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ORIGINAL PAPER

Adult Service-Users' Experiences of Trauma-Focused Cognitive Behavioural Therapy

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Abstract This study aimed to gain an understanding of the aspects of trauma-focused cognitive behavioural therapy (Trauma-Focused-CBT) for post-traumatic stress disorder (PTSD) that service-users find important in contributing to their improvement. Nine people (5 females and 4 males, mean age 53 years old who had received on average 12 sessions of Trauma-Focused-CBT) who reported a significant reduction in their symptoms following treatment of PTSD took part in semi-structured interviews. Interpretative phenomenological analysis identified five themes: Living with Symptoms before Therapy; Feeling Ready for Therapy; Being Involved; Bringing About Therapeutic Change; and Life After Therapy. This study contributes towards a clearer understanding of the aspects of the Trauma-Focused-CBT process that service-users found important in aiding their improvement. In particular, it highlights the central role that participants attributed to their own involvement in the therapeutic process and how much they valued this. Limitations and future directions are discussed.

Keywords Cognitive behavioural therapy · Qualitative · Service users · Trauma

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Introduction

Post traumatic stress disorder (PTSD) is a common and disabling condition that can develop as a consequence of traumatic events such as interpersonal violence or severe accidents, and is characterised by distressing re-experiencing of parts of the trauma, avoidance behaviour, emotional numbing and hyperarousal (Ehlers et al. 2009). Trauma-focused cognitive behaviour therapy (Trauma-Focused-CBT) is seen as one of the treatments of choice for PTSD and trauma (National Institute of Clinical Excellence 2005). One influential model for the treatment of PTSD is that of Ehlers and Clark (2000). They argue that PTSD becomes persistent when individuals process a trauma in a way that leads to a sense of current threat. They describe how this arises from excessive negative appraisals of the trauma, strong sensory memories and poor autobiographical memory. PTSD memories are inadequately integrated in time and place, hence the perception of a current threat (Ehlers and Clark 2000). They argue that this perceived threat also motivates a series of behavioural and cognitive responses that are intended to reduce perceived threat and distress in the short-term, but have the consequence of preventing cognitive change and therefore maintaining the disorder.

Components of Trauma-Focused-CBT typically include psychoeducation, relaxation training, imaginal and in vivo exposure, cognitive restructuring, homework exercises and discussions around social support (Beck and Coffey 2005). Forbes et al. (2007) argued that the active ingredients of Trauma-Focused-CBT appear to be exposure to the traumatic memory and cognitive processing of the meaning or interpretations of the trauma. Studies have also shown clients' perceptions of the therapist and the quality of the therapeutic relationship are vital to the outcome of CBT therapies (Borrill and Foreman 1996).

A neglected area in psychotherapy process research is service-users' perspectives, with researchers tending to focus on the views of therapists rather than service-users to help them understand the therapeutic process (Messari and Hallam 2003; Rennie 1994). Given the collaborative emphasis of CBT (Chadwick et al. 1996), and as the focus is on changing cognitions and behaviours, a more detailed understanding of service-users' experience of therapy could contribute to the effectiveness of CBT techniques.

Although quantitative methods allow researchers to demonstrate treatment outcomes, they are less effective in providing the type of in-depth accounts which Klein and Elliott (2006) argue allow for a full understanding of therapy as experienced by the service-user. In contrast, qualitative therapy research tends to focus on process rather than outcome to discover what accounts for change Smith (1996).

Qualitative methods have been employed successfully when examining service-users perspectives following CBT for many other conditions, such as psychosis (McGowan et al. 2005; Messari and Hallam 2003), depression (Clarke et al. 2004) and with individuals suffering from eating disorders (Laberg et al. 2001). However, previous research has not investigated service-users' experiences of receiving Trauma-Focused-CBT for PTSD. Such work would enable a more complete understanding of what clients find facilitative of therapeutic change. The aim of the present study was therefore to examine service users' experiences of receiving a positive outcome following Trauma-Focused-CBT for PTSD.

Method

Design

The study adopted a qualitative, phenomenological and idiographic design to enable exploration in interviews of service users' perspectives on a specialist PTSD outpatient treatment service. Interpretative phenomenological analysis (IPA; Smith and Osborn 2003) was used to guide data collection and analysis. The study focused on participants' views and experiences of the service, specifically which aspects of the service they received made the most useful contribution towards effective therapeutic change. Ethical approval was obtained in accordance with the authors' institutional research and governance procedures.

Sampling and Participants

Nine participants (5 females and 4 males, mean age 53 years old), who received an average of 12 Trauma-Focused-CBT sessions and who reported significant symptom reduction following treatment for PTSD, were included in the study. The research was primarily interested in those who had found therapy to be a positive experience for them. They had received on average 12 sessions of Trauma-Focused-CBT and reported a significant reduction in their symptoms following Trauma-Focused-CBT.

Symptoms of PTSD were measured using the Clinician Administered PTSD scale for DSM-IV (CAPS), prior to and following completion of therapy (Forbes et al. 2001). This questionnaire assesses three main clusters of symptoms; re-experiencing, avoidance and numbing, and hyper arousal symptoms. The mean pre-treatment CAPS score for participants was 61 (severe range), and the mean post-treatment CAPS score was 23 (mild range). For the initial 15 months that the service was open and up until the time of the interviews taking place, 54 clients had either completed treatment or were still receiving treatment at the service. Based on a significant reduction in CAPS scores, all participants who completed treatment found therapy to be effective. Therapists were experienced in the treatment they administered. Two were experienced cognitive therapists with additional qualifications in EMDR (Richard and Louise), one was an experienced clinical psychologist with CBT and EMDR qualifications (Simon) and one was a psychologist who was near completion of a CBT post diploma (Peter) (Table 1).

Intervention

The Trauma-Focused-CBT intervention consisted of many different therapeutic components. Psychoeducation around PTSD and Trauma-Focused-CBT provided clients with a sense of normalisation around their reactions to the traumatic events. Clients recounted in detail their traumatic memory, with both imaginal and in vivo exposure being used to further expose the client to their traumatic experience. Audio-recordings of their narratives were offered to clients, which allowed them to practice imaginal exposure at home. Clients were introduced to the idea that their emotional reactions to the traumatic events were determined by their interpretations of those events. Throughout the intervention, cognitive restructuring enabled clients to challenge and modify any negative appraisals held towards their traumatic experience.

Homework exercises were also an essential element in the Trauma-Focused-CBT interventions. They provided clients with an opportunity to test hypotheses discussed during therapy at home on their own. The therapeutic process was used to teach functional behaviours which may have deteriorated following clients' traumatic experiences. For example, therapy involved teaching relationship, problem-solving and anger management skills. Relapse prevention and practicing coping strategies were also essential during the final stages of the therapeutic process.

Table 1 Participants demographic table

Participant	Age	Gender	Chronic versus acute	Occupational status	Employment status at time of interview	Relationship status	Therapist	Pre CAPS score	Post CAPS score	No. of TF-CBT sessions	Interviewed at home/service	Experience measure score
Sarah	58	Female	Acute	Teacher	Retired	Widowed	Richard	71	27	15	Home	38
Rebecca	56	Female	Acute	NHS Employee	Employed	Married	Louise	57	17	8	Service	40
Diane	57	Female	Acute	NHS Employee	Employed	Married	Simon	41	11	6	Service	40
John	30	Male	Chronic	Army	Unemployed	Relationship	Simon	71	26	13	Service	40
Mohamed	51	Male	Acute	NHS Employee	Employed	Married	Louise	59	31	11	Service	39
Lisa	63	Female	Acute	Social Worker	Retired	Married	Simon	51	26	12	Home	40
Patrick	57	Male	Chronic	Army	Retired	Divorced	Louise	59	14	14	Home	40
Brian	61	Male	Acute	Farmer	Retired	Married	Richard	56	35	15	Service	40
Vicky	41	Female	Acute	NHS Employee	Employed	Relationship	Peter	83	19	11	Service	40
Average	53	–	–	–	–	–	–	61	23	12	–	40

There was a range in the number of therapy sessions each participant had as these were not pre-determined prior to therapy. Rather, there was flexibility in the number of sessions assigned to each client. The service was still in its pilot stage therefore the maximum number of sessions had not been decided. It was therefore up to both the discretion of the therapist and client to determine when they thought therapy should come to an end, depending on whether significant symptom reduction had been reached. At the end of each week therapists met in a group debriefing to discuss clients they were currently seeing. This provided them with an opportunity to offer each other advice and support, and ensure therapists were adhering to the model. It also allowed therapists to discuss recent research and present any findings to team members.

Data Collection and Analysis

Therapists offered participants an interview during their final therapy sessions, usually at the follow up session. Interviewees were arranged at a time most suitable for them and ranged between 1 and 4 weeks following termination of therapy.

Interviews were conducted at a venue chosen by participants (six at the service and three at participants' homes) and audio-recorded. Examples of questions included are "In your own words, can you describe how you found the therapy sessions?" and "What effects did therapy have on the symptoms of PTSD that you were or are experiencing?" The schedule was reviewed following consideration of the first interview when it was agreed that no changes were required.

Interviews transcripts were analysed using interpretative phenomenological analysis (IPA; Smith and Osborn 2003). Each transcript was read a number of times and notes were made in the left hand margin independently by both authors. Key words and phrases relating to the research aims formed the initial analysis. Further interpretations were then noted in the right hand margin after numerous readings of the transcripts and notes. Interpretations were then clustered into related concepts in order to develop integrated, explanatory representations of the data. The themes were audited by a clinical psychologist working with patients with PTSD and a peer group of experienced qualitative researchers. Feedback from these sources consisted of advice regarding the clearing wording of analysis.

Results

Analysis identified five key themes (see below). In the following each is presented in turn and supported by

excerpts from the research interviews. Pseudonyms are used to ensure anonymity.

Living with Symptoms Before Therapy

Participants gave accounts of their mental states prior to receiving trauma-focused cognitive behavioural therapy (Trauma-Focused-CBT). These descriptions often centred on their perceived 'breakdown' of their sense of self following their traumatic experiences. A loss of identity, believing that they were 'no longer the same person' (Mohamed) and 'losing confidence' in themselves and their abilities were reported;

> I felt like I'd got a personality disorder. And he [therapist] said well a lot of people feel like that, that they're going crazy and stuff like that, but I did actually feel I was completely disintegrating. (Sarah).

Prior to the therapy sessions participants described feeling 'bewildered', with their minds being 'mixed up at the time' (Lisa). Feelings of guilt associated with their traumatic experiences were also frequently reported, with some initially thinking that they would not recover;

> Yeah and I'm glad I saw it through now. Because at the time I couldn't see. It was like fog. And I couldn't see getting any better really. So I'd have used any excuse to put anything off. (Rebecca).

A range of symptoms associated with suffering from PTSD were discussed by participants. These included intrusive memories and images associated with the traumatic event, negative and suicidal thoughts, and the suppression of these thoughts, negative behaviours, such as using alcohol to try to cope with the difficult feelings and thoughts, and difficulties sleeping. These symptoms experienced prior to therapy were found to improve for participants in a number of ways following completion of the therapeutic process;

> I remember before coming here I had the violent mood swings, not being able to sleep, not being able to eat. Just wanting to shut myself off completely. I mean a couple of times I'd go upstairs and lock the door and I would stay upstairs for two days. Completely shut off. Not eating, not drinking nothing for two days. So like I said without this place, I probably wouldn't be here. (John).

Such symptoms impacted not only on the lives of participants, but also their partners and family members. Additional challenges associated with PTSD were 'out of character' behaviours, such as feeling irritable and on occasions being aggressive with people close to them;

> So everybody, my family, was aware that I was short-tempered. They were leaving me alone. I'd lock myself in my study out the way. I just lost interest in everything… I knew I was short with people, but I couldn't stop myself from being short with them… I was volatile. (Mohamed).

These accounts reflect the distressing symptoms participants experienced prior to receiving Trauma-Focused-CBT. Their lives, as well as people close to them, were affected negatively in a number of ways.

Feeling Ready for Therapy

Following recognition of their symptoms, participants reported thoughts around wanting change by accepting some therapeutic help. Descriptions centered on the time they spent waiting for therapy, and what it meant for them to receive their diagnosis;

> So when I got the initial diagnosis of severe post-traumatic stress disorder, I felt a great relief actually… But for me having that label was actually a relief because it gave a name to this demon, the suffering. (Sarah).

By the time participants were referred for therapy, most felt prepared and ready for this help. They prioritised therapy over other areas of their lives, as they recognised it was something which they really needed;

> I was desperate for help, yes I was I admit that. (Lisa).

However, some interviewees were not aware at the time that they were unwell, and partners and family members often played a key role in helping them to identify that something was wrong;

> Well I was as ready as I'm ever going to be. […] It was my partner who picked up on it. It was causing a lot of rifts between me and her. But I was like yeah, let's go and give it a go and see what happens. (John).

There was some variation between participants' accounts relating to the speed at which they actually received therapy following their referral. Some were very satisfied with the length of time they had to wait, thinking they did not have to wait very long at all for therapy. Conversely, others would have liked to have received the help a lot sooner, believing they had to wait too long;

> Well I was a bit anxious over the length of time. I thought it was a good wait. I suppose everybody has that problem, but in my circumstances I thought it was quite a wait… I mean I was looking forward to it.

> I really was looking forward to coming here and I thought it was a long wait… I would have been happier if it had been sooner. (Brian).

Alongside discussion of their decision that some therapeutic help would be beneficial, participants discussed the factors associated with the therapeutic process and the therapeutic relationship that were of primary importance to them. These issues are addressed in the following theme.

Being Involved

A strong sense of involvement in therapy was wanted and enabled for participants. This related not only to themselves, but also partners, friends and family members who attended the therapy sessions.[1] As such, therapy was described as a collaborative process;

> The therapist takes the time to listen to what I want to say, apart from having to listen to what he wants to say. We worked through the problems and we worked together on it, and we come up with some answers. I've been quite happy with it. (Brian).

Participants often decided on the direction therapy should take, along with the pace at which they moved along at. As a result, they felt understood; they felt their therapists listened to them and respected their views, which resulted in them feeling more involved in the therapeutic process;

> It was taken at my pace. You know, my therapist suggested things what sort of like… Instead of saying do this do that, she made suggestions and I sort of come out with suggestions and then she said, "Oh yeah, try that." (Rebecca).

Along with feeling very involved in the therapeutic process, participants described becoming semi-independent during therapy. This related to making decisions for themselves during therapy, and also by using techniques learnt in therapy independently and outside of the therapeutic environment;

> Yeah because Louise made suggestions and I'd try it and she'd ask me when I went back, "Did you try it?" I'd be honest and say yes or no, or I did it a different way to what she said… I decided on my own and she said, "Well that was good, you worked that out for yourself." And I felt a lot easier with it. (Rebecca).

Participants also recognised the possibility of becoming 'dependent' on therapy and the therapeutic relationship but felt in control of when the therapy sessions came to an end;

> I think I was in control of when I felt those sessions could end. I don't know how long they would have gone on had I not made that decision. I suppose you can become quite dependent on things. But I don't know for some reason I just felt OK and I thought, "We've gone as we need to go." So I don't know whether control is the right word, the way it's used, but I felt that I had a really big say. (Sarah).

This idea of taking control and becoming more independent was also emphasised in relation to other areas of participants' lives, outside of the therapeutic environment. Participants described becoming more positive, and engaging in activities that they had previously stopped taking part in.

Bringing About Therapeutic Change

All participants provided accounts of the factors they found facilitative of therapeutic change for them personally. Once again, these accounts emphasized their own agency in bringing about therapeutic change. Empathy, understanding, being non-judgemental and patient were identified by participants as important characteristics for therapists to possess, but participants also emphasised the need to talk to someone who was a stranger to them. As a result, participants often felt more comfortable and able to be open with their therapist than with family members;

> She was very, very good… Louise's patience. Her ability to pull the conversation back to where it should be if I had wandered off anywhere. Her understanding, her empathy. […] I wanted to speak to someone who was a total stranger to me, didn't know me and I didn't know them… (Mohamed).

Specific tools used during therapy were identified as beneficial. Being exposed to and discussing the traumatic event was described by participants as being important, as was psychoeducation concerning their reactions to the traumatic events;

> Just talking about it I think because you keep it to yourself don't you?… He's like instilled that what happened in the incident and things, that I was not wrong in reacting in that way. Because you do think. (Vicky).

The homework element of therapy allowed participants to 'practise' the techniques learnt during therapy at home independently. Some suggested that this helped to 'move

[1] The Trauma-Focused-CBT sessions were run as individual sessions. However, partners and family members were allowed to sit in on any of the sessions if requested by the client.

things on' during therapy. Participants also emphasised the importance of questioning their thought processes and thinking patterns during therapy, whilst recognising that their 'thoughts were just thoughts';

> I think it was probably having somebody to listen and help me explore more objectively the situation that I found myself in. And sort of be able to take a step back. And also some of the techniques that were sort of discussed and going away and practicing those and actually coming back and finding that they were working. (Diane).

Other techniques which were found to be beneficial for participants included the concept of mindfulness, relaxation during anxious situations, and the diagrammatic work completed with their therapists. Feelings of safety were identified as important for some individuals, with therapy and the therapeutic relationship being described as a 'little safe house' and a 'safety valve' for them;

> So diagrammatically again we were able to look at those patterns of behaviour and my belief system, which is a very entrenched belief system… So examining when things happen and how that belief system comes into play, and you know, questioning it, again which is a very important… I felt Richard gave me the tools to understand my own belief system and I was able to reinterpret things myself. I had the facilitation to examine my own beliefs and ideas with help and support. Rather than directing me, he facilitated me. (Sarah).

The flexibility in the use of time within therapy sessions and when each session took place were important aspects of therapeutic change for participants. Individuals placed importance on 'never feeling the pressure of time'. They described valuing the fact that therapy sessions were 'allowed to run over'. The length of time between appointments was also important, providing necessary time to 'deal with things' between sessions. One participant commented on the importance of the support provided by her therapist in-between sessions. She reported how at one point she was unsure whether to continue with the therapy sessions. However, her therapist telephoned her and this had encouraged her to begin attending again.

Life After Therapy

Participants discussed the effects of receiving therapy. It was recognised that the initial therapy sessions were quite 'draining' and many reported becoming upset during these sessions. However, gradually the therapy sessions became easier for participants;

> I honestly can't remember coming here for the very first time… but I remember parts of it… I remember being like a little kid crying my heart out in front of Simon. A couple of times when I was talking about my experiences and sort of like reliving them. That was uncomfortable, but I knew that you've got to do that otherwise you aren't going to get anywhere. So it was just like a stepping-stone that I had to face. (John).

Participants described the effects therapy had on the symptoms of PTSD they experienced. Many suggested that their sleep had improved, with participants no longer suffering from disturbed sleep and nightmares. The ability to 're-evaluate negative thoughts and behaviours' (Sarah) associated with the traumatic experience was also of central importance. Participants believed that therapy provided them with hope again after feeling 'hopeless and helpless';

> But I am sleeping much better, I'm eating. Certainly my sleep patterns have changed, although I've had a couple of nights where it is not quite right. But I am not having the nightmares and not waking up and then not being able to go back to sleep… I can go back to sleep. I don't have this constant feeling of impending doom anymore. (Sarah).

The effects of therapy on other areas of their lives were highlighted by participants. Positive effects were reported in terms of improvements in relationships with partners, family members and work colleagues. Participants noted how 'things had become quite stressful at home, but following therapy they have settled down again' (Diane). Some also discussed the positive effects in terms of their work, with completion of therapy often resulting in them returning to paid or voluntary employment.

> So I think I've done well to get where I've got to today… It enabled me to focus on other things, other points of my life… I went to MENCAP and learnt how to be a carer. (Patrick).

Participants discussed how the techniques and 'tools' acquired during therapy could be used to help them to cope with other issues in their lives, as well as being able to transfer them to other situations;

> In my sessions I was introduced to the idea of mindfulness and that was a concept I have never sort of come across before. And going away and learning a little bit more about that and actually trying to use some of them techniques to sort of, help with perhaps anger issues and things like that… It's something that I can take away and continue to use and I do use in other situations. (Diane).

Although participants stated how the therapy that they received had helped with many aspects of their lives, some discussed how 'everything is still not perfect' (Sarah). A number of participants still held very strong feelings towards their traumatic experience;

> I'm not saying it took away everything or the guilt and all that, because it hasn't, because I've still got it. But it did help a lot. (Lisa).

Participants recognised that there were still things they felt unable to do and 'may not be able to do for a long time' (John). However, participants could now 'recognise the signs' (John) and felt more able to cope than prior to receiving therapy. Some still had periods when things were difficult, and a few had not regained interest in activities they previously enjoyed. Others believed that they had actually changed as people, and would 'never be the same again' (Mohamed).

Discussion

Prior research has employed qualitative methods to examine service-user perspectives following CBT for a number of conditions. However, no research exists which uses qualitative methodology to investigate service-users' experiences of receiving Trauma-Focused-CBT for PTSD. The present study therefore aimed to explore the positive experiences of such individuals. The aim of the study was not to evaluate the efficacy of Trauma-Focused-CBT, but rather to highlight what aspects of the therapeutic process participants found beneficial for them and stimulate thought about these. The themes presented represent participants' beliefs around the factors they found important in facilitating therapeutic change.

It has previously been suggested that some service-users struggle to conceptualise their ill-health (Kinderman et al. 2006). Prior to therapy, some participants in this study did not view themselves as being unwell. Partners and family members often played a key role in helping them to identify that help was required. However, generally participants were aware of the symptoms they experienced, and explained how these impacted on their lives in a negative way. They also recognised the negative impact of their behaviour on their partners and family members.

As reported by Ehlers et al. (2009), secondary problems may occur if PTSD remains untreated. Along with the core symptoms of PTSD, depression, interpersonal conflict, alcohol use and sleep difficulties were identified by participants in this study. For these particular participants it is apparent that receiving Trauma-focused-CBT had a significant impact on many of their symptoms, however certain symptoms seemed to decrease more than others. Participants reported a number of positive changes in relation to their behaviour and thinking patterns. With the help of therapists, participants were able to re-evaluate their thoughts and provide alternative explanations. In addition, participants reported that therapy provided them with hope for the future, improved their relationships with others and increased their motivation to return to employment.

Participants reported that following completion of therapy some of their symptoms of PTSD were still present. Trauma-related guilt associated with their traumatic experiences was still reported by a number of participants following completion of therapy. Kubany et al. (2004) defines guilt as an unpleasant feeling accompanied by a belief that one should have thought, felt or acted differently. He recognises that not only is trauma-related guilt unhelpful, but these feelings are also very difficult to change. On-going identity issues were also still noted by a number of individuals. Some described being changed as people following their traumatic experience and how they 'would never be the same again'. It is possible that Trauma-focused-CBT specifically targets certain symptoms of PTSD (Ehlers and Clark 2000), or that a greater number of sessions are needed in order to eradicate these particular symptoms. Therapists could be aware of this when working with clients and make sure that more of the therapy sessions are spent targeting these symptoms. This would ensure therapists' time and resources are used more efficiently.

Participants emphasised factors they found facilitative of therapeutic change. The most researched factor involved in CBT appears to be the 'therapeutic alliance'. In line with previous research (Hansson et al. 1993; Gordan 2000; Rossberg 2004), empathy and understanding were identified as important characteristics for therapists to possess. However, participants in this study also described being non-judgemental and patient as significant therapist characteristics. These characteristics encouraged participants to be open and honest with their therapists, consequently facilitating therapeutic change. The building of this therapeutic relationship appears to be a generic requirement in all CBT therapies, with some researchers claiming that the outcome of CBT therapies is dependent on the quality of this relationship (Borrill and Foreman 1996). Participants in this research also emphasised the importance of feeling safe in the therapeutic environment. However, this may be specific to this client group given the nature of PTSD.

Participants' wanted to contribute to their own recovery' by being involved in the therapeutic process. Participants' own preference for involvement, then, provided a good fit with the collaborative emphasis of CBT (Chadwick et al. 1996). Therapists should therefore recognise that allowing individuals to feel in control during the therapy sessions

may facilitate therapeutic change for participants with PTSD. However, participants described feeling 'overwhelmed' during the earlier stages of therapy, which indicates that more guidance may be required from therapists during this initial period.

While clients in previous research (Borrill and Foreman 1996; Laberg et al. 2001) have reported a sense of the psychologist being in control and leading their CBT therapy sessions, participants in this study experienced therapy as a collaborative process. They described feeling in control throughout the therapy sessions and became more independent as the sessions went on, particularly with regards to using 'tools' acquired during therapy independently. This has been discussed in previous research, with therapy being described as a skill-teaching process whereby skills learnt during therapy are practised and applied outside of therapy (Clarke et al. 2004). This need for participants to feel in control and contribute to their own recovery seemed to be especially important for participants in this research.

Participants in the research by Bevan et al. (2010) recognised the importance of on-going support, by having follow-up appointments with their therapists following completion of therapy. In addition, participants in this study highlighted the value of support from therapists being provided between the therapy sessions. They also valued the flexibility of the therapy sessions, by 'never feeling the pressure of time' and 'being allowed to run over'. This ensured they did not have anything left 'hanging in the air' following completion of the therapy sessions. This is in contrast to participants in research by Laberg et al. (2001) who reported that due to time constraints placed on therapy, they completed their therapy sessions still having unresolved issues. Therapists should consider this when working with clients with PTSD. If possible, it would be beneficial for therapists to leave a short time period immediately following the therapy sessions, which would provide participants with an opportunity to settle themselves before leaving. This is especially true given that many participants reported that 'things were stirred up during the sessions'. Similarly, as many participants reported that 'everything was still not perfect' following therapy, further follow-up sessions would provide a chance to recap on what was learnt during therapy and ensure the 'skills' acquired had been sustained.

Research has demonstrated that even though service-users can express high levels of motivation to change, they still report difficulties in following through with that motivation (Bevan et al. 2010). This can be expressed both in terms of completing homework tasks and addressing their distressing beliefs during therapy. However, participants in this study discussed completing their homework tasks without any difficulties and actually finding the homework beneficial. The importance of homework compliance in CBT has long been recognised (Dunn et al. 2002). Participants suggested that the homework given to them during therapy was important as it helped to maintain the 'focus' of therapy at home. This enabled them to become more independent by practicing these skills at home without their therapist's support.

Although therapy was found to benefit participants in a number of ways, the recognition that their lives were 'still not perfect' was expressed. There were still things they 'felt unable to do' following therapy, but participants' reported feeling prepared, and 'more able to cope' than prior to receiving therapy. They also discussed how the benefits of therapy would continue despite their sessions coming to an end.

Methodological Limitations

The present study was limited to a small number of participants treated at a single service, and only those who found therapy to be effective were included in the study. Smith and Osborn (2008) have argued that IPA is not opposed to more general claims for larger populations, but is ''committed to the painstaking analysis of cases rather than jumping to generalizations'' (p. 54). They further argue that while generalizable claims regarding a sample in a single IPA study is not possible, as more studies with other samples are carried out with similar findings, more general claims would become possible. Conducting a similar investigation within a different PTSD service, or preferably a variety of services would therefore be beneficial and contribute to potential generalisabilty. It would also be interesting to look at samples of differing age ranges as most participants within this study were in the older age range.

Future studies recruiting service-users who dropped out of therapy, or who did not find it to be effective, could provide particularly valuable insights into the factors which make Trauma-Focused-CBT difficult for some service-users. In particular, it would be interesting to explore such person's experience of personal agency and involvement over the course of therapy, in order to determine if this is a particular difficulty which hinders a successful outcome.

Conclusion

This study contributes towards a clearer understanding of the aspects of the Trauma-Focused-CBT process that service-users found important in contributing to their improvement. In particular, it highlights the central role that participants attributed to their own involvement in the therapeutic process and how much they valued this. It

highlights the value of an in-depth analysis of participants' experiences of therapy, which can complement information provided by brief satisfaction questionnaires. It also confirms that for this particular group of individuals, receiving Trauma-focused-CBT was found to have a positive impact on their lives in many ways.

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