The CR program presented by Mueser, Rosenberg, and Rosenberg provides a viable alternative to exposure-based therapies, such as prolonged exposure (PE), when patients are unwilling or unable to participate or emotionally engage in imaginal exposure. In general, the treatment strategies described are informative for all providers delivering PTSD treatments that include cognitive restructuring with or without exposure. The specific adaptations for CR with special populations are particularly useful across treatment approaches that include a cognitive restructuring component.

As the authors argue, we agree that CR is preferable to exposure therapy in treating posttrauma symptoms in certain special populations, particularly psychotic individuals. However, we disagree with the authors’ claim that CR is generally preferable to exposure therapy due to equivalent outcomes and hesitation among patients and clinicians to experience or induce distress. First, the most recent large-scale meta-analytic reviews and treatment guidelines have concluded that among existing psycho-social therapies, the strongest evidence exists for exposure-based models (Bisson & Andrew, 2007; Institute of Medicine, 2008). Second, experienced therapists understand that distress induced by exposure decreases with continued exposure and is a necessary component of emotional processing that leads to psychological recovery, similar to physical pain secondary to surgery. These clinicians are trained in supporting patients to tolerate, rather than avoid, distress associated with remembering the trauma, and highlighting the patient’s ability to do so is therapeutic. As with CR, we contend that exposure therapy is feasible and beneficial with members of most special populations (e.g., borderline personality disordered individuals, addicted individuals). For example, using PE with borderline personality disordered individuals has the potential to facilitate improvements in emotion regulation in addition to reducing PTSD symptoms. Through habituation and extinction, all patients have the opportunity to learn that they can tolerate and effectively manage negative and painful emotions. The authors present alternatives to exposure therapies, which are always welcome, but the extent research doesn’t support any claims to superiority.

This volume highlights the need for further research into best practices for treatment of PTSD in members of special populations. In the future, comparative studies can identify treatments that are indicated for members of different special populations. This suggests a need for
controlled clinical trials comparing the effectiveness of existing PTSD treatments (e.g., CR versus exposure therapy) in these populations.

Overall, this book addresses a much-needed gap in the literature by recognizing the important issue of trauma exposure and treatment of PTSD in members of special populations, the most vulnerable to developing the disorder. The authors adopt an optimistic view of this problem and present specific instructions for tailoring PTSD treatment for members of these special populations. The authors demonstrate vast experience regarding PTSD in these individuals. Currently, this is the only treatment manual for PTSD that addresses and equips helping professionals to meet the unique needs of these special populations. Their contribution is instructive to anyone working with members of these populations and, hopefully, will encourage clinicians who are currently hesitant to treat PTSD in special populations to begin doing so, opening up access to care to more in need.

References


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