Notice of correction 1/31/2018: Figure 1 has been corrected to display the Participant Flowchart, and Figure 2 now displays the Mean Estimates of Inventory of Complicated Grief Scores. These graphics were initially transposed. The staff regret the error.

Treating Prolonged Grief Disorder:
A 2-Year Follow-Up of a Randomized Controlled Trial

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ABSTRACT

Background: Prolonged grief disorder (PGD) causes significant impairment in approximately 7% of bereaved people. Although cognitive-behavioral therapy (CBT) has been shown to effectively treat PGD, there is no evidence of long-term effects of CBT.

Objective: To determine the long-term efficacies of CBT with exposure or CBT without exposure in treating PGD by assessing outcome at 2 years.

Methods: A randomized controlled trial of PGD patients (N = 80) attending an outpatient clinic took place between September 2007 and June 2010, and a 2-year follow-up occurred between December 2009 and October 2012. All patients received 10 weekly 2-hour group therapy sessions that comprised CBT techniques. Patients also received 4 individual sessions in which they were randomly allocated to receive exposure therapy (CBT/Exposure) for memories of the death or supportive counseling (CBT). Prolonged grief disorder was assessed by clinical interview using the Complicated Grief Assessment. Severity of PGD, the primary outcome, was assessed using the Inventory of Complicated Grief.

Results: Intent-to-treat analyses indicated a significant linear time × treatment condition interaction effect at 2 years (B = −0.63; SE = 0.26; $t_{225} = -2.44$; $P = .02$; 95% CI, −1.14 to −0.12), indicating that CBT/Exposure led to greater reductions in PGD than CBT. Further, the linear between-group effect size at the 2-year follow-up was 1.15.

Conclusions: Exposure therapy in the course of CBT leads to greater reduction in symptoms of PGD than CBT without exposure, and this additive gain extends 2 years after treatment is complete. To achieve optimal treatment gains in patients with PGD, therapists should encourage some form of exposure therapy to memories of the death.

Trial Registration: Australian New Zealand Clinical Trials Registry identifier: ACTRN12609000229279

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Prolonged grief disorder (PGD) is a potentially debilitating condition that affects approximately 7% of bereaved people.[1] It has been proposed as a new diagnosis for ICD-11, in which it is described as persistent and severe yearning for the deceased and can be accompanied by a sense of meaninglessness, loss of one's identity, anger, and lack of engagement in social or productive activity.[2] Prolonged grief disorder, which in recent times has also been referred to as complicated grief, traumatic grief, persistent complex bereavement disorder, and unresolved grief, is associated with marked functional impairment, increased suicidality and comorbidity, poor health behaviors, and somatic complaints.[3]

Initial evidence pointed to the potential for grief-focused cognitive-behavioral therapy (CBT) to reduce symptoms of PGD.[4] This CBT comprises exposure to memories of the death, cognitive restructuring, and developing strategies to foster new goals and relationships. This initial study was followed by another trial supporting CBT, in which it was found that providing exposure prior to cognitive restructuring was more effective than providing these 2 strategies in the reverse order.[5] Another study compared 20 sessions of CBT that included both exposure and cognitive restructuring against a wait-list and found that CBT outperformed wait-list in reducing grief symptoms[6]; these effects were maintained at a subsequent 1.5-year follow-up.[7] In an internet-based study, participants with PGD were randomized to either internet-based exposure therapy, behavioral activation, or a wait-list condition.[8] Following the 6- to 8-week program, exposure and behavioral activation resulted in lower grief and depression levels than wait-list, with exposure leading to larger reductions in depression than behavioral activation at the 3-month follow-up. Another internet study targeted people who were at high risk for PGD on the basis of grief severity scores at 3 months and randomized them either to an internet program that emphasized self-care, stress management, and re-engagement with others and new goals (no exposure therapy was included) or to a wait-list.[9] At 3 months, those participants in the active treatment reported lower grief, depression, and anxiety levels than those in the wait-list. Most of these studies concluded that an exposure-based treatment was important for reduction of symptoms. Supporting the role of treatments focused on PGD, 1 meta-analysis[10] has reported an effect size of 0.53.

To specifically understand the role of exposure in treating PGD, we conducted a trial that compared CBT that did and did not include exposure therapy; this trial of 80 patients with PGD found that patients who received exposure had greater reductions 6 months after treatment than those who received CBT without exposure.[11] This finding was consistent with our hypothesis because we expected that exposure to memories of the loss would reduce avoidance of grief reminders, facilitate processing of grief-related emotions, and promote cognitive reframing of appraisals maintaining PGD.

A limitation of all trials of PGD to date has been the brevity of time between treatment and follow-up assessments. Each trial reported

patients' status only 6 months following completion of treatment, thereby limiting measurement of the longer-term benefit of therapy. There is a need to map the longer-term effects of treating PGD because of longitudinal evidence that the trajectory of grief symptoms can change as time elapses after bereavement,[12] and, thus, posttreatment assessments that index levels of PGD only several months after treatment may not accurately reflect the longer-term effects of the interventions. To overcome this shortcoming, we report a subsequent follow-up of the Bryant et al study[11] in which patients were assessed 2 years after completion of treatment. We selected this timeframe for the follow-up because it provided a balance between sufficient time to index long-term benefits of treatment and retention of participants in the study. We hypothesized that 2 years after treatment, patients who had initially received CBT with exposure would still have reduced symptoms of PGD more than those who received CBT without exposure.

Clinical Points

- Cognitive-behavioral therapy (CBT) is the frontline treatment for prolonged grief disorder.
- Adding exposure therapy to CBT for prolonged grief disorder significantly reduces symptoms more than CBT without exposure therapy, and this gain extends to 2 years after treatment.
- Treatment planning for patients with prolonged grief disorder should include exposure therapy to optimize treatment response.

METHODS

Participants

Participants were bereaved patients treated at the University of New South Wales (UNSW) Traumatic Stress Clinic between September 17, 2007, and June 7, 2010. Inclusion criteria were that the patient had experienced bereavement at least 12 months earlier and satisfied criteria for PGD (see Measures below). Patients were excluded if they were unable to converse in English, less than 17 years of age, or more than 70 years of age. Further, participants were excluded if they had a history of psychosis or current substance dependence, borderline personality disorder, or severe suicidal risk to minimize the possibility that treatment may exacerbate their condition. All participants completed written informed consent approved by the UNSW Human Research Ethics Committee (Australian New Zealand Clinical Trials Registry identifier: ACTRN12609000229279).

Sample characteristics are presented in Table 1.

Table 1. Characteristics of Participants Randomized to 2 Treatment Conditions

Characteristic	CBT/Exposure (n = 41)	CBT (n = 39)	Test	*P* Value
Age, mean (SD), y	51.0 (14.40)	54.8 (9.80)	$F_{78} = 1.3$	.18
Time since death, mean (SD), y	4.00 (3.39)	3.62 (3.10)	$F_{78} = 0.53$	.60
Education, mean (SD), y	13.6 (2.62)	13.3 (2.88)	$F_{78} = 0.5$	.65
Gender, n (%)			$\chi^2 = 1.13$	.29
Male	4 (10)	7 (18)		
Female	37 (90)	32 (82)		
Employed, n (%)	31 (76)	28 (72)	$\chi^2 = 0.04$	.84
Relationship to deceased, n (%)			$\chi^2 = 4.23$	.52
Partner	11 (27)	13 (33)		
Child	11 (27)	14 (36)		
Parent	14 (34)	9 (23)		
Other	5 (12)	3 (8)		
Death type, n (%)			$\chi^2 = 0.76$	.86
Sudden illness	9 (22)	7 (18)		
Chronic illness	22 (54)	21 (54)		
Accident	6 (15)	6 (15)		
Suicide	4 (10)	5 (13)		
Comorbid disorder, n (%)				
Depression	26 (63)	24 (62)	$\chi^2 = 0.01$	.93
PTSD	21 (51)	25 (64)	$\chi^2 = 1.36$	.25
Anxiety disorder	11 (27)	8 (21)	$\chi^2 = 0.53$	.47
Substance use disorder	4 (10)	4 (10)	$\chi^2 = 0.00$	.97
Logic rating, mean (SD)	7.0 (1.42)	7.8 (1.73)	$F_{78} = 1.42$	.16
Expectancy rating, mean (SD)	6.3 (1.62)	7.0 (2.20)	$F_{78} = 1.1$	.24

Abbreviations: CBT = cognitive-behavioral therapy, PTSD = posttraumatic stress disorder.

Procedures

Participants were randomized by a process of minimization stratified on gender and grief severity score (cutoff of 50 on the Complicated Grief Assessment). Randomization was conducted by an individual independent of the study. Adverse reactions were monitored by a therapist and recorded on the basis of significant exacerbation of symptoms requiring removal or respite from the program. Figure 1 summarizes the participant flow. Eighty patients were randomized into the study and were allocated to either CBT/Exposure (n = 41) or CBT (n = 39). Sixty-one participants (76%) completed treatment, 56 patients (70%) completed the 6-month follow-up assessment, and 41 patients (51%) completed the 2-year follow-up assessment. Posttreatment, 6-month follow-up, and 2-year follow-up assessments were conducted by independent clinicians who were unaware of the treatment condition of participants. Blindness was maintained by ensuring that clinicians who conducted assessments did not have access to (1) participant notes or (2) condition allocation of participants. At the commencement of therapy, all participants completed the Credibility/Expectancy Questionnaire,[13] in which they rated their confidence in the treatment and the logic of the treatment (1 = "not at all," 10 = "extremely").

Treatment Conditions

Therapy comprised 10 × weekly 2-hour group sessions as well as 4 × weekly 1-hour individual sessions that were conducted by Master's-level clinical psychologists (from a pool of 6), who were trained and received weekly supervision from R.A.B. All therapists provided each type of treatment. Patients in each treatment condition participated in group sessions dedicated to that condition.

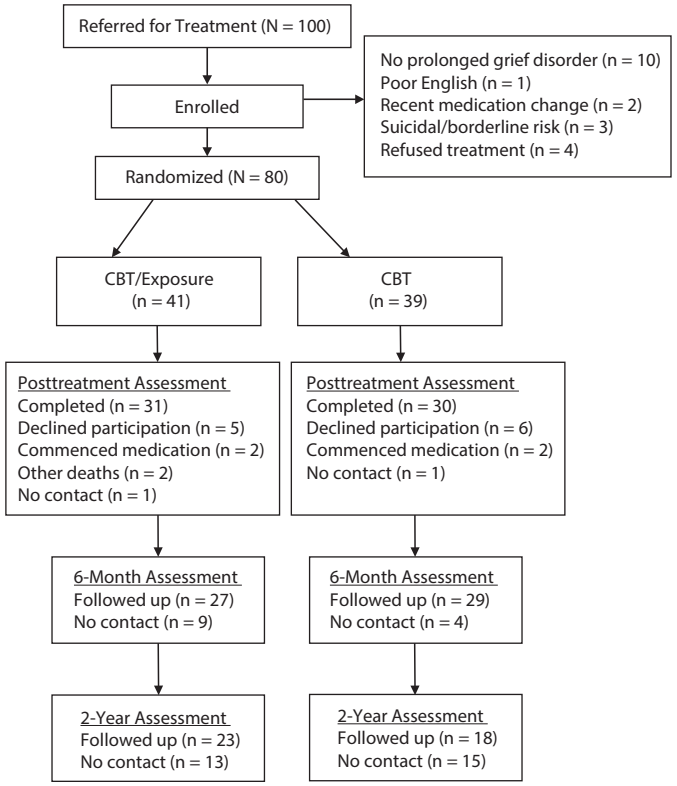
CBT/Exposure

Session 1 comprised education about grief and an overview of treatment components. Session 2 addressed the rationales for treatment components. Sessions 3, 4, and 5 focused on strategies in cognitive restructuring to reframe maladaptive appraisals (eg, hopelessness, guilt). Session 6 addressed rumination management, including the problems of repetitive thinking, and distraction techniques. This session also included a letter writing task in which participants expressed unresolved issues that they wished to communicate to the deceased; this element followed previous treatments that have used this approach to consolidate reframing of adaptive appraisals.[4] Session 7 continued with cognitive challenging and letter writing to the deceased and began facilitation of positive memories in which participants described memories of positive experiences with the deceased. Session 8 continued letter writing and facilitation of positive memories and initiated steps for new goals and activities. Session 9 focused predominantly on identification of future goals and steps to achieve them. This strategy was continued in Session 10, which also developed relapse prevention strategies for high-risk times (eg, anniversaries). Following group Session 2, participants commenced 4 weekly 1-hour individual therapy sessions that focused on imaginal exposure to memories of the death. Participants were instructed to relive the time they experienced the death of the person for 40 minutes, following standard procedures for posttraumatic stress disorder (PTSD).[14] Participants were instructed to verbalize their reliving of the loss, commencing with the moment they became aware of the person dying and focusing on that day, although latitude was given to the participants if key elements of the loss extended beyond the day of the death. The person was guided to provide accounts of their emotional, cognitive, sensory, and somatic reactions, and, if this did not require 40 minutes, they were instructed to provide the account a second time. After the exposure, approximately 15 minutes were devoted to discussing the reliving with the participant. Exposure was not audiotaped, but patients were instructed to repeat the exposure exercise, as conducted in the therapy session, at least once between sessions for homework; this approach was done because each exposure session can elicit additional information, and reliance on a previously recorded session can limit this additional processing of information.

CBT

The group therapy was identical to the treatment provided in the CBT/Exposure condition. In each of the 4 weekly 1-hour individual sessions, however, participants in CBT were invited to discuss anything they wished to. The facilitators of the individual sessions, who were the same therapists who conducted the exposure sessions, did not instruct participants in any exposure-based approaches. Facilitators responded to participants in a nondirective manner. To equate for the homework activity of those in the exposure condition, participants were asked to complete a diary of grief states between sessions.

Figure 1. Participant Flowchart



Abbreviations: CBT = cognitive-behavioral therapy, ICG = Inventory of Complicated Grief.

Audiotapes of 20% of individual and group therapy sessions were randomly selected and rated by 3 clinicians who were independent of the study. All CBT/Exposure individual sessions included adequate exposure sessions, and no CBT individual session included exposure. The mean quality ratings for treatment components were measured on a 7-point scale (1 = very low quality, 7 = very high quality), and across conditions, therapy was rated an average of 5.30 (SD = 1.58).

Measures

The Complicated Grief Assessment (CGA)[15] is a clinician administered semistructured interview for assessing PGD. The CGA interview is based on the Inventory of Complicated Grief[16] and provided a diagnosis and severity index of PGD. The interview assesses for the presence of separation distress (Criterion A) and difficulty accepting the death, emotional numbness, bitterness, difficulty re-engaging in life, and a sense of purposelessness and meaninglessness (Criterion B). A diagnosis of complicated grief is given if 6 months have passed since the death, Criteria A and B have been met for at least 6 months, and there is evidence of functional impairment (Criterion C). This diagnosis is consistent with the proposed definition of PGD in *ICD-11*.[17] Entry into the study required meeting diagnostic criteria for PGD according to the CGA.

The Mini-International Neuropsychiatric Interview (version 5.5; MINI)[18] was used to assess for comorbid Axis I depression and anxiety disorders.

The Inventory of Complicated Grief (ICG)[16] is a 19-item self-report measure for assessing PGD. The ICG assesses for the presence of separation distress (Criterion A) and other symptoms including a difficulty accepting the death, numbness, bitterness, difficulty engaging in life, and a sense of purposelessness and meaninglessness. The ICG has strong internal consistency (0.94) and content validity with other measures of grief, such as the Texas Revised Inventory of Grief (0.87). The ICG was used to assess severity of PGD at each assessment.

Data Analysis

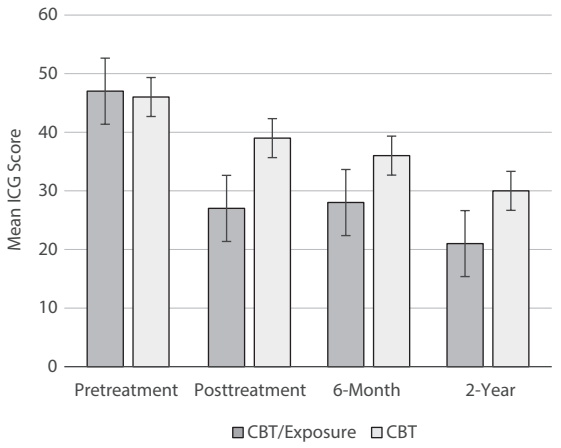
To achieve power of 80%, we calculated, on the basis of a previous study that employed exposure-based therapy with PGD,[5] that we required 80 participants to detect an 8-point difference in grief scores ($\alpha = .05$). Using SPSS version 21 (IBM Corp; Armonk, New York), we adopted hierarchical linear models to study treatment effects because this allows the number of observations to vary between participants and effectively handles missing data.[19] Use of hierarchical linear models allows analysis of all 80 participants who were randomized. Hierarchical linear models use a multilevel data structure in which repeated measurements (level 1 variable) are nested within participants (level 2 variable). For these analyses, we estimated both fixed and random intercepts and slopes. The model included linear and quadratic time parameters, treatment condition, and the interaction between time and treatment ($P < .05$). Linear effects provide an estimate of change from pretreatment to follow-up, whereas quadratic effects provide an estimate of change that accommodates the changing trends from the posttreatment assessment to follow-up assessment. We evaluated fixed effects parameters using the Wald test (t test) and 95% confidence intervals. We estimated both level 1 and level 2 models; however, we focus here on level 2 results relating to the 2-year follow-up period. We calculated effect sizes based on previous recommendations for multilevel models, using the following formula [$d = B \times$ time/raw score of pretreatment standard deviation].[20]

Table 2. Characteristics of Participants Retained and Missing at Follow-Up

	Retained (n = 41)	Not Retained (n = 39)	Test	P Value
Age, mean (SD), y	54.18 (13.06)	51.97 (12.27)	$F_{78} = 1.32$	.19
Time since death, mean (SD), y	3.80 (2.85)	4.71 (5.53)	$F_{78} = 0.96$	.34
Education, mean (SD), y	14.42 (2.75)	13.75 (2.75)	$F_{78} = 1.51$	.14
Gender, n (%)			$\chi^2 = 1.13$	.29
Male	6 (14.6)	5 (12.8)		
Female	35 (85.4)	34 (87.2)		
Employed, n (%)	29 (70.7)	27 (69.2)	$\chi^2 = 0.02$	.99
Relationship to deceased, n (%)			$\chi^2 = 3.24$	.66
Partner	12 (29.3)	12 (30.8)		
Child	14 (34.1)	9 (23.1)		
Parent	10 (24.4)	15 (38.5)		
Other	5 (12.2)	3 (7.7)		
Death type, n (%)			$\chi^2 = 0.84$	.84
Sudden illness	9 (22.0)	7 (17.9)		
Chronic illness	21 (51.2)	24 (61.5)		
Accident	6 (14.6)	5 (12.8)		
Suicide	5 (12.2)	3 (7.7)		
Comorbid disorder, n (%)				
Depression	26 (63.4)	22 (56.4)	$\chi^2 = 0.52$	.47
PTSD	26 (63.4)	19 (48.7)	$\chi^2 = 1.54$	.21
Anxiety disorder	10 (24.4)	10 (25.6)	$\chi^2 = 0.03$	.85
Substance use disorder	5 (12.2)	3 (7.7)	$\chi^2 = 0.39$	.53
Logic rating, mean (SD)	7.70 (1.30)	6.92 (1.89)	$F_{78} = 1.40$	.17
Expectancy rating, mean (SD)	7.05 (1.67)	6.00 (2.00)	$F_{78} = 1.63$	.11
Baseline ICG score, mean (SD)	46.76 (11.23)	46.81 (10.56)	$F_{78} = 0.02$	.98
Posttreatment ICG score, mean (SD)	30.47 (15.68)	30.93 (14.83)	$F_{78} = 1.13$	.26
6-month follow-up ICG score, mean (SD)	30.93 (14.87)	33.14 (11.56)	$F_{78} = 0.62$	.54

Abbreviations: ICG = Inventory of Complicated Grief, PTSD = posttraumatic stress disorder.

Figure 2. Mean Estimates of Inventory of Complicated Grief (ICG) Scores[a]



[a]Standard error bars presented.
Abbreviation: CBT = cognitive-behavioral therapy.

RESULTS

Participants who completed the 2-year follow-up did not differ from those who did not in terms of age, time since death, initial ICG score, years of education, or treatment expectancy (Table 2). Further, participants who did and did not complete the 2-year follow-up did not differ on ICG scores at posttreatment or 6-month follow-up.

Least-square mean scores for prolonged grief symptoms by treatment condition are presented in Figure 2. Level 2 results of the random effect regression analyses indicated a significant linear time × treatment interaction from pretreatment to 2-year follow-up ($B = -0.63$; $SE = 0.26$; $t_{225} = -2.44$; $P = .02$; 95% CI, −1.14 to −0.12), indicating that CBT/Exposure led to significantly greater decreases in prolonged grief symptoms at 2 years relative to CBT. There was also a marginally significant quadratic time × treatment interaction ($B = 0.05$; $SE = 0.02$; $t_{225} = 1.87$; $P = .06$; 95% CI,

Table 3. Random Effects Regression Analysis Results Predicting Prolonged Grief Symptoms

	Estimate (Standard Error)	*t*	*P* Value	95% CI
Intercept	41.91 (1.63)	25.66	<.001	38.69 to 45.13
Treatment (CBT/Exposure vs CBT)	−5.54 (2.28)	−2.42	.016	−10.04 to −1.03
Linear time	−0.77 (0.18)	−4.22	<.001	−1.13 to −0.41
Quadratic time	0.03 (0.02)	1.89	.060	−0.01 to −0.07
Treatment × time (linear) (CBT/Exposure vs CBT)	−0.63 (0.26)	−2.44	.015	−1.14 to −0.12
Treatment × time (quad) (CBT/Exposure vs CBT)	0.05 (0.02)	1.87	.063	−0.01 to 0.09

Abbreviation: CBT = cognitive-behavioral therapy.

−0.01 to 0.09), indicating that, to a marginal extent, the participants in the CBT condition had a greater reduction in symptoms between posttreatment and 2-year follow-up than the CBT/Exposure condition (see Table 3 for full level 2 model results). These results suggest that gains made by the CBT/Exposure condition relative to the CBT condition at posttreatment marginally diminished during the following 2 years, even though the CBT/Exposure condition still enjoyed lower grief symptoms relative to CBT compared to their pretreatment levels. The pretreatment to follow-up linear effect size was 2.51 for CBT/Exposure and 1.51 for CBT. The quadratic effect sizes were 0.14 and 0.06, respectively. The linear effect size between conditions (pretreatment to follow-up) was 1.15, and the quadratic effect size was 0.08. That is, patients in the CBT/Exposure conditions demonstrated a large reduction in PGD symptoms relative to those who received CBT. To shed light on how the 2 conditions compared between the 6-month and 2-year assessments, we calculated the effect sizes for each condition; CBT/Exposure (0.41) and CBT (0.38) displayed comparable effect sizes from the 6-month to 2-year assessments. In terms of those who completed the 2-year follow-up assessment, fewer participants in the CBT/Exposure condition (n = 4, 17.4%) met criteria for PGD than those in CBT (n = 8, 50.0%) ($\chi^2_{40} = 4.71$, $P = .03$).

DISCUSSION

Consistent with our observation at the 6-month assessment,[11] patients who received exposure in combination with other CBT strategies were enjoying a greater reduction in grief symptoms 2 years later than those who received CBT without exposure. Although at the 2-year follow-up the CBT condition had marginally greater symptom reduction compared to posttreatment levels ($P = .06$), the CBT/Exposure condition was nonetheless enjoying greater reduction of grief symptoms relative to the CBT condition compared to their pretreatment levels. This conclusion is underscored by the observation of a large between-group effect size (1.15) at the 2-year follow-up, suggesting that patients in the CBT/Exposure condition experienced greater long-term reductions in symptoms of PGD than patients in the CBT condition.

This finding suggests that therapy gains following psychotherapy for PGD are greatest in the long term (as well as the short term) if emotional processing of the loss is encouraged in therapy. This is consistent with previous successful trials that have implemented exposure.[4,5] This finding can be understood in the context of emotional processing theory. Initial conceptualizations of emotional processing, focusing primarily on PTSD,[21] posited that successful treatment entailed engaging fear memory structures via reliving the trauma memory; it was proposed that this process would allow corrective information to be integrated into these memory structures, along with more adaptive beliefs and thoughts pertaining to the trauma response. It has been argued that exposure therapy is effective with anxiety disorders because it may target a number of mechanisms, including habituation of anxiety, extinction of previously conditioned responses, integration of corrective information, and mastery of the fear of recalling the distressing event.[22] Any of these mechanisms may explain the finding that using exposure therapy in treatment of PGD results in superior outcomes. It is also possible that reliving distressing memories about the death facilitates the cognitive reframing of maladaptive thoughts about the loss. Supporting this interpretation, evidence found that providing exposure prior to cognitive restructuring can be superior to provision of exposure after cognitive restructuring[5]; this pattern suggests that emotional processing may facilitate cognitive reframing of the loss and facilitate outcomes. The conclusion that providing exposure is beneficial for other treatment components also accords with theoretical models of grief that posit that bereaved people need to process difficult emotions associated with memories of the loss to allow them to develop new attachments in the future.[23,24] We recognize, however, that we did not specifically index these potential processes, and so considering the mechanisms underpinning the superior effect of exposure therapy remains speculative.

It should be noted, however, that CBT was also apparently effective in reducing symptoms of PGD. The pretreatment to follow-up effect size for CBT was 1.51, which represents a large reduction in symptoms over the 2 years since treatment commenced. Cognitive models of PGD propose that the condition is maintained, in part, by excessively negative appraisals about the loss and one's capacity to cope with the future.[25] This model is supported by evidence that maladaptive appraisals characterize PGD[26,27] and also predict the course of PGD over time.[28] We also note that CBT included letter writing to the deceased, which may also have involved emotional processing of the loss and contributed to clinical gains.

Our conclusions are limited by several methodological factors. First, most importantly, only 51% of the sample was retained at the 2-year follow-up, which limits confidence in the findings. However, those not retained did not differ from those who were retained on core pretreatment

factors. Second, 23% of the sample was taking concurrent antidepressant medication during the study, and this potential effect could not be controlled for. We do not believe that concurrent antidepressant use confounded the findings, however, because there was no difference in medication use between treatment conditions. Third, approximately half of the sample met criteria for PTSD, and it is difficult to disentangle how the treatments impacted PTSD levels because we did not assess these following treatment; relatedly, few in our sample comprised bereaved people following traumatic loss, such as homicide or suicide, and future research needs to determine how applicable these findings are to these populations. Fourth, to increase compliance in the follow-up assessment, we assessed only for grief symptoms and did not assess for other psychopathology or functioning.

These limitations notwithstanding, this study provides the first evidence of long-term gains of grief-focused CBT for patients with PGD. Further, our finding highlights that therapists should encourage emotional processing of grief memories to achieve optimal treatment gains in patients with PGD. Although therapists are often reluctant to use exposure therapy because of concerns that it may cause excessive distress in patients,[29,30] our initial study demonstrated no adverse reactions to the exposure therapy. This supports increasing evidence that exposure does not lead to adverse outcomes or increased dropout rates.[31,32] In summary, the balance of evidence does support the use of exposure techniques in the treatment of PGD, and, in combination with other CBT strategies, exposure therapy can lead to long-term clinical gains.

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