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Research Article

An Exploration of Forensic Patient's Perspectives of the Impact of Psycho-education

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Abstract

Introduction: Clinicians working in forensic services are eager to explore benefits of psychological interventions as part of the patient's recovery journey.

Aim: To capture patient's perspectives of personal change through use of a psycho-education programme.

Design: A purposive sample of (n = 20) participants were selected from two secure forensic units during the final year of a Randomised Controlled Trial. Structured interviews were completed using Repertory Grid.

Results: Significant differences were apparent in three areas: have confidence to engage in groups, ($z = -2.203$, $N = 18$, $p < .05$); understand my own illness and how it affects me, ($z = -2.203$, $N = 18$, $p < .05$) and feel normal, ($z = -1.997$, $N = 18$, $p < .05$). Themes emerging from field notes focussed on participant's desire to 'feel normal'. Feeling normal being closely correlated with feeling valued, having hope, feeling confident, understanding your illness and realising others have the same problems.

Conclusions: Patient's perceptions highlighted importance of feeling normal as part of their recovery journey.

Keywords: *Personal Construct Psychology; Repertory Grid; Psychosis; Forensic; Psycho-education Psychosocial Interventions*

Background

High ideals such as recovery are driving continuing innovation in forensic care [1]. Yet there is much less evidence to support the value or applicability of the recovery approach in specialist mental health services [2]. Despite this, clinical practice is being guided in the direction of enabling people to recover as opposed to having them rehabilitated, one of the key objectives is to prevent relapse [3]. Preventing relapse presents a challenge, since about three quarters of people who meet the diagnostic criteria for schizophrenia will experience a relapse [4]. The suggestion is that psycho-education can contribute to relapse prevention [5], through improving understanding of the association between illness and re-offending.

It is recommended that psycho-education is delivered during the stabilisation phase of a patient's recovery [6]. While some forensic patients may never be entirely symptom free during this phase and continue to present with psychotic symptoms, some have still shown an ability to engage in the psycho-education programmes [7] and demonstrate some benefit. These benefits include: improved knowledge [8,9]; improved self-esteem [10]; reduced relapse and length of hospital stay, readmission and encourage medication compliance [11].

These findings are of interest and important clinically, but with a collaborative, recovery focussed approach, it is crucial that the patient perception is presented.

The patient perspective is considered particularly valuable to clinicians and researchers, especially where there is limited rigorous clinical evidence, as in the forensic context [12-14]. Sibitz., *et al*. [13] found that receiving and exchanging information with peers was seen to be essential by people diagnosed with schizophrenia and a focus on changes relating to quality of life rather than over-emphasis on improving symptoms was preferred.

Forensic mental health patients generally have complex needs [15]. A recent study described the Scottish High Secure population as having a mean age of 38, range 20 - 66, 85% with a diagnosis of schizophrenia, 23% with a secondary diagnosis of personality disorder and 64% with a record of drug or alcohol misuse [16]. They are reputedly difficult to engage and often do not want to be seen to be conforming with staff because they have a reputation to uphold.

The aim of this project was to capture patient's perspectives of personal change following attendance at a psycho-education group (Coping With Mental Illness – see Box 1), designed for delivery in forensic settings.

Module1 Foundation, includes:
Session 1: Introduction to the Programme;
Session 2: Understanding mental illness and personality disorder;
Session 3: Stigma and Myths;
Session 4: Looking at 'symptoms' of psychosis;
Session 5: What's caused *my illness*? and how the brain works;
Session 6: Reflecting on the 'symptoms' of psychosis;
Session 7: Looking at mood difficulties;
Session 8: Reflecting on mood difficulties;
Session 9: Anxiety, and
Session 10: Post Traumatic Stress Disorder (PTSD).
Module 2 The Legal System, includes:
Session 11: Risk assessment and planning;
Session 12: Legal issues around admission;
Session 13: Legal issues around discharge and appeal, and
Session 14: Coping with assessment for moving on.
Module 3 Coping Skills and Recovery, includes:
Session 15: Coping with 'highly charged' atmospheres;
Session 16: Looking at treatment;
Session 17: Relapse and 'early warning' signs;
Session 18: Problem-solving;
Session 19: Difficulties relating to people;
Session 20: Recovery;
Session 21: Families and mental illness, and
Session 22: Reflecting on living with schizophrenia.
The programme was devised in 1998 through collaboration with patients in a high secure setting discussing what they felt they needed to understand [8]. It incorporates elements of the group psycho-education programme devised by Atkinson., *et al*. [17] for people with psychosis and was influenced by encounters with the "Hearing Voices" philosophy. The philosophy the programme mimics is that of the Early Psychosis Prevention and Intervention Centre [EPPIC] programme [18]. It includes elements of cognitive therapy such as the stress-vulnerability model of psychosis [19]. The programme comprises of three modules: Foundation; Legal system and Coping skills and Recovery.

Box 1: *Outline of the Coping with Mental Illness programme.*

The null hypothesis is

- there will be no difference in the forensic patient's impression of why things might change following attendance at the Coping With Mental Illness group.

Method

Procedure

A Randomised Controlled Trial (RCT) was undertaken over forty-two months, across four forensic mental health sites in Central Scotland, including one High secure, two Medium secure and one Low secure service. A battery of psychometric assessments was under-

taken at baseline, post intervention and at six month follow up with the experimental group and waiting list control group. The outcome measure for insight was the Schedule for Assessment of Insight [SAI] David [20]. Forensic Assessment of Knowledge Tool [FAKT] was developed to measure patient understanding of symptoms, management of illness and legal issues using semi-structured questionnaire [8]. The Positive and Negative Syndrome Scale (PANSS) [21] was used to measure mental state. The Calgary Depression Scale for Schizophrenia (CDSS) [22] measured depression. The Schizophrenia Quality of Life Scale Revision 4 (SQLS-R4) [23] assessed quality of life and Behaviour Status Index [BEST-Index] [24] measured social behaviour. Basic demographic details were gathered to supplement these data. Findings from these assessments are reported elsewhere [9]. Repertory Grid was also used but only during the final year of the study. Its use was designed to assist understanding and explore personal meanings which underpin any change in the following areas: hope to move on; have confidence to engage in groups; understand my illness and how it affects me; realise others have the same problems; realise I'm a valuable person in society; have control over my illness and feel normal.

There are many ways to gather patient perspectives, for example via interviews, focus groups or questionnaires [25]. One of the well-established methods in forensic services is Repertory Grid. Repertory Grid technique has been used to gain information from people in relation to how they make sense of any specific subject. This technique was originally created in order to support Personal Construct Theory [26] and enables a researcher to capture how people make sense of the world around them. Personal construct psychology (PCP) describes the way in which Personal Construct Theory applies to an individual. PCP is based on the following underlying principles: people are active in the world and not passive recipients of events going on around them; the explanation for any individual's behaviour lies within that individual and change is always possible – no one is the victim of their own history. The four key concepts which are important in understanding PCP are: the process of construing, people as 'active scientists', constructive alternativism and PCP as a universal theory [27].

Repertory Grid has been described by Bell [28] as: 'a measurement device that has a solid conceptual basis for its structure; it provides a succinct representation of the way a person construes his world or some aspect of it; it is flexible in allowing for both individualised and normative kinds of assessments; it can be applied on an almost limitless range of contexts, and it can be used to promote many different kinds of information'. It is thought that this unique blend of projective and objective testing has made Repertory Grid technique useful to clinicians and researchers keen to understand how different individuals and groups organise their views of themselves and the world [29,30]. Repertory Grid has been subject to tests for reliability and validity, earlier findings report test-retest reliability in one hour = 0.95; one week = 0.95; 1 month = 0.94 [31].

Beail [32] suggests Repertory Grid should not be seen as a standardised test, rather as a technique where the procedure is flexible, with a diversity of options about form and application. Neimeyer and Bridges [33] and Bell [34] explain why the Repertory Grid is considered unique, in that it combines aspects of both idiographic assessment and nomothetic research by enabling the researcher to uncover unique dimensions of an individual's outlook (idiographic) or alternatively to search for general patterns across individuals (nomothetic). It differs from questionnaires because the participant does not simply answer standardised questions, instead he/she is guided to construe his/her own questionnaire by eliciting the individual's own constructs and relevant elements to rate, while permitting comparisons across different people or groups [30].

The Repertory Grid was completed at baseline and post intervention. The Chief Investigator (CI) (HW) undertook all interviews and completed the Grid out of sight of the participant in order not to influence the scores; all participants were aware of this procedure on commencement of the study. The Repertory Grid is enclosed in Table 1, elements lie along the top of the Grid and constructs run down each side. The elements were selected by the CI and supervisor - in keeping with recognised methodology [35] - and the constructs developed through discussion with former attendees of the Coping With Mental Illness (CWMI) group programme. Participants who assisted with the development of the Grid were not part of the RCT but had formerly attended the group.

A (1)	How I was 10 years ago, (past self)	How I am now (actual self)	How I am as a learner now	How someone who has faith in me sees me	How my Doctor sees me now	How someone I admire sees me now	How a person I don't like sees me now	How another patient sees me (learner)	How I would like to be (ideal self) in the future	How I expect to be (expected self) in the future	B (7)
Have hope to move on											Have no sense of hope to move on
Have confidence to engage in groups											Negative feelings about groups
Understand my own illness and how it affects me											Have no understanding of what illness is all about
Don't realise others have the same problems											Realise that others have the same problems
Realise I am a valuable person in society											Think I am worthless
Have little or no control over how I think and feel											Have control of my illness
Feel normal											Don't feel normal

Table 1: *Repertory Grid.*

Selection of elements: This relates to the questions the Repertory Grid intends to address. The ten elements selected were designed to enable the potential participant to consider his/her response from how he/ she felt historically, for example, 10 years ago (past self), currently (self now and self as a learner) and in the future (ideal self and expected self). Other elements were created to enable the participant to think of himself/herself as others see him/her, for example, from the view point of someone he/she admired, someone who has faith in him/her and someone he/she disliked, also from a fellow learner's view and from his/her doctors view (Box 1). A conscious effort was made to ensure that elements did not overlap or contain one another and that they were concrete and discrete. In addition to this the element set was designed to be homogeneous, that is, each element carried the same 'weight' and had the same right to be in the element set [36].

Gathering of constructs: Constructs are the templates by which a person comes to know and anticipate their personal world [26]. It is by means of personal constructs that individuals anticipate the outcome of a particular event. It is through experience that constructs develop, but they are also tested, confirmed or disconfirmed, and revised as a result of experience [26]. A decision was made to supply the majority of constructs (7) and elicit an additional few (3), this was in order that comparisons could be made across data generated from the entire sample, whilst still allowing for unique individual contributions. The topic of 'supplied' or 'elicited' constructs making a difference is a much debated issue and the literature on the subject has developed over the years. The traditional method was to elicit constructs and there is evidence to show that elicited constructs produce more differentiation or cognitive complexity [37]. Bonarius [38] supports this, claiming that people give more extreme ratings on constructs elicited from them than on supplied constructs (the assumption being, that the more extreme rating, the more meaningful the construct). More recently Adams- Webber [39] found that people could more easily make inferences about another person on constructs that had been supplied, but ease of use depends on the skills of the designer in providing meaningful constructs. Neimeyer and Leso [40] do concede that it may just be that the difference, when found, between elicited and supplied constructs stems from the fact that the interviewee has been asked to construe his or her own construing processes during the elicitation process, and so is more sure about them than when faced with the constructs 'cold', so to speak.

Constructs were drawn from open ended discussions with the patients, where they were asked to firstly consider what were the key features of this psycho-education group and what they thought other people (fellow patients) might get from their participation in such a group. Thoughts focussed on being hopeful, confident, knowledgeable, understanding, valuable, in control and self aware. Discussions then centred on exploring the bi-polar nature of each area the patient had focussed on. For example, when 'hopeful' was mentioned patients were asked 'what is the opposite of this in your own words and how can this be worded in relation to what people take from the group?', until eventually seven bi-polar constructs were created that all patients agreed on: (1) have hope to move on versus (vs.) have no sense of hope to move on (2) have confidence to engage in groups vs. have negative feelings towards groups (3) understand my own illness and how it affects me vs. have no understand my own illness and how it affects me (4) realise others have the same problems vs. do not realise others have the same problems (5) realise I am a valuable person in society vs. think I am worthless (6) have control over my illness vs. have little or no control over how I think and feel (7) feel normal vs. don't feel normal.

Repertory Grids are commonly reported to have ten elements and ten constructs [35]. With seven 'supplied' constructs, this allowed a degree of freedom for participants to 'elicit' three further unique personal constructs as part of the interview process. A seven point scale was used to score responses on the Repertory Grid, using the poles of elicited constructs as anchors for discrimination. This is a commonly used length of scale and is useful because it gives a mid-point [35].

Participants

The sample comprised of all male inpatients between the ages of 18 - 65. All were Mentally Disordered Offenders with a diagnosis of F20-29 schizophrenia, schizotypal, or delusional disorder International Classification of Diseases-10 [41]. Patients were residing at either the High secure unit (The State Hospital) or the Medium secure unit (Orchard Clinic). All patients were able to take part in the CWMI

education programme, for the duration of 11 weeks. The High secure unit is all male and Medium secure predominantly male hence the selection criteria based on gender was appropriate. Patients were excluded if they had a primary diagnosis of Learning Disability or were too unwell to take part, as decided by the Responsible Medical Officer /Consultant Psychiatrist, using their clinical judgement.

Sample selection

Although participants were randomly selected for inclusion in the wider RCT, they were purposively selected for inclusion in providing patient perception. A purposive sample was obtained by approaching all Responsible Medical Officers (RMO)/Consultant Psychiatrists (across two sites) who had patients referred to the Coping with Mental Illness group. Patients who were drawn from The State Hospital sample were due to be included in the final two groups of the RCT and the final group at Orchard Clinic, during the data collection phase (between 2011 and 2012). RMOs were asked to recommend participants for this additional stage of the study. Each were advised of the criteria for inclusion into this element of the study and that participants were already involved in data collection which included completion of a significant number of psychometric tests as outlined earlier. This stage involved further discussion as part of a structured interview and completion of a Repertory Grid. All RMOs were given written information on the study and asked if the Chief Investigator (CI) could approach their patients for consent. The CI then asked RMOs to select a number of patients for inclusion in the project. RMOs were also required to sign a consent form allowing the CI to approach their patients.

Ethical considerations

Ethical approval was gained through the Integrated Research Application System (IRAS). One of the key considerations was whether participants were willing to complete all psychometric tests and the Repertory Grid, without feeling obliged. Prior to engaging in the project, all participants were approached by the CI and asked if they would like to participate in the study. They were issued with an information sheet detailing the purpose and process, they were also asked to sign a consent form. Everyone approached was advised that their care would not be affected whether they did or did not take part and had seven days to consider this. Participants were reassured that the Chief Investigator (who undertook the interviews) and PhD supervisors were the only people who had access to the data. Following interviews the interviews were transcribed by the CI and data were stored securely in locked units. Participants were allocated a unique identifier to protect their anonymity.

Statistical analysis

The end-product of the Repertory Grid procedure was a matrix of numbers and field notes from the discussions with participants. The data in the Repertory Grid define the relationship between elements and constructs as set out in Kelly's [26] fundamental postulate that, a person's processes are psychologically channelized by the ways in which he interprets events. Results of Repertory Grid can be interpreted at two basic levels, focussing on the content and structure of the participant's constructions [42]. At the content level, grids can be analysed in a qualitative way by considering the unique constructions of specific figures on the grid and the idiographic meanings of particular constructs [31]. At the structural level the focus is on specific relationships between given constructs and between certain elements, the overall degree of differentiation or complexity within the participant's construct system and many other features through use of computerised grid scoring programmes [35].

Gridsuite [43,44] was the specialised computer programme used and was designed to examine individual participant's scores using Principal Component Analysis, thus capturing the relationship between elements and constructs. This element of the analysis is not reported here.

Gridsuite was limited to comparisons of individual baseline and post intervention scores (idiographic assessment) and was not able to undertake analysis for wider group comparison (nomothetic assessment), thus additional analysis was necessary using SPSS Version

19 [45]. Treatment effect was measured as the difference in post-treatment means, adjusted for any difference in pre-treatment means. Ordinal data was generated from the Grid. Wilcoxons Signed Ranked Test was used to explore differences in group scores relating to how the participants felt: now at baseline and post group and now vs. the future at baseline and post group, in relation to each construct [46].

In the Grid, all patients rated on a seven-point scale (1-7) on seven supplied constructs [39] and some added up to a further three elicited constructs. All scores from the Repertory Grid were entered into SPSS Version 19 (SPSS Inc., 2012). Scores of 1-7 on the Repertory Grid were denoted as the following: 1= strongly agree, 2 = agree mostly, 3 = agree a little, 4 = unsure, 5 = disagree a little, 6 = disagree mostly and 7= strongly disagree.

Results

Results are presented for eighteen of twenty selected. Two participants terminated the interview early due to difficulties incurred completing the Repertory Grid, there were no difference in their demographic characteristics by comparison to the wider group. The majority (n = 16) were single, Caucasian (n = 17) and had poor employment history prior to entering the forensic services. Although all were educated in mainstream schools, few (n = 3) completed their schooling with higher level results. Many reported low attendance throughout their school years.

No scores reached a significant level when exploring how participants feel (now) at baseline and post group. There is however an indication that something may have changed because they are very close to reaching a significant difference in relation to hope to move on ($z = -1.930$, $n = 18$, $p = .054$), being a valuable person ($z = -1.887$, $n = 18$, $p = .059$) and feeling normal ($z = -1.917$, $n = 18$, $p = .055$). Due to these findings, the null hypothesis indicating there will be no difference in the patient's impression of why things might change following attendance at the Coping with Mental Illness group can be accepted.

Analysis of how participants feel now versus how they expect to feel in the future revealed a number of statistically significant differences at the baseline stage where participants seemed very positive in relation to the following: have hope to move on ($z = -2.241$, $n = 18$, $p < .05$); have confidence to engage in groups, ($z = -2.437$, $n = 18$, $p < .05$); understand my own illness and how it affects me ($z = -2.831$, $n = 18$, $p < .001$); realise I am a valuable person in society, ($z = -3.346$, $n = 18$, $p < .01$); have control over how I think and feel, ($z = -2.831$, $n = 18$, $p < .01$) and feel normal, ($z = -2.930$, $n = 18$, $p < .01$).

Perception at post group stage was perhaps more tempered and realistic revealing significant differences in three areas: have confidence to engage in groups, ($z = -2.203$, $n = 18$, $p < .05$); understand my own illness and how it affects me, ($z = -2.203$, $n = 18$, $p < .05$) and feel normal, ($z = -1.997$, $n = 18$, $p < .05$). Realistic expectations are actively encouraged within the group, although a balance has to be reached between realism and maintaining hope. There is evidence here that hope to move on is no longer significant post group, ($z = -.172$, $n = 18$, $p = .863$).

Another finding that emerged was the use of extreme scores, for example, scoring number one across the majority of the grid, making the Grid lopsided. This was evident in instances where the participant seemed particularly eager to show themselves in a positive light. In the four cases (22%) where this occurred (case 7,11, 15 and 18) neither participant was able to think of a person they did not like - because they 'liked everyone' in society and 'couldn't think of a soul I don't like', all felt this element was not applicable. They were all very keen to indicate that 'everything was going well' for them and all shared the view that there was 'absolutely no need for them to be in a secure setting'.

Correlations between elements and constructs were also explored, key findings are highlighted in Table 2. The themes emerging from the Repertory Grid particularly focussed on the participant's desire to 'feel normal'. Feeling normal being closely correlated with feeling

valued (r = .735, n = 18, p = .01), having hope (r = .589, n = 18, p = .01), feeling confident (r = .542, n = 18, p = .05), understanding your illness (r = .455, n = 18, p = .05) and realising others have the same problems (r = .480, n = 18, p = .05).

Variable	Construct	Spearmans Rho	Level of significance	Number of participants
Self now	Feel normal vs Feel valued	.735	.000 Significant at .01 level (2-tailed)	18
	Feel normal vs Hope	.589	.005 Significant at .01 level (2-tailed)	18
	Feel normal vs Confident	.542	.011 Significant at .05 level (2-tailed)	18
	Feel normal vs Understand illness	.455	.038 Significant at .05 level (2-tailed)	18
	Feel normal vs Realise other have same problems	.480	.028 Significant at .05 level (2-tailed)	18
	Hope vs understand illness	.492	.023 Significant at .05 level (2-tailed)	18
	Hope vs Confidence	.504	.020 Significant at .05 level (2-tailed)	18

Table 2: *Correlations within group post intervention.*

Qualitative data gathered from interview

In addition to quantitative data Repertory Grid captures individual's thoughts through the interview process. A few opposing opinions are offered below, both of which centre on the issue of hope to move on. A few participants (case 01 and 03) noted 'one of the main things that holds you together, is the hope that one day you'll get out of here'. The expressed desired to move on was emphasised repeatedly by the high secure care sample of participants during interviews with the CI as part of the Repertory Grid feedback process. One participant (case 04) quoted 'if you lose hope you lose everything'. Yet not all participants shared this level of positivity. One participant from the high secure service had a very negative attitude prior to attending the psycho-education group (case 16) stating 'there's no point in thinking' you're gonnae get out o' this joint any time soon, so ah might as well just get used to it'….'what's the use of hoping, you'll just be disappointed'. There was only evidence of a marginal shift of thinking post intervention, where he acknowledged that 'you see some folk moving on, but only after a long stretch'.

In addition to maintaining a degree of hope, the desire to 'feel normal' and 'get back to normal' seemed to be a motivating factor associated with attending the group. A number of patients reflected on this during discussions with the CI (case 02, 09, 11).

Discussion

Blagden., *et al*. [29] do believe that Repertory Grids have the potential to be hugely beneficial in forensic settings as the position is concerned with the individual, constructs and elements are elicited from them and by them. In addition, the approach can aid in identify-

ing, exploring and formulating issues relevant to an offender's offending behaviour and idiosyncratic beliefs [47,48]. The clinician may be working with offenders who are resistant to change and those for whom either a lack of, or a preoccupation with, guilt, is a major issue in therapy [27]. This perhaps explains why there is a limited amount of personal construct work currently applied in forensic settings.

Normalisation is one of the key features inherent throughout the CWMI psycho-education programme and discussed from the early sessions. Perhaps the desire to be 'normal' links to participants' desire to be more socially acceptable thus less of a risk and less of a threat to others, consequently more ready to re-integrate into society. This fits in with the Sociality Corollary, which states the extent that one person construes the construction processes of another may play a role in the social process involving the other person [26].

Williams., *et al*. [49] published a study on the experiences of stigma and discrimination as described by predominantly black and minority ethnic group (BME) in a high security service via a slow-open therapy group. One of the points authors noted as a limitation was that stigma and discrimination are difficult concepts to hold in mind and therefore access, yet their effects can be so all encompassing for patients that in high security hope is hard to sustain. There is evidence of this sentiment reflected by a minority of participants in the current study.

Carroll., *et al*. [50] found that awareness of illness was positively correlated with level of hopelessness. A higher level of awareness of having a mental illness was associated with feeling more hopeless about the future. Despite the lack of significance in relation to these constructs using the Wilcoxon's t test, there certainly does appear to be a modest correlation between 'hope to move on' and 'understanding illness and how it affects you', ($r = .492$, $n = 18$, $p = .023$) at baseline and this correlation strengthens post group ($r = .899$, $n = 18$, $p = .005$), correlation is significant at the 0.01 level (2-tailed). We could conclude that hope to move on is not lost, but perhaps better understood.

Hope is consistently identified as important in recovery [51], and was rated highly in a recent review of Mentally Disordered Offender's opinion in a Medium Secure service in England [52]. One of the key outcomes of a forensic psycho-education project undertaken in Finland [10] was improved knowledge, quality of life, self-esteem and hope. The findings from that study stress the importance of hope and trust at different stages of the process, for example, in the development and delivery of the intervention. This can in turn help forensic patients with schizophrenia to gain information, build their self-esteem and even improve their insight. In the current trial 'hope to move on' versus 'no hope to move on' was one of the constructs supplied to participants in the Repertory Grid. Pre-group comparison between how participants viewed hope to move on (now) versus how they expected to feel in the future generated a significantly different score, yet when the same analysis was carried out post group there was no significant difference in relation to hope.

A small proportion ($n = 2$) of the participants did find the Repertory Grid challenging, and were quite confused particularly when the scores were reversed. The earlier suggestion was that difficulties arose due to the Repertory Grid being out with the participants' frame of reference. It could also be the case that the participants had reached their core constructs, thus they had nowhere to go, which is an issue that sometimes occurs through use of the Repertory Grid [35]. Another suggestion is that people suffering from a psychotic illness have defects of cognitive functions such as general intellectual capacities [53] which may have been the reason for their inability to complete the task. Arguably results of the magnitude of intellectual deficit in patients with psychosis do not show a clear pattern [54], so this could well be speculative. Another suggestion for poorer performance and clouded thinking is the use of anti-psychotic medication [55]. Whilst acknowledging these issues could make the use of such an assessment tool more difficult than the average interview, there are many other potential explanations for drop-out, such as, a disinclination to complete or dislike of the assessment.

Adams-Webber [56] have demonstrated repeatedly that people assign the positive constructs of the pole to about 62% of the events they rate / people they name, this is now known as the Golden Section hypothesis. Results here were clearly in excess of this expected fig-

ure. Several studies have shown that the 62% of judgements of others being assigned to 'like self' poles of constructs can be altered if the person is role playing- for example, 'being stoned' [57] or being a serious failure rather than highly successful [58]. These findings relate to the Choice Corollary which suggests we choose the pole of a construct which is likely to lead to the greater extension and definition of our construing system [35]. It would be expected that we naturally extend and define through the positive aspects of ourselves rather than the negative ones.

Working clinically with the PCP approach with offenders involves trying to understand how the client's unique view of the world contributes to the development and maintenance of their offending behaviour [27]. The clinician using the PCP approach with offenders does not condone the client's behaviour, but assumes that understanding the perspective on this is a prerequisite to setting realistic goals for change. The approach requires specific techniques for assessing construing and suggests means of therapeutic change. However, in keeping with the theory itself, working with a PCP perspective does not necessarily involve one specific way of working. It is more an approach to understanding people and seeing the world from their perspective. PCP can either be used alone or as complementary to other therapeutic interventions, as 'one tool in an armoury of possibilities' [59,60]. Today there is limited reported use of PCP across forensic services offering a real opportunity to formally explore its use in this unique clinical context.

Strengths and limitations

The use of Repertory Grid has enhanced the information gathered from the RCT offering a rare insight into the patient experience and substantiating the findings drawn from the range of psychometric assessments. The use of supplied grids created by former participants worked well and majority of the participants were clearly able to relate to the constructs presented before them, indeed many made comment about their relevance. In relation to the issue of relevance of supplied grids, the literature does imply there is little difference between traditional research methods using questionnaire and the use of supplied Repertory Grids [61-65], because both implicitly assume respondents construe the material present in a similar fashion. Findings from a small scale sample such as this do tend to limit the generalisability to the wider population, so it must be acknowledged that these results may not be typical of all Mentally Disordered Offenders. While purposive sampling is appropriate it is less objective than random sampling and could result in biased results. Researchers and clinicians must err on the cautious side when interpreting results due to the tendency for self-report to produce a favourable and sometimes skewed picture. Given the sample size this can have an impact on the findings. Evidence suggests that clinical stability allows patients to benefit from psycho-education groups [4,6,10]. However, patients take part in psycho-education programmes whilst they are in a psychiatric hospital, at a time when their mental health may lack such stability [13] which may affect perceptions of the interventions and undermine the therapeutic intent.

Conclusions

The use of Repertory Grid to capture therapeutic change through patient perspective is quite unique and worthy of further exploration. There was a demonstrable change in how patient's viewed themselves in the foreseeable future as a consequence of completing the psycho-education programme, but change did not quite reach significance when exploring how participants felt in the 'here and now' on baseline versus post intervention. Recovery seems to be closely aligned to feeling normal and remaining hopeful. Findings emerging from the Repertory Grid particularly focussed on the participants' desire to 'feel normal'. Feeling normal being closely correlated with feeling valued, having hope, feeling confident, understanding your illness and realising others have the same problems.

Implications for practice

Repertory Grid has generated a unique and valuable insight into life world of Mentally Disordered Offenders. The technique itself could be used in a variety of different clinical or educational situations to enable people to gain a better understanding of particular initiatives.

It is recommended for use in the evaluation of psycho-education programmes.

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