



Intensive outpatient treatment for post-traumatic stress disorder: a thematic analysis of patient experience

Tratamiento ambulatorio intensivo para el trastorno de estrés postraumático (TEPT): Un análisis temático de la experiencia de los pacientes

PTSD 的强化门诊治疗: 患者体验的主题分析

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BACKGROUND Intensive treatments have shown encouraging results in the treatment of several psychological disorders, including post-traumatic stress disorder (PTSD). However, qualitative studies on patient experiences with intensive treatment for PTSD remain scarce.

OBJECTIVE The aim of this study was to explore patient experiences with an intensive, outpatient treatment for PTSD and to discover important factors behind treatment feasibility.

METHOD Eight participants were recruited from two groups of patients having completed the intensive treatment programme. Semi-structured qualitative interviews were conducted, and data sets were analysed using thematic analysis.

RESULTS The main result indicated that patients experienced the treatment as very demanding, but still worth the effort in terms of reducing symptoms. The intensity was valued as useful. Participants emphasized the sense of unity with other participants as well as physical activity as important factors for completion of the treatment programme. The rotation of therapists was also highlighted as important for treatment efficacy.

CONCLUSIONS This study provides insights into what the patients experienced and emphasized as important aspects of treatment and essential factors for completing treatment. The main conclusions were that all of the patients evaluated the treatment as demanding, but the reward of reduced symptoms made it worthwhile. The high frequency of therapy sessions and the therapist rotation were reported to counteract avoidance and increase the patients' commitment to therapy. Physical activity and unity in the group were highlighted as essential for treatment feasibility.

HIGHLIGHTS • High treatment intensity enabled increased focus and adherence, and reduced avoidance.

- Therapist rotation led to heightened intensity and new learning experiences.
- Physical activity and sense of unity through group elements were reported as important factors for treatment feasibility.

Antecedentes:

Los tratamientos intensivos han mostrado resultados prometedores para el tratamiento de diversos trastornos psicológicos, incluyendo al trastorno de estrés postraumático (TEPT). Sin embargo, los estudios cualitativos sobre las experiencias de los pacientes con tratamiento intensivo para el TEPT siguen siendo escasos.

Objetivo:

El objetivo de este estudio fue el de explorar las experiencias de los pacientes que recibieron tratamiento ambulatorio e intensivo para el TEPT y descubrir factores importantes para la viabilidad del tratamiento.

Métodos:

De dos grupos de tratamiento se reclutó a ocho participantes que hubiesen completado un programa de tratamiento intensivo. Se realizaron entrevistas cualitativas semiestructuradas y se analizaron los conjuntos de datos mediante el análisis temático.

Resultados:

El principal resultado mostró que los pacientes experimentaban el tratamiento como muy demandante; aún así, consideraron que valía el esfuerzo para conseguir la reducción de los síntomas. La intensidad del tratamiento fue valorada como útil. Los participantes enfatizaron el sentimiento de unidad con otros participantes y a la actividad física como factores importantes para completar el programa del tratamiento. Asimismo, se resaltó la rotación de los terapeutas como importante para la eficacia del tratamiento.

Conclusiones:

Este estudio da una perspectiva de aquello que los pacientes experimentaron, enfatizando también los aspectos importantes del tratamiento y los factores esenciales para completarlo. Las principales conclusiones fueron que todos los pacientes consideraron al tratamiento como demandante, pero que la recompensa de reducir los síntomas hacía que valiese el esfuerzo. Se reportó que la alta frecuencia de las sesiones de terapia y la rotación de los terapeutas contrarrestaban las evitaciones y mejoraban el compromiso de los pacientes con la terapia. Se enfatizó que la actividad física y la unidad en el grupo eran esenciales para la viabilidad del tratamiento.

背景:

强化治疗在对包括 PTSD 的几种心理障碍治疗方面显示出令人鼓舞的结果。然而，对于 PTSD 强化治疗的患者体验的定性研究仍然很少。

目的:

本研究旨在探究 PTSD 强化门诊治疗的患者体验，并发现治疗可行性背后的重要因素。

方法:

从完成强化治疗计划的两组患者中招募了八名参与者。进行了半结构化的定性访谈，并使用主题分析对数据集进行了分析。

结果:

主要结果表明，患者体验到治疗的要求很高，但在减轻症状方面仍然值得付出努力。强化被认为是有用的。参与者强调与其他参与者的团结感以及身体活动是完成治疗计划的重要因素。治疗师的轮换也被强调对治疗效果很重要。

结论:

本研究提供了对患者体验和强调的治疗的重要方面和完成治疗的基本因素的见解。主要结论是，所有患者都认为治疗要求很高，但减轻症状的回报使其值得。高频率的治疗和治疗师轮换可以抵消回避并增加患者对治疗的承诺。小组中的身体活动和团结被强调为治疗可行性的必要条件。

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1. Introduction

Epidemiological studies on trauma and post-traumatic stress disorder (PTSD) indicate that PTSD is becoming a global health issue and should be deemed a public mental health priority, owing to the burden it places on both patient and society (Kessler et al., 2017; Watson, 2019). A systematic review of psychological treatments for PTSD published in 2020 supports the current recommendation of cognitive behavioural therapy (CBT) with trauma focus and eye movement desensitization and reprocessing (EMDR) (Shapiro, 2018) as treatments of choice (Lewis, Roberts, Andrew, Starling, & Bisson, 2020). Despite the documented effect of both therapies, mean dropout rates are found to be significantly higher for trauma-focused interventions than for other treatments. Difficulties tolerating the trauma focus are suggested as an explanation (Lewis, Roberts, Gibson, & Bisson, 2020).

Intensive treatment, commonly operationalized as treatment delivered more than twice weekly, has shown encouraging results in the treatment of a number of psychiatric diseases (Brujniks et al., 2020; Launes et al., 2019; Foa et al., 2018). In addition, intensified CBT and EMDR for PTSD show similar and comparable effects to CBT and EMDR delivered weekly (Ehlers et al., 2014; Harvey et al., 2017; Hurley, 2018). A systematic review of intensive empirically supported treatments for PTSD also concluded that ‘intensive delivery of these treatments can be an effective alternative to standard delivery and contribute to improved treatment response and reduced treatment dropout’ (Sciarrino, Warnecke, & Teng, 2020, p. 443). Sherrill et al. (2020) examined the perceived benefits and drawbacks of massed prolonged exposure in treating veterans with PTSD. Their results indicated that patients viewed massed treatment in a much more positive than negative light. Positive views included that treatment engagement was reinforced through quick and meaningful symptom relief, avoidance was limited, and treatment was prioritized. Furthermore, motivation was continually instilled and/or sustained, frequent therapist contact provided both substantial support and feedback in therapeutic processes, learning was continuously consolidated, and patient preferences were matched (Sherrill et al., 2020). More frequent support during treatment and rapid symptom improvement may help patients to tolerate trauma-focused therapy better and thereby may reduce dropout (Sciarrino et al., 2020; Sherrill et al., 2020).

van Woudenberg et al. (2018) studied the treatment effect of an 8 day intensive, inpatient treatment programme for PTSD ($N = 347$), consisting of prolonged exposure (PE) (Foa, Hembree, & Rothbaum, 2019), EMDR (Shapiro, 2018), group psychoeducation, and group physical activity. When combined with ordinary treatment for PTSD, physical activity has shown to be associated with stronger treatment outcomes (Rosenbaum, Sherrington, & Tiedemann, 2015). Over 80% of patients had a clinically significant response, over 50% no longer qualified for PTSD, and the dropout rate was 2.3% (van Woudenberg et al., 2018). Another aspect of the Dutch treatment programme was the utilization of therapist rotation, where patients meet several therapists. Such rotation is theorized to prevent therapist drift and maximize therapists’ adherence to the protocol (Becker, Zayfert, & Anderson, 2004; van Minnen, Hendriks, & Olf, 2010; Watts et al., 2013).

A Norwegian study (Auren, Jensen, Klæth, Maksic, & Solem, 2021) implemented a modified version of the Dutch intensive treatment programme for outpatients with PTSD, combining PE and EMDR. Results from this pilot indicate that this treatment is feasible. With the exception of the Sherrill et al. (2020) study, there is a lack of qualitative studies on patient experiences with intensive treatment for PTSD. The aim of the current qualitative study was to explore the patient experience with the intensive treatment programme for PTSD, tested by Auren et al. (2021). As far as we know, there has been no other qualitative study conducted on patient experiences with intensive treatment combining these two therapies. Central questions were: ‘How is undergoing intensive trauma-focused treatment experienced?’, ‘What are the challenges and strengths to such a treatment programme?’ and ‘What are experienced as important prerequisites for recovery?’

2. Method

2.1. Participants and procedure

Eight participants, seven women and one man, were recruited from two treatment groups that had completed an intensive treatment programme at a Norwegian outpatient clinic specializing in treatment of patients with severe symptoms of post-traumatic stress (Auren et al. 2021). Informed consent was obtained both written and verbally upon recruitment. Participants included all of the patients from the most recent intensive treatment group and the pilot group. The selection was a consequence of the availability of interviewers. Groups differed in numbers (five versus three participants) and gender, the latter group consisting of female patients only. To be included in the treatment programme, patients had to have a primary PTSD diagnosis, be aged 18 years or higher, and speak Norwegian adequately. All patients had the opportunity to choose weekly treatment instead of intensive treatment. Before inclusion, patients underwent diagnostic assessment. The assessment was performed by a psychologist, and included anamnesis, self-report questionnaires, and structured diagnostic interviews: the PTSD Symptom Scale – Interview (PSS-I) (Foa, Riggs, Dancu, & Rothbaum, 1993) and Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) or Mini-International Neuropsychiatric Interview (MINI) Plus (Brown, Barlow, & DiNardo, 1994; Sheehan et al., 1998). Three participants were diagnosed with comorbid disorders (attention-deficit hyperactivity disorder, moderate depressive episode, and social phobia).

Participants were aged 25–57 years ($M=39.5$). Six were of ethnic Norwegian origin. Reported traumas included war, terror, robbery, sudden death in immediate family, rape, physical and sexual abuse in childhood, sexual and physical domestic abuse, acute physical illness, and severe parental neglect. All participants reported multiple traumas. For five of them, these included physical and/or sexual abuse in childhood. Each participant had a history of previous psychiatric illness, spanning from 3 to 30 years ($M=22.3$). All of the participants had previously received psychotherapy (one to six therapies each, $M=3.3$). Six reported earlier pharmacological treatment with antipsychotic medicines, mood stabilizers, benzodiazepines, and/or antidepressants. Four participants reported previous alcohol or drug abuse. All participants were receiving social security benefits at the start of treatment.

The selection of eight participants was considered sufficient by the authors, as this number is deemed satisfactory when conducting a thematic analysis in a project of this size (Clarke, Braun, & Hayfield, 2015, p. 229). Furthermore, emphasis was placed not on the number of participants or on choosing patients with similar trauma histories, but on the depth and richness of the data provided, as is traditional in qualitative research designs (Smith, 2015, p. 2). All participants are presented with gender-neutral pseudonyms.

2.2. Treatment

Treatment had a duration of 8 days and was delivered within a 2 week time frame, on 4 days per week. Each day consisted of a 90 min PE session in the morning followed by 45 min of physical activity, the latter in a group setting. After lunch, each patient had an individual 90 min EMDR session, followed by 45 min of group psychoeducation. Each patient met with five to seven different therapists during treatment. Therapists had two daily meetings to ensure adherence to the treatment protocol and to discuss therapy progress and future sessions. All patients were offered follow-up sessions after completion of treatment (after 2 weeks and 3, 6, and 12 months). Three patients also received a follow-up telephone call in the first week after treatment. This telephone call was added to the treatment programme based on requests made by the first five patients.

The aim of the physical activity was to allow patients to develop a sense of bodily mastery, and to experience well-being and positive effects of detachment from trauma memories. Psychoeducation sessions included information about the mental and physical health benefits of physical activity in addition to

elements obtained from the PE psychoeducation protocol: PTSD symptoms as reactions to trauma; PE treatment rationale, avoidance and other maladaptive strategies; emotional processing in healing from trauma; negative beliefs, thoughts, and cognitive distortions; self-image and self-compassion; and, lastly, relapse prevention. Patients were also given homework in line with the PE protocol (imaginary and *in vivo* exposure tasks).

2.3. Data collection

This was a qualitative study based on eight semi-structured patient interviews. Semi-structured interviews allow for flexibility while preserving the essence of the interview, to ensure thematic equality between interviewers (Alvesson & Deetz, 2000; Kvale & Brinkmann, 2009; Qu & Dumay, 2011). All interviews were conducted 2 weeks after treatment by independent therapists and students not involved in the individual treatment of patients. Therapists met with patients one on one, whereas student interviews were performed two on one. Emphasis was placed on subjective experiences. The semi-structured interviews were prepared in advance and included follow-up questions. The interview guide used was developed by the therapists involved in the treatment programme to uncover aspects of patients' treatment experience, and was reviewed by all authors during the course of this research project. The guide consisted of 11 questions on the following subjects: the experience of the intensive treatment in general; positive and negative impressions of treatment; the experience of treatment intensity or session frequency in particular; and the perception of other treatment elements (individual PE and EMDR, therapist rotation, group physical activity, and group psychoeducation). All interviews were video recorded and transcribed.

2.4. Thematic analysis

The analysis followed the framework for thematic analysis in psychological research (Braun & Clarke, 2006). The purpose of thematic analysis is the identification of recurring themes and patterns of meaning in the data (Braun & Clarke, 2006; Sandelowski, 2004).

The analysis consisted of six phases. A short description of each phase is included to increase traceability (Castleberry & Nolen, 2018). Phase 1 included reviewing video recordings of the interviews, followed by a precise transcription checked against recordings and by a second researcher. Phase 2 consisted of identifying basic aspects in the entire data set that were relevant to the research question (Braun & Clarke, 2006). Specific words and syntax from the transcriptions were included to ensure proximity between raw data and codes (Boyatzis, 1998, p. 30). Specifically, initial codes were identified by marking sentences and words with a 'note' in the margin of the electronic document.

Transcriptions were coded separately by two different researchers. Initial codes were then compared and discussed by two additional researchers, which was essential to counterbalance individual influences on coding (Jenner, Flick, von Kardoff, & Steinke, 2004). In phase 3, the list of identified codes was reviewed in order to reorganize codes into possible themes. Associated quotes from the transcriptions were also added. Potential themes and subthemes were created, compared, and discussed. To keep track of the emerging themes, each theme and subtheme was assigned a colour code, and each note in the margin of the document designating a code was coloured accordingly.

In phase 4, themes and subthemes were refined and reviewed against the coded data, to verify that they were based on information from participants. A review against the entire data set ensures inner homogeneity and outer heterogeneity (Patton, 1990). Codes sorted under one theme were also compared to other codes and themes. This led to some codes being reorganized and consequently placed in a new theme. In phase 5, a last review of themes and their possible significance for the study and the research question took place. The 'essence' or 'core' of each theme and subtheme was identified and presented list-wise, with headlines or names of themes marked in the corresponding colour code of the theme. Subthemes were added if

deemed relevant to theme structure or complexity. Phase 6 consisted of the presentation of each theme in a report, with emphasis placed on each theme narrative from phase 5. Quotes from all participants were added to substantiate discussions and arguments. All phases were conducted by the same four researchers. Memos were used to track the process during coding and the development of themes.

2.5. Member validation

Participants were able to comment on summaries of their interviews and were specifically asked if there was anything that they objected to or would prefer to be removed from or added to the transcripts.

2.6. Ethics

The study was approved by REC (Norwegian Regional committees for medical and health research ethics; REK 2019/245).

3. Results

The analytical process resulted in the identification of five major themes, two of which also included subthemes. The themes were: (1) ‘Terrible, but worth it’, with subthemes ‘High intensity makes treatment challenging and leaves less room for avoidance’ and ‘Beyond symptom reduction: increased vitality and hope for the future’; (2) ‘Continuous pressure through therapist rotation’, with subthemes ‘Therapist rotation enables different perspectives and new relational experiences’ and ‘Therapist rotation maintains intensity’; (3) ‘Physical activity as a necessary break from a mental marathon’; (4) ‘Sense of unity in an intensive treatment programme’; and (5) ‘The whole is greater than the sum of its parts’.

3.1. Terrible, but worth it

This first major theme was related to participants’ impression of treatment as very demanding, but also as having advantages compared to a traditional, weekly treatment programme. This was first and foremost related to the fact that there were several treatment sessions a day, sessions lasted longer, and that there were no ‘break days’, except for a weekend. After completion of the treatment, all participants described a general reduction in symptoms and a feeling of having acquired useful knowledge and specific tools for further recovery.

3.1.1. High intensity makes treatment challenging and leaves less room for avoidance

Participants felt prepared for the treatment. However, it proved to be harder than they expected. They reported being continuously challenged and focused by treatment intensity, and were also left with limited opportunities for avoidance behaviour. Because of this, participants reported going through a period of adaptation for the first 2–3 days of treatment. In general, treatment felt somewhat easier during the second week:

In my opinion, talking about your trauma every day, then afterwards ... going home, and listening to tape recordings ... it’s very tough, especially the first week ... was very tough, but the second week was a little better.

– Nicky

All participants would have chosen the intensive format again. Several participants also reported more easily ‘getting back into it’ with less time between sessions. As Andy said: ‘It’s a lot easier to stay tuned in to treatment, because when a few days pass between sessions something might happen that occupies your thoughts and the link between sessions might not be as easy to catch’. In addition, participants pointed out

that cancelling sessions is easier in weekly treatment programmes, thus rendering such avoidance behaviour less likely when participating in an intensified treatment programme.

3.1.2. Beyond symptom reduction: increased vitality and hope for the future

Participants described significant treatment effects. Each of them reported a decrease in PTSD symptoms. Several participants recounted improvements in sleep after treatment (i.e. a reduction in nightmares, and higher sleep quality). For many participants, treatment also led to a greater ability to be present in the moment and to maintain an outward focus. Several participants also reported feeling considerably calmer after treatment, which was a novel experience: '(...) it scares me deeply, because I haven't had peace my entire life, so I don't know what it is' (Elija). Overall, for a majority of participants, this resulted in a more positive outlook on their life ahead. Changes like these were apparent to participants themselves, but also to their close friends and family.

So that leaves me hopeful, or, I no longer view my prospects in such a negative light, and things are no longer as heavy, as heavy and sad and painful (...). As I said to my doctor, it is just magical!

– Bo

In summary, participants felt greatly helped by treatment, despite its being challenging. As Sasha said: '(...) I have received the equipment, and now I'm going to do the work by myself.'

3.2. Continuous pressure through therapist rotation

The second theme captured the patients' experience of therapist rotation, which a majority of participants viewed as an entirely novel treatment element. Rotation challenged participants' ability to adapt, which, in turn, gave them a sense of mastery when having 'made it'. After treatment, several participants stated that rotation was especially useful for effectively working through trauma symptoms. Two subthemes were identified.

3.2.1. Therapist rotation enables both different perspectives and new relational experiences

All participants recognized and appreciated therapist differences related to therapeutic strategies and perspectives. Some described therapist rotation as contributing towards a change in their view of therapy in general, and expressed a preference for therapist rotation as opposed to being treated by one therapist only. Two participants reported having mixed emotions related to therapist rotation: They were fearful that information would not be relayed properly between therapists. They did not view rotation in itself as particularly distressing. As Sasha puts it:

Because everyone is so different, you sort of 'tapped into' different ... areas of my personality, and my trauma. That might not have been viewed from all of these angles if I only had one therapist to respond to. It is as if every corner (of my mind) is illuminated.

3.2.2. Therapist rotation maintains intensity

Several participants described meeting a different therapist in every session as being crucial in preventing them from becoming too 'relaxed' in the therapy room. A number of participants had had previous experiences with this kind of mood in therapy, and saw it as being detrimental to the effect of treatment. Kim explained: 'If you sit down with someone you're used to being with, you get down in the chair and you feel comfortable. If you're with someone new, you ... have to pay attention'. Bo said:

In a way, you don't get to know your therapist that well, so ... you avoid ... you know, playing it safe. I felt less in control over it (during intensive treatment).

A few participants also felt that therapist rotation made exposure therapy easier to accomplish, because attention was focused more on them as patients – and not on the patient–therapist relationship:

I think I worked a great deal better on myself, because I was unable to attach deeply to one person. Then the focal point was very ... clear and obvious, the spotlight is on me, it is on me! It is on me, I'm the protagonist now. And that's great.

– Elija

In summary, being treated by several therapists provided participants with multiple opportunities for relearning trust, and helped them to focus on the task at hand – engaging in therapy.

3.3. Physical activity as a necessary break from a mental marathon

The third major theme illuminated the role of physical activity. All of the participants described physical activity as essential in ensuring treatment completion overall and on a day-to-day basis. They depicted it as an important mental 'breathing space' where attention was focused on something other than their trauma experiences. They were convinced that a break without physical activity would not have been equally beneficial or resulted in a similar, immediate effect on both state of mind and mood:

It doesn't take much before everything is a little brighter. You know? And that is how I felt after every workout, everything got ... You almost feel a little stronger mentally as well.

– Kris

Three participants reported feeling sceptical of physical activity before starting treatment. Having to start working out in the middle of an intensive treatment programme was, in their view, a frightening idea. This was especially the case for participants who were not used to, or disliked being physically active before treatment. Still, these participants echoed the sentiment of the other participants and described it as a positive experience, and as a vital arena for achieving a sense of mastery and group unity. Several participants also underlined the importance of being guided by a knowledgeable physiotherapist during workouts. Some participants wanted the physiotherapist to have more time for psychoeducation related to the physical activity:

Maybe he could have had more time to talk about ... physical versus mental health. The fact that ... they are connected. Because I think, many people who have PTSD wear their bodies out.

– Elija

Overall, participants were left with positive bodily and mental experiences from this treatment element.

3.4. Sense of unity in an intensive treatment programme

The fourth theme concerned patient experience of the group setting. Most participants appreciated the opportunity to share their experiences with the other participants, and found group physical activity especially valuable. Many participants expressed that a sense of unity with other participants made it easier to endure and complete treatment. Being 'in it together' also provided participants with a sense of normality. In addition, psychoeducation groups were described as a safe space where one could be open about

symptoms while knowing that the audience had first hand experience with PTSD and would be non-judgemental.

The fact that I was able to share that (experience) and that day with (name of co-participant) was so helpful ... you know, it was just, it meant everything, it really did. To be able to talk to someone who just ... (it) makes you feel normal.

– Sasha

One participant reported feeling nervous because of the group setting prior to starting treatment. Nevertheless, this participant reported becoming appreciative of the presence of the others during treatment:

What I dreaded the most was being in a group. Because I was so afraid of the others. What are their reactions like, what are they like, are they scary and violent (... .) but it was great meeting other, completely ... normal people. And experiencing, as time went by, that we got better at sharing our experiences, and there was more nodding, and there was more laughter and ... there was more 'do you feel that way too?' And I think that was very nice.

– Elija

All in all, this fourth theme underlines the importance of community in psychotherapy, as in life.

3.5. The whole is greater than the sum of its parts

Statements from the participants suggest that it was hard to pinpoint exactly what led to the described treatment effects. Two participants underscored the effects of EMDR and reported that this intervention triggered emotions in them in a new way. They experienced the different interventions as part of treatment in its entirety. The effects of one treatment intervention were therefore assessed in the context of the entire treatment programme, and not as an isolated unit. For instance, several participants indicated that it was the combination of the two psychotherapeutic treatment interventions EMDR and PE that made the intensive treatment efficacious, because they each were effective in distinct ways: 'I think it is very important that you get both ... because in a certain manner, you have to talk about what is being triggered' (Alex).

Follow-up was another central aspect of treatment. Participants from the first round of treatment revealed that going for 2 weeks without seeing their therapists after completion was difficult. Several of them reported considering reaching out to the therapists, but ended up not doing so because they felt that they were meant to cope:

It would be a bit ... embarrassing, sort of, to call and say ... 'help'. (...) But if I had known that ... I had a scheduled session in the midst of it, I would have ... that would have felt like a great security. In the midst of the ... chaos.

– Kris

Based on this feedback, a telephone consultation was introduced to the following rounds of treatment. Despite remarks about lack of contact in the 2 weeks immediately after completion of treatment, all participants stressed that they were more than satisfied with the attention they received during treatment. They reported feeling understood and looked after and described all of the therapists as competent and warm: '(...) they weren't fazed (by symptoms)' (Elija). Participants who described themselves as doubtful of treatment interventions before or during treatment reported becoming convinced that the therapists knew what they were doing. They described being able to relax despite the hard work they had to endure:

(...) and then you get here, and you know that there are people here who know what to do, they deal with this sort of thing every day. They have a thousand experiences like this, right ... and that's when I felt like, 'ah ... this is a place where I can share'.

– Alex

Our results indicate that participants felt they were being taken care of not only by one therapist at a time, but by all of them: 'It was like the entire team of therapists had your back' (Kris). The different parts of the intensive treatment all had unique and significant contributions in addition to a combined effect, where the total experience of being both 'pushed' and cared for describes the essence of the participants' experiences.

4. Discussion

The purpose of this study was to explore patient experience with an intensive outpatient treatment for PTSD. The main findings were that all of the participants evaluated the intensity as useful, therapist rotation as promoting effective exposure, physical activity as a necessary mental break, and the group elements as supportive.

All of the participants evaluated the intensive treatment as demanding, but worthwhile. They described that the high continuity facilitated commitment to treatment, limited avoidance behaviour, reduced drift in therapy, and prevented session cancelling. These findings are in line with the study conducted by Sherrill et al. (2020), which concluded that massed PE had positive results in terms of limiting avoidance, that treatment was prioritized by patients, motivation was sustained, and frequent therapist contact provided substantial support and feedback. It is likely that all of these aspects will influence the outcome of therapy. Studies on PTSD treatment often find problematic high dropout rates (Lewis, Roberts, Gibson, & Bisson, 2020), whereas in intensive treatments, this rate is lower (Sciarrino et al., 2020). The results from this study contribute towards a better understanding of why and how intensive treatment can prevent dropout. Even though the treatment programme was difficult to endure, patients reported that it was easier to stay tuned in to therapy. It is conceivable that intensive treatment increased patients' motivation and facilitated treatment prioritization compared to treatment delivered on a weekly basis. This probably affected the dropout rate and session cancellations. In addition, factors besides the intensive format itself may have influenced the low dropout. Actively choosing the intensive treatment programme over ordinary weekly therapy may have contributed to the commitment to and completion of the treatment. Matching patient preferences is associated with positive reaction to intensive treatment (Sherrill et al., 2020), and may affect dropout. The experience of symptom relief was also emphasized by the patients in this study. An intensive format of treatment can lead to more rapid improvement in symptoms than traditionally paced treatment (Ehlers et al., 2014; Sciarrino et al., 2020), which, in turn, may reinforce treatment engagement through quick and meaningful symptom relief (Sherrill et al., 2020).

In contrast to their initial scepticism towards therapist rotation, the participants reported this element as profitable, both in maintaining intensity through focus on the task and in enabling slightly different therapeutic approaches and new relational experiences. Therapist factors are linked to positive and negative therapeutic effects (Owen, Drinane, Idigo, & Valentine, 2015). When meeting several therapists, one is less at the mercy of each therapist's limitations. Therapist rotation may also lead to more opportunities for corrective relational experiences, which are understood as a significant curative element in psychotherapy (Goldfried, 1980, 2012). All of our participants also reported receiving satisfactory care despite therapist rotation, feeling like they were being taken care of both by the individual therapists and by the team of therapists as a whole during treatment. This resonates well with the study by Van Minnen et al. (2018), which found that patients receiving intensive treatment for PTSD with therapist rotation form alliances with the team of therapists.

Participants reported that therapist rotation maintained intensity through heightened focus on therapeutic tasks, and limited avoidance and safety-seeking behaviour. Patient avoidance and safety-seeking behaviours are common problems reported by clinical psychologists when treating PTSD (Becker et al., 2004). The removal of avoidance and safety-seeking behaviours is one of the key elements in optimizing the effect of exposure therapy (Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014), and therapist rotation may be one way to overcome this issue. In addition, conducting exposure therapy in different contexts and in a variety of ways is proposed to lead to more efficient exposure therapy (Craske et al., 2014). In accordance with this, the, therapist rotation, different therapeutic approaches (PE, EMDR), *in vivo* exposure tasks, and listening to audio recordings may all be important treatment elements in enhancing the efficiency of exposure therapy. The therapist rotation is also argued to decrease therapist drift (Van Minnen et al., 2018), which is another common problem in treating PTSD (Becker et al., 2004).

Participants described the frequent exposure to trauma memories as severely emotionally activating. The physical activity was emphasized as a crucial tool that enabled a shift in focus and promoted detachment from trauma memories. Thus, physical activity may have affected participants' view of the total treatment load, making it easier to endure. This resonates with the findings of Rosenbaum, Vancampfort, et al. (2015), which state that physical activity as an adjunct treatment leads to a stronger reduction in PTSD symptoms compared to control conditions, through increased commitment to therapy. Both physical activity and psychoeducation were delivered in a group setting in this programme. The participants described that going through treatment with other patients helped them to endure therapy, despite its demanding elements. Sripada et al. (2016) found that PTSD patients who initially received group therapy were more likely to complete psychotherapy, compared to those who only received individual therapy. A central symptom in PTSD is feeling alienated and detached from others. Normalization of post-traumatic reactions and symptoms is thought to be crucial in the treatment of PTSD (Foa et al., 2019). The sense of unity that the group format entails may have had an effect on treatment outcome through normalizing symptoms, heightened commitment to therapy, and reduced dropout.

There are some limitations to this study. Because of technical issues with the recording, one patient interview could not be included in the data set and consequent analysis. The inclusion of this interview could potentially have led to somewhat different results. All of the participants included in this study chose intensive treatment instead of weekly therapy. Thus, the study population did not include participants who were reluctant regarding the intensive format and other aspects with the programme. The study also included only one male participant.

In conclusion, this thematic analysis based on a sample of PTSD patients with a broad range of traumatic experiences found that intensive treatment was perceived as a beneficial approach by patients. This suggests that intensive treatment for PTSD should be considered as an alternative to traditional weekly therapy. Future research should aim to explore the different elements included in this treatment, through a dismantling design, to evaluate the importance of the different elements. Moreover, studying the long-term effect of treatment would be relevant. A comparison of the long-term effect of traditional once-a-week outpatient psychotherapy with intensive treatment could also yield useful information.

Disclosure statement

No potential conflict of interest was reported by the authors.

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