H.;Chard, Kathleen M.;Davis, Paul A.

Psychological Trauma: Theory, Research, Practice, and Policy, Vol 4(2), Mar 2012, 221-228.

doi: 10.1037/a0024251

Recent research has explored the use of mindfulness principles as a component in treatments for various mental health difficulties, although limited research has explored the relationships between mindfulness and PTSD. Therefore, the current study assessed the relationships between mindfulness skills and PTSD and depression severity for a veteran sample (N = 149) in a residential PTSD treatment program. Although overall mindfulness skills did not change significantly over the course of treatment, specific subscales of the Kentucky Inventory of Mindfulness Skills (KIMS) were negatively associated with clinician-rated measures of PTSD and depression. Veterans who reported greater improvement on

Acting with Awareness skills over the course of treatment had lower levels of clinician-rated PTSD and depression at posttreatment. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

<http://www.ncbi.nlm.nih.gov/pubmed/22411107?dopt=Abstract>

J Head Trauma Rehabil. 2012 Mar-Apr;27(2):87-98.

Association of depressive symptoms with functional outcome after traumatic brain injury.

Hudak AM, Hynan LS, Harper CR, Diaz-Arrastia R.

Source: Department of Physical Medicine and Rehabilitation, Virginia Commonwealth University (Dr Hudak), Departments of Clinical Sciences (Division of Biostatistics) and Psychiatry (Dr Hynan), and Department of Neurology (Ms Harper), University of Texas Southwestern Medical Center, Dallas, Department of Neurology (Dr Diaz-Arrastia), Uniformed Services University of the Health Sciences, Rockville, Maryland.

Abstract

OBJECTIVE:

To test whether improved functional status correlates with more depressive symptoms after traumatic brain injury(TBI). This is based on the concept that increasing awareness of deficits may exacerbate depression, even while survivors are making functional improvements.

PARTICIPANTS:

A total of 471 individuals with TBI (72% white; 71% men; median Glasgow Coma Scale (GCS) score = 11) enrolled during acute care or inpatient rehabilitation and followed up at a median of 6 months.

MAIN MEASURE:

Beck Depression Inventory-II (BDI-II), Glasgow Outcome Scale-Extended, and Functional Status Examination (FSE).

RESULTS:

We found significant Spearman rank order correlations between BDI-II scores and the total FSE as well as all domains of the FSE. Lower functional levels correlated with more depressive symptoms. Modeling of predictive factors, including subject characteristics, injury-related characteristics, and outcome measures, resulted in 2 models, both containing age and GCS along with other factors.

CONCLUSION:

The relation between depressive symptoms and functional outcomes is complex and a fertile area for further research. The authors would encourage clinicians to monitor patients for depressive symptoms to help to prevent the detrimental impact on recovery.

<http://www.ncbi.nlm.nih.gov/pubmed/22410412?dopt=Abstract>

Neuropsychologia. 2012 Mar 5. [Epub ahead of print]

Effective factors on linguistic disorder during acute phase following traumatic brain injury in adults.

Chabok SY, Kapourchali SR, Leili EK, Saberi A, Mohtasham-Amiri Z.

Source: Neurosurgery in Guilan University of Medical Sciences, Guilan Road Trauma Research Center, Rasht 4193713194, Guilan Province, Iran.

Abstract

Traumatic brain injury (TBI) has been known to be the leading cause of breakdown and long-term disability in people under 45 years of age. This study highlights the effective factors on post-traumatic (PT) linguistic disorder and relations between linguistic and cognitive function after trauma in adults with acute TBI. A cross-sectional design was employed to study 60 post-TBI hospitalized adults aged 18-65 years. Post-traumatic (PT) linguistic disorder and cognitive deficit after TBI were respectively diagnosed using the Persian Aphasia Test (PAT) and Persian version of Mini-Mental State Examination (MMSE) at discharge. Primary post-resuscitation consciousness level was determined using the Glasgow Coma Scale (GCS). Paracilinal data was obtained by CT scan technique. Multiple logistic regression analysis illustrated that brain injury severity was the first powerful significant predictor of PT linguistic disorder after TBI and fronto-temporal lesion was the second. It was also revealed that cognitive function score was significantly correlated with score of each language skill except repetition. Subsequences of TBI are more commonly language dysfunctions that demand cognitive flexibility. Moderate, severe and fronto-temporal lesion can increase the risk of processing deficit in linguistic macrostructure production and comprehension. The dissociation risk of cortical and subcortical pathways related to cognitive-linguistic processing due to intracranial lesions can augment possibility of lexical-semantic processing deficit in acute phase which probably contributes to later cognitive-communication disorder.

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<http://www.ncbi.nlm.nih.gov/pubmed/22408635?dopt=Abstract>

Front Neurol. 2012;3:31. Epub 2012 Mar 7.

Perspectives on creating clinically relevant blast models for mild traumatic brain injury and post traumatic stress disorder symptoms.

Brenner LA, Bahraini N, Hernández TD.

Source: Veterans Integrated Service Network 19, Mental Illness Research Education and Clinical Center Denver, CO, USA.

Abstract

Military personnel are returning from Iraq and Afghanistan and reporting non-specific physical (somatic), behavioral, psychological, and cognitive symptoms. Many of these symptoms are frequently associated with mild traumatic brain injury (mTBI) and/or post traumatic stress disorder (PTSD). Despite significant attention and advances in assessment and intervention for these two conditions, challenges persist. To address this, clinically relevant blast models are essential in the full characterization of this type of injury, as well as in the testing and identification of potential treatment strategies. In this publication, existing diagnostic challenges and current treatment practices for mTBI and/or PTSD will be summarized, along with suggestions regarding how what has been learned from existing models of PTSD and traditional mechanism (e.g., non-blast) traumatic brain injury can be used to facilitate the development of clinically relevant blast models.

<http://www.ncbi.nlm.nih.gov/pubmed/22406052?dopt=Abstract>

J Subst Abuse Treat. 2012 Mar 8. [Epub ahead of print]

Comorbid depression and substance use disorder: Longitudinal associations between symptoms in a controlled trial.

Worley MJ, Trim RS, Roesch SC, Mrnak-Meyer J, Tate SR, Brown SA.

Source: San Diego State University/University of California, San Diego Joint Doctoral Program in Clinical Psychology, San Diego, CA, USA.

Abstract

This study examined the longitudinal association between substance use and depressive symptoms in veterans receiving outpatient treatment for comorbid substance use disorder and major depression. Veterans (N = 237, mean age = 48.2 years, 90% male, 70% Caucasian) received either 6 months of group integrated cognitive-behavioral therapy or twelve-step facilitation. Hamilton Depression Rating Scale scores and percent days using any substance were assessed every 3 months up to 1 year posttreatment. Greater substance use predicted time-varying elevations in depression above individual patterns of change in depression. Moreover, change in depressive symptoms was associated with change in both the likelihood of any substance use and the frequency of use during the treatment and follow-up periods. Changes in these symptoms appear to be linked, such that individuals with greater reductions in substance use have greater reductions in depressive symptoms (and vice versa).

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<http://www.sciencedirect.com/science/article/pii/S0165032712000924>

Journal of Affective Disorders

Suicidal ideation and the subjective aspects of depression.

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Received 28 November 2011. Revised 13 January 2012. Accepted 30 January 2012. Available online 8 March 2012.

<http://dx.doi.org/10.1016/j.jad.2012.01.045>

Background

Suicidal ideation is common in depression, but only moderately related to depression severity — in part because certain clusters of symptoms, such as those related to core mood disturbance, have a differential relationship to suicidal thinking.

Methods

400 medication free participants with current major depression were assessed with either or both the Hamilton Depression Rating Scale (HDRS, $n = 396$) and Beck Depression Inventory (BDI, $n = 366$), and the Scale for Suicide Ideation (SSI). Depression rating scales were decomposed into symptoms clusters previously reported (Grunebaum et al., 2005), in order to evaluate their association to suicidal thinking.

Results

Correlations between overall depression severity ratings and the measure of suicidal ideation were modest, and reduced when specific items assessing suicidal thinking on these depression scales were removed. Symptom clusters assessing Psychic Depression (HDRS), Subjective Depression (BDI), and Self-Blame (BDI) were the strongest correlates of suicidal ideation; other somatic and vegetative symptoms had little or no association to suicidal ideation. Severity of these symptom clusters effectively discriminated those with ($SSI > 0$) and without ($SSI = 0$) ideation; severity of these symptom clusters was less strongly associated with the severity of ideation once ideation was present.

Limitations

This is a cross-sectional study, and the dynamic relationship between changes in the severity of various depressive symptoms and change in suicidal thinking remains to be explored.

Conclusions

Depression severity is moderately associated with suicidal ideation, and accounted for primarily by core mood disturbance symptoms and self-punitive thinking. These associations may explain why suicide risk might remain high during treatment even though somatic and vegetative symptoms improve.

<http://guilfordjournals.com/doi/abs/10.1521/psyc.2012.75.1.49>

Norman Jones, Rachel Seddon, Nicola T. Fear, Pete McAllister, Simon Wessely, and Neil Greenberg (2012).

Leadership, Cohesion, Morale, and the Mental Health of UK Armed Forces in Afghanistan.

Psychiatry: Interpersonal and Biological Processes: Vol. 75, No. 1, pp. 49-59.

doi: 10.1521/psyc.2012.75.1.49

UK Armed Forces (AF) personnel deployed to Afghanistan are frequently exposed to intense combat and yet little is known about the short-term mental health consequences of this exposure and the potential mitigating effects of military factors such as cohesion, morale, and leadership. To assess the possible modulating influence of cohesion, morale, and leadership on post-traumatic stress disorder (PTSD) symptoms and common mental disorders resulting from combat exposure among UK AF personnel deployed to Afghanistan, UK AF personnel, during their deployment to Afghanistan in 2010, completed a self-report survey about aspects of their current deployment, including perceived levels of cohesion, morale, leadership, combat exposure, and their mental health status. Outcomes were symptoms of common mental disorder and symptoms of PTSD. Combat exposure was associated with both PTSD symptoms and symptoms of common mental disorder. Of the 1,431 participants, 17.1% reported caseness levels of common mental disorder, and 2.7% were classified as probable PTSD cases. Greater self-reported levels of unit cohesion, morale, and perceived good leadership were all associated with lower levels of common mental disorder and PTSD. Greater levels of unit cohesion, morale, and good leadership may help to modulate the effects of combat exposure and the subsequent development of mental health problems among UK Armed Forces personnel deployed to Afghanistan,

<http://www.ingentaconnect.com/content/amsus/zmm/2012/00000177/00000003/art00018>

Automated Neuropsychological Assessment Metrics (v4) Traumatic Brain Injury Battery: Military Normative Data.

Authors: Vincent, Andrea S.; Roebuck-Spencer, Tresa; Gilliland, Kirby; Schlegel, Robert

Source: Military Medicine, Volume 177, Number 3, March 2012 , pp. 256-269(14)

The aim of the present study was to establish normative data for the Automated Neuropsychological Assessment Metrics (v4) Traumatic Brain Injury (ANAM4 TBI) battery in a military context. ANAM4 data from over 107,500 active duty service members ranging from 17 to 65 years of age were included in this study. The influence of the demographic variables of age and gender were also examined. These norms, stratified by age and gender, represent a more comprehensive set of norms than previously available and are provided as a representative set of norms for clinical practice. Additionally, base rates of below average performance in a normal population are provided to help inform clinical decision making.

<http://www.ingentaconnect.com/content/amsus/zmm/2012/00000177/00000003/art00017>

Effects of Military Deployment on Cognitive Functioning.

Authors: Vincent, Andrea S.; Roebuck-Spencer, Tresa; Lopez, Mary S.; Twillie, David A.; Logan, Bret W.; Grate, Stephen J.; Friedl, Karl E.; Schlegel, Robert E.; Gilliland, Kirby

Source: Military Medicine, Volume 177, Number 3, March 2012 , pp. 248-255(8)

Military deployment poses many risks for cognitive functioning. When deployed individuals are compared to a nondeployed control group, there is some evidence that deployment may be associated with declines in cognitive functioning. The current study examined cognitive performance before and following deployment in a large sample of active duty military personnel (N = 8,002) who reported no traumatic brain injury (TBI). Cognition was assessed using the Automated Neuropsychological Assessment Metrics version 4 TBI Military (ANAM4 TBI-MIL) battery, a computer-based battery of tests measuring attention, processing speed, and general cognitive efficiency. Pre- and postdeployment scores were compared using repeated measures analyses. Although statistically significant differences were observed for all tests (with 5 of 7 tests demonstrating performance improvement), effect sizes were very small for all but 1 test, indicating that performance differences had minimal clinical significance. Likewise, determination of change for individuals using reliable change indices revealed that a very small percentage (<3%) of this presumed healthy sample showed meaningful decline in cognition following deployment. Analyses indicated that despite risks for cognitive decline while in theater, deployment had minimal to no lasting effect on cognition as measured by ANAM4 TBI-Mil upon return from deployment.

<http://onlinelibrary.wiley.com/doi/10.1111/j.1548-1387.2011.01196.x/abstract>

Armor and Anesthesia: Exposure, Feeling, and the Soldier's Body.

Kenneth T. MacLeish

Medical Anthropology Quarterly

Volume 26, Issue 1, pages 49–68, March 2012

For many civilians, the high-tech weapons, armor, and military medicine with which U.S. soldiers are equipped present an image of lethal capacity and physical invulnerability. But, as this article explores, soldiers themselves just as often associate the life-sustaining technology of modern warfare with feelings that range from a pragmatic ambivalence about exposure to harm all the way to profoundly unsettling vulnerability. This article, based on fieldwork among soldiers and military families at the U.S. Army's Ft. Hood, examines sensory and affective dimensions of soldiers' intimate bodily relationships with the technologies that alternately or even simultaneously keep them alive and expose them to harm. I argue that modern military discipline and technology conspire to cultivate soldiers as highly durable, capable, unfeeling, interchangeable bodies, or what might be called, after Susan Buck-Morss (1992), anesthetic subjects. But for soldiers themselves, their training, combat environment, protective gear, and weapons are a rich font of both emotional and bodily feeling that exists in complex tension with the also deeply felt military imperative to carry on in the face of extreme discomfort and danger. [Iraq War, U.S. military, armor, biopolitics, embodiment, the senses]

<http://www.ncbi.nlm.nih.gov/pubmed/22414023?dopt=Abstract>

J Neurotrauma. 2012 Mar 13. [Epub ahead of print]

Medical care costs associated with traumatic brain injury (TBI) over the full spectrum of disease: A controlled population-based study.

Leibson CL, Brown AW, Hall Long K, Ransom JE, Mandrekar JN, Osler TM, Malec JF.

Source: Mayo Clinic, Health Sciences Research, 200 First St SW, Rochester, Minnesota, United States, 55905; leibson.cynthia@mayo.edu.

Abstract

Data on TBI economic outcomes are limited. We used Rochester Epidemiology Project (REP) resources to estimate long-term medical costs for clinically-confirmed incident TBI across the full range of severity and controlling for pre-existing conditions and co-occurring injuries. All Olmsted County, MN, residents with diagnoses indicative of potential TBI 1985-2000 (N=46,114) were identified; a random sample (N=7,175) was selected for medical-record review to confirm case status and characterize as definite (moderate/severe), probable (mild), or possible (symptomatic) TBI. For each case, we identified one age-sex-matched non-TBI control registered in REP in the year (± 1) of case's TBI. Cases with co-occurring non-head injuries were assessed for non-head-injury severity and assigned similar non-head-injury-severity controls. The 1,145 case/control pairs for 1988-2000 were followed until earliest death/emigration of either member for medical costs 12-months before and up to 6 years after baseline, i.e., injury date for cases and comparable dates for controls. Differences between case and control costs were stratified by TBI severity, as defined by evidence of brain injury; comparisons used Wilcoxon signed-rank plus multivariate modeling (adjusted for pre-baseline characteristics). From baseline-6 years, each TBI category exhibited significant incremental costs. For definite and probable

TBI, most incremental costs occurred within the first 6 months; significant long-term incremental medical costs were not apparent among 1-year survivors. By contrast, cost differences between possible TBI cases and controls were not as great within the first 6 months but were substantial among 1 year survivors. Although mean incremental costs were highest for definite cases, probable and possible cases accounted for >90% of all TBI events and 66% of total incremental costs. Preventing probable and possible events might contribute substantial reductions in TBI-associated medical care costs.

Links of Interest

PTSD Sufferers Face 'Stigma Issue,' Hammer Says

<http://www.bloomberg.com/video/87942330/>

Fort Bragg addresses wounded warriors' concerns at town hall meeting

http://www.army.mil/article/75441/Fort_Bragg_addresses_wounded_warriors_concerns_at_town_hall_meeting/

Where will the (new) drugs for traumatic brain injury treatment be coming from?

<http://www.frontiersin.org/Neurotrauma/10.3389/fneur.2012.00027/full>

Nearly 300 soldiers getting PTSD case reviews at Madigan

<http://www.theolympian.com/2012/03/08/2021107/joint-base-lewis-mcchord-army.html>

More than 280 service members offered third opinion on psych evals

http://www.army.mil/article/75544/More_than_280_service_members_offered_third_opinion_on_psych_evals/

Afghan shootings refocus attention at Fort Lewis-McChord base

http://www.washingtonpost.com/world/national-security/afghan-shootings-refocus-attention-on-fort-lewis-mcchord/2012/03/13/gIQApTNYAS_story.html

Warrior Resilience Conference 2012: Restoring Readiness; Enhancing Resilience

<http://dcoe.health.mil/NewsArticle.aspx?id=3061>

The New Battle Our Soldiers Face: the Bias of Some Corporate Hiring Managers

<http://www.prnewswire.com/news-releases/the-new-battle-our-soldiers-face-the-bias-of-some-corporate-hiring-managers-140887863.html>

Aggressive Care Best for Brain Trauma, Study Shows

http://www.nlm.nih.gov/medlineplus/news/fullstory_122783.html

'Delayed Reactions' May Outlast Other Concussion Effects

http://www.nlm.nih.gov/medlineplus/news/fullstory_122816.html

Report raises concerns for homeless female vets

http://www.cbsnews.com/8301-201_162-57395924/report-raises-concerns-for-homeless-female-vets/

Just 60 Seconds of Combat Impairs Memory

<http://www.sciencedaily.com/releases/2012/03/120313085838.htm>

What Are Sleep Deprivation and Deficiency?

<http://www.nhlbi.nih.gov/health/health-topics/topics/sdd/>

Research Tip of the Week:

[LetterWhiz - Online Literary Encyclopedia](#)

Welcome to the LetterWhiz, a massive online literary encyclopedia. Check out our database for letter templates, quotes and poems for all occasions, we're constantly adding to it every day.

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- **Love**
We have plenty of letters for you if want to tell that special somebody how much you care for them, or perhaps how you want to break up. We have letters on almost every topic of relationships that you can think of in here.
- **Educational**
Applying for school, or are you a teacher in the educational system, then we can offer you many letters on a broad range of topics here.
- **Career**
Job application letters, cover letters, retirement, maternity leave, quitting, all these career related letters are covered here.
- **Personal**
Everything from writing a thank-you letter to congratulations on graduating are covered here, all personal letters.

Also available on this website:

- [A directory of quotations](#)
- [A collection of poems](#)
- [Letter-writing tips](#)

- [Links to sites offering related information](#)

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