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REVIEW

Ten Years of Brief Intensive Trauma-Focused Treatment at PSYTREC: A Programmatic Narrative Review and Research Agenda

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ABSTRACT

Since its establishment in 2015, psychotrauma expertise centre PSYTREC has developed and evaluated brief intensive trauma-focused treatment programs for post-traumatic stress disorder (PTSD) and complex PTSD (CPTSD), with a more recent extension to personality disorders. This programmatic narrative review summarizes ten years of research conducted within and around the PSYTREC treatment program. The research program has examined clinical outcomes of highly concentrated treatment combining established trauma-focused interventions, particularly prolonged exposure (PE) and EMDR therapy, within a structured multidisciplinary context; whether presumed complicating factors, including dissociation, emotion regulation difficulties, childhood sexual abuse, and borderline personality disorder (BPD) symptoms, are associated with poorer outcome; and how treatment delivery can be refined. Across predominantly naturalistic and uncontrolled studies, brief intensive trauma-focused treatment was associated with substantial within-group reductions in PTSD symptoms, low observed dropout in many cohorts, and substantial diagnostic remission, including among eligible patients in groups traditionally considered difficult to treat. In studies that explicitly monitored adverse events or deterioration, no clear safety signal was reported. These findings provide evidence regarding feasibility and clinical outcomes but, in the absence of control conditions in most studies, do not establish causal efficacy or comparative superiority. Future research should prioritize independent controlled replication, direct comparison with standard-frequency treatment, and longer follow-up.

Keywords: Post-Traumatic Stress Disorder; Complex Post-Traumatic Stress Disorder; Intensive Trauma-Focused Treatment; Prolonged Exposure; EMDR Therapy; Treatment Intensification.

1. Introduction: from treatment resistance to treatment intensification

Post-traumatic stress disorder (PTSD) is often chronic, disabling, and highly comorbid, especially following repeated, interpersonal, or early-life trauma. Complex post-traumatic stress disorder (CPTSD), as defined in ICD-11, comprises the core PTSD symptom clusters together with disturbances in self-organization, characterized by affect dysregulation, persistent negative self-concept, and difficulties in interpersonal relationships. Historically, patients with severe PTSD, CPTSD, dissociation, borderline personality disorder (BPD) symptoms, or major emotion regulation difficulties were often

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considered too unstable for immediate trauma-focused treatment. Trauma processing was therefore frequently delayed or preceded by lengthy stabilization, despite limited evidence that such preparation improves outcomes.[1]

PSYTREC was founded in 2015 with the aim of making evidence-based trauma treatment more accessible to patients with severe and complex trauma-related presentations. Its central proposition is that many patients may not need less trauma-focused treatment, but a more concentrated and better organized delivery with maximum retention. The program therefore combines repeated prolonged exposure (PE) and eye movement desensitization and reprocessing (EMDR) therapy sessions within a time frame of days, not months or years, with psychoeducation, physical activity, and multidisciplinary support. The first major naturalistic outcome study evaluated an eight-day program in 347 patients with severe PTSD, multiple trauma histories, extensive comorbidity, frequent sexual abuse exposure, and substantial suicidal ideation.[2] The program comprised 16 trauma-focused sessions, physical activity, and psychoeducation. PTSD symptoms decreased markedly; 82.9% showed a clinically meaningful response, 54.9% lost the PTSD diagnosis, and only 2.3% dropped out. This study provided the empirical foundation for the subsequent research program and further refinement of the treatment model.

Methods and Scope

This article is a programmatic narrative review of research conducted within or directly related to the PSYTREC treatment program and was not designed as a systematic review or meta-analysis. Publications were considered when they described the treatment model or evaluated its clinical outcomes, potential moderators or predictors, treatment processes, implementation characteristics, safety, or broader outcomes. Recent meta-analytic findings were additionally used to place results from the PSYTREC program within the broader evidence base on treatment intensity and dosage.[3] Because the purpose was to synthesize a defined research program rather than to exhaustively identify all studies of intensive PTSD treatment, no formal systematic search, study-selection flowchart, or study-level risk-of-bias assessment was conducted. Accordingly, study designs are explicitly identified throughout the review, and causal or comparative conclusions are avoided where findings derive from uncontrolled observational data.

2. The PSYTREC treatment model

The PSYTREC program is not a novel stand-alone psychotherapy but a delivery model in which established evidence-based trauma-focused interventions are provided in a highly concentrated format. In the foundational eight-day program, patients received 16 individual trauma-focused treatment sessions distributed over two four-day treatment blocks. Treatment typically combined PE and EMDR therapy, with trauma memories being actively targeted from the beginning of treatment rather than after a mandatory preparatory stabilization phase. Trauma-focused sessions were embedded within a structured multidisciplinary program that also included psychoeducation and physical activity.

A further distinguishing feature is therapist rotation. Rather than receiving all trauma-focused sessions from a single clinician, patients work with multiple therapists who are trained in the same treatment protocols and share relevant treatment information.[4] The purpose is to maintain protocol continuity while reducing dependence on an individual therapist and facilitating intensive delivery at

service level; research within the program suggests that a therapeutic alliance can be established in this rotation model.[5] Comorbidity and clinical complexity are incorporated into assessment and treatment planning but are not, in themselves, regarded as reasons to postpone trauma processing. Thus, what distinguishes the PSYTREC model is primarily its organization and delivery architecture, the concentration and combination of established trauma-focused interventions within a structured multidisciplinary program, rather than the introduction of a new trauma-focused psychotherapy.

The PSYTREC model should not be interpreted as a new trauma-focused psychotherapy or as having been demonstrated to be superior to other guideline-recommended treatments. Its distinctive feature lies primarily in the organization and intensity of treatment delivery. This distinction is consistent with the broader evidence base. In a recent meta-analysis of 73 randomized controlled trials, high-intensity trauma-focused treatment did not produce significantly greater post-treatment PTSD symptom reduction than standard-intensity treatment in direct comparisons, but was associated with a higher likelihood of treatment completion.[3] Intensive delivery may additionally shorten the calendar time required to obtain symptom improvement. Thus, the principal potential advantage of the PSYTREC model concerns concentrated access to evidence-based treatment, rapid delivery, and treatment retention rather than superior efficacy of its constituent interventions. Direct randomized comparisons with standard-frequency trauma-focused treatment are required to determine whether these potential advantages translate into clinically or economically meaningful superiority.

2.1 Patient selection and clinical representativeness

The cohorts described in this review should not be regarded as unselected samples of all individuals referred for PTSD treatment. Eligibility criteria varied across studies and program periods, and individual studies applied study-specific inclusion and exclusion criteria. Consequently, although the samples were generally characterized by substantial PTSD severity, repeated trauma exposure, and psychiatric comorbidity, the findings apply to patients who met the relevant clinical and study eligibility criteria. Moreover, characteristics of all individuals referred but not admitted to the program and of non-completers were not reported consistently across publications. Conclusions regarding factors such as dissociation or BPD should therefore be interpreted as indicating that these characteristics did not predict poorer outcomes among eligible patients treated within this program, rather than demonstrating that they can never represent clinically relevant barriers in all PTSD populations. Study-specific eligibility criteria are described in the original publications.

3. Foundational outcome studies: can severe and complex PTSD be treated intensively?

The initial outcome findings were followed by research on CPTSD. In an uncontrolled subgroup analysis, most patients classified as having CPTSD showed substantial improvement within the same intensive treatment context, with almost 90% no longer meeting diagnostic criteria for CPTSD after completion.[6] Taken together, these uncontrolled cohort findings indicate that marked clinical improvement can occur during intensive trauma-focused treatment among patients with severe PTSD and CPTSD treated in this specialist setting. However, because

these studies did not include a control condition, they cannot establish that treatment itself caused the observed improvement or that intensive delivery is superior to standard-frequency trauma-focused treatment.

4. Moderator studies: who should not be excluded?

4.1 Dissociation and dissociation-related phenomena

PSYTREC studies have examined several forms of dissociation. The dissociative subtype of PTSD, characterized by prominent depersonalization and/or derealization in addition to PTSD symptoms, did not moderate treatment outcome within the treated cohort.[7] Likewise, in a sample of 219 patients with severe PTSD, somatoform dissociation - dissociative phenomena expressed predominantly through bodily or sensorimotor experiences - did not predict poorer PTSD treatment outcome, while somatoform dissociative symptoms themselves decreased during treatment.[8] These findings suggest that dissociation was not associated with poorer treatment response within these selected cohorts.

4.2 Emotion regulation difficulties

Emotion regulation difficulties are another common reason for postponing trauma processing. Within the treated cohort, greater emotion regulation difficulties were not associated with poorer PTSD outcomes or relapse and decreased during treatment.[9] These findings indicate that baseline emotion regulation difficulties did not identify a subgroup with poorer outcome in this program, although the observational design does not establish that trauma-focused treatment itself caused the change in emotion regulation.

4.3 Childhood sexual abuse

A history of childhood sexual abuse was not associated with poorer PTSD treatment outcome within the treated cohort.[10] Although such histories are often accompanied by shame, dissociation, and interpersonal difficulties, these findings suggest that childhood sexual abuse history alone did not identify patients with poorer outcome in this program; they do not establish equivalence across all treatment settings.

4.4 Borderline personality disorder (BPD) symptoms and comorbid BPD

Among eligible patients with clinically elevated BPD symptoms, intensive trauma-focused treatment was associated with reductions in both PTSD and BPD symptoms, and the study reported no clear safety signal.[11] Patients meeting criteria for both PTSD and BPD similarly showed reductions in PTSD and BPD symptoms, with improvements documented at one-year follow-up.[12] These findings suggest that BPD symptoms were not associated with an absence of clinical improvement among eligible patients treated in these cohorts, rather than demonstrating that BPD can never constitute a clinically relevant treatment consideration.

4.5 Some additional moderator studies

Other studies addressed groups often considered difficult to treat. In a matched observational comparison, older adults showed improvements comparable to matched younger adults.[13] Veterans and non-veterans with war-related PTSD also showed substantial symptom reductions, without evidence within that comparative cohort that veterans had poorer outcomes.[14]

5. Treatment optimization: from effectiveness to refinement

5.1 Physical activity and the APPART study

Physical activity was included as a potential augmentation strategy. In the APPART randomized controlled trial, intensive trauma-focused treatment combined with physical activities was compared with the same treatment combined with non-physical activities. Both conditions showed substantial symptom reductions and high diagnostic remission, but physical activity showed no clear specific advantage.[15]

5.2 Sequence of prolonged exposure and EMDR therapy

An exploratory, non-randomized sequencing study compared consecutive cohorts receiving either PE followed by EMDR therapy or EMDR therapy followed by PE, with sequence allocation determined by treatment period rather than randomization. PE followed by EMDR therapy was associated with greater PTSD symptom reduction and more favourable patient evaluations. Given the non-randomized design, these findings should be regarded as hypothesis-generating and require confirmation in a randomized comparison.[16]

5.3 Remote and home-based delivery

Remote delivery of the trauma-focused program was also evaluated. Home-based and fully remote intensive trauma-focused programs were feasible and associated with substantial symptom reductions in patients with PTSD or CPTSD; these studies also explicitly monitored safety outcomes and reported no clear treatment-related safety signal.[17,18]

6. Broader outcomes beyond PTSD symptoms

6.1 Safety, deterioration, and treatment completion

Safety outcomes were not assessed uniformly across studies. Several cohorts explicitly monitored adverse events or reliable symptom deterioration and reported no clear treatment-related safety signal.[6,11,17,18] However, these assessments were not standardized across the entire research program, and published studies do not provide a standardized estimate of dissociative crises or other in-treatment crises across cohorts. Accordingly, the present review reserves the term "safe" for individual studies in which safety outcomes were explicitly assessed and does not infer general safety from the absence of reported events. Future studies should prospectively and systematically monitor suicidality, self-harm, hospitalization, crisis contacts, dissociative crises, and reliable symptom deterioration using predefined criteria.

6.2 Comorbidity and residual symptoms

Research has increasingly extended beyond PTSD severity. Comorbid depressive symptoms decreased during intensive treatment, although patients with CPTSD appeared more vulnerable to depressive relapse.[19] Residual-symptom research further showed that loss of the PTSD diagnosis does not necessarily equal full recovery, supporting continued monitoring and targeted follow-up when clinically indicated.[20]

7. Extending the model to personality disorders

More recently, PSYTREC researchers have proposed a memory-focused conceptual framework for extending trauma-focused treatment principles to personality pathology.[21] Empirical studies are currently being conducted to determine whether this approach improves personality functioning, reduces diagnostic status, and produces durable changes in self-image, interpersonal functioning, emotion regulation, and quality of life.

8. Discussion

The PSYTREC research program provides a decade of programmatic evidence concerning the feasibility and clinical outcomes of delivering established trauma-focused interventions in a highly concentrated format to patients with severe and frequently comorbid PTSD presentations. At the same time, the strength of inference differs substantially across studies. Most findings reviewed here derive from uncontrolled naturalistic cohorts and moderator or predictor analyses and therefore primarily inform feasibility, clinical change, and the identification of factors that were or were not associated with poorer outcome within treated samples. The APPART trial provides randomized evidence regarding one component of the program, whereas other program characteristics, including intensive scheduling, combining PE and EMDR therapy, and their optimal sequencing, require stronger controlled evaluation.[15,16] These distinctions are important when interpreting the consistently substantial within-group improvements reported across the program.

Importantly, the broader literature does not indicate that intensive delivery necessarily produces greater PTSD symptom reduction than standard-frequency trauma-focused treatment. In the recent meta-analysis by Leithner et al, direct comparisons of high- versus standard-intensity treatment showed no significant difference in post-treatment PTSD severity, although treatment completion was higher under high-intensity delivery.[3] The potential value of intensification may therefore concern speed and treatment retention at least as much as greater symptom efficacy.

Taken together, the PSYTREC findings and the wider literature suggest that treatment intensity may be conceptualized as a delivery characteristic rather than a distinct therapeutic mechanism. The available evidence does not support the conclusion that the PSYTREC model is intrinsically more efficacious than other evidence-based trauma-focused approaches. Rather, its potential contribution is to demonstrate how substantial amounts of evidence-based trauma-focused treatment can be delivered within a short period, with potentially favourable implications for treatment completion and speed of improvement. Whether these advantages outweigh the organizational demands of intensive treatment requires direct comparative and health-economic evaluation.

The findings of the research program have four principal implications. First, within eligible PSYTREC cohorts, severe PTSD, CPTSD, dissociation, emotion dysregulation, childhood sexual abuse, and BPD symptoms were not consistently associated with poorer treatment outcome; these characteristics should therefore not automatically be treated as reasons to postpone trauma-focused treatment. Second, intensification represents a plausible clinical delivery strategy, particularly where rapid access, treatment retention, or reduction of calendar time in treatment are priorities, but its comparative superiority has not been established. Third, studies of therapist rotation, remote delivery, physical activity, and treatment sequencing contribute to implementation and program refinement while also identifying components that require stronger controlled evaluation. Fourth, outcomes should encompass comorbidity, residual symptoms, functioning, quality of life, adverse events, and deterioration rather than PTSD diagnosis alone.

Table 1. Overview of PSYTREC-related publications and research themes

Theme	Citation	Design	Sample / size	Treatment / focus	Main contribution
Foundation / intensive care	Van Woudenberg et al.[2]	Uncontrolled naturalistic pre-post outcome study	N = 347 severe PTSD	8-day PE + EMDR program	Marked within-group reductions; 54.9% lost diagnosis; 2.3% dropout
Complex PTSD	Voorendonk et al.[6]	Uncontrolled CPTSD subgroup/outcome analysis	Patients with CPTSD	Intensive PE + EMDR	Marked within-group improvement; stabilization not directly tested
Physical activity	Voorendonk et al.[15]	Randomized controlled trial	N = 119 PTSD/CPTSD	TFT + physical vs non-physical activity	Substantial improvement in both groups; no specific physical-activity advantage
Therapeutic alliance	Hoogeveen et al.[5]	Observational process/outcome study	Intensive PTSD sample	Therapist rotation	Alliance established within therapist rotation; small associations with symptom change
Residual symptoms	Wesseling et al.[20]	Observational residual-symptom study	Diagnostic remitters	Post-treatment assessment	Meaningful residual symptoms remained among diagnostic remitters
War-related PTSD	Reij et al.[14]	Observational comparative study	Veterans and non-veterans	Brief intensive TFT	Both groups showed symptom reductions; no evidence of poorer veteran outcome
Personality disorders	de Jongh et al.[21]	Theoretical/conceptual article	Not applicable	AIP-based EMDR for personality disorders	Theoretical memory-focused framework; empirical efficacy not established
Depression	Paridaen et al.[19]	Uncontrolled outcome study	PTSD/CPTSD with depression	Intensive TFT	Depressive symptoms decreased; relapse vulnerability remained in CPTSD
PTSD + BPD	Kolthof et al.[12]	Uncontrolled outcome study with 1-year follow-up	PTSD + BPD	Intensive TFT	PTSD and BPD symptoms decreased; improvement maintained at follow-up
Somatoform dissociation	Zoet et al.[8]	Predictor/outcome analysis in an uncontrolled cohort	N = 219 severe PTSD	PE + EMDR	Somatoform dissociation did not predict poorer outcome
Older adults	Gielkens et al.[13]	Matched observational comparison	62 older + 62 younger adults	Intensive TFT	Comparable improvement across matched age groups

Table 1. Overview of PSYTREC-related publications and research themes

Theme	Citation	Design	Sample / size	Treatment / focus	Main contribution
Home-based telehealth	Bongaerts et al.[17]	Uncontrolled telehealth outcome study	CPTSD sample	Home-based intensive TFT	Feasible; symptom reductions observed; safety outcomes monitored
Emotion regulation	Van Toorenburg et al.[9]	Predictor/outcome analysis in an uncontrolled cohort	Severe PTSD sample	Intensive TFT	Emotion regulation difficulties did not predict poorer outcome
PE/EMDR sequence	Van Minnen et al.[16]	Exploratory non-randomized sequential-cohort comparison	Intensive PTSD sample	PE→EMDR vs EMDR→PE	PE→EMDR associated with better outcome; hypothesis-generating non-randomized finding
Dissociative subtype	Zoet et al.[7]	Moderator analysis in an uncontrolled cohort	Severe PTSD sample	Intensive TFT	Dissociative subtype did not moderate outcome in the treated cohort
BPD symptoms	de Jongh et al.[11]	Uncontrolled outcome study	PTSD with BPD symptoms	Brief intensive TFT	BPD symptoms decreased alongside PTSD symptoms
Childhood sexual abuse	Wagenmans et al.[10]	Moderator analysis in an uncontrolled cohort	PTSD sample	Intensive TFT	Childhood sexual abuse history did not predict poorer outcome
Therapist rotation model	Van Minnen et al.[4]	Implementation article	Two treatment settings	Therapist rotation	Therapist rotation described as an implementation strategy
Fully remote treatment	Bongaerts et al.[18]	Uncontrolled remote outcome study	PTSD/CPTSD sample	Fully remote intensive TFT	Feasible; substantial symptom reduction; safety outcomes monitored

Abbreviations: BPD = borderline personality disorder; CPTSD = complex PTSD; EMDR = eye movement desensitization and reprocessing; PE = prolonged exposure; PTSD = post-traumatic stress disorder; RCT = randomized controlled trial; TFT = trauma-focused treatment.

9. Limitations of the current evidence base

The evidence base has important limitations. Many studies are observational, uncontrolled, or based on routine clinical data, which strengthens ecological validity but restricts causal inference. Some subgroup samples are small, follow-up periods vary, durability beyond one year remains insufficiently established, and eligibility criteria and information on non-completers were not reported consistently across publications. Although intensive trauma-focused programs have increasingly been described and implemented internationally,[22] more systematic adverse-event and deterioration monitoring, health-economic evaluation, direct comparisons with standard-frequency treatment, and controlled mechanism studies are needed. Because PSYTREC is a highly specialized centre, implementation research should also establish whether the model generalizes to other services and healthcare systems.

10. Conclusion

Over its first decade, PSYTREC has generated a substantial programmatic evidence base on brief intensive trauma-focused treatment for severe PTSD and CPTSD. Across predominantly naturalistic and uncontrolled studies, treatment has been associated with marked symptom improvement, low observed dropout in many cohorts, and favourable outcomes among eligible patients with several markers of clinical complexity, including dissociation, emotion regulation difficulties, childhood sexual abuse, and BPD symptoms. In those studies in which adverse events or deterioration were explicitly monitored, no clear safety signal was reported. These observations are consistent with a broader literature indicating that evidence-based trauma-focused treatment can be delivered intensively without apparent loss of efficacy and with potential advantages in treatment completion. They should not, however, be interpreted as demonstrating superiority of the PSYTREC model or as establishing that all patients with complex presentations can be treated safely in this format. Independent controlled replication, systematic adverse-event and deterioration monitoring, direct comparison with standard-frequency treatment, health-economic evaluation, and longer-term follow-up are important next steps. A recently proposed trauma-focused application to personality disorders represents an emerging research direction.

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REFERENCES

1. de Jongh A, Resick PA, Zoellner LA, et al. A critical analysis of the current treatment guidelines for complex PTSD in adults. Depress Anxiety. 2016;33(5):359-369. doi:10.1002/da.22469
2. van Woudenberg C, Voorendonk EM, Bongaerts H, et al. Effectiveness of an intensive treatment program combining

prolonged exposure and eye movement desensitization and reprocessing for severe post-traumatic stress disorder. Eur J Psychotraumatol. 2018;9(1):1487225. doi:10.1080/20008198.2018.1487225

3. Leithner C, Schreyer B, Däumling S, Semmlinger V, Ehring T. The role of dosage and intensity in trauma-focused treatments for posttraumatic stress disorder: a meta-analysis. Clin Psychol Rev. 2026;125:102720. doi:10.1016/j.cpr.2026.102720
4. van Minnen A, Hendriks L, de Kleine RA, Hendriks GJ, Verhagen M, de Jongh A. Therapist rotation: a novel approach for implementation of trauma-focused treatment in post-traumatic stress disorder. Eur J Psychotraumatol. 2018;9(1):1492836. doi:10.1080/20008198.2018.1492836
5. Hoogeveen M, de Jongh A, Matthijssen SJMA, Voorendonk EM. Therapeutic alliance in intensive PTSD treatment with a therapist rotation model. Eur J Psychotraumatol. 2026;17(1):2664272. doi:10.1080/20008066.2026.2664272
6. Voorendonk EM, de Jongh A, Rozendaal L, van Minnen A. Trauma-focused treatment outcome for complex PTSD patients: results of an intensive treatment program. Eur J Psychotraumatol. 2020;11(1):1783955. doi:10.1080/20008066.2020.1783955
7. Zoet HA, Wagenmans A, van Minnen A, de Jongh A. Presence of the dissociative subtype of PTSD does not moderate the outcome of intensive trauma-focused treatment for PTSD. Eur J Psychotraumatol. 2018;9(1):1468707. doi:10.1080/20008198.2018.1468707
8. Zoet HA, de Jongh A, van Minnen A. Somatoform dissociative symptoms have no impact on the outcome of trauma-focused treatment for severe PTSD. J Clin Med. 2021;10(8):1553. doi:10.3390/jcm10081553
9. van Toorenburg MM, Sanches SA, Linders B, et al. Do emotion regulation difficulties affect outcome of intensive trauma-focused treatment of patients with severe PTSD? Eur J Psychotraumatol. 2020;11(1):1724417. doi:10.1080/20008198.2020.1724417
10. Wagenmans A, van Minnen A, Sleijpen MJT, de Jongh A. The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD. Eur J Psychotraumatol. 2018;9(1):1430962. doi:10.1080/20008198.2018.1430962
11. de Jongh A, Groenland GN, Sanches S, Bongaerts H, Voorendonk EM, van Minnen A. The impact of brief intensive trauma-focused treatment for PTSD on symptoms of borderline personality disorder. Eur J Psychotraumatol. 2020;11(1):1721142. doi:10.1080/20008198.2020.1721142
12. Kolthof KA, Voorendonk EM, van Minnen A, de Jongh A. Effects of intensive trauma-focused treatment of individuals with both post-traumatic stress disorder and borderline personality disorder. Eur J Psychotraumatol. 2022;13(2):2143076. doi:10.1080/20008066.2022.2143076
13. Gielkens EMJ, de Jongh A, Sobczak S, et al. Comparing intensive trauma-focused treatment outcome on PTSD symptom severity in older and younger adults. J Clin Med. 2021;10(6):1246. doi:10.3390/jcm10061246
14. Reij KM, de Jongh A, Swens EP, Voorendonk EM. PTSD symptoms change in response to a brief intensive trauma-focused treatment program in non-veterans and veterans with war-related PTSD. Eur J Psychotraumatol. 2025;16(1):2511571. doi:10.1080/20008066.2025.2511571
15. Voorendonk EM, Sanches SA, Tollenaar MS, Hoogendoorn EA, de Jongh A, van Minnen A. Adding physical activity to intensive trauma-focused treatment for post-traumatic stress disorder: results of a randomized controlled trial. Front Psychol. 2023;14:1215250. doi:10.3389/fpsyg.2023.1215250
16. van Minnen A, Voorendonk EM, Rozendaal L, de Jongh A. Sequence matters: combining prolonged exposure and EMDR therapy for PTSD. Psychiatry Res. 2020;290:113032. doi:10.1016/j.psychres.2020.113032
17. Bongaerts H, Voorendonk EM, van Minnen A, de Jongh A. Safety and effectiveness of intensive treatment for complex PTSD delivered via home-based telehealth. Eur J Psychotraumatol. 2021;12(1):1860346. doi:10.1080/20008198.2020.1860346
18. Bongaerts H, Voorendonk EM, van Minnen A, Rozendaal L, Telkamp BSD, de Jongh A. Fully remote intensive trauma-focused treatment for PTSD and Complex PTSD. Eur J Psychotraumatol. 2022;13(2):2103287. doi:10.1080/20008066.2022.2103287
19. Paridaen P, Voorendonk EM, Gomon G, Hoogendoorn EA, van Minnen A, de Jongh A. Changes in comorbid depression following intensive trauma-focused treatment for PTSD and complex PTSD. Eur J Psychotraumatol. 2023;14(2):2258313. doi:10.1080/20008066.2023.2258313
20. Wesseling FAM, Voorendonk EM, Rozendaal L, de Jongh A. Symptom retention after successful intensive trauma-focused treatment for post-traumatic stress disorder. Eur J Psychotraumatol. 2025;16(1):2537546. doi:10.1080/20008066.2025.2537546
21. de Jongh A, Hafkemeijer L, Hofman S, Slotema K, Hornsveld H. The AIP model as a theoretical framework for the treatment of personality disorders with EMDR therapy. Front Psychiatry. 2024;15:1331876. doi:10.3389/fpsyt.2024.1331876
22. Leroy A, Bui E, Verkest E, Warembourg F, de Jongh A, Vaiva G. Therapeutic intensification in post-traumatic stress disorder worldwide: where do we stand? Eur J Psychotraumatol. 2026;17(1):2697553. doi:10.1080/20008066.2026.2697553