SYMPOSIUM

Hippocampal volume and declarative memory function in combat-related PTSD

STEVEN H. WOODWARD,1 DANNY G. KALOUPEK,2,3 LAURA J. GRANDE,4 WENDY K. STEGMAN,5 CATHERINE J. KUTTER,6 LORAINES LESKIN,7 REBECCA PRESTEL,2 MARIE SCHAER,8,9 ALLAN L. REISS,10 AND STEPHAN ELIEZ8

1Dissemination and Training Division, National Center for PTSD, VA Palo Alto Health Care System, Palo Alto, California
2Behavioral Science Division, National Center for PTSD, VA New England Health Care System, Boston, Massachusetts
3Division of Psychiatry, Boston University School of Medicine, Boston, Massachusetts
4Psychology Service, VA New England Health Care System, Boston, Massachusetts
5Earth Systems, Melbourne, Australia
6Psychology Service, White River Junction Veterans Affairs Medical Center, White River Junction, Vermont
7Psychology Service, VA Greater Los Angeles Health Care System, Los Angeles, California
8Department of Psychiatry, University of Geneva, Geneva, Switzerland
9Signal Processing Laboratory, Swiss Federal Institute of Technology, Lausanne, Switzerland
10Department of Psychiatry and Behavioral Sciences, Stanford University Medical School, Stanford, California

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Abstract

The proposition that declarative memory deficits are systematically related to smaller hippocampal volume was tested in a relatively large sample (n = 95) of U.S. military veterans with and without combat-related posttraumatic stress disorder. This correlative analysis was extended by including multiple measures of verbal and visual declarative memory and multiple memory-relevant regional brain volumes that had been shown to exhibit main effects of PTSD in prior work. Small-to-moderate effects were observed on verbal declarative memory in line with a recent meta-analysis; nevertheless, little or no evidence of systematic linear covariation between memory measures and brain volumes was observed. (JINS, 2009, 15, 830–839.)

Keywords: PTSD, Memory, Cognition, Hippocampus, Neocortex, Magnetic resonance imaging

INTRODUCTION

The idea that the hippocampus contributes to declarative memory is a marquee finding of human neuropsychology; thus, it is natural to hypothesize that if PTSD patients have smaller hippocampi, and impaired declarative memory, then the two must be related. After all, a very strong confirmatory example is supplied by senile dementia of the Alzheimer’s type (SDAT). Since the 1990s, numerous studies have reported significant correlations between hippocampal volume and declarative memory performances in SDAT (Laakso et al., 1995; Soininen et al., 1994) and also in minimally impaired elderly people (Convit et al., 1995; Zimmerman et al., 2008). Even a strongly disconfirmatory study, such as that of Marquis, which failed to find hippocampal volume and paragraph memory correlation in 108 older adults, many of whom progressed to dementia (Marquis et al., 2002), cannot dent our faith in the underlying relationship. The role of the hippocampus in memory, the histopathologically confirmed degeneration of that structure, combined with profound memory loss in SDAT, together constitute an unchallengeable framework. But unlike in SDAT, the memory impairments of PTSD are not profound. This is evidenced not only by the Brewin meta-analysis that found only a modest effect size for verbal memory (Brewin, Kleiner, Vasterling, & Field, 2007). Memory loss is not among the diagnostic criteria for PTSD (the C3 symptom is specific to the circumstances of trauma.), is generally absent from self-report psychodiagnosics in this field, and is rarely, if ever, a focus of treatment. At the same time, hippocampal functionality has additional facets of potential relevance to PTSD. These include spatial/contextual processing (Bilkey, 2007; Fortin
et al., 2008; Lang et al., 2009) and perhaps subservient to these, configural cue processing (Gilbertson et al., 2007). There is a danger that such alternative avenues for understanding the hippocampus in PTSD could be under-researched to the extent that a declarative memory framework is overvalued.

This article asks whether the framework that has been so successful in understanding SDAT should be applied to PTSD. In our view, strong tests of that framework are predicated on the presence of main effects of a PTSD diagnosis on both hippocampal structure and declarative memory performance. Employing these requirements, we have reviewed studies in the Karl meta-analysis of hippocampal findings in PTSD (Karl et al., 2006) and five studies published since then (Bonne et al., 2008; Bossini et al., 2008; Pavic et al., 2007; Tischler et al., 2006; Yehuda et al., 2007). Among those 26 studies, 16 reported a smaller hippocampus in PTSD in at least one hemisphere. Of those 16, 10 tested memory, but in one case, this was a test of implicit memory (Shin et al., 2004). Of the 9 studies testing declarative memory, 2 did not report whether group differences were found, and only 4 reported significantly worse memory in PTSD. Hence, notwithstanding the power of the SDAT example, a strong test of its applicability to PTSD rests on only four studies (Bremner et al., 1995, 1997; Nakano et al., 2002; Vythilingam et al., 2005). Of those four, two reported the expected correlations (Bremner et al., 1995; Vythilingam et al., 2005), and two did not, a chance rate. Among studies that have reported significant PTSD effects on hippocampal volume or declarative memory (but not both) and also tested structural-functional correlations, one reported positive findings (Tischler et al., 2006; Yehuda et al., 2007; these publications report on the same sample) and two had negative findings (Gurvits et al., 1996; Stein, Keverola, Hanna, Torchia, & McClarty, 1997). Two additional studies that gathered data relevant to these correlations did not report them (Bremner et al., 2003; Pederson et al., 2004).

It could be argued that prior studies in this area have suffered from limited statistical power. The current study employed a sample of 95, two to three times larger than prior samples. As will be described later, and perhaps in part as a result of its greater power, this study met our criteria for a strong test in which both hippocampal volume and selected memory variables exhibited effects of PTSD (cf. Woodward, Kaloupek, Streeter, Kimble et al., 2006a). While the effects of a social stressor on declarative memory performances did not demonstrate effects of PTSD, we examined whether individual pre-/post-stress difference scores were related to hippocampal volumes (cf. McEwen & Magarinos, 1997). We also had the opportunity of incorporating in the analyses other regional brain volumes arguably relevant to memory task performance, parahippocampal cortical volume and total cortical volume, that have been observed to differ over the PTSD-positive and PTSD-negative groups (cf. Woodward, Schaer, Kaloupek, Cediel, & Eliez, in press).

METHODS

Screening and Psychiatric Assessment

Participants provided written informed consent in accordance with the procedures of the Institutional Review Boards of Stanford University Medical School/VA Palo Alto HCS or Boston VA Medical Center and the McLean Hospital. Recruitment and screening of this sample at two sites was described in detail in a prior publication (Woodward, et al., 2006a; Woodward, Kaloupek, Streeter, Martinez et al., 2006b). Two subjects were excluded because of an imaging artifact that disrupted cortical sheet extraction, and two because of the loss of testing data. PTSD was diagnosed and its severity estimated using the Clinician-Administered PTSD Scale (CAPS, Blake et al., 1997). Assessments of mood status, psychosis and associated symptoms, alcohol and substance use disorders, and anxiety disorders were performed using the Structured Clinical Interview for the DSM-IV (First, Spitzer, Gibbon, & Williams, 1995). Also administered were the Combat Exposure Scale (Keane et al., 1989), Life Events Checklist (LEC, Blake et al., 2000), Mississippi Scale for Combat-related PTSD (MISS, Keane, Caddell, & Taylor, 1988), Beck Depression Inventory (BDI, Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and Michigan Alcohol Screening Test – Short Form (SMAST, Selzer, 1971). Eighty-four subjects also underwent a structured interview to determine whether LEC-elicited trauma endorsements fulfilled PTSD Criterion A1 and A2 and when they occurred.

Participants

All 95 final participants were combat veterans of the Vietnam or Persian Gulf wars. All were free of acute medical disease, current substance abuse/dependence (abstinent more than six months), central nervous system (CNS) disease, and psychosis. PTSD-positive (PTSD+) participants met criteria as a result of experiencing one or more military traumas, but some also experienced civilian traumas before or after their military service. PTSD-negative (PTSD–) participants had never met criteria for PTSD as a result of military or civilian trauma. Table 1 presents selected subsample means. Noteworthy among them, the combat exposure scale (CES), and CAPS score means indicate that the PTSD+ subsample was heavily combat-exposed and severely symptomatic. They were also severely dysphoric, as indexed by mean BDI scores greater than 20. Of the PTSD+ participants, 75% also met criteria for current major depressive disorder (MDD) versus 4% of PTSD– participants, while for lifetime MDD the corresponding rates were 85% and 22%. Among subjects with histories of alcohol abuse/dependence (ETOH), those with PTSD had begun drinking, on average, 4.7 years earlier than those without PTSD (20.7 vs. 25.4 years, respectively). Participants were maintained on their psychotropic medications. In line with their symptomatic status, 69% of the PTSD+ participants were taking...
psychotropic medications versus 11% of PTSD− participants. Forty-four percent of the PTSD+ participants, 44% were taking selective serotonin reuptake inhibitors versus only 4% of PTSD− participants. Twenty-one percent of PTSD+ participants were taking anticonvulsant/mood-stabilizing medications, whereas no PTSD− participants were taking medications from this class.

Procedures

Participants arrived at the laboratory at approximately 0800. Structured psychodiagnostic interviews, self-report psychometrics, and baseline memory and cognitive testing required approximately four hours including breaks. After lunch, participants were prepared for psychophysiological recording (electroencephalogram, electro-oculogram, facial electromyogram, electrocardiogram, abdominal respiration, electrodermal activity). They then underwent two administrations of the Trier Social Stress Test (TSST, Kirschbaum, Wolf, May, Wippich, & Hellhammer, 1996) separated by a 40-minute rest period. After each TSST, declarative memory was assessed and a brief “oddball” event-related potential protocol was administered. After the completion of laboratory testing, participants were transported to the magnetic resonance imaging (MRI) laboratories for neuroimaging.

Verbal declarative memory was assessed at baseline using the Logical Memory (LM) subtest of the Wechsler Memory Scale-III (WMS-III, Wechsler, 1997) and the Hopkins Verbal Learning Test (HVLT, Brandt, 1991). Visual declarative memory was assessed using the Rey-Osterrieth Complex Figure Test (ROCFT) (Osterrieth, 1944; Rey, 1941; Spreen & Strauss, 1991) and the Rey Visual Design Learning Test (RVDLT, see Spreen & Strauss, 1991). The baseline assessment also included administrations of the Vocabulary subtest (VOCAB) and Digit Symbol Substitution (DSS) subtest of the Wechsler Adult Intelligence Test-III (WAIS-III, Psychological Corporation, 1997). After each administration of the TSST, the HVLT and the RVDLT were repeated using equivalent forms.
**Image Acquisition and Processing**

Magnetic resonance (MR) images of subjects’ brains were acquired with 1.5T GE Signa II systems located near each study site (Diagnostic Radiology Center of Veterans Affairs, Palo Alto Health Care System and the Brain Imaging Center of McLean Hospital, Belmont, MA). Coronal images were acquired with a 3D spoiled-gradient recalled (SPGR) volumetric pulse sequence (TR = 35 ms, TE = 6 ms, flip angle = 45°, NEX = 1, matrix size = 256 × 192, field of view = 24 cm², slice thickness = 1.5–1.7 mm, slices = 124.)

This article considers brain structural indices obtained through two independent MR image analysis methods. Volumes of the hippocampus were obtained using manual tracing in accordance with the methods of the Stanford Psychiatry Neuroimaging Laboratory (Kates, Abrams, Kaufmann, Breiter, & Reiss, 1997; Reiss et al., 1998; Woodward, et al., 2006a). Image optimizations promoted accurate and reliable delineation of the hippocampal cross-sections on each slice. The anterior limit of the hippocampus was defined by the hippocampal sulcus or alveus, and the posterior limit by the fusion of the fornix with the splenium. Manual delineation was performed by a single rater (W.K.S.), trained to criterion within the Stanford Psychiatry Neuroimaging Laboratory, and blinded to participant identity and diagnosis. This processing protocol also produced various lobar tissue volume estimates via projection to and parcellation in Talairach space (Talairach & Tournoux, 1988). We have observed trends for these macro-volumes to be smaller in the PSTD+ participants in this study, but these trends have not achieved significance despite the relatively large size of this sample (Woodward et al., 2007; Woodward, et al., 2006a). Hence, this article employed total cerebral tissue volume only to normalize hippocampal volume across persons differing in gross body size. Cross-site reliabilities were established by imaging seven study staff in both magnets and recalculating all volumes in a blinded fashion. Cross-site reliabilities of hippocampal and total cerebral tissue volumes (gray + white) exceeded ICC = 0.90.

Estimates of the volumes of parahippocampal and total cortices were obtained using FreeSurfer (version 4.0.1; Martinos Center for Biomedical Imaging, Massachusetts General Hospital, Boston, MA). This automated approach extracts an accurate yet geometrically tractable model of the 2-dimensional cortical sheet (for details, see Dale Fischl, & Sereno, 1999; Fischl & Dale, 2000; Fischl, Sereno, & Dale, 1999). One key feature of FreeSurfer is its exploitation of the fact that the gray–white boundary is planar at short distances, which prior analyses showed to be smaller in volume (the product of area and thickness) in association with PTSD in this sample, the parahippocampal cortex and the total cerebral cortex (see below, Woodward et al., in press).

**RESULTS**

**Cognition**

WAIS VOCAB and DSS were compared over groups using analyses of covariance (ANCOVAs) covarying for age. VOCAB exhibited an interaction between PTSD and ETOH (F(1, 90) = 8.44, p < .01, partial η² = 0.086) related to the fact that the effect of PTSD (lower scores associated with PTSD) was only significant in participants with lifetime ETOH (ETOH+: F(1, 39) = 18.7, p < 0.001; ETOH–: F(1, 50) = 0.42, ns). VOCAB also exhibited a main effect of PTSD, F(1, 92) = 14.2, p < .001, partial η² = 0.136. The effect of ETOH was also significant, F(1, 90) = 5.07, ns, partial η² = 0.053, with lower VOCAB performance observed in participants with histories of ETOH. PTSD was strongly associated with lower DSS scores, F(1, 92) = 33.0, p < .001, partial η² = 0.268; however, unlike VOCAB, DSS exhibited no effect of ETOH and no interaction of PTSD and ETOH (Fs < 1). The size of the PTSD effect on DSS was similar in ETOH+ and ETOH– subgroups (partial η² = 0.275 vs. 0.285).

**Regional Brain Volumes**

The reader is directed to our prior publications for detailed presentations of the differences we have found between PTSD+ and PTSD– participants in this sample. In those studies, hippocampal tissue (gray + white) volume, parahippocampal cortical volume, and total cerebral cortical volume have all been shown to be smaller in the PTSD+ relative to the PTSD– participants (Woodward, et al., 2006a; Woodward et al., in press).

**Memory**

Table 2 presents means and standard deviations of the memory variables considered in this study. Baseline performance on the LM subtest of the WMS-III was analyzed for associations with PTSD and lifetime alcoholism (ETOH) using repeated-measures ANCOVA covarying for age and VOCAB. A within-subjects factor of recall trial contrasted immediate versus delayed recall. Participants with PTSD exhibited mildly reduced LM performance relative to those without PTSD, F(1, 89) = 4.27, p < .05, partial η² = 0.046. Although subjects’ performances declined nominally at recall, the
effect of recall trial did not approach significance ($F < 1$). Recall trial also did not interact with PTSD, ETOH, or their interaction. Similarly, neither ETOH, $F(1, 89) = 1.65, ns$, nor the PTSD $\times$ ETOH interaction ($F < 1$) influenced overall LM performance. Baseline performance on the ROCFT, analyzed in a similar fashion, exhibited the expected effect of trial [copy vs. recall: $F(1, 90) = 12.2, p < .001$], and a main effect of PTSD, $F(1, 89 = 6.9, p < .01$, partial $\eta^2 = 0.072$. There was no effect of ETOH and no interactions.

Performances on the HVLT and the RVDLT were analyzed using repeated-measures ANCOVAs, covarying for age and VOCAB. The within-subjects factor, session, had three levels contrasting baseline, post-TSST1, and post-TSST2 administrations. Thus, the session factor incorporated the impact of the TSST on subsequent verbal memory and visual declarative memory performances. For both, total learning and percent retention were analyzed separately. HVLT total learning exhibited a modest effect of PTSD, $F(1, 89) = 5.89, p < .05$, partial $\eta^2 = 0.062$. There was no effect of ETOH, $F(1, 89) = 1.63, ns$, partial $\eta^2 = 0.018$, and no PTSD $\times$ ETOH interaction, $F(1, 89) = 0.731, ns$, partial $\eta^2 = 0.008$. The effect of session was not significant, Wilks’ Lambda = 0.974, $F(2, 88) = 1.16, ns$. HVLT percent retention exhibited a significant interaction of PTSD, ETOH, and Session, Wilks’ Lambda = 0.900, $F(2, 88) = 4.89, p < .01$, partial $\eta^2 = 0.10$. Underlying this three-way interaction was a difference between PTSD+ and PTSD− subgroups as to the presence of an ETOH $\times$ Session interaction. This two-way interaction was significant only in PTSD+ participants, Wilks’ Lambda = 0.842, $F(2, 43) = 4.89, p < .01$, partial $\eta^2 = 0.158$, among whom HVLT percent retention diverged on the third (post-TSST2) trial as a function of ETOH. That is, for PTSD+/ETOH+ participants, HVLT retention dropped precipitously at post-TSST2 (96%, 91%, 82%, respectively), whereas for PTSD+/ETOH− participants, it improved relative to post-TSST1 (91%, 87%, 94%, respectively). There were no additional group effects or interactions influencing HVLT percent retention. RVDLT performances exhibited no significant main effects or interactions.

Covariations Among Regional Brain Volumes and Memory Performances

Table 3 presents zero-order correlations between the regional brain volumes and memory performances considered in this study. Also included are HVLT and RVDLT total learning pre-/post-stress change scores. All variables exhibited normal distributions, supporting the use of parametric Pearson product-moment correlations. Review of bivariate plots confirmed that no correlation was artifactually amplified or attenuated by outliers or range restriction. By far, the strongest

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### Table 2. Raw means and standard deviations of selected sample description variables

<table>
<thead>
<tr>
<th></th>
<th>PTSD+</th>
<th>ETOH+</th>
<th>PTSD−</th>
<th>ETOH−</th>
</tr>
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<tbody>
<tr>
<td>N</td>
<td>23</td>
<td>25</td>
<td>19</td>
<td>28</td>
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<tr>
<td>AGE</td>
<td>50.2</td>
<td>7.3</td>
<td>48.3</td>
<td>9.0</td>
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<tr>
<td>WAIS VOCAB</td>
<td>42.7</td>
<td>11.2</td>
<td>52.2</td>
<td>9.5</td>
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<tr>
<td>WAIS DSS</td>
<td>57.8</td>
<td>14.0</td>
<td>57.1</td>
<td>16.4</td>
</tr>
<tr>
<td>CES</td>
<td>26.9</td>
<td>12.3</td>
<td>27.5</td>
<td>11.1</td>
</tr>
<tr>
<td>CAPS-TS</td>
<td>78.3</td>
<td>14.9</td>
<td>73.0</td>
<td>21.5</td>
</tr>
<tr>
<td>BDI</td>
<td>24.9</td>
<td>7.7</td>
<td>22.2</td>
<td>9.1</td>
</tr>
<tr>
<td>SMAST</td>
<td>6.6</td>
<td>3.8</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Height</td>
<td>70.3</td>
<td>2.3</td>
<td>69.8</td>
<td>3.1</td>
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</tbody>
</table>

**Partials**

<table>
<thead>
<tr>
<th></th>
<th>PTSD</th>
<th>ETOH</th>
<th>Interactions</th>
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<tbody>
<tr>
<td>partial $\eta^2$</td>
<td>0.136</td>
<td>0.053</td>
<td>PTSD $\times$ ETOH: 0.086</td>
</tr>
</tbody>
</table>

**Note.** Effect sizes are supplied for statistically significant effects. Effect sizes on WAIS variables derived from ANCOVAs covarying age.

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### Table 3. Raw means and standard deviations of memory performance variables

<table>
<thead>
<tr>
<th></th>
<th>PTSD+</th>
<th>PTSD−</th>
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</thead>
<tbody>
<tr>
<td>LM total learning</td>
<td>27.9</td>
<td>32.8</td>
</tr>
<tr>
<td>LM delayed recall</td>
<td>23.6</td>
<td>27.7</td>
</tr>
<tr>
<td>HVLT total learning</td>
<td>26.3</td>
<td>28.6</td>
</tr>
<tr>
<td>HVLT retention</td>
<td>0.92</td>
<td>0.93</td>
</tr>
<tr>
<td>ROCFT copy</td>
<td>60</td>
<td>63.4</td>
</tr>
<tr>
<td>ROCFT recall</td>
<td>30.6</td>
<td>36.9</td>
</tr>
<tr>
<td>RVDLT total learning</td>
<td>9.4</td>
<td>10.6</td>
</tr>
<tr>
<td>RVDLT retention</td>
<td>0.89</td>
<td>0.97</td>
</tr>
<tr>
<td>HVLT change (trial 2 - trial 1)</td>
<td>0.6</td>
<td>−0.2</td>
</tr>
<tr>
<td>RVDLT change (trial 2 - trial 1)</td>
<td>0.3</td>
<td>−0.3</td>
</tr>
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Hippocampal volume and declarative memory in PTSD

<table>
<thead>
<tr>
<th>Table 4. Pearson product-moment correlations between regional brain volumes implicated in declarative memory and memory performances computed over all 95 subjects</th>
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<tr>
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<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Left hippocampal tissue volume</td>
</tr>
<tr>
<td>Right hippocampal tissue volume</td>
</tr>
<tr>
<td>Left parahippocampal gyrus</td>
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<tr>
<td>Right parahippocampal gyrus</td>
</tr>
<tr>
<td>Left hemisphere cortical volume</td>
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<tr>
<td>Right hemisphere cortical volume</td>
</tr>
<tr>
<td>Total hippocampal tissue volume as percent of total brain tissue volume</td>
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<tr>
<td>Total parahippocampal cortex volume as percent of total cortical volume</td>
</tr>
</tbody>
</table>

Note. Some variables represent the ratio of a subvolume to a whole brain index in an effort to remove variance associated with body size. One, two, or three asterisks indicate nominal significance at

$p < 0.05$, 0.01, and 0.001, respectively. Boldface indicates correlations exceeding significance after Bonferroni correction for multiple comparisons ($\alpha = 0.05/80 = 0.000625$).

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$p < 0.05$, 0.01, and 0.001, respectively. Boldface indicates correlations exceeding significance after Bonferroni correction for multiple comparisons ($\alpha = 0.05/80 = 0.000625$).

Because a history of ETOH could have moderated the relationship between brain structure and memory (Harris et al., 2008), these correlations were recalculated in the ETOH+ and ETOH− subjects, separately. Within both groups, a cluster of nominally significant positive correlations were again observed to involve ROCFT copy and recall measures. Among ETOH+ participants, a second cluster of four positive correlations were observed to associate total cortical volume (left and right) with LM performance (total learning and delayed recall); however, none of these remained even nominally significant after partialing out shared variance with VOCAB. In the end, in neither subgroup analysis did a single correlation exceed a level of statistical significance corrected for multiple comparisons ($\alpha = 0.05/80 = 0.000625$).

An analysis of the impacts of depression and/or medication status on cognitive performances is beyond the scope of this article, as both are highly confounded with PTSD in this sample. The sample does provide a limited opportunity to test medication effects within the PTSD group. DSS performance did not differ over PTSD+ subjects who were and were not taking GABAergic medications, 56.1 vs. 57.8, t(46) = 0.311, ns. Similarly, neither LM total learning nor HVLT total learning exhibited differences between subgroups of PTSD+ subjects who were versus were not taking (1) any psychotropic drug, (2) an SSRI, or (3) a GABAergic medication.

DISCUSSION

Participants in this study exhibited a pattern of small to moderate effects of PTSD on memory for nonemotional materials with no effect of delay. This pattern is very similar to that observed by Brewin et al. in their meta-analysis of memory
studies in PTSD (Brewin et al., 2007). As noted, this same sample had previously demonstrated effects of PTSD on hippocampal volume in line with most studies in this area (Karl et al., 2006; Woodward, et al., 2006a). This study employed a sample more than twice as large as earlier studies reporting correlations between hippocampal volume and memory performance (Bremner et al., 1995; Vytlalingam et al., 2005). It used similar or identical memory measures. In addition, a widened net was cast by assessing the volumes of additional brain structures such as parahippocampal and total cortex that were both smaller, and likely mediated in part by verbal performance, though in biologically plausible directions, were substantially smaller, and likely mediated in part by verbal memory-relevant (cf. Wais, 2008). We also examined correlations between memory and regional brain subvolumes expressed as percentages of the embedding whole-brain or whole-cortex volumes in an effort to control for differences in body size, and separately examined alcoholic and nonalcoholic subsamples. Unexpectedly strong relationships were observed between ROCFT copy performances and most brain volumes considered. These relationships were apparent in participants with and without histories of alcoholism. The origins of these associations deserve further attention, and provide further support for casting a wide net in our efforts to document the neurocognitive deficits of PTSD. Findings from emotional Stroop tasks (McNally, 1998; Metzger, Orr, Lasko, McNally, & Pitman, 1997; Vytlalingam et al., 2007) suggest that functional cognitive impairments in PTSD may lie preferentially at the interface with fear- and other trauma-related affects; however, Stroop tasks test only word reading. Novel assessments of the cognition-affect interface could borrow from the PTSD literature methods for safely inducing mood states and cognitive sets harkening back to the conditions of traumatization. Although such procedures might pose challenges to face-to-face neuropsychological assessment, they may be compatible with computer-based assessments such as the Automated Neuropsychological Assessment Metrics (cf. Vasterling et al., 2006).

In conclusion, a review of the existing literature relating hippocampal volume to memory performance in PTSD, and an extended re-examination of that relationship in a larger sample, appear to be in agreement. The strong example of SDAT may not be heuristic in this disorder, and alternative perspectives on the function of the hippocampus and related structures may be more revealing.

ACKNOWLEDGMENTS

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