

## COMMENTARY

Beyond Exposure: A Healthy Broadening of Posttraumatic Stress Disorder Treatment Options: Commentary on [Rubenstein et al. \(2024\)](#)

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This commentary on [Rubenstein et al. \(2024\)](#) applauds their sensitive historical exploration of exposure therapy for posttraumatic stress disorder (PTSD) and balanced review of the strengths and weaknesses of that approach. I offer five points to expand on their contribution. (a) Stringent exposure therapy workforce requirements limit scalability, thus restricting access for the large number of patients in need of PTSD treatment. (b) There are additional non-trauma-focused approaches that show efficacy for PTSD. (c) Results of exposure therapy trials should be interpreted in light of how much the study designs align with real-world conditions. (d) Some surprising results from the subfield of PTSD/substance use disorder could suggest new treatment options. (e) There is a need for stronger reporting of clinical worsening (iatrogenesis) outside of clinical trials.

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[Rubenstein et al.'s \(2024\)](#) article “To Expose or Not to Expose: A Comprehensive Perspective on Treatment for Posttraumatic Stress Disorder” is elegantly written and provides an exceptionally rich exploration of the history of exposure-based treatment. Most importantly, it offers a viewpoint that is increasingly borne out by research as well as clinical experience: exposure is not essential for posttraumatic stress disorder (PTSD) treatment, although it can be one option among many.

I will add here, in the spirit of enhancing the article, a few points to expand on the authors’ findings.

1. An additional consideration are workforce issues. Exposure treatments are expensive and difficult to scale for the large number of PTSD patients in need

of treatment. Exposure models are limited to a narrow range of providers as they require advanced degrees as well as costly training and certification ([Najavits et al., 2020](#)). The argument is often made that exposure models outperform nonexposure models. This is not always the case, but even if it were, from a public health perspective, small differences in efficacy are offset by nonexposure treatments that can be implemented by a broader workforce, are less emotionally intense for patients, and incur lower dropout.

2. The authors make the compelling point that although exposure therapy is typically emphasized in PTSD treatment, nonexposure models also reduce PTSD and offer an important option for therapists. We can add to the authors’ list of nonexposure models transcendental meditation, which performed as well as exposure in a randomized controlled trial in veterans with PTSD ([Nidich et al., 2018](#)), and mindfulness-based stress reduction ([Davis et al., 2019](#)). There are also several nonexposure models from the field of comorbid PTSD/substance use disorder (SUD), as the heightened vulnerability of that patient population led to prioritizing nonexposure models. The most evidence-based of these are Seeking Safety ([Najavits, 2002](#)) and Integrated

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cognitive Behavioral Therapy (McGovern et al., 2009). These models evidence significant reduction in PTSD as well as SUD and can be implemented with patients who have PTSD alone.

3. It is advised to look beyond the “headlines” of exposure studies to obtain an accurate sense of how well the study designs relate to real-world practice. To offer an example from the PTSD/SUD field, recent years have seen the advent of models that adapted exposure for PTSD/SUD. Yet such studies typically had exclusions that resulted in easier-to-treat patient samples. For example, they have excluded self-harm in the past 6 months (Mills et al., 2012); assault by a current intimate partner (Foa et al., 2013); and even for specific SUDs (despite the goal of these adapted models being the treatment of SUD). Examples of the latter are exclusions for recent opioid use (Foa et al., 2013), benzodiazepine use (Coffey et al., 2016), intravenous drug use (Norman et al., 2019), severe substance dependence (Sannibale et al., 2013), and cannabis dependence (Kehle-Forbes et al., 2019). Exposure models studied in PTSD/SUD samples are also typically situated amid high levels of ancillary treatment, such as inpatient, residential, intensive outpatient, or intensive SUD treatment, which limits their generalizability (Najavits et al., 2020).
4. There is potential benefit in exploring models that were not developed for PTSD per se. A remarkable finding from the PTSD/SUD field is that exposure models such as Prolonged Exposure (as well as classic trauma treatment such as Cognitive Processing Therapy and Eye Movement Desensitization and Reprocessing Therapy, when studied in PTSD/SUD samples, do not significantly outperform SUD treatment on either PTSD or SUD primary outcomes (e.g., Foa et al., 2013; Kehle-Forbes et al., 2019; Simpson et al., 2022; van Dam et al., 2013). In other words, SUD treatment does as well in reducing PTSD as classic PTSD treatments, even though it does not address PTSD directly. This has strong public health implications as SUD models are less prone to dropout, can typically be done in group as well as individual modality, can be implemented in almost any setting (including criminal justice and homelessness programs), and can be conducted with more vulnerable patient populations such as those with current domestic violence and suicidality. Such models could perhaps be adapted for PTSD patients without SUD.
5. Finally, it is worth mentioning clinical worsening (iatrogenesis). Randomized controlled trials often

report few adverse events (Tripp et al., 2021), but such studies are conducted under optimal conditions with highly monitored therapists and, as noted above, healthier patients than found in routine practice. There are reports of worsening due to exposure, and clients as well as therapists feeling overly pressured into it (e.g., Doran et al., 2019; Hundt et al., 2020; Morris, 2015). It could help the field for therapists to have a clearinghouse or other systematic way to confidentially report adverse experiences or other concerns with exposure therapies (as well as other therapies). The limited uptake of exposure even after significant training in it (Cook et al., 2020) suggests concerns that may include more iatrogenesis than is typically reported in formal studies.

Exposure remains a viable option for some patients and some therapists, but, as the current article describes, the hegemony and overly strong allegiance to exposure over the past few decades are now undergoing a healthy correction that can move PTSD treatment forward by balancing the benefits of exposure with the benefits of a wider array of models, recognizing the strengths of each.

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